A Study of the Incidence of Post-traumatic Stress Disorder (PTSD) among Emergency Relief Workers in Selected International Organizations

Prevailing Conditions, Policies and Attitudes to Stress-related Illnesses in Relief Organizations

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Alison Mary Small

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ABSTRACT

The staff of United Nations and non-governmental organisations (NGOs) are frequently at the forefront of emergency relief efforts. Such staff, including consultants, often work long hours, are sent at short notice to assignments in the field and often constitute the frontline of assistance in relief work. In the process of providing help to the victims of emergencies, relief workers may themselves be affected by the stress resulting from working in highly emotionally and physically charged situations.

Since 1980, Post-traumatic Stress Disorder was officially recognised as a disorder by the American Psychiatric Association which may affect those who have been exposed and or experienced repeated exposure to large-scale disasters and emergencies, in particular. Given the multiple stresses involved in providing emergency relief, it is possible that relief workers may be vulnerable to developing PTSD and or other severe stress-related conditions. This study seeks to determine, from among the staff of several UN agencies and NGOs active in this area, the incidence of PTSD.

The study also considers how the attitudes, policies and conditions extant in these organisations may exacerbate or alleviate the development of PTSD and provides suggestions, through a review of literature on the subject, on measures which can be taken by these organisations to prevent, minimize or at the very least address the problem.

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CHAPTER I. INTRODUCTION

Context and aims of the study

As international emergencies increase[1], and humanitarian relief efforts attempt to keep up with the need to provide emergency assistance on a wide scale, pressure grows on relief workers to provide timely and effective assistance. International organizations responsible for organizing the relief effort and fielding staff to areas where disasters have occurred and or emergencies are ongoing are under pressure to, inter alia, take action swiftly, find the necessary resources to finance the relief effort and frequently to work with governments and other authorities or institutions (for example inter-governmental organizations (IGOs), representatives of non-governmental organizations (NGOs)) whose priorities and needs may be highly specific. This may necessitate complex negotiation and planning within a limited and pressurized timeframe.

Staff of the relief agencies who are sent to work in disaster or emergency relief may represent the frontline of the intervention while others may be called in at a later stage following the initial impact. In both cases, physical and emotional conditions are difficult and demanding, and the pressures and responsibilities under which such staff work can prove overwhelming. Often, however, the health, wellbeing and even personal security of emergency relief staff appear to be overlooked, or at least, issues of last resort for the employing organizations. The assumption appears to be that if someone has volunteered or is working-in emergency and humanitarian relief, they must be physically and mentally prepared for the demands of the job. This may be the case, however, what of the effect over time, on even the strongest? And what of the situation of those who may not have what it takes?

Given the important role that emergency workers (both international and nationally-recruited staff) play and will continue to play in emergency relief, this study aims to consider firstly the incidence (if any) of one possible manifestation of exposure

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[1] The study recognises the difference between disasters (natural and man-made), which may signal the start of an emergency, and emergencies which may be distinguished by their scale and complexity, generally necessitating both short and long-term humanitarian assistance as well as other forms of aid and assistance.

to severe trauma which might be supposed to exist among emergency relief staff – that of Post-traumatic Stress Disorder (PTSD). Secondly, within the context of examining the incidence of PTSD, and other stress-related problems, to consider the prevailing attitudes, policies and strategies prevailing among select IGOs and NGOs. Third and finally, to review some of the literature on approaches to prevention and treatment of PTSD which may assist in preventing other stress-related conditions and to improving the situation of staff working for relief organizations.

CHAPTER II. BACKGROUND

What does emergency relief work entail?

There are various levels of emergency work from the first-to-the-emergency, frontline operational assistance to more managerial and logistical work associated with organizing relief efforts both at the site of the emergency and at Headquarters. This study primarily considers the effects of emergency relief operations on those who are involved in working with and or organizing the relief effort either at the emergency site or from the field office responsible for operations. In general it does not include the body of staff who are responsible for logistics and personnel at Headquarters except as they may have been moved back to Headquarters following service in the field or are involved in emergencies which directly affect the Headquarters staff themselves (an example of the latter being the effect of the Kosovo plane crash on Headquarters staff of the World Food Programme (WFP), see Chapter V below).

Emergency relief work can involve working directly with the injured, including the traumatized and severely traumatized and in assisting the sick and or famine and drought stricken, by providing medical and or food aid, shelter and services such as sanitation and transport. It may also involve assisting people – often large groups of people to move from one area, or means of transport to another, and or in helping the primary victims of emergencies to adapt to changed conditions in their own environments. It may also involve body handling, identification and burial, clearing physical wreckage and debris, and working with local institutions to arrange logistical and basic goods and services needed by direct victims and others in affected communities.

While many of the tasks involved in emergency relief involve helping the primary victims of a disaster, there are also a wide variety of jobs which involve emergency relief personnel after the immediate disaster has finished but the period of emergency continues. For example, the disaster provoking major refugee movements, like civil conflict and or famine or drought, may be relieved by large amounts of food and other aid provision, nevertheless, the refugee groups may need to be housed for

lengthy periods in camps where conditions are rudimentary at best. Alternatively, communities hit by flooding, earthquakes, chemical spills etc may also require long-term assistance in reconstruction and rehabilitation of the community. Emergency relief workers, may be involved in these later stages of emergency assistance where many of the initial heavy impact sights and sounds of the disaster have finished but the resultant individual/family/community disruption may require long-term assistance from trained relief workers[2] and other staff of relief organizations.

Consequently, those involved in relief work may also include, officers posted to monitor the situation and report back to headquarters, logistics and communication experts who report back on stocks, supplies etc, assistants to professionally-trained officers (such as volunteers, trainees, administrative personnel) as well as policy advisers, planners and even members of the media (many organizations for example have in-house journalists whom they send to cover relief missions). For the purposes of this study, all those involved in field work at whatever level are included in the term relief workers (sometimes also referred to as humanitarian workers), since the experience alone of working abroad under emergency conditions may qualify as a significant stressor and could have potential impacts on staff.

Particular demands of the job - stressors

Emergency work is by its nature stressful. It places both victims and relief workers (themselves potentially victims) in both physical and psychological situations which are beyond routine experience. The scale and suddeness of disasters and the emergencies which often result following a disaster are in themselves potentially traumatic. Similarly, the hasty and often ad hoc nature of the relief effort which may require working under time constraints, frequently in conditions of physical discomfort, over long hours and amidst scenes of death, sickness, destruction and human misery, must in themselves be considered stressors. Even the toughest individuals are liable to experience fatigue, tension, disillusion, frustration, etc especially in the face of poor

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[2] I use the term trained relief workers in reality, however, there are many situations where new recruits may be learning by doing which carries its own risks. With the exception of medical and nutrition personnel and logistics experts, there are many instances of generalists being employed with little skills' or previous field experience.

organization and administration of the relief effort.

Other more subtle factors which may act as stressors are for example, job insecurity among staff who have been recruited on temporary or fixed term contracts, lack of sufficient training or adequate preparation for the conditions that will be met and the requirements of the job to be done, as well as the time constraints resulting from limited time to prepare for assignments, and working under pressure during the field operation.

Finally, personal problems may also act as stressors when relief workers are concerned about the wellbeing of their spouses, families and or their own emotional and or physical wellbeing.

Post-traumatic Stress Disorder (PTSD) and emergency relief workers

As the incidence of large-scale disasters has risen in the last 20 years, so too has the pressure on relief workers. Much of the responsibility for emergency relief has fallen to staff and consultants employed by non-governmental organizations (NGOs) and, to a lesser extent in terms of immediate frontline relief, to employees of United Nations agencies.

A recent study conducted by the World Health Organization (WHO)[3] concluded that since 1980 there have been an estimated 130 conflicts around the world, involving over 100 million people in that year alone. By 1991, that figure had reached 310 million people involved in civil conflicts. In the five years 1990 to 1995, 93 wars resulted in the deaths of over 5.5 million individuals.

To cope with the enormous scale of humanitarian relief required, NGOs and UN agencies have been under pressure to provide staff, mostly at short notice, to work in relief operations. At the same time, the nature of relief has also changed and most relief efforts are now directed at what are known as 'complex emergencies'. According to WHO, the term reflects

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[3] *Occupational Health of Field Personnel in Complex Emergencies: Report of a Pilot Study* (1998) WHO, Geneva, Switzerland, p.5.

"the changing form and nature of national and international conflict, and the fact that recent wars have increasingly targeted civilian populations and sought to cause civilian casualties. They have been more apparently associated with human rights abuse, and have forced the displacement of more people than ever before....The deliberate use of food as a weapon of war has also led to severe famines and food shortages in many locations. The fact that the duration of conflicts also appears to have grown, has meant a perceptible increase in the length of time people remain at risk."[4]

In addition to complex emergencies, natural disasters are also occuring at a level which is frequently beyond the ability of individual governments, especially in developing countries, to provide an effective relief effort without the assistance of external aid resources, including externally-recruited relief workers. According to a report produced by IFAD (1999)[5], "natural disasters alone increased from 16 in the 1960s, 29 in the 1970s, to 68 in the 1980s. The accompanying economic losses escalated from US$ 10 billion in the 1960s ....to US$ 93 billion in the 1980s."

Such phenomena as *El Nino*[6] and other climatic and natural disasters have resulted in the deaths and injury of hundreds of thousands of people. These include in the last three years alone, the 2001 earthquake in El Salvador, the 1999 earthquake in Turkey which resulted in thousands of deaths, recurrent droughts in large parts of sub-Saharan Africa resulting in famine and the outbreak of disease affecting whole communities and populations, and the effects of cyclones and flooding in Central and Latin America. These disasters, which often become large-scale emergencies, require a constant force of emergency relief workers at the ready to respond to relief programmes.

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[4] Ibid, p.6.

[5] *Post-Crisis Assistance, the Role of IFAD*, International Fund for Agricultural Development (IFAD) 1999, Rome, Italy, p.6.

[6] "Developing countries will continue to suffer thousands of deaths and injuries and tens of billions of dollars of economic damage every two to seven years until investments are made in forecasting and preparedness for the *El Nino* weather phenomenon...*El Nino* is not a freak occurrence – it is becoming an increasingly predictable part of the global climate system." in Mithre J. Sandrasagra (30 October 2000) *El Nino: Once Burned, Twice Shy,* TERRAVIVA: The Inter Press Service daily journal, Vol. 8, No. 196, p.1.

Both NGOs and UN agencies have been at the forefront of providing such emergency assistance. According to the WHO study[7],

> "the number of UN agencies involved in responding to emergencies has grown…the number of NGOs working in the area of humanitarian assistance as well as health, social development and environmental protection has (also) increased substantially. This relatively new role has inevitably placed new demands on UN agencies, intergovernmental organizations, NGOs and other groups in terms of their preparation for emergency work, and their recruitment, training, deployment and support of staff."

Some of the largest organizations such as the International Red Cross, CARE International, the United Nations Children's Fund (UNICEF), and the Salvation Army have been working in disaster relief for over 20 and 30 years and have acquired considerable experience in providing emergency services – frequently at short notice.

There is, however, emerging evidence that employees (including consultants) of both UN and non-governmental organizations may be overstrained and or under-prepared for the demands that relief work can have on both physical and mental health.

A recent article warned that

> "What we see is a new type of war veteran, the international humanitarian worker, returning from the battlefields unable to escape the horrors there. It is obviously very important that aid organizations begin considering seriously the factors affecting their project personnel. Someone must be able to spot the danger signals at an early stage, and help exposed personnel in dealing with their situation."[8]

While it is beyond the scope of this study to consider medical health problems resulting from humanitarian relief work in detail, the study is concerned with at least

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[7] Op. Cit., *Occupational Health*…WHO study, p.6.

[8] Smith et al (1996) in Peter Salama (2000) *The Psychological Health of Relief Workers: Some practical suggestions*, Humanitarian Practice Network, Newsletter, http://www.odihpn.org.uk/newslet/newslet15/article8.html, p.1

one manifestation of severe strain or stress – the incidence of Post-traumatic Stress Disorder (PTSD).

The study examines the incidence (or otherwise) of PTSD and to a lesser extent other forms of stress such as chronic and acute stress but concentrates on PTSD, due to the fact that the disorder is unusually difficult to identify, given the late onset of symptoms as compared with other stress-related disorders. This fact alone may have policy implications for the organizations concerned, and at the very least has practical implications in terms of institutional strategies concerned with preparation and prevention of PTSD and other conditions associated with stress.

At the same time, while the number of emergencies, in particular complex emergencies has grown – especially in the last decade, the author also acknowledges that one study conducted among an international sample of organizations involved in emergency relief indicates that there has been a decline in the "numbers of people involved in emergency operations, the majority of which are also involved in longer-term rehabilitation and development work. In 1994, over two-fifths (43 percent) of these agencies employed more than 100 people in emergency relief but by 1996, this figure had fallen to just over a third (37 percent)". [9]

As might be expected (in view of general budget cutting and the higher costs involved in meeting expatriate salaries), the decline "has been most pronounced amongst expatriate relief workers while conversely, the number of relief staff recruited locally has increased."[10] At the same time, the increasing use of local staff may result from the "increasing body of qualified, knowledgeable and experienced southern-based staff located in the regions where disasters arise and who speak the local languages."[11] There is also growing pressure on many international organizations to employ local staff in order to enhance local capacity in developing countries.

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[9] Francesca Taylor (February 1998) *The Recruitment of emergency personnel: different agency perspectives*, Relief and Rehabilitation Newsletter (RRN), http://www.odihpn.org.uk/newslet/newslet10/article4.html.

[10] Ibid

[11] Ibid

Given the already limited attention paid by many international relief organizations, especially the United Nations, to measures aimed at preventing and providing for trauma-related disorders among so called Headquarters staff, the issue of the status and of relief/prevention measures and services available to locally-employed staff, of such organizations is especially pertinent. The author's own experience to date regarding facilities and services for southern nationals in UN organizations indicates that they do not benefit from the same priviledges as expatriate staff members, in part because they usually obtain health services locally which in many cases may not be adequate, especially in countries where civil conflict and extreme general poverty are ubiquitous, as opposed to the opportunities available to Headquarters personnel i.e. being referred to Headquarters and Headquarters-listed specialists.

More critically perhaps, is the fact that such staff often feel intimidated by senior expatriate staff, and by the power exhibited by Headquarters generally. Locally-recruited nationals often do not feel that they have recourse to assistance or advice, especially in situations where they are recruited by the field office on the basis of short-term or temporary contracts. Ironically, abuse of power may come from fellow nationals in more senior positions, especially those who have been working in a field or branch office for a number of years. On the other hand, locally-hired staff often benefit by having a network of family and long-standing friends which their expatriate colleagues do not have.

With the increasing incidence of international emergencies, in particular those requiring multi-national peacekeeping forces, the United Nations, for example, has come under growing pressure to recognize its weaknesses as an effective global peacekeeper, not least of all in the area of security of its own staff. In reporting on just one humanitarian emergency in Somalia for example, the Associated Press stated that "Intensifying fighting in southern Somalia had cut nearly 1.6 million people off from aid, ...Combatants had killed three humanitarian workers in three months, forcing aid agencies to cut back operations to protect their staff."[12] On the same day, the same agency reported from Burundi that "an escalation of violence in rural areas had forced a suspension of virtually all humanitarian assistance. Fighting between government

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[12] Taken from the Associated Press (Rome), 5 November 1999, Newsedge Insight, the AP reports are compiled from information provided by various humanitarian relief agencies.

forces and rebels during the past two months, had caused loss of civilian lives, including the death of two UN international humanitarian workers".[13]

As recently as September 2000, the Deputy Secretary-General of the United Nations, Louise Frechette asserted "that there is no more basic requirement of the UN and its member states than to provide security for the men and women sent to the field to do the Organization's work, and to bring to justice the perpetrators of violence against UN staff."[14] She noted that despite statements made at the year 2000 Millennium Summit, in which both the General Assembly and the Security Council reaffirmed their commitment to staff security "less than one-quarter of the membership is party to the Convention on Safety of United Nations and Associated Personnel." [15]

Frechette observed that "danger in the field does not need to lead to death for it to leave its ghastly mark. Many staff members have been held hostage, assaulted or raped. Others have been detained with their fate unknown, leaving their families to imagine only the worst."[16] There is now increasing evidence that the results of peacekeeping and or humanitarian interventions can have an adverse effect on those who provide assistance, Frechette's observation can be compared with a recent well-publicized case of PTSD involving a United Nations employee, which has received global attention. The case highlights not only the problem but its conseqences. It is the case of Lt. Gen. Romeo Dallaire of Canada, commander of U.N. forces in Rwanda.

Dallaire has become, in his own way, a victim of Rwanda's violence and of the limitations of UN peacekeeping. In late June, he has confirmed, he was found semiconscious in a park in Hull, Quebec. Two months before, he had taken early retirement from the military for medical reasons. Psychotherapy has helped Dallaire recover enough to start a job as an adviser to Canada's minister for international cooperation on protecting children in wartime, but he is still suffering from what he calls the "peacekeepers' injury," post-traumatic stress.

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[13] Ibid

[14] Taken from the IPS Daily Journal, 26 September 2000, Vol. 8, No. 172, p.4

[15] Ibid

[16] Ibid

It had first hit him four years after his return from Rwanda. He couldn't eat, sleep or concentrate enough to read a newspaper. "I am in a valley at sunset, waist deep in bodies, covered in blood," he said, describing one of the scenes that appeared, over and over, before his eyes. "I am holding up my arms trying to get out. Each time it comes back, the scene is worse. I can hear the rustle of bodies, and I am afraid to move for fear of hurting someone."

Post-traumatic stress disorder was once known as shell shock, and the soldiers who had it used to be considered shirkers or weak. It is far more common than acknowledged...

Now new imaging methods show that the brain processes traumatic memories very differently from normal ones. For one thing, they are not integrated into the stream of memories, so the sufferer does not recognize that what he is seeing took place inn the past. "When these events happen, they are a blur," Dallaire said. "But the flashbacks are digitally clear and come one at a time. They do not disappear over time, and your normal state becomes acute depression. You look for ways of reducing your depression with booze and drugs."

His experience, and his willingness to talk about it, has led to reforms in the way Canada treats post-traumatic stress. It is now officially recognized as a war injury, and Canada has set up centers for educating peacekeepers about stress and treating it early. Post-traumatic stress is as old as war, but it is a particular danger for peacekeepers. All soldiers witness horror, but in some peacekeeping missions, like the one in Rwanda, troops are barred from acting. "Soldiers witness crimes against humanity but are ordered not to interfere," Dallaire said. "There is enormous frustration in witnessing genocide and being powerless to do anything."[17]

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[17] Tina Rosenberg (October 15, 2000) *The Unbearable Memories of a UN peacekeeper,* Seattle Post-Intelligencer (Reprinted from The New York Times) Seattle, USA.

Given the increasing incidence of international emergencies and the need for interventions by relief and aid organizations, the issue is whether examples such as the Dallaire case are isolated incidents or part of a recognizable trend? According to the observation by the UN Deputy Secretary-General, the UN, albeit belatedly, appears to be taking the dangers seriously. The issue therefore is to consider the extent of the problem and to consider what if any preventative and for that matter curative measures are being taken and policies adopted.

What is Post-traumatic Stress Disorder (PTSD)?

During the twentieth century, symptoms of a condition were noted among some victims of large-scale disasters – soldiers who had fought in either the first or second World War or still later in the war in Viet Nam[18] and those who had been involved in other kinds of natural or man-made disasters - and suffered, as a result, a kind of post-trauma-related stress. Symptoms varied from person to person but normally involved one or a combination of occurrences such as flashbacks, recurring nightmares, sleeping problems, emotional instability sometimes leading to violent outbursts, emotional and or physical withdrawal from family, friends and colleagues, alcohol and drug abuse and a number of other related problems.

Whether pertaining to soldiers, victims of rape or other violence, or victims of natural and or man-made disasters, most studies concur that three of the most significant predictors affecting development of post-traumatic stress disorder (PTSD) are magnitude and suddenness of exposure to a trauma, exposure to prior trauma and lack of social support.

Given the increasing incidence of such stress-related conditions (see below), the psychiatric community began to document and study the set of symptoms which could not otherwise be classified on the basis of existing stress and psychiatric disorders. In particular, the fact that symptoms showed themselves months or even years after the

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[18] "There was a sudden unexpected rise in the incidence of combat-related psychiatric disorders towards the end of the war as the conflict was winding down, and a surprising increase over a decade later in the number of veterans seeking assistance." Douglas Paton and Nigel Long (Eds.) 1996, *Post-traumatic Stress Disorder, Definition and Classification,* in Psychological Aspects of Disasters: Impact, Coping and Intervention, Dunmore Press, Palmerston North, New Zealand, Chapter 2, p. 41.

main traumatic event, as opposed to other stress-related illnesses which manifest themselves closely following upon a trauma, meant that a new definition needed to be found to account for the symptoms. By 1980, the American Psychiatric Association had attached a name to the condition, post-traumatic stress disorder (PTSD) and included the pathology in the third (and subsequent) edition of its Manual of Mental Disorders (DSM-III).

In its Public Information Fact Sheet, the American Psychiatric Association states that PTSD usually appears within three months of a trauma but sometimes the disorder appears later. It notes that PTSD's symptoms fall into three categories: (1) intrusion, (2) avoidance; and (3) hyperarousal.

In the first instance, 'intrusion' may be characterized by flashbacks which happen in "sudden, vivid memories that are accompanied by painful emotions that take over the victim's attention....it may be so strong that individuals almost feel like they are actually experiencing the trauma again or seeing it unfold before their eyes and in nightmares."[19]

In the second instance, 'avoidance' frequently takes the form of an avoidance of close relationships with others including family, friends and colleagues. "Depression is a common product of the inability to resolve painful feelings. Some people also feel guilty because they survived a disaster while others – particularly friends or family – did not."[20]

Bessel A. van der Kolk et al (1999)[21] add that once people "become dominated by intrusions of the trauma, traumatized individuals begin organizing their lives around avoiding having them. Avoidance may take many different forms: keeping away from reminders, ingesting drugs or alcohol that numb awareness of distressing emotional states, or utilizing dissociation to keep unpleasant experiences from conscious awareness."

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[19] *Let's talk facts about Post-traumatic Stress Disorder,* http://www.psych.org/public_info/ptsd.html, p.1
[20] Ibid.
[21] *Approaches to the Treatment of PTSD,* Bessel A van der Kolk, M.D., Onno van der Hart, Ph.D., Jennifer Burbridge, M.A., Harvard, USA, http://www.trauma-pages.com/vanderk.htm, p.1

Finally, 'hyperarousal' can lead individuals who may feel that they are still threatened by the trauma to become suddenly "irritable or explosive, even when they are not provoked."[22]

Bessel A. van der Kolk et al. (1999) note that "physiological arousal in general can trigger trauma-related memories, while conversely, trauma-related memories precipitate generalized physiological arousal." Thus they maintain that "It is likely that the frequent reliving of a traumatic event in flashbacks or nightmares cause a re-release of stress hormones which further kindle the strength of the memory trace. Such a positive feedback loop" they claim could cause what are termed "subclinical PTSD to escalate into clinical PTSD, in which the strength of the memories appear so deeply engraved that Pitman and Orr have called it 'the black hole' in the mental life of the PTSD patient, that attracts all associations to it and saps current life of its significance."[23]

In its definition of PTSD, a study on police officers[24] notes that examples of life-threatening traumas that can cause PTSD in order of severity are:
- "natural disasters
- serious accidents
- serious accidents where a person is at fault
- intentional life-threatening violence by another person
- life threatening trauma caused by betrayal by a trusted individual
- life threatening trauma caused by betrayal by someone you depend on for survival"

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[22] Ibid, p.2.

[23] *The body keeps the score: Memory and the evolving psychobiology of post traumatic stress*, Bessel A. van der Kolk, Harvard Medical School, Harvard, Mass. USA, http://www.trauma-pages.com/vanderk4.htm , p 10.

[24] Police Officers and Posttraumatic Stress Disorder, http://pw1.netcom.com/-jpmock/ptsd.htm, p.1

While noting that it is impossible to predict who will develop PTSD, several factors are known to contribute to the development of the disorder and include:

- "personal identification with the event
- knowing the victim
- lack of preparation, or lack of knowledge of the event ahead of time
- the severity and intensity of the event
- accumulative exposures to Post Trauma Stress
- chronic exposure to a traumatic incident
- pre-existing PTSD
- helplessness."[25]

Finally, the study warns that

"PTSD is a serious illness....It affects a person physically, mentally and emotionally, and emotionally to the point it is life altering. The symptoms people with PTSD exhibit are extreme and typically adversely impact their lives every day. To cope with these symptoms, they may develop addictions. It can destroy their marriage and other relationships, and cause some of them to commit suicide."[26]

Differentiation from other stress conditions

Many other reactions to stress exist, and it is not the purpose of this study to minimize their importance. Many of the symptoms that have been ascribed to PTSD, for example are also a sign of "acute stress" for example, depression, anxiety, anger, despair, overactivity and withdrawal. In the case of acute stress "the symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within 2-3 days (often within hours). Partial or complete amnesia for the episode may be present."[27]

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[25] Ibid p.5

[26] Ibid.

[27] See http://www.mentalhealth.com/icd/p22-an08, *Acute Stress Disorder, European Description.*

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As reported by Bessel A. van der Kolk, et al (1999),

> "what distinguishes people who develop PTSD from people who are merely temporarily overwhelmed is that people who develop PTSD become 'stuck' on the trauma, keep reliving it in thoughts, feelings or images. Evidence during the past decade supports the notion it is the intrusive reliving, rather than the traumatic event itself that is responsible for the complex biobehavioural change that we call PTSD."

A recent UN study on UN Peacekeepers and Humanitarian Personnel noted that while the original definition of PTSD described in DSM-III (1980, see introduction) elaborated a

> "constellation of symptoms that develop when individuals are exposed to an extreme emotional stress. In its original formulation, exposure to the personal vulnerability, deprivation, human suffering and witnessing of ongoing trauma associated with many UN peacekeeping or humanitarian deployments, would have easily qualified as a 'traumatic" experience. As reformulated in the DSM-IV in 1994 (APA, 1994), such events must produce an intense emotional response such as "fear, hopelessness, and horror" to meet the criterion for a traumatic experience. The DSM-IV's greater emphasis on an individual's subjective emotional response to a stressful event is especially pertinent to UN personnel, since under the old definition, almost all peacekeepers and humanitarian staff would have been 'traumatized' simply by virtue of their assignment to a war zone or disaster site. Under the DSM-IV definition, however, only those UN personnel who have had an intense emotional reaction to their stressful surroundings would be considered to have been traumatized." (bold added by author).

Given the particular nature of emergency relief work carried out by both UN agencies and NGOs which frequently exposes workers to situations which are beyond the norm of most individuals' experience (i.e. staff and consultants are sent to assist in emergencies where both the magnitude of the relief effort and the conditions of work, long hours, poor communications and frequently limited access to information from organizers of the relief effort, lack of adequate organization and coordination etc., can

be extremely stressful), the potential for developing PTSD which appears little studied in these organizations to date, if at all, given exposure to a number of stressors, may be considerable[28].

As has been noted above, PTSD is much more difficult to diagnose than other stress conditions, because its onset is delayed and it may continue for months or even years. It is similar to other acute and chronic stress conditions in that it may affect the sufferer's ability to function normally at work and at home. PTSD however probably has more serious implications in terms of the long term mental as well as physical health of the sufferer which in turn has implications for treatment and policy of the organizations in which they are employed.

The UN study in fact acknowledges that

"recognition has been slow that UN responsibilities may have adverse psychological consequences which may deleteriously affect both functional performance and long-term adjustment. In contrast to UN peacekeepers, there is sparse scientific literature, little official national or international attention to this problem, and virtually no institutional resolve to address this challenge systematically."[29]

Finally, despite the ongoing debate on the absolute efficacy of debriefing as an effective tool in the prevention of the development of post-traumatic reactions for victims of emergencies including relief staff, respondents' replies to the questionnaires, comments made either directly or by implication by Case Study interviewees (see Chapters IV and VI) and a general review of the literature would indicate that debriefing or at the very least defusing techniques should be considered as part of a preventative policy by all organizations working in humanitarian relief.

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[28] Not only PTSD but the incidence of most disorders and illnesses appears to be poorly documented in international organizations generally. A noteworthy exception was the occupational health study carried out among staff of the World Health Organization (WHO) in 1998 (see bibliography below).

[29] Matthew J. Friedman, Peter G. Warfe (2000) Gladys K. Mwiti, *Mission-Related Stress and its Consequences among UN Peacekeepers and Humanitarian Personnel*, UN Peacekeepers and Humanitarian Personnel (Draft document, UN, New York).

Defusing is defined as

"a process developed for disaster workers (Young et al, 1998), defusing
is designed as a brief (10-30 minute) conversational intervention that can take
place informally during a meal or while standing in line for services and is
designed to give survivors an opportunity to receive support, reassurance and
information....an opportunity to assess and refer individuals who may benefit
from more in-depth support (Young et al., 1998). ...The main goal of defusing is
to attenuate acute stress reactions and fortify coping mechanisms that have
worked before."[30]

Weaver, defines defusing as the process of talking it out.

"It works like taking the fuse out of a bomb (or an explosive situation),
by allowing victims and workers the opportunity to ventilate about their
disaster-related memories, stresses, losses and methods of coping, and allowing
them to do so in a safe and supportive atmosphere. ...Because the alloted time
(for defusing) is often too short, it is simply a starting point. Further intervention
is often required and this can be anything from offering ongoing support (e.g.
briefly touching base with the persons/groups in the coming days/weeks) to
scheduling and providing formal debriefing missions."[31]

By contrast, debriefing is a formal meeting organized

"individually or in small groups"[32] and is usually held within the first
24-72 hours after a traumatic event, with follow-up sessions as needed.
According to the report by Weaver, the American Red Cross (ARC) offers
defusing as necessary, throughout a person's tour of duty at a disaster scene.
"ARC also recommends (but does not require) having a debriefing before
leaving for home. Once ARC workers get home, their local ARC chapter usually
offers them a formal debriefing."[33]

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[30] Op. Cit., UN Peacekeepers and Humanitarian Personnel, p.19.

[31] John D. Weaver, LCSW, BCD, ACSW, CBHE, *Traumatic Stress, Self-Awareness, and Self-Care*, at
http://ourworld.compuserve.com/homepages/johndweaver/selfcare.html, p4.

[32] Ibid

[33] Ibid

Similarly, adequate education providing information about stress in terms of what to expect and suggestions on how to cope should also be part of the generalized briefing of all staff, particularly frontline relief workers. However, in consulting the Humanitarian Assistance Training Inventory (HATI) which is maintained by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the author noted that only one UN agency (the United Nations Volunteers) had included a course on stress management as part of their staff training. Of the total respondents surveyed in this paper, only one person indicated that he had attended, on one occasion a one-hour course on stress management. This seems incredible when compared with the sometimes lengthy generalized policy briefings (as opposed to security, or welfare or stress management briefings) and medical examinations required by many international organizations before sending staff to the field.

Is the incidence of PTSD in other situations high enough to justify concern?

A recent article found that several studies have shown that PTSD "is among the most common of psychiatric disorders"[34] and that it is not confined to combat soldiers (where it was initially documented) "but is quite common in the general population, particularly among psychiatric patients. Various studies have demonstrated a lifetime prevalence of between 1.3 percent (Heizer et al, 1987) and 9 percent (Breslau and Davies, 1991) in the general population and at least 15 percent in psychiatric inpatients."

However, the same authors add that although PTSD is associated with "high levels of chronicity, co-morbidity and functional impairment, the general level of functioning varies a great deal between affected individuals."

A study by John Reid (1990)[35] found that

> "about 7 percent of the US population experience severely traumatic
> events such as robbery, sexual assault, serious motor vehicle accidents,
> bereavement and natural disaster each year. Add to this the number of people

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[34] Op.Cit, Bessel A. van der Kolk et al (1999), p.1.

[35] *A role for prospective longitudinal investigations in the study of traumatic stress and disasters*, p. 6, John B. Reid, 1990, Journal of Applied Social Psychology, 1990, 20(20), 1695-1703, http://www.Trauma-pages.com/reid90.htm

experiencing technological disaster, family violence, the more traumatic divorces resulting in precipitous drops in family income or in childrens' out-of-home placements, and the overall base rate of seriously traumatic events may approach 10 percent per year or more. Given that the average family size is over three, then the base rate of seriously stressful events captured in a longitudinal study of children and their families should be even higher."

The lack of knowledge about PTSD and other chronic stress related conditions and their consequences may have relevance in terms of a generalized institutional 'malaise' which appears to exist in many organisations in terms of both acknowledging the existence of potentially debilitating mental disorders and hence in developing policies towards PTSD or any other severe psychiatric disturbance for that matter. And yet, the UN study for example states that

> "some UN personnel may become so emotionally distressed that they develop acute and/or chronic psychological symptoms which may impair their functional capacity in the field or at home. The institutional costs of this problem include productivity, morale, attrition of trained personnel, increased costs, successful completion of the mission, and the reputation of the UN as an effective organization that can achieve its stated aims."[36]

For the purposes of this study, it is assumed that PTSD is a significant pathology and one which has potentially serious implications for organizations which may, albeit unwittingly, place their employees in situations which make them vulnerable to developing the disorder.

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[36] Op.Cit, <u>UN Peacekeepers and Humanitarian Personnel,</u> Chapter, Personnel, p.6.

CHAPTER III. IMPLICATIONS OF POST-TRAUMATIC STRESS DISORDER (PTSD) FOR ORGANIZATIONS WORKING IN EMERGENCY RELIEF

Background

While the fact sheet on acute stress disorder claims that ten percent of the population has been affected at some point by clinically diagnosable PTSD, **still more show some symptoms of the disorder**. As noted earlier, although it was once thought to be mostly a disorder of war veterans who had been involved in heavy combat, researchers now know that PTSD also affects both female and male civilians, and that **it strikes more females than males.**

If it is indeed true that a relatively large percentage of the population have been affected by PTSD and a still greater number have apparently displayed some symptoms of the disorder, given that this paper considers the incidence of PTSD among emergency relief workers in several organizations, the issue is, if this is the percentage which exists in a normal population, what then is likely to be the proportion among people who are often repeatedly exposed to abnormally high levels of stress, both job-related and in the context of the specific conditions which prevail in emergency environments?

As observed above, it is relevant to bear in mind that there are also important differences here in level of exposure between emergency relief staff of UN organizations and those of NGOs involved in emergency relief. In general, NGO staff have much more experience of frontline, first-to-the-emergency work than their UN counterparts who may assist in emergencies only some time after the initial impact has occurred. This means that NGO staff are almost certainly more exposed to the true magnitude, suddness, deaths and injuries associated with disaster relief than their UN counterparts. Hence, UN staff may be supposed to be less vulnerable to developing PTSD, at least as a result of stressors associated with the immediate sights and sounds associated with the first stage of an emergency.

While one study noted that "emergency workers are affected by certain types of incidents, and after intense emergency situations, a majority show evidence of traumatic stress"[37], and the recent UN study asserts that "Humanitarian personnel …may be more likely to experience, hopelessness and guilt due to their inability to change the external situation (e.g. starvation), inability to meet personal expectations for success, or a sense of powerlessness versus denial in the face of unremitting demands by the massive number of people requesting assistance"[38]. At the same time, it is also true that the researchers Raphael et al (1983-84) also noted that "the experience of working in a disaster can have enriching effects as described by 35 percent of respondents who felt more positive about their lives as a result of their involvement in the disaster (the Granville rail disaster)."[39]

In this last example, it may be relevant to note that this, however, refers only to involvement by relief staff in a single disaster. One of the premises of this study is the fact of repeated exposure increasing vulnerability of individuals to developing some kind of stress related morbidity, in this case PTSD. Moreover, Raphael et al. had also found that about half of disaster 'helpers' interviewed had "found the experience stressful, 70 percent had expressed evidence of strain and about a quarter had symptoms of anxiety, depression and insomnia in the months after the disaster."[40]

The claim that PTSD strikes more females than males[41] is also significant as most international organizations, and the United Nations agencies in particular, are currently required to recruit as many female staff as possible to create a more equal gender balance within the Organizations. In 1990, the UN General Assembly "established the goal of achieving 50:50 gender balance in all categories of posts within

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[37] Susan McCammon, Thomas W. Durham, E. Jackson Allison, Jr., and Joseph E. Williamson (1987) *Emergency Workers' Cognitive Appraisal and Coping with Traumatic Events*, Journal of Traumatic Stress, 1, 3, pp. 353-372.

[38] Op.Cit., UN Peacekeepers and Humanitarian Personnel, Chapter, Personnel p.3.

[39] E.F. Berah, H.J. Jones and P. Valent, (1984) *The Experience of a Mental Health Team involved in the Early Phase of a Disaster*, Australian and New Zealand Journal of Psychiatry, 18, pp. 355.

[40] Ibid.

[41] Epidemiological studies have generally shown higher rates of PTSD for women than men. There may be a gender difference in expressing distress. For example, in a study of disaster survivors, women were rated higher on anxiety and depression, while men were rated higher on belligerence and alcohol abuse (Gleser et al., 1981), Op.Cit., UN Peacekeepers and Humanitarian Personnel, p.11.

the UN system by the year 2000".[42] It is also true that "the progress, in any, has been extremely slow"[43], there are considerable differences in levels of recruitment of female staff among different agencies with the tendency, at least among the Rome-based UN agencies, in WFP, and IFAD and to much less extent FAO (until mid-2000) to recruit more women, including consultants. This implies that more rather than less female staff (both internationally and nationally recruited personnel) are likely to be sent into emergency situations in the future. It would therefore seem to follow that if females are more prone to developing PTSD generally, they may also be at greater risk than their male colleagues of developing the disorder as a result of their work.

Information provided by Health-Centre.Com notes that "traumatic events are more likely to lead to PTSD if they are the result of human malice as opposed to an accident or a natural disaster" thus it continues "most men who have the disorder have experienced combat and most women have been the victim of a physical assault or rape."[44] Civil conflict, in particular, genocide, as occurred within the last five years in Rwanda and in Kosovo, for example, can generate feelings of hopelessness and frustration, not only among primary victims but also in relief workers as secondary or tertiary victims.

Comorbidity – the relationship between alcohol/drug abuse and PTSD

General literature on PTSD has found a strong relationship between the incidence of the disorder and physical injury on the one hand, and alcohol and drug abuse, on the other. While the incidence of on-the-job injury may be relatively infrequent among staff of most of the organisations reviewed (one noteworthy exception being that detailed in Case Study One below), alcoholism was mentioned informally to the author by many staff of the UN agencies, in particular, as being a problem.

Conditions in the field often exacerbate the situation since drinking may constitute the only means of relaxation available to those working in emergency areas.

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[42] Op.Cit, IPS Daily Journal, Vol.8, No. 196, p.6.

[43] Ibid

[44] *What is Post-Traumatic Stress Disorder* http://www.health-centre.com/english/brain/ptsd, *p.2*

As one colleague who had just returned from six months in Kosovo following the refugee crisis there said,

> "drinking was the only entertainment we had in the evenings, often there was no electricity so you couldn't listen to the radio or watch television, and the restaurants, such as there were, were very basic, so after work we would just get together in someone's house and sit around drinking by candle light. For security reasons we didn't go around the city much in the evenings so that also meant it was difficult to get any exercise for example."

The problem arises when those with a tendency to drink heavily and who work under pressure in foreign countries, particularly in the field of emergency relief use alcohol as a coping mechanism, and an escape from reality (see 'avoidance' above).

Worse still are situations in which these same individuals may be facing personal crises (such as divorce, death or illness of friends, family or colleagues, threats to job security etc). Already emotionally weakened, they may also be suffering, either consciously or otherwise from tensions and stress resulting from their work and coping in a new environment. The risks of dependency are heightened and they may be putting themselves at greater risk of developing symptoms of acute stress or PTSD.

The following case history was related by a long-standing member of Alcoholics Anonymous (AA). It concerns the case of an experienced emergency relief worker who was on mission for a relief agency. An alcoholic, he had suffered a serious setback in his battle with alcohol, largely he believed due to work-related stress combined with his existing weakness for alcohol. Prior to going on mission he had been attending AA meetings albeit intermittently for a number of years. As soon as he was sent on assignment, however, he began drinking heavily again.

At a certain point, he was recalled by the organisation concerned since he appeared to be having a nervous breakdown. He was asked to take several weeks rest and recreation (R&R) in his home country, but on returning continued to work for the same agency. Upon his return he began attending AA meetings as regularly as possible, acknowledging that without the support of AA, and under pressure of the work he was

doing, he had started drinking heavily again. When I asked why he had gone back to work, after what appeared to be a relatively short amount of time, and why had the agency allowed him to resume his work before the extent of his condition was known, his co-member of AA hypothesized that as a consultant, rather than a staff member, he was obliged to continue working to support himself even despite the toll it was having on both his mental and physical health.

The problems of alcoholism, drug dependency and of mental health have in general, not been dealt with effectively by the UN agencies generally (with the noteworthy exception of the World Health Organization - at least until very recently and to a lesser extent by NGOs (a noteworthy exception appears to be Concern). Only in the year 2000, for example, did FAO provide its headquarters staff with a policy document on alcoholism and drug abuse (see Appendix III). As with most serious illnesses and disorders, the policy has generally been one of referral by the Medical Services of staff to specialists and specialist organisations. Public admission by the agencies that such problems exist has been very slow in developing not least because such problems have repercussions in terms of social security and medical benefits and other costs incurred by the Organisations.

Perhaps one of the most serious problems and one that will be considered in more detail later on, is the question of suitability and preparation of staff for working in foreign countries and in situations which may incur risks to personal health and security. The author talked to a number of staff working for the two main Rome-based inter-governmental organizations, FAO and WFP, who had received little specific training. Much of their work involved learning as they went along, and little provision has, until recently been made to ensure that they are adequately briefed about the risks which they may encounter in the field. Even security briefings appear to be patchy and for the most part inadequate, as partially evidenced by the recent high level of staff losses in at least one agency over the past five years (see WFP under Organizations Surveyed below).

Nevertheless, greater involvement of staff in emergencies was, for example, confirmed by the Head of the FAO's Medical Unit, Dr. Pille who observed that "FAO is

increasingly exposed to emergencies as the workload of the Special Relief Operations Service (TCOR) increases, with more staff either directly involved themselves or seeing things happen to others."

Dr. Pille noted that many staff appeared able to cope with exposure to traumatic situations, especially those who "were more gradually exposed and gaining more experience more slowly, were able to establish their own coping mechanisms". However, the danger existed that these same staff could suffer from repeated exposure leading to emotional detachment. In the long run, such detachment was not healthy because the individual did not show signs of an emotional processing of the events that had been witnessed which could have repercussions later on (such as problems in personal/collegial relationships, inability to appreciate the weaknesses or problems of others around them etc).

Dr. Pille also voiced concern for those who were sent on assignment for the first time and for whom sudden exposure to traumatic situations for which they were not adequately prepared also posed a mental health risk.

He said that culture shock and reverse culture shock (which was sometimes experienced on returning from an assignment or posting) were already factors that could negatively affect staff. As with severe stress, culture shock is itself a stressor, and much depended on an individual's general emotional state and or other personal and professional circumstances as to whether staff developed abnormal stress reactions.

Dr. Pille cautioned that certain emotional reactions were a necessary part of synthesizing traumatic experience. He was more concerned for those individuals who did not display what would be thought of as 'perfectly normal' grieving or other emotions following exposure to traumatic events. He believed that **what was important was to consider the kinds of safeguarding mechanisms which were built into assignments and for which the organizations themselves had an institutional responsibility.**

Van Brabant observes that there are "different types of stress and not all stress is debilitating:

♦ **Positive stress:** Stress is a natural reaction and it can be positive and stimulating. For example, quite a number of people need a 'deadline' to get a task completed. Positive stress helps us focus on the task or situation at hand, mobilises energy, and prepares us for action. In that sense, stress can contribute to our safety and security in a situation of tension and risk.

♦ **Negative stress**: Stress uses energy. When it occurs too often, is too intense or lasts too long, it turns from positive to negative. A never-ending series of tight deadlines, just like continued exposure to risk situations, depletes our energy reserves. **Less easily recognized or admitted and yet very much present among many professionals, including aid workers, is so-called 'cumulative stress'. Prolonged stress eventually leads to physical and emotional exhaustion or 'burn-out".** (Bold added by author)

♦ **Traumatic stress**: This results form the direct experience of, or close exposure to, traumatic events or incidents that are life-threatening or involve death, and involve physical and emotional loss. A term often used here is that of 'critical incident'. Mental health experts further distinguish here between acute stress disorders, which occur a few hours or days after the event, and post-traumatic stress, which can occur after several months or, sometimes, years."[45]

Defining levels of stress and stress reactions

The problem is one of defining levels of stress, identifying reactions to it and thereafter determining whether such stress constitutes grounds for providing assistance, especially at the level of institutional responsibility, not only in terms of treatment and follow-up but also as regards approaches and strategies for preparation and prevention.

A recent stress survey available on the internet asks respondents to look back over the past six months and note whether changes were seen by the respondent in themselves or in the world around, particularly in terms of job, family and social

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[45] Op. Cit, Van Brabant., p.282.

situations. It then gives 30 seconds for each answer to the following questions (scored on the basis of 1 representing little change and 5, a great amount of change. Thus:

1. Do you tire more easily? Feel fatigued rather than energetic?
2. Are people annoying you be telling you "you don't look so good lately?
3. Are you working harder and harder and accomplishing less and less?
4. Are you increasingly cynical and disenchanted?
5. Are you often invaded by sadness you can't explain?
6. Are you forgetting? (appointments, deadlines, personal possessions)
7. Are you increasingly irritable? More short-termpered? More disappointed in the people around you?
8. Are you seeing close friends and family members less frequently?
9. Are you too busy to do even routine things like make phone calls or read reports or memos?
10. Are you suffering from physical complaints (aches, pains, headaches, a lingering cold or illness)?
11. Do you feel disoriented when the activity of the day comes to an halt?
12 Is joy elusive?
13. Are you unable to laugh at a joke about yourself?
14. Does sex seem like more trouble than its worth?
15. Do you have very little to say to people?

Based on the calculation of the total score using the 1 to 5 points system, the author provides a scale as follows:

0 – 25	Your doing fine
26 – 35	There are things you should be watching.
36 – 50	You're a candidate for being stressed out.
51 – 65	You are burning out.
Over 65	You're in a dangerous place, threatening to your physical and mental well-being."[46]

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[46] *Stress calculator,* http://www.docinthebox.com/cgi-bin/webform/langcalc.html.

Determining levels of stress in the population at large, may be contrasted with Myers (2000) identification of specific stress reactions occurring in disaster relief workers which were defined as a means of alerting workers and supervisors to determine whether they are experiencing problematic levels of stress.

Psychological/Emotional

Feeling heroic, invulnerable, euphoric

Denial

Anxiety and fear

Worry about safety of self or 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 disaster

Blaming

Behavioral

Change in activity

Decreased efficiency and effectiveness

Difficulty communicating

Increased use of humour

Outbursts of anger; frequent arguments

Inability to rest or "let down"

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, drugs

Social withdrawal, silence

Vigilance about safety of environment

Avoidance of activities or places that trigger memories

Proneness to accidents

Physical

Increased heartbeat

Increased blood pressure

Upset stomach, nausea, diarrhea

Change in appetite, weight loss or gain

Sweating or chills

Tremor (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

Physical stress reactions requiring prompt medical evaluation

Chest pain

Irregular heartbeat

Difficulty breathing

Fainting or dizziness

Collapse

Unusually high blood pressure

Numbness or paralysis of part of body

Excessive dehydration

Frequent vomiting

Blood in stool"[47]

> In considering the duration of the above reactions, Myers notes that
>> "stress symptoms related to the actual disaster usually subside in about
> six weeks to three months. Intense symptoms lasting longer may require
> professional asssitance.... Careful attention should be paid to eliminating
> occupational stressors, providing organizational supports for workers, and
> building stress management strategies into the workplace.[48] (see also
> Recommendations below).

**As noted earlier, PTSD presents particular problems both of diagnosis and
of treatment and has even greater implications in terms of institutional
responsibility. Such responsibility relates both to attempting to limit**

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[47] Op. Cit., Myers p. 91.

[48] Ibid., p.92.

organizational and work-related stressors and to establishing staff policies for victims (including locally-recruited relief staff) of the disorder.

What makes working for international relief organizations potentially stressful?

Apart from the field work itself, which by its very nature exposes staff of relief organizations to abnormal amounts of stress, as determined by the particular stressors involved, notably large-scale of an emergency, presence of dead and dying victims, long working hours, frequently difficult physical conditions (i.e. lack of adequate numbers of relief workers, disorganisation of relief effort, administrative problems, lack of information, time pressure, extremes of heat, cold and other physical factors, etc), the conditions existing within the organizations responsible for emergency relief may themselves act as stressors.

Salama (2000) notes that

"relief workers do not usually benefit from being in a well-trained, tightly knit unit with a clear command structure. In addition, training and briefing, particularly with regard to psychological issues, is generally inadequate. This is particularly pertinent for those organizations which deploy a high proportion of first assignment volunteers. Aid workers are often called upon to perform duties outside their realm of professional competency and experience. Finally, there is the pressure when the drive to ensure the visibility of their own organisation may over-ride questions of the appropriateness or quality of interventions."[49]

Certainly within most organizations, a noteworthy exception being the Salvation Army, there tends to be a high degree of competition among professionals. This competition is partly a result, in the UN System, of the fact that specific in-job time requirements exist before staff are eligible to move to a higher level unless the individual applies for another position which is at a higher level, either within or outside the same organisation.

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[49] Op. cit, Salama, p.3.

Moreover, as with most organisations, the higher up the organisation, the scarcer the number of senior positions, and therefore of senior positions likely to become available. Further, because of the nature of the academic and skills' requirements defined in the job description of most posts in the organisations, this has led *de facto* to a high degree of homogeneity in terms of qualifications and (field) experience among professional staff and consultants. Competition is thus constant and as in the wider job market, increasing almost exponentially. Although there is a fair to good chance that a staff member or consultant who is working in a position for which a recognised post exists will be confirmed in that post, there is also a possibility that the person concerned will not be confirmed or will be delayed in their confirmation for months or even one year or more. This causes insecurity and uncertainty among employees including consultants.

In theory, staff may be terminated at the end of their formal recruitment period. So called 'continuing' or permanent positions are becoming a rarity in most organizations. Possession of such contracts is therefore a priviledge and not one which staff will lightly give up. In consequence, there is a considerable degree of low-level competition among colleagues both from within and outside the organization, especially given the requirement in many cases for vacancies to be advertised internationally - or at the very least – open to all qualified staff working in the same organization.

In addition to the homogeneity of those competing for a relatively scarce number of positions in these organisations, there is also the fact of political placements. This is not unique to the United Nations system, but is a very real factor determining staff employment within the United Nations system and tends to become particularly pronounced at the managerial level where top managerial positions are frequently awarded to members of a particular regional group or country.

The result is a high degree of competition and frequent job dissatisfaction, tension, boredom and its resulting inefficiencies and repercussions in terms of both work output and personal health and job satisfaction.

Partly as a result of the competition for a scarce number of places, staff members and consultants frequently feel a degree of pressure either to apply/volunteer for and or accept if offered assignments which are likely to bring them greater exposure and a higher profile in the organisation and thus increase their chances of either maintaining their current position or of being promoted in the not-too-distant future. In the former case, hopes of having a contract extended, especially from fixed term to permanent status, may put individuals under particular pressure to accept or volunteer for assignments in order to keep their jobs.

Further, as noted by Brabant (2000) stress can be a direct result of poor organisation and management. Among these factors are

"lack of adequate pre-departure briefing, training and or preparation, including about the work context; the complexities of the tasks and the stresses that the assignment is likely to bring; poor leadership and lack of supportive supervision; poor security management; poor communications between headquarters and field and between field offices and within teams: organisational conflict and crisis; lack of clear situational updates and guidance, and of supportive organisational policies on rest and relaxation and family contact; no or poor post-assignment debriefing; an organisational macho culture that denies stress, hardship and emotional difficulties and that, implicitly, completely personalises all stress-related problems and treats the acknowledgement of stress as 'failure'or 'weakness'."[50]

This last point has special significance in terms of the results of this study. One of the greatest hindrances to receiving accurate information from respondents completing the questionnaires was the fear of being regarded as weak or incapable – in short unfit for the demands of the work. While this author would not argue that employees, shouldn't expect a degree of hardship associated with emergency work, i.e. primarily working in developing countries where conditions can be anywhere from optimal (i.e. a good chance to save money – where dollars may be exchanged for weak currencies and relatively more goods and services purchased than at home) to dangerous – i.e. in least developing and or high security-risk countries, they should not be obliged

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[50] Op cit., Brabant, pp. 283-84.

for reasons of job security primarily, to accept assignments in the field for which they do not believe themselves fit. At the very least, they should be given recourse to an alternative and or be encouraged to take sufficient rest periods and holidays if they do accept such assignments. This is particularly true of female staff who may be sent on assignment to countries where women are particularly vulnerable, for socio-cultural and or religious reasons.

CHAPTER IV. METHODOLOGY AND SAMPLING

Background

In order to determine the incidence of PTSD among emergency relief workers in UN agencies and NGOs, several approaches were taken. One, to undertake a general survey of staff (including consultants) working for at least two UN agencies and two NGOs. It would have been desirable, not to limit the number of agencies and NGOs involved in order to survey as wide a population as possible. However given time and logistical constraints (i.e. contacting and obtaining approvals from the respective organizations to allow staff to be interviewed or surveyed. Moreover, the author was not part of a team and therefore was limited to interviewing a select number of individuals, and the physical distance between organizations and respondents) the sample had to be limited to just two or three organizations.

Two, to carry out Case Studies of individuals for whom more extensive and detailed information might be available to supplement the more general findings resulting from the broader-based survey.

Various methods were considered for carrying out the survey. These were individual or even group interviewing, organization or department-wide surveys, or random surveys using one or several questionnaires either with or without interviews, and or interviews by telephone to lists of staff provided by the organizations themselves or even, to attempt to interview staff without the approval or knowledge of the organizations themselves . At one stage this last option appeared the only way to obtain any kind of response, as the process of contacting UN organizations, for the most part, resulted in no or limited responses by Human Resources or Personnel Divisions in the agencies concerned.

At the same time, a large number of different NGOs and UN agencies were reviewed in terms of relevance and availability for sampling. These were, for the UN agencies either directly or indirectly involved in emergency relief operations and for the most part known to the author: FAO (Special Relief Operations Service, TCOR), IFAD

(operational divisions), United Nations Children's Fund (UNICEF) Emergency Services, Office of the United Nations High Commissioner for Refugees (UNHCR), and WFP. The international NGOs were: CARE International, Concern International, Doctors without Borders, the Salvation Army, and the International Committee of the Red Cross (ICRC).

In terms of the samplying methodology, the methodology which evoked the least negative responses, albeit from the one UN agency which ultimately agreed semi-formally[51] to allow some of its staff to be surveyed, and in the event, appeared to provide the greatest opportunity to achieve the widest coverage possible, was random sampling using a standard questionnaire. Inititally, I had wanted to have the questionnaires completed or at least given to interviewees in person. As it happened, this did not prove feasible, as most respondents were either in the field, on duty-travel or were too busy or otherwise not contactable. Moreover, the agencies themselves proved to be the greatest impediment to interviewing staff in person. While there was relatively little objection to the informal distribution of a questionnaire (that is through channels such as electronic mail or passed on from one individual to another) that could be completed on a voluntary basis, there was marked objection to the formal distribution of the questionnaire and or personal interviewing. Reasons given were the time constraints of busy relief staff, and the logistical difficulties in contacting such staff. Unwanted emotional interference in the wellbeing of staff by asking potentially distressing questions on mental and emotional states was also given as a justification, for not allowing staff to be individually interviewed.

Various other possibilities were considered, such as requesting agencies and NGOs to provide lists of staff members and consultants who had been working in the field in the last ten years, whether for a single intervention or in multiple emergencies.

Two practical constraints however hampered this latter option. Firstly, the UN agencies in particular, are extremely difficult to approach being both heavily bureaucratic and thus requiring a complex process of approvals at the highest level for

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[51] By semi-formal I mean that the staff counselor agreed to distribute the questionnaire to a list of staff. Had the questionnaire been circulated by the Human Resources Department itself this would have constituted a 'formal' distribution of the questionnaire.

the undertaking of any kind of staff survey. This is to say nothing of a definite stone-walling attitude which was met with initially, in at least in two of the agencies considered (WFP and UNHCR).

The senior human resources staff approached at both agencies showed extreme reluctance, if not outright antagonism at the prospect of having their staff surveyed or interviewed. In the former case, due ostensibly to the fact that staff are already under heavy strain in their normal day-to-day tasks and "did not have the time to participate in a survey, much less interview". In fact, as noted above, where WFP is concerned,there was also extreme sensitivity to the issue for two reasons. On the one hand, because the proposed survey followed closely upon the Kosovo plane crash. This had taken place in November 1999 (the author carried out initial enquiries in mid-January 2000), and on the other because the agency is generally sensitive to having its staff surveyed or interviewed, being the UN agency with the dubious notoriety of having the greatest loss of life of staff whilst on duty.

There was also the simple logistical problem of obtaining staff lists and contacting individuals and from there arranging interviews in sufficient time to obtain results that could be included within the limited timeframe of this study. In the case of UNHCR, senior operations staff, when approached, believed that there were too many logistical problems involved in getting staff lists, obtaining clearance from Human Resources and finally, in stimulating enough enthusiasm among staff to allow/have them to take part in interviews, that the project appeared impossible to orchestrate with (or for that matter without) the consent of the Organization's management.

In the event, the random sample was achieved by sending questionnaires, almost entirely by e-mail or forwarded among colleagues.

The majority of questionnaires were sent to respondents during July and to a lesser extent August 2000 with the deadline for replies stipulated as 30 September 2000. Respondents were asked to complete the forms provided (see Appendices I and II) and to return them either by e-mail or to ensure complete anonymity by normal mail. In the

event, all but three respondents replied by e-mail, the three having sent their completed forms by facsimile.

Given the generally impersonal nature of such surveying, i.e. no or limited personal contact between the interviewer and the interviewee, the author tried to supplement the information obtained from the questionnaires with a second approach - that of carrying out a limited number of Case Studies based on personal or in at least one case, third-person interviews. In general those who agreed to be interviewed and included as Case Studies were persons previously unknown to the author. In three cases, Case Studies One and Two and Four, the interviewees volunteered the information provided. In three other cases, the interviewees were slightly known to the author.

The case studies also had the advantage of allowing isolated staff of organizations whom it was otherwise not possible to contact directly, mainly through the author's personal contacts with colleagues and friends, to be interviewed. In one case, the author also received an interviewee's personal account of her experiences by audio cassette which proved invaluable in terms of illustrating some of the complex aspects of PTSD (as her case appeared to be).

Implementation

Before beginning the interview process, and as a means of contacting some of the core organizations involved in emergency relief, the author travelled from Rome to Geneva to meet or talk by phone with senior officials of UNICEF Emergency Services, the ICRC, UNHCR and the World Health Organization (WHO). The author met with a senior consultant working with WHO, Dr. Manuel Carballo who had in 1998 completed a large-scale occupational health survey for WHO and from whom valuable suggestions were obtained concerning the best approaches to be used in drafting the questionnaires to obtain the maximum information, in contacting respondents and in determining a diagnosis of PTSD (or otherwise).

Initial and subsequent contacts with the International Committee of the Red Cross (ICRC) proved fruitless, due mainly to the vast scale of that NGO's operations. The ICRC appears, as, if not more, bureaucratic than the UN agencies considered, and in the end, I abandoned hope of achieving interviews at any but a purely informal level with its field staff.

The same was true of *Doctors without Borders*. Cutting through the so-called redtape of the organization was a task in itself and given the time constraint was simply not possible for the present survey, although undoubtably a rich source of information for a future survey.

Prior to travelling to Geneva, I had also visited the World Food Programme (WFP) and met with the staff counselor who had provided names of contacts of her colleagues in other agencies in Geneva.

Despite repeated phone contacts with UNHCR, intransigence of both the senior staff to take the necessary steps to gain approval for a survey or random interviews of staff to be conducted meant that, although one of the most desirable agencies in terms of frequent exposure of its staff to emergency situations, the logistics of gaining approvals and carrying out interviews was too difficult given the timeframe and lack of proximity of the author to both the agency and its staff.

Organizations included in the survey

As noted above, while the author had intended to involve as many organizations as possible, in the event, only three agreed to participate. These were **WFP, Care International** and the **Salvation Army**.

A few individual staff from other agencies also finally agreed to be interviewed and these were included in the case studies. The respondents were from **Concern Worldwide, FAO** and **UNICEF Emergency Services**.

Design of the questionnaire

Much of the work involved in carrying out the survey involved the design of the questionnaire. As noted above, the author had received some assistance from the WHO which had one year earlier conducted an occupational health survey of its own staff. In the case of the present study, however, the questionnaire needed to elicit both more detailed and more comprehensive information.

In order to determine the incidence (or not) of PTSD, various groups of questions needed to be asked. The first part of the questionnaire had to provide basic factual information about the respondent. This included: age cohort; gender; profession or professional training; type of organization by whom respondent was employed; education and training (in addition to professional training); nationality (though this last was not a necessary question except from a general perspective of determining whether there were any cultural patterns which emerged from the answers of groups of respondents of the same nationality/cultural/regional group).

Secondly, the questionnaire needed to elicit information on physical health, in particular concerning whether the respondents had suffered injuries or had other health problems which were work related (i.e. malaria and other sicknesses and or wounds sustained while on duty in the field). Development of PTSD is frequently linked with physical illness or injury (see comorbidity above). This section also needed to determine whether the organization itself assumed responsibility for occupational illness and injury and if so, if staff were briefed and or given assistance both before and after their assignment(s).

Since one of the purposes of the study is to consider the policies and responsibilities of organizations towards staff, the questionnaire needed to make sufficient reference to services/briefings provided or not by the relevant organization. This also has direct relevance to the role of the organizations in preparedness and prevention.

Thirdly, the questionnaire needed to consider perceptions by respondents of stress and or its symptoms including what if any measures they took to alleviate stress and tension. Here again, what if any role the organization played in assisting staff to avoid or alleviate stress while in the field.

Related to this last is the idea of the extent to which the organization, as a bureaucracy, added to the stress experienced by staff while undertaking assignments in the field. For example, did individuals feel obliged to accept assignments in order to continue working in the organization or in order to gain a promotion? Did respondents feel they had the support of the the organization or were they 'going it alone'? This last point was gleaned more by inference than by direct questioning but was certainly a point which was to emerge from several of the case studies.

Further, Salama (1999) in considering problems exacerbated by the humanitarian sector in general observes that

"relief workers do not usually benefit from being in a well-trained, tightly knit unit with a clear command structure. In addition, training and briefing, particularly with regard to psychological issues, is generally inadequate. This is particularly pertinent for those organizations which deploy a high proportion of first assignment volunteers. Aid workers are often called upon to perform duties outside their realm of professional competency and experience. Finally, there is the pressure when the drive to ensure the visibility of their own organization may over-ride questions of the appropriateness or quality of interventions."[52]

Salama also mentions two other issues which he believes deserve mention

"as relatively modern sources of tension in the humanitarian sector. First is the pressure of discovering that one's internal mandate in terms of personal ethics and preferred approach does not match the mandate of a particular organization. Second is the changing culture of humanitarian work. Organizations are more self-critical than previously and are increasingly putting resources towards evaluating their activities. Inevitably, external criticism, even if constructive, leads to a re-assessment of an individual's perception of his/her

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[52] Op. Cit, Peter Salama, p.13.

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own effectiveness. The latter is particularly true if individuals have an unrealistic expectation of what they may achieve under any given circumstance."[53]

The questionnaire thus sought to identify through questions on: (a) whether respondents had been given briefings prior to and or debriefing upon returning from assignments, (b) if so whether these were effective, and (c) if other institutionally-related stressors existed such as insecure contract status, which might have a bearing on the level of stress and ability to cope with same'.

The questionnaire was designed to determine both by implicit and explicit questions whether the individual concerned believed he/she had experienced stress as a result of their relief work, if so to what extent? And if severely, were the symptoms consistent with a diagnosis of PTSD, as has been variously defined above.

Further, did the organization of the relief effort exacerbate the situation? Could the institution have done more to assist its staff both physically and emotionally. In the first instance, the question was asked: How much rest did you take? In the second instance, did the contractual situation of the individual influence his/her decision to accept the assignment

Finally, in respect of length and structure of the questionnaire, the form was just under six A4 pages in length and was mainly composed of yes/no answers. Opportunity was given to respondents to provide more detailed explanations but such questions were restricted in order to facilitate to the extent possible completion of the questionnaires by respondents. Since all the authorities addressed emphasized the fact that staff did not have the time to undertake interviews and complete surveys the author therefore attempted to keep the questionnaire within a manageable length and format.

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[53]Ibid.

Structure of the questionnaire

The questionnaire was informally divided into separate parts (see Appendix 1). The first part was devoted to basic information about the respondent which included age cohort, gender, nationality, level of education, current job, and field experience. This was followed by a series of questions relating to medical history, whether the respondent had been given a medical examination prior to taking up field assignments, whether a medical kit had been provided, if the respondent had had malaria, whether the respondent had been briefed about malaria risks and what other risks or dangers he/she had been exposed to.

I used questions about malaria, vaccinations etc to determine to what extent the organizations took responsibility for basic health concerns which were likely to affect staff carrying out work in developing countries. At the same time, it was relevant to establish whether respondents had sustained physical injuries or illnesses which, as has been stated earlier, could increase their vulnerability to developing PTSD. **The care taken by organizations in determining the physical health of staff being sent on assignment, as evidenced by the requirement to undergo medical examinations before being sent on assignment, throws into stark relief the limited if any provision made by these same organizations to safeguard psychological health.**

The second part of the questionnaire concentrated to a greater extent on determining respondents' emotional and mental wellbeing. On the one hand, I asked direct questions about any symptoms they might have experienced notably, somatic disorders, avoidance, increases in smoking and or alcohol consumption, lack of concentration, helplessness, inability to cope, palpitations etc. In retrospect, I should also have asked directly whether respondents had experienced flashbacks. I had been hesistant to include this question as I felt that respondents might seek to evade questions on symptoms which were too obviously para normal. I would argue that it is not a normal occurrence to experience flashbacks (as opposed to day dreams) unless a person has been exposed either recently or historically to serious trauma(s).

People are often reluctant, even anonymously, to provide information about their mental health. Mental health problems still carry a stigma. I therefore designed the questionnaire so that it appeared that my interest was as much about organizational responsibility in terms of adequately preparing staff in terms of health safety and personal security generally, as it was about the mental health of the subjects themselves.

I also included questions on whether respondents felt stressed and if they were worried about their personal security, their health and diseases, about their contractual status, their relations with colleagues, friends and family and whether they were worried about their families. Finally, I asked whether they felt to some degree pressured to accept field assignments for contractual reasons.

The rationale for these latter questions was to determine whether external factors beyond the nature of the emergency work itself, add significantly to levels of stress and ability to cope, thus making people more vulnerable to developing symptoms of PTSD. I further believe it is essential to establish whether individuals volunteer for, and continue to undertake emergency work of their own volition or whether there is a degree of institutional pressure to accept such assignments regardless of the personal and emotional circumstances. Whatever the results of the survey, it is a fact that all organizations tend to, one, rely too heavily on experienced staff who have proven that they can do the job, with the result that the same staff and consultants tend to be used repeatedly. And two, to use those with very limited experience who are keen to prove themselves but may not be fully aware of the magnitude of the demands of relief work and may become overwhelmed by the experience.

In both cases, there appears to be a strong element of organizational responsibility. Does the organization provide effective support for its staff, ensuring through a system of checks and controls that those who are sent on assignment are physically and psychologically prepared for the experience? Moreover, on returning from assignments, is there a system of monitoring and support foreseen and provided for by the Organization? Is basic information provided, i.e. adequate briefing carried out prior to departure on assignment? Is a process of educational or psychological

debriefing provided on return or debriefing/defusing techniques carried out, or at least foreseen whilst on assignment?

Results

The total number of relief workers surveyed (taken from the e-mail list forwarded by the staff counselor at WFP to staff in the field) was **79,** plus staff of CARE International and the Salvation Army (absolute numbers unknown but probably in the region of at least **20** each). In the case of WFP, the staff counselor kindly forwarded the survey on the author's behalf to a list of staff whom she considered it appropriate to fill out the questionnaire. In addition, the author also sent the questionnaire to about half a dozen individuals known in that organization. A senior officer in the Salvation Army volunteered to forward the survey to an unspecified number of colleagues in that NGO, of which two replied.

Another officer of the Salvation Army also volunteered her experiences for inclusion among the case studies. With respect to CARE International, a senior officer of the NGO also agreed to forward the questionnaires to an unspecified number of staff of that organization and encouraged them to respond. By the deadline, three staff of CARE had completed the questionnaire.

In addition, as noted earlier, the author also carried out personal interviews with several members of WFP, one staff member of FAO, one former staff member of Concern Worldwide, Ireland and a staff member of UNICEF emergency services.The total number of respondents was **18** (not including case studies) of which **8** were men and **10** women. Of these: **13** worked for an IGO and **5** worked for NGOs.

Of the total of 18 respondents to the questionnaire, three were in the age cohort **25 to 35,** ten were in the age cohort **35 to 45,** 22 percent were in the cohort **45 to 55** and one respondent was **over 55** years of age.

Table 1. Regional distribution of respondents surveyed

North America	Latin America and the Caribbean	Africa	Asia	Europe
5	1	2	4	6

Of those surveyed well over half were from developed countries.

Level of respondents' professional experience

Twelve of the respondents, had worked for four years or more in emergency relief. Of these five had worked for seven or more years with the maximum number being 10.5 years. The remainder had worked for three years or fewer, the average amount of time being four years, eight months. The minimum worked in emergency relief was one month. Of the total sample one respondent had not provided information on the amount of experience acquired but had reached the level of a project manager for an NGO. Two respondents indicated that they had had three and seven postings respectively but did not indicate the duration of their postings. These three cases have therefore not been included in the calculation of the mean.

Incidence of symptoms

Respondents were asked whether they suffered from any of the following symptoms:
- irritability
- sleeplessness
- bad or recurrent dreams
- headaches
- palpitations
- feeling overwhelmed
- difficulty in concentrating
- depression
- anger
- frustration

- difficulty in coping
- feeling of losing control
- change in eating habits
- increase in smoking
- increase in alcohol consumption
- feeling of detachment
- feeling of helplessness
- feelings of guilt or remorse
- conflicts with family/friends

The results were as follows:

- Exactly half the respondents replied that they suffered from sleeping problems either sleeplessness and or bad or recurrent dreams. In general they indicated that this was due to tension, distress at having witnessed disturbing situations and or having worked in conditions where they often felt powerless and frustrated or angry due mainly to their limited ability to make a substantial difference to the lives of the victims they were assisting;
- Fourteen respondents or nearly 75 percent of the total sample admitted to feeling stressed, although in only a few cases was this to a level which could be considered cause for concern. Those who had replied that they suffered from sleeping problems also admitted feeling stressed;
- Just over half the respondents admitted to feelings of anger, irritability, frustration (in general with the nature of the emergencies they were confronting and or with the ineptitude of the relief effort and other administrative/organizational aspects), helplessness, difficulty in concentrating and headaches. Of these symptoms, the most prevalent were frustration and irritability. The least prevalent were helplessness, inability to concentrate, and feelings of detachment. None of the respondents indicated feeling guilt or having conflicts with family/friends;
- Only 10 percent indicated a change in eating habits;
- Five percent an increase in alcohol consumption;
- Twenty percent an increase in smoking.

The questionnaire also asked respondents to answer yes or no to being worried about their:

- contractual status
- personal security
- health and diseases
- family
- interpersonal relations with the following results:

- Ten respondents or over 60 percent of those surveyed indicated that they were worried about health and diseases. In general, personnel working in developing countries expect to catch malaria or some tropical disease or virus at least once as a result of mission work. In a sense this is less cause for concern as it tends to be an area where many organizations, certainly the UN organizations are well prepared and insist on adequate precautions being taken by staff prior to accepting field assignments;

- Exactly half the respondents indicated that they were concerned about their families and in particular their spouses while on mission (in several cases this was cited as a major preoccupation and worry). While some organizations, such as the Salvation Army allow spouses to work and travel with their partners, others, such as the UN place restrictions on the participation of partners, especially for short-term field assignments. This has frequently been cited as an unfair limitation on staff, with potentially negative consequences for both the employee and his/her partner who might serve as a positive influence both as a worker and as a source of stability in an otherwise difficult environment. The issue is relevant in the context of this study in so far as spouses may help to alleviate the effect of such stressors as loneliness, frustration, anger etc.

- Twenty-two percent of respondents admitted to being worried about personal security. This is a surprising low level and may reflect the fact that many of those interviewed were not in fact working in situations of high personal risk. As noted below, however, the reality is that the risk factor for humanitarian staff is relatively high and seems to be an increasing preoccupation by management of the

organizations themselves, who perhaps consider the global figures and trends (WFP for example having the highest loss of life of all UN agencies; ICRC personnel being intermittently subject to arrest and capture while on mission);

- Thirty-three percent of respondents were concerned about their contractual status. This is an area where one might expect increasing concern as the trend continues to hire staff on contract basis, thus increasing the likelihood of insecurity among short or fixed term staff; and

- Seventy percent indicated that if they hadn't accepted assignments they believed this could have influenced future work prospects. This relates to concern about contractual status generally and similarly reflects an increasing reality in many organizations. For the purposes of this study, it is relevant because it implies that beyond altruistic motives, relief staff accept assignments because they have little choice. Several respondents indicated that if they hadn't taken missions that were offered to them they believed that other offers would not have been forthcoming in the future. While one respondent stated that he believed anyone working for a relief organization should expect to be sent on mission, others admitted that the lack of an alternative, especially where individuals felt that their personnel security could be jeopardized, acted as a significant stressor and was not in the long term interests of either the individual or the organization concerned. In the latter case, the organization might expect a better performance from staff who were enthusiastic and eager to participate in missions rather than accepting assignments for lack of an alternative.

Table 2. Total hours worked while on mission

Over 12 hours	9 to 11 hours	6 to 9 hours	Fewer than 6 hours
6	9	3	0

The results indicate that the majority of relief staff work a longer than average day - average being defined as an 8 to 9-hour day. While the majority also indicated that they did take regular rests while working on mission, a little over half indicated that

rest periods were not required. Of the six respondents who said that they did not take rest periods while on mission, there was no difference between genders. Both genders responded equally that they did not take rest periods, even when required by the Organization. Of these six, two worked for NGOs and four were employed by and IGO.

Seventy percent of the sample indicated that they would benefit from a rest period after finishing a mission. Given a choice of number of days/months of the rest period, the choices were: 3 to 5 days, 5 to 10 days, two weeks, three weeks, or more. The majority of those indicating that they would benefit from R&R after a mission chose a period of 3 to 5 days, with none of the respondents indicating more than 5 to 10 days. There was no significant difference in replies between gender or between IGOs and NGOs.

The practice is generally that rest and recreation is granted to staff members in particular those on so called 'hardship' posts but does not appear to be consistently applied and is only given to staff members, with consultants excluded.

The reality is that those returning from assignments return to their desks and may have little or no time to recover following a field assignment unless they apply for paid or unpaid leave. It is noteworthy, that while paid leave is often generous in terms of the total amount of time allowed, usually up to 30 days to six weeks (in the UN system), it is rarely feasible to take more than one or two weeks at a time (at most). This is particularly the case, in busy agencies with limited staff. The more experienced the staff, the more they are likely to be under pressure to restrict leave time because their skills and experience are required in the organization. This can have negative results, as pressure builds on the few experienced personnel who in turn accept progressively more responsibility and may not feel the effects of stress until their condition is well advanced. The author has met at least three senior staff of relief organizations who have had to retire early or take indefinite sick leave due to job-induced burn-out resulting in severe depression (attempts at suicide, drug or alcohol addiction). Such policies also have a negative effect on colleagues who may wish to be considered for field assignments that are repeatedly given to the same people.

As noted above, the total sample of respondents was 18 people, not including the case studies. Of those 18, if we consider the description of symptoms which were defined at the beginning of this paper which "normally involved one or a combination of occurences such as flashbacks, recurring nightmares, sleeping problems, emotional instability sometimes leading to violent outbursts, emotional and or physical withdrawal from family, friends and colleagues, alcohol and drug abuse and a number of other related problems."And compare these with the responses, there is a limited coincidence of the following symptoms: sleeping problems, irritability, anger, frustration.

Others which were indicated by respondents and which may be related were depression, difficulty in concentrating, a feeling of helplessness, and in one case feelings of detachment (this respondent also explained that she was having marital problems and was not coping well emotionally in general). Of the eight cases of respondents with one or more of the above symptoms, five were from developing countries. Five of the eight were also women. All but one had four or more years of experience as a relief worker and included the person with the longest service, 10.5 years. In terms of educational level, five of the eight had Masters level degrees (as against a total sample in which 84 percent of respondents had one or more university degrees). Of these eight, four worked for an IGO and four for NGOs. This may be statistically relevant, when we consider the proportion of the total sample that worked for IGOs and NGOs, where over 75 percent of the sample worked for an IGO.

Finally, the questionnaire also asked for information on personal coping strategies. Fourteen respondents indicated that they had developed a coping strategy. The most prevalent methods of dealing with stress being socializing, exercise and relaxation techniques such as yoga, massage and meditation. Seventy percent of respondents lived with a partner. To the question whether they preferred to talk about their experiences with friends and colleagues, all those sampled replied in the affirmative. As a result, this may be significant, given that a primary symptom of PTSD is avoidance. Most respondents indicated that it was important to share their experiences with spouses, colleagues and friends both in the course of their assignments and on returning from the field.

CHAPTER V. ABOUT THE ORGANIZATIONS SURVEYED

Introduction

Initially, it had been my intention to include a number of IGOs as well as diverse NGOs in the survey. In the event, it was possible only to circulate the questionnaire among volunteer staff of one IGO – the World Food Programme, and only this after many setbacks. However, I did include in the case studies, and in my general discussions with senior staff of several other UN agencies, interviews with staff at UNICEF Emergency Services, FAO and the International Fund for Agricultural Development (IFAD).

In terms of approaching NGOs, the task was easier with those approached much more receptive to the proposal to include volunteer staff of their organizations in the survey. CARE and the Salvation Army were more geniunely interested in assisting me and in considering issues associated with PTSD. The World Food Programme was dubious in the beginning as to the merits of such a study and as noted below, perhaps understandably given the high-level of deaths of staff in the field, as well as the fact of the Kosovo plane crash (see below) which had occurred not long before my proposed survey.

In summary, the following organizations were consulted and staff members either agreed to direct interviews or to complete the questionnaire:

- CARE International
- FAO
- The Salvation Army
- WFP

Other organizations consulted were UNICEF Emergency Services (Geneva) and IFAD. Profiles of all organizations are based on media information obtained from the organizations including their own Web sites (see Bibliography), and in the case of FAO and IFAD, from the author's own access to information about the organizations as a

consultant for both agencies. For WFP, the information was from the Web site as well as personal knowledge of events and media sources cited in the text.

CARE International

Among the largest of the international NGOs, CARE works both in emergency relief as well as in longer term development assistance. Founded just after World War II, it is extremely well established in both relief work and development, probably having accumulated greater experience than most of the more recently established relief-oriented UN agencies.

The organisation also claims[54] to be politically influential "CARE has the international stature and public support to help influence policy decisions in the United States and overseas. According to their description of their activities their "on-the-ground experience and independence lend us nonpartisan credibility and respect. We use these, very selectively, to advocate in favor of policies that will help foster development, peace and justice."

Given its very broad international outreach – reaching some tens of millions of people in more than 60 countries – CARE's mandate and accumulated experience would indicate that it should therefore have a corresponding experience and approach to providing in-house support to its own relief staff. Unfortunately the author was only able to include a few CARE staffers in the questionnaire survey neither of whom indicated special attention in this area.

The Food and Agriculture Organization of the United Nations (FAO)

Established in 1945, FAO is the largest specialized UN agency, with over 4 300 staff members and 80 field offices around the world. It is concerned primarily with providing technical assistance to its 180 member states. In the past five years, since the World Food Summit held at FAO Headquarters in Rome in 1996, at which member

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[54] http://www.Careinternational.org

governments pledged to halve the number of undernourished to half their present number (800 million) by the year 2015, the Organization has also become increasingly involved in emergency rehabilitation and reconstruction. This is in part due to an increased commitment following the Summit to assist member states in their food security planning and implementation of strategies and policies, and partly due to emergency assistance initiatives started by the present Director-General during the Great Lakes crisis in Africa which was occuring in parallel with the World Food Summit in the autumn of 1996.

In 1999, the FAO's Special Relief Operations Service (TCOR) obtained funding for US 45 million for a total of 120 projects in over 50 countries, in 2000 this level had already been reached by July of that year.

FAO's office for Special Relief Operations (TCOR) provides information through assessment missions about the food and agriculture situation in areas where emergencies have started or are ongoing. While it is rarely if ever at that forefront of primary relief efforts, FAO increasingly sees its role as an essential provider of basic inputs to farmers and others affected by drought, desertification, civil conflict etc. For this reason, TCOR fields a steadily increasing number of needs' assessment missions to emergency zones, in order to begin planning, together with other specialized agencies and national and international NGOs, strategies for short-, and medium-term rehabilitation. While staff may not be involved in direct disaster relief work, employees (including consultants) are sent with increasing frequency to emergency zones, often at very short notice. They are therefore exposed, albeit mainly at the level of observers and negotiators with government ministries involved in reconstruction and rehabilitation, to emergency situations.

As FAO takes its role increasingly seriously in this area, the relatively small staff of TCOR are under considerable strain not only in terms of the workload but also because they may be required to travel on mission at short notice to areas where death and wide-spread poverty and disease are rampant. Although such staff may not be sent on mission for more than several weeks at a time (aside from those on long-term

postings with the field offices), the heavy workload and difficulties inherent in working with governments often in crisis situations is potentially very stressful.

The Salvation Army

Unlike many other international NGOs, the Salvation Army is somewhat exceptional in so far as it is a church as well as being a *de facto* aid organisation. According to the Army, Salvation Army officers have the status of ordained ministers and are employed by the Army in a professional capacity and on a full-time basis. They are members of The Salvation Army who have committed to working for the church and serving others. They come from all walks of life - from varying backgrounds and occupations - to complete a two year residential course at a Salvation Army Training College. On commissioning (equivalent to ordination in other denominations) they receive the rank of lieutenant. After five years, they are promoted to the rank of captain and after a further fifteen years they receive the rank of major. All officers wear uniform. Married women undertake the same training and receive the same commission as their husbands.

The majority of officers are responsible for a Salvation Army corps (church), with a pastoral role and community service. Others serve in social service centres, Goodwill community centres or in an administrative capacity at headquarters. They receive a standard allowance of money whatever job they do and accommodation is provided. The hours of work are long and officers are expected to be ready for duty at any time of day or night.

An officer's Ministry includes preaching, distributing Salvation Army literature, visiting hospitals, institutions and prisons, counselling, conducting weddings and funerals, being a pastor to their congregation and administrating the church programme.

Members of The Salvation Army are known as soldiers. They sign the 'Articles of War' which state the Army's beliefs and accept certain moral standards, eg, Salvation Army soldiers do not smoke or drink alcohol. Most have their own job or profession.

Given that the commitment to work with The Salvation Army is also a commitment of faith, one might expect that some of the tensions associated with working for a large bureaucracy such as a UN aid agency may be lessened, since the commitment,at least in theory is presumably stronger, and it would appear more truely philanthropic.

In addition, as can be seen from the variety of different areas in which the Salvation Army works, its members may have more flexibility in the kinds of assistance that they offer, as opposed to UN agency staff and consultants, who tend to work only in the field of specialisation of the agency concerned (i.e., food aid in the case of WFP, resettlement and refugees in the case of the United Nations High Commissioner for Refugees (UNHCR), health in the case of the World Health Organisation (WHO), etc.).

Areas of operation

The Salvation Army works in just over 100 countries using more than 140 languages. There are over 14 000 centres as well as a wide range of social, medical, educational and other community services including: accommodation for the homeless; rehabilitation through occupational centres; food aid; care for the elderly; health and child care; education; refugee assistance, and drug and alcohol rehabilitation.

The World Food Programme (WFP)

Described as the United Nations' "front-line agency" in fighting world hunger, the World Food Programme (WFP) provided emergency food aid to 16 million people in the first eight months of 2000 (this compares with just three million in 1996). The agency employs 5 248 staff (August 2000) of whom 2 355 are regular staff and of these 1 764 work in the field and 591 work at the agency's headquarters in Rome, Italy. An additional 2 893 staff are employed on a temporary basis.

To give some idea of the scale on which WFP operates, in 1999, the Programme delivered 3.4 million tons of food to 82 countries facing either natural or man-made disasters and large-scale emergencies. Total expenditure by WFP in 1999 was US$1.568 billion. By August 2000, there were an estimated 100 million people in 20 countries severely affected by drought alone. As described by an official of the Organization[55] WFP was

> "literally working in every part of the world to provide emergency food aid to people who have lost their crops or livelihoods due to drought." The same official had noted, for example, that "throughout the 1990s, drought-related emergency operations represented 52 percent of WFP's 194 natural disaster responses. Droughts required 102 interventions, while flooding called for 50, hurricanes, typhoons and cyclones accounted for 21, damages from pests 10, earthquakes seven, and the rest were due to volcanic eruptions, avalanches and cold waves. "

According to the WFP Website, the Programme "has the smallest headquarters staff and the lowest percentage of budget devoted to administration (averaging only nine percent) of any UN agency." It claims that "this is important because WFP's budget is voluntary and based on performance, linked to the tonnage of food it moves. Contributions - either in cash, commodities or services -- to WFP come from donor nations, inter-governmental bodies such as the European Union, corporations and individuals."

Logistics

In providing food aid to countries, the WFP charters its own airplanes and boats with food donations provided by individual donors or purchased by WFP where direct food donations are not available. This means that most of the transport and distribution of food aid is organised by the Programme with the assistance of Member Governments. Staff are therefore responsible not only for monitoring and implementing emergency relief but also for providing logistics support and back up.

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[55] IPS Daily Journal, *Drought Spreads Through Poorest Nations*, 11 August 2000 Vol. 8, No.148, page 6.

Being sent to the field

In general, WFP staff expect to be sent into the field for periods of days, weeks or months, or when being posted to areas where the Programme maintains a country or regional office, sometimes for one or more years. The salary system is based on the United Nations salary scale for both Professional and General Service Staff (secretaries, administrative assistants, clerks, drivers, etc) and there is no additional remuneration or "danger money".

Security in the field

Security has become a priority issue for WFP. This point was underscored in a press release distributed by the Programme in November 1999 which quoted the Director-General of WFP, Mrs. Catherine Bertine as warning "that an alarming trend had surfaced in the last few years, that of the deliberate targetting of aid workers as a political strategy by groups in a conflict..... Last year, for the first time in UN history, the deaths of civilian relief workers outnumbered those of military peacekeepers. Between 1992 and 1998, 173 UN employees were killed in the line of duty. WFP has lost more employees than any other UN agency -- 50 since 1988 -- in murders or work-related accidents or illnesses". Mrs. Bertini had also warned that "safety and security for aid workers were non-negotiable".

The press release reported that the Director-General was "urging the international community to work closely with the parties in conflicts to restore respect and protection for all humanitarian workers. The high-risk jobs for many of WFP's more than 5 000 staff members are in emergency operations in countries with civil conflicts or major refugee crises. Many of those who died were attacked or fired upon while they were delivering, monitoring or safeguarding food aid." The release further noted that WFP maintained "a policy of suspending its operations in a country if its employees are not guaranteed secure conditions in which to work."

The same report noted that "the intent of the Geneva Convention was clear: personnel of humanitarian organisations were to be respected and protected in times of

war," to wit Mrs. Bertini had stated "We must not allow any further erosion of this agreement."

But while public statements from the Organization express the high level of concern about the issue of staff security, in real terms this does not appear to have translated into the adoption of rigorous security measures being introduced to support staff sent to the field. As with FAO, the main responsibility for ensuring security comes under the aegis of the United Nations Security Coordinator for a given country or region. The individual agencies have thus been constrained in their freedom to impose their own conditions, although it is by no means clear whether they would to an effective degree if given the opportunity.

At the same time, however, there are measures which could be taken, and which are currently not being implemented to make staff less vulnerable to attack and menace in the field which would not jeopardise the relationship or hegemony of the United Nations Security Coordinator. These include providing better information and strategies for defense to staff and by ensuring that staff who may be especially vulnerable in certain countries and areas such as women, are not sent to high risk zones.

Staffing and recruitment

Staff positions in WFP, as in most UN agencies, are much sought after due to the relatively good UN salary system, associated benefits such as staff pensions, medical insurance and subsidies for housing and education and for the international experience which such organisations provide both at headquarters and in the field.

Consultants' contracts with this and other UN organisations are also very popular, as the pay is relatively competitive in international terms, and while there are few additional benefits for consultants, regular work with the Organisations can lead eventually to a fixed term, staff contract and or to consultancies with other UN agencies or national aid agencies (such as the Danish International Aid Agency, DANIDA, or the Norwegian aid agency, NORAD) or to work with prestigious international

non-governmental organisations such as the International Red Cross, Doctors without Borders, CARE International and the like.

As with all UN agencies, at present, the general conditions for employees are such that the organisations do not have trouble recruiting staff (recent vacancy announcements for mid-level career professionals have resulted in receipts of several hundred applications per position advertised). Exceptions to this are in those countries where very high national salary scales may make the UN salary system less attractive or in recruiting from developing countries where there may be a dearth of skilled professionals. In the former case, this applies mainly to Japan, the United States, Germany and Switzerland. In the case of Japan this is true to the extent that where, in particular, senior Japanese staff are employed, their government may offer an additional amount to bring the UN salary in line with national salaries for the qualifications and experience.

In the latter case, the recruitment of suitably skilled men and women from developing countries has traditionally been found to be difficult but this is becoming less of a problem every year, as more educated and skilled professionals enter the job market and access to recruitment information is better publicised. It has nevertheless been cited by the Human Resources services of several UN agencies, especially those which try to achieve a representative regional, country balance and increasingly gender balance, as a major problem.

The Kosovo plane crash: implications and effects

On 12 November, 1999, three staff members of WFP and another 21 persons, most of whom were UN and other aid workers were killed in a plane crash near to Pristina in Kosovo. The plane was run as a regular charter flight (KSV3275) by WFP, as part of its general relief effort in Kosovo. The Pristina-bound plane which departed daily from Rome had been expected to arrive at its destination at 11:30. The last radio contact with the plane was at 11:15. Upon learning of the news of the plane's disappearance, WFP contacted the authorities in the capitol, Pristina to begin a search and rescue mission. The plane was eventually located in the evening of the same day,

approximately 15 kilometres north of Pristina in a rough and hilly terrain, dotted with land mines. Ironically, it was unofficially reported at the time, that the plane had just been replaced having been in very poor condition and laughingly referred to as the 'old bucket'. There were no survivors from the flight and the relief effort itself was hampered by poor visibility.

The immediate effect on WFP and its staff was unparalled in the agency's history. Many staff worked around the clock to assist in the relief effort – most notably in the identification of victims and in contacting the families of the victims as well as in dealing with the press and in carrying out administrative and formal duties associated with liaising with the local authorities, the plane's charter company and to a much lesser extent in clearing the wreckage of bodies and debris, as this was mostly carried out by emergency services in Kosovo. Many of the staff, and regular colleagues that the author spoke to during this period and for about one to three months after, were extremely shocked and saddened by the accident and the lives that it had cost. **The plane crash had a much greater impact than the lone killings and other security-related incidents to which agency staff have been increasingly exposed. This is in line with the findings of a number of studies which have found that levels of stress and trauma are directly related to the magnitude and suddenness of a disaster.**

In the wake of the plane crash, a specialist agency, Kenya International was reportedly called in to provide its services to staff who may have been affected by the shock resulting from the accident. Kenya International is specialised in dealing with PTSD and other stress-related conditions associated with disasters of this magnitude. Human resources and senior staff however were reluctant to talk about the effects on the organization except to admit that the disaster had resulted in a much greater awareness and concentration on security issues and the possible effects of trauma-related shock on staff working for the Programme.

Why were staff more affected by this disaster than by isolated incidents of aggression, injury and even death among individual staff members? The reasons probably are due to the the large scale of the accident, its suddenness and unexpectedness, and to the fact that the plane had departed from Rome where the

agency is based and was under charter to WFP. This meant that most of the regular headquarters staff and headquarters consultants were probably affected either directly or indirectly by the incident as were some of the local field staff.

Having to deal with the victims' families, and to be involved in the formal death duties, memorial services and funerals of the victims, many of whom were Italian, directly involved or indirectly affected many of the staff working, not only for WFP but also for FAO and to a much lesser extent IFAD.

Relationship with other Rome-based agencies – the Food and Agriculture Organization (FAO) and the International Fund for Agricultural Development (IFAD)

As noted above, the Kosovo plane crash had some indirect affects on staff working in other UN agencies in Rome. One of the reasons for this is that until the mid-1990s, WFP was housed together with FAO in one of the same sets of buildings set aside by the Italian Government for the food-based UN agencies. Personnel and administrative policies were traditionally very similar among the agencies with the wives and children of staff of one agency often working for a sister agency (only recently however have staff of FAO been allowed to have spouses working at WFP, whereas they were eligible to work for other agencies such as IFAD and the International Centre for the Preservation and Conservation of Cultural Heritage (ICCROM) in the same city). Many consultants both based inside and outside Rome work for several of the agencies and thus there is a fair degree of inter-agency collaboration and sharing of information as well as staff, and to a much lesser extent of services.

The fact that personnel policies are very closely allied means that any innovation or policy taken by one agency may, but will not necessarily be replicated in a sister agency. It is becoming obvious however, and especially according to this author in the light of FAO's increasing role in international emergency relief efforts, that issues of personal security, and agency approaches to medical benefits, counseling services etc,

are likely to receive much greater attention in the near future, particularly as a result of increasing security risks experienced by staff of both WFP and FAO in the field.

Regarding the latter, in July 2000, two FAO staff members working in the FAO office in Baghdad were shot by gunmen while at work. FAO's assistance to Iraq under the Oil-for-Food programme had brought the organisation under criticism from a number of quarters antagonistic to Iraqi President Saddam Hussein. FAO's task under the Iraq programme,which has deployed a total of 32 international staff and 326 national staff, is to formulate and implement agricultural assistance projects in three northern Governorates of Iraq. The total value of the agricultural component of the Oil-for-Food programme for example, is US$ 139 million and compared with the total volume of operations undertaken by FAO's Special Relief Operations Service (TCOR) of US$ 45 million in 1999.

Currently FAO has Emergency Coordination Units operating in 13 countries, although TCOR runs 130 projects in 48 countries with activities ranging from the reintegration of ex-combatants and refugees, locust control, aerial spraying, distribution of seeds and other inputs and the coordination of agricultural interventions. With the ongoing crisis in the Horn of Africa, FAO is expected to increase its emergency operations, the level of operations by August 2000 already surpassing the level reached for the whole of 1999.

This means that FAO, while generally not in the front line of emergency relief efforts like WFP, should nevertheless be prepared to face some of the same problems which may affect staff members and consultants as those agencies which undertake emergency relief as a matter of routine (WFP, UNHCR, UNICEF Emergency Services, etc). One might expect therefore that in terms of policies on security and risk in the field, the Organisation would seek to ally itself as closely as possible with WFP which has more direct experience in emergency relief operations. To date, this does not appear to be the case but could change rapidly as security and its related insurance concerns become issues of increasing attention by all agencies.

The third food and agriculture based agency in Rome is IFAD with whom both FAO and WFP have regular contacts. Many of the same consultants [56] who work for FAO and WFP also work for IFAD. IFAD is nevertheless tiny in comparison with the other two agencies having not more than 300 fulltime staff members. Most field work is done by consultants on short missions. Since the nature of IFAD's work is generally, longer-term development assistance, those working for the Fund have only very limited exposure to emergency situations and thus to the kinds of strains to which many of the staff of its sister agencies are exposed. Nevertheless, IFAD recognises an increasing role in emergency assistance and would doubtless be involved in any major reforms or policy changes taken by the other agencies in terms of dealing with the welfare and mental health of its employees.

Implications on staff health and wellbeing

For years, the agencies have failed to establish effective policies for dealing with problems of alcohol and drug abuse, mental crisis and psychiatric complaints all of which arguably result from varying degrees of work-induced stress. These problems have frequently been handled in a half-hearted manner, especially as nervous breakdowns, substance abuse and severe strain and anxiety are often difficult to diagnose until the condition has developed to a critical level.

The danger is, and has been, that such conditions may even be suspected but sufficient efforts are frequently not made by colleagues and those in authority to confront the sufferer and provide the needed guidance and assistance before the condition is far gone. Of still greater concern is the fact that employees may be severely strained but adequate efforts are rarely made to prevent them from incurring further risks to their health, even where they may have indicated (and or taken increasing amounts of time off on sick leave) that they were having problems in coping. Examples include inability to work with colleagues, recurring illnesses and other justifications for absenteeism, refusal to undertake assigned tasks.

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[56] *Post-crisis Assistance: the Role of IFAD* (1999) printed by Christengraf S.r.l., Rome, Italy.

CHAPTER VI. CASE STUDIES

Introduction

Aside from the respondents to the questionnaires, some detailed descriptions were also received from six interviewees who I used for the purposes of carrying out individual Case Studies. These varied considerably in degree of detail as their accounts depended on the length of time interviewed, whether the interview had been carried out in person, and personal preference in terms of how much information each interviewee was prepared to provide. In four of the six cases, the interviewees were previously unknown to me. One of these four had sent me two audio tapes which I have transcribed below (Case Study One), another provided me with a detailed written description based on having seen my questionnaire but preferring to give me his own written account rather than completing the questionnaire (Case Study Two).

The remaining four were compiled on the basis of one-to-one interviews. None of the six had completed a questionnaire, although four of the six had seen copies of the questionnaires. All of the six preferred to give me their own description of their experiences as emergency relief workers. The fourth Case Study refers to a husband and wife who have been doing similar jobs as emergency workers. While the interview was carried out with the wife, who was referring mainly to her husband's condition, her situation is also relevant and has a bearing on the issue of organizational responsibility.

Since all but one of the interviewees are still working for international relief organizations I have changed their names so as not to jeopardize their positions and out of respect for their privacy.

What emerges from the descriptions in all six cases is that all of the interviewees have experienced extreme forms of work-induced stress which has had a traumatic effect on each person (to greater and lesser degrees). In several of the case studies this results from threats to their personal security. In others, the major stressors are the demands of their jobs which require working under pressure, being given excessive responsibility, coping with very emotive situations like the handling of the dead and the

dying, and having to deal with exceptional situations in their personal lives in parallel with the pressures of their jobs.

Case One - Liliane D.

Liliane D., a former nurse, and her husband headed a Salvation Army relief team in Rwanda for three months following the 1994 genocide in that country. One team followed another. The team worked to repair roads, build houses, run a feeding and clothing programme, as well as run health, orphan, agriculture, husbandry and other programmes, together with a mission. The team had 40 000 people to care for in remote areas.

During this period, Liliane was taken hostage during an armed robbery. During the robbery she was severely injured which resulted in surgery for massive abscess – a neurological problem from infection of which is ongoing. She now has only partial use of her legs and arms and is likely to lose all use of her legs in future. She says that in general she has coped well because of her 'spiritual attitude'. In the following transciption of the tape which she sent me explaining her reactions to attack and the after effects; she noted that while on mission, no care in the form of counseling had been available. On returning to the United Kingdom 12 weeks later she had declined counseling. She now says that she has no regrets, no anger, no hang ups and would return to Africa if she was well enough. She said that she was currently on permanent medication for Irritable Bowel syndrome, panic attacks and pain. She observed that she does relive fear when she hears of hostages being taken.

Transcript from audio tape one:

"The way I reacted after the armed robbery and since has been very much governed by my spiritual life. A lot of relief workers are not christian, and I am amazed at how they face up to the difficulties of relief work. I don't think without my religion I could go out into a dangerous environment as well as face all the daily hardships....

When I was first stabbed in the calf with the barrel end of a machine gun, which went in about two inches, I cried out and my husband tried to say something but he was kicked in the back. After that I can't really remember feeling any pain. I remember being hit across my pelvis five or six times with a machine gun (which later bruised below the skin and caused all the after affects). They stood me up and the gunman said whatever happened he would take the money and "kill the woman", so I really did feel my time was up. (The gunman was obviously high on drugs, he kept running about and spitting and snarling like a caged animal). The gunman said to the other two men "take the woman out of the room and I'll cover the men with the gun." I think then, everybody realized that I might be raped or something because very quickly, the Project Chief said "she doesn't know where the money is and I do". Then they just pushed me against a wall and started to deal with him, they pulled him onto his feet and demanded that he give them the money. (We had a lot of money in the house because the banks in Rwanda and not started functioning so all the aid agencies were working with cash in dollars. We, however, were the only agency that lived in our own compound therefore we had the money in the house. they). Once they had got the money, they locked us in a bedroom, having first pulled out the telephone wires. It took about 20 minutes for the men to get out of the bedroom and raise the alarm at which point the UN came to rescue us. But I had had to stop the five men I was with from making lots of noise in an effort to break out of the bedroom, I made them lie still on the floor for some time until I felt the gunmen were safely out of the way, otherwise they could have shot at us from the window. I could almost feel the fear of the African guard who was lying next to me on the floor, and had lied to the gunmen saying that the big boss was due back any time and would find it strange not to find the guard at the gate, the guard had been hit over the head and bundled into the room with us. Strangely enough, when we were lying on the floor - the three men and myself - it was me that actually took control. Everytime they had opened their mouths to say something they got kicked or something, they didn't seem to have the common sense to shut up, so I simply told them to lie still, be quiet and pray.

When we got out of the room, again I took over, I went and made a big
pot of hot, strong, sweet tea while they radioed the UN troops. It is interesting,
that at the end of the day it was the woman that swung into action and organized
things.

After this there was lots of questioning and I attended to my wound.
Then we must have slept or something because it was only the next day that I
really fell apart, I kept bursting into tears, I was really touchy and jumpy and it
was really at that point that the men started to take over. The men then decided
that I and another two women should go to a hotel until such time as security
arrangements had been improved in the compound. But I just couldn't return to
the house and I couldn't even carry on with my work, I felt like a piece of
chewed string. We decided to take a day of prayer with some of the other
officers. After that I felt my stronger and calmer and I knew I didn't want to go
back to England just yet. We did in fact have several more holdups but we did
everything to sure ourselves up. We made ourselves as secure as possible. I
settled back to my routine as much as possible, although the wound in my leg
was nasty and I had to be very careful with it as we only had one course of
antibiotics. We tried all the other agencies including the UN, but although they
had doctors around they didn't have any medicines. The whole country was at a
standstill. In the end, I made poultices of smashed up papaya and wild honey,
and amazingly, it healed perfectly and I barely have a scar. However, after
about ten days my legs started to swell and tingle, I continued working. This
brought me much closer to the Rwandese who felt I had been touched by the
same evil that was affecting them, even though my injuries were nothing in
comparison to theirs. I continued on until two weeks before we were due to
return. I was also very tense and afraid for my own security. Every day when I
went out to work, I would be stopped and searched at three road blocks.
Sometimes the guards who didn't know me would be very rough and this didn't
help to decrease the general tension I was living under. However, ten days
before we left, I had been having physiotherapy informally from a local
therapist, as there were no painkillers available but unfortunatley during these
treatments an enormous abcess had been growing which was ruptured with the

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therapy. It burst and spread poison throughout my system. Although we did manage to get a little morphine, by the time I got the flight home to England I couldn't walk anymore. I went to hospital for three weeks and was operated on for the abcess but for which reason I had not been able to visit 'INTERHEALTH' in London, the health centre that all missionaries go to on returning from overseas missions.

Four months later I did visit INTERHEALTH and they checked me out for tropical diseases. When the doctor heard about my experience, he was very keen that I should go for counseling but I said no because I thought I had come to terms with it. For the next six months, every time I went to my GP he would ask me questions about what had happened and I didn't know why he was doing this. I must admit that I had begun to feel very jumpy, a bit tearful and depressed and I wasn't sleeping well. After nine months, I went to visit him and I just burst into tears, and he said "this is what I'd been waiting for". He put me on anti-depressants which I have been on ever since (also because one side effect seems to be irritable bowl syndrome which doesn't seem to affect me when I'm on the anti-depressants). I am now on a very low dosage but I am still taking the pills. I have noticed that if anything distressful happens I feel more than usually depressed. About two months ago I started feeling tearful and jumpy again and I upped the dosage and I seem to be alright again. But these are all warning signs. But exactly two years after the accident, not just one but both legs but began to go numb because the nerves have been damaged. Recently, I have also begun to lose feeling in my hands and arms. I am told that I may lose the ability to use my legs completely and possibly also my arms. In the light of this news, I really have had problems being positive about everything. The only positive thing is the hope that maybe I won't lose the use of my legs and arms.

I still don't think I need any professional counseling, although I have been out talking to a lot of church groups about my experience which is very therapeutic and also I am talking to many doctors about my health generally. I am not angry or resentful but some little thinks upset me like hearing of people

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being taken hostage on the news, or hearing an ambulance alarm (which reminds me of the guards alarms on the compound). But what happened to me is still not half as traumatic as what the population itself was experiencing. Watching parents see shallow graves dug up and identifying their children and other terrible incidents were much worse than my experience."

Transcript from audio tape two:

"Oh dear yesterday I had one of the most dreadful but fascinating experiences. Yesterday I had to go to the hospital for an MRI scan on my back which is all to do with my post Rwanda injuries. I am actually a very sensible person, I don't panic and I am very strong-minded. But I have had problems with claustrophobia since the Rwanda injury. Now I knew what was going to happen with the MRI. I knew I was going to go into a sort of tunnel, a bit like being in a sunbed, and I am sure I have had hundreds of sunbeds in the past, and I knew that I would have a buzzer that I could ring and that I would be able to hear one of the girls talking to me. I wouldn't be in the dark. I knew it was going to be noisy and I knew it wasn't going to hurt me.

I basically knew everything about it and a lot of people had talked to me about it. They did seem to be a little bit tentative about being claustrophobic. But I didn't take anybody with me, I was perfectly alright. As a former nurse, hospital equipment doesn't phase me either although I said to the radiographer that I was a little claustrophobic. I went in and saw the machine, saw the tunnel which did look a little narrower and more enclosed than I had imagined but I knew nothing was going to hurt me. I went in, laydown on the machine, the radiographer talked to me and I said that that was fine and she started to shunt me in. I got in as far as my waist and suddenly I just blew. I just panicked. I tried to keep calm and I said "you just have to get me out, you have to get me out."

They agreed and brought me out and I started to breath deeply and I can't begin to explain what happened to me then. It wasn't just claustrophobia, I was absolutely terrified. They talked to me calmly, but I said to them that I just couldn't go in and I burst into tears and I sobbed and sobbed. Apparently I went absolutely ashen and the radiographer said every time I looked at the machine, she had never seen a patient so terrified. She had seen patients not wanting to be closed in but it was something beyond that. Suddenly I started to tell her about Rwanda, the whole lot began to tumble out. I told her that it brought back memories of being held at gunpoint. I had had a gun actually touching me for about 40 minutes. I was in a position where I couldn't get out. I couldn't talk my way out and I couldn't physically run away or fight my way out. I was absolutely trapped. I was at the end of a gun. Then, although I had never really talked about it, five of us, including a guard, had been locked into a bedroom with

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three single beds. We were locked in and I can remember feeling the terror of the moment when all the men wanted to start breaking out and I could remember feeling so terrified that they were going to do that before the gunmen had actually left the property and they would turn back on us and shoot us out of panic. I just didn't know if I could hold four men back from getting all excited and trying to break our way out. All that came back to me, the fact that I was lying on the floor in this bedroom and I could see the robbers going past the window and counting them. There had been three, I counted two going out but the third (black) man I hadn't seen and I remember that feeling of terror of not knowing where people were, especially black men in the dark. And all this came back to me just going through that MRI scanner. I was in such a state that I was nearly hyperventilating and they had to take my blood pressure and pulse before putting me in it again. But all I could think of was that the surgeon was going to be furious with me if I didn't do the scan, because he would never understand how I'd feel. In the end the radiographer gave me some eyeshields. I pulled them over my eyes and I simply talked non-stop and kept telling myself that I had to be patient.

I went in singing Salvation Army choruses and I was praying. I said to them "you'll hear me talking to somebody, I shall be praying and I am not a bit ashamed of it", so I basically just talked my way through it. I finally did it and I was so proud of myself but I am just so ashamed of what happened and nobody will ever know how I felt. It wasn't just claustrophobia. It was a very real flashback and I panicked. The radiographer said she had seen people suffering from claustrophobia and not being able to go in but she had never seen anybody so terrified, "you would have thought somebody was in there beside you with a gun."

It is so ridiculous. I tend to think now that I should have had counseling. I haven't come to terms with it, not deep down. But I am just going to avoid MRI scanners again. It was terrifying but very interesting. I could even detach myself and see that it was fascinating that five years on, something just triggered it off."

Despite Liliane's initial assertion that she doesn't need counseling, I think the fact of being on anti-depressents, together with, among other indicators her reaction to the above incident, are indicative of PTSD, for which some sort of counseling or other psychiatric assistance might be appropriate, particularly were she to accept further mission work. While her religion has played a very strong part in pulling her through, there is no doubt that she has been the victim of trauma resulting from, to use the definition from the police officers' study of an "intentional life-threatening violence by another person(s)". From the same study, factors which may have contributed to the development of the disorder were the surprise nature of the original attack and "lack of

perparation, or lack of knowledge of the event ahead of time" and her "helplessness" during the violence itself.

This is an interesting example because it is difficult to determine whether the Salvation Army itself is partly responsible for the event, i.e. not ensuring sufficient security to protect members from the violence itself, and not having provided as a contingency for effective medical assistance after the trauma which eventually led to the subsequent deterioration in her physical and emotional condition. This is both an ethical question and a policy issue. Since the Salvation Army is a voluntary organization and members believe they have a 'calling', it is difficult to define where individual responsibility ends and organizational responsibility begins. By her own admission, her initial reluctance to leave the compound following the attack, and later to leave the country, earlier than her scheduled return home were more than partly responsible for the decline in her physical condition after the incident. As she points out, her husband and colleagues had tried to persuade her to move to a hotel directly after the event.

I believe the organization has a responsibility to its staff, or in this case its members, to protect them from further incident even if the individuals themselves may prefer to "rough it out". If the organization doesn't intervene to protect the individual from further trauma, the risk is that the physical and mental state may deteriorate to a level which has greater long term implications for both the wellbeing of the victim and the potential costs to the organization. Again, this is perhaps a special case, because is is so closely allied to ethical issues of personal choice, self-determination governed to a large extent by religious belief.

Case Two - John L.

At dawn on October 29 1999, a super cyclone[57] which lasted for nearly two full days devastated the area from Balasore to Khurda on the East Coast of Orissa. Causing heavy tidal waves and torrential rains, the latter blowing for 36 hours at speeds of 350 to 400 km per hour, it was reported to be the millennium's worst ever cyclone, leaving thousands of people, dead, injured, shelterless and without food. Countless people lost

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[57] Detailed background provided by respondent.

their lives, thousands of cattle died and hectares of trees were uprooted. The cyclone affected nearly 50 villages in twelve districts and essentially destroyed the economy of the State. The cyclone wreaked havoc in most of coastal Orissa destroying all crops in its path. The saline water left everything disfigured and discolored. Transportation was seriously hindered by the uprooted trees and lines of communication were barely possible. Over 5000 children were washed away in the cyclone. Total deaths were estimated at 80 000 to 100 000 by observers but the official records put the figure at well over 100 000 people.

A group of, initially four people, traveled to Orissa soon after the cyclone was over to carry out a survey and to review the general situation. In the words of one of them, Sergent John L of the Salvation Army,

"It was not very easy to see the kind of condition of the people victimized by a cyclone. Mostly trees were uprooted and homes were washed away. Dead bodies were laying on the ground, and in the thousands, the carcasses were there to see even after eight days following the cyclone.

Though it was not very easy to see this all and work among these people, our team received encouragement from a woman who was Principal of a Convent School at Paradip. When we went to see the authorities in Paradip, she was crying and shouting for the authorities when she was unable to get kerosene oil or diesel to burn the three thousand dead bodies which she collected from an island with the help of school children and the Indian Army. We saw this woman was doing very boldly all this work, we felt we should do even more.

Our team of 15 people consisted of officers, doctors, nurses assistants, volunteers, cooks and drivers. We reached Paradip on 20 November 1999 and started our relief work divided into three teams a medical team, social team and a counciling team.

The medical team distributed the medicines. The social team visited homes to assess the needs of the people. The counseling team was doing a very important job which was very necessary at that time. These people who had lost

their relatives were very upset at that time. Some of them were mentally affected, like the person who lost his whole family and was left with just one or two relatives. Our team members were doing counseling with them and recommended to the social team to help in particular these worst affected.

Our team worked with dedication - willingly among the people made victim by the super cyclone.

During the one month spent working in that area, there were at least three or four days when it was very difficult for me. Although every day we would see dead bodies - almost 5 to 10 - every day; one day about one month after the cyclone, we visited a village, named Rongiagarh about six kilometres from Paradip. As a team leader people wanted to show me the condition of that village. I saw 20-25 dead bodies of children aged about 5 to 10 years laying on the ground. I saw more than 200 bodies of women and men and thousands of animal carcasses. I felt very bad and for three nights I could not sleep whenever I tried to sleep the whole picture appeared in front of me. But the encouragement provided by the group leader was extremely helpful.

Case Three – Jeanne F.

Currently working for FAO in the field of nutrition, Jeanne F. a medical doctor, worked for ten years with the NGOs, *Medecins sans Frontiers* (Doctors without Borders), *Save the Children UK* and with *World Relief, USA*. Jeanne spent five years working in Central America between 1981 and 1986. In Honduras she was put in sole charge of running a refugee camp which was responsible for distributing food rations. While working in the refugee camp, she received a number of death threats from interest groups which were pressuring her to have the food rations distributed to particular groups in the camps. On informing her local embassy and NGO headquarters she was, eventually given a personal guard.

Jeanne F. noted in fact that the threats to her life had probably been mainly intimidatory with little real probability that she would have been killed. Nevertheless,

she found several years later when working in Africa, that she continued to be haunted by the feeling that she was being watched and followed even though, "living in a state of fear becomes life as normal and eventually if you are tough, you learn how to cope with it." Nevertheless, later, on returning home to France where she lived in the countryside she suffered from nightmares in which she imagined that her house was being encircled, nightmares that were so real that she routinely searched the house outside and in for intruders.

For the last few years however she reported that the nightmares and general feeling of watchfulness and alertness had left her and she no longer felt a victim of her circumstances. One of the main supports she recognised during all her missions to the field over the past 20 years was that provided by colleagues. As she said, even if, in terms of character and personality, people were very different, and may have had little in common outside the rarefied atmosphere of an emergency or field mission, nevertheless colleagues became very close and even necessary to maintain a sense of perspective in the face of stress.

When asked what she believed were the differences between working for the United Nations and working for NGOs she said that the two kinds of organisations had very different recruiting systems. The UN tended to emphasize academic qualifications much more than the NGOs. Her experience was that employees of NGOs were more committed to their jobs and found them generally more emotionally fulfilling than their IGO counterparts. There was no denying however, that the professional benefits such as salaries, healthcare and special allowances such as education and travel benefits were far superior in the UN system and an alluring incentive, particularly to those who had worked for comparatively low pay in highly stressful conditions often experienced when working for international NGOs.

Case Four – Mark and Susan Q.

The interview was conducted with the wife of an emergency relief worker who herself worked for UNICEF both at its office for Emergency Services in Geneva and in the field. She said that her husband, a senior officer for an unspecified relief agency had

been working in the frontline for over 20 years. At the time of the interview, he was in hospital in America suffering from "strain" due to excessive work pressure. She said that off and on for the past five years he had been suffering from depression, insomnia and simply feeling overwhelmed. He had been reluctant to seek help, until such time as he returned from a recent assignment and had not been able to cope. He had therefore applied for an extended leave of absence from the organization. She believed that the constant exposure to disaster, to death and at the same time, the long hours and too frequent/sometimes back-to-back assignments had culminated in his current depression and inability to cope. As she noted, however, it was only when physical and mental fatigue had overwhelmed him, had he sought help.

She herself coped with stress because she had to, both she and her husband had been involved in relief for nearly a quarter of a century and it had become part of their lives. But partly because of her family's own experiences in working in emergencies and the lack of readily available support services, she believed a real problem existed – especially among those who undertook repeated field missions involving humanitarian relief, logistics and operational work. It appeared to her that most of the organizations had little or no provision for people suffering from stress and strain, especially for those whose symptoms had passed from mild to chronic. It was also apparent, both from her schedule and that of her husband, that time constraints, made it difficult to seek and undertake counselling or other treatments, even if these were encouraged by the Organizations concerned (which in fact they weren't).

While Susan was more involved in describing her husband's situation and the long-term effects of his involvement in emergency work which have resulted by her own admission in PTSD, she also admitted to being under a lot of pressure both from the demands of her job as well as in caring for her husband and bringing up children with relatively little support received from the organization.

Case Five – Patricia D.

Patricia D. had worked for over 15 years for Concern Worldwide based in Ireland. Now living in Italy, she is single, and 38 years old. An accountant by training,

she had been working for the NGO as a logistics officer. She briefly described her experiences in Somalia, Rwanda and Zaire where she said she had been working to assist in refugee relief after the conflicts and subsequent emergencies resulting from mass refugee movements, famine and outbreaks of diseases such as cholera.

Patricia said that she had always been unaffected by the scenes that she witnessed, the one thought in her mind being to work as hard and as effectively as possible. She said that her colleagues had always been very supportive and there existed a de facto peer support network among them. For the most part, her experiences had been extremely positive and rewarding. However, she noted that after having worked for a number of years for very little remuneration, she had really welcomed the move to a UN agency as a finance officer. One of the reasons for making the move, or rather in helping her to decide to take a long break from the NGO where she held a permanent position was an experience she had had while working for Concern in Goma, some years earlier.

She had been working to clear dead bodies from a camp where an enormous population of refugees were only partially managing to survive. She worked for several weeks in the camp and then returned to Dublin. Some weeks after her assignment, she had been walking in the city and had passed a shop selling plastic mats, the same kind of mats she had been using to wrap up the bodies of the dead when in Goma. Just the sight of the mats brought back all the sights and smells and horror of the camp. The flashback didn't last for a long time, but its effect was profound and she realized that she had simply seen, heard and smelt too much death and suffering. Whilst she wanted to continue helping the sick and needy, she also understood that she needed a long break.

A recent draft UN report also highlights the truly devastating situation in Goma:
"Humanitarian aid workers in Goma, Zaire in 1994 had to function in a situation where they were exposed to people dying by the thousands due to dehydration, children sitting for hours uncomprehendingly beside their mothers who had just died, and the daily visual, olfactory and emotional reminders of such enormous suffering because disposal of dead bodies was such a massive logistic challenge that the same

dead bodies often remained in the same location for days or weeks (Smith et al., 1996)... "The conditions in the camps were unnerving to relief workers not only because of the crowding, the smells, the filth and the bodies but because no one was able to fill a small percentage of the need."(Smith et al., 1996, p.401)."[58]

Patricia believed she had suffered from a mild form of PTSD brought on by both the scale of the human tragedy she had witnessed and the general strain and frustration experienced working in an environment where there was little hope, and the ubiquitous sight and sound of sickness and death were horrifying. She reported that the organization for which she worked, Concern provided support to its staff and acknowledged the emotional and psychological risks associated with relief work. Colleagues were extremely supportive and there was a strong sense of altruism and purpose among staff. She had since started working for a large IGO where the physical working conditions were less stressful, since she worked at Headquarters rather than in the field and the salary was much higher. However, she acknowledged that lack of job security and the tediousness of the work itself were frustrating and much less fulfilling.

In only two other cases (Cases One and Two), did the relief organization appear to provide the kind of support and collegial spirit which may be important in helping staff to cope with emergency situations. Even so, the intensity of the experience appears to have resulted in the development of symptoms associated with chronic stress which fortunately was of relatively brief duration.

Case Six – Sonia R.

Sonia, a national of Iceland, had joined WFP four years earlier, before which she had worked for a Norwegian shipping company in Germany. She is single, 35 years old and lives alone. She has had no direct field experience but has undertaken some limited travel for WFP to oversee logistics arrangements during and immediately following the crisis in Kosovo. Nevertheless, her job is highly stressful since it involves chartering ships, often at immediate notice to carry food aid supplies wherever food is

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[58] Matthew J. Friedman, Peter G. Warfe (2000) Gladys K. Mwiti, *Mission-Related Stress and its Consequences among UN Peacekeepers and Humanitarian Personnel* , UN Peacekeepers and Humanitarian Personnel (draft document, UN, New York).

needed by the Programme. Often she works a 12 to 16-hour day. During the Kosovo plane crisis, she was working around the clock as a contact person within the organization dealing with the logistics issues related to the crisis. A close friend and former flatmate of Sonia's was the person (a consultant) partially responsible for chartering the plane that crashed in 1999. Thus she experienced indirect exposure to the stress and guilt which her friend had suffered immediately following the crash.

Sonia is a very heavy drinker and has had a history of severe depression. For the past two years she has also been seeing a psychiatrist and has been on strong medication for her depression. During the worst of her illness she spent weeks away from her job on holiday or intermittent sick leave. WFP was aware of her problems, as she had consulted the staff counselor on a regular basis. She has continued to work, even through the worst of her depressions and for the last year, her humour improved considerably to the extent that she is currently on lower dosage pills. While a traumatic love story was the stimulus that pulled her into a crisis several years ago, not helped by a history of heavy drinking, she also admits that she has found her job extremely stressful. The stress is partly a function of the job itself, meeting tight schedules and having limited collegial support. Sonia also admitted that poor management was a significant stressor coupled with an uncertain contractual situation and simple overwork. She has a wide circle of friends but like many of her colleagues has had to make a home away from home while working at Headquarters.

Although she has volunteered for field assignments on several occasions, her particular job skills and institutional memory in her present position have kept her bound to her current position with little hope of either promotion or lateral transfer within the Organization. While hers is not a case of PTSD but of severe depression exacerbated by work-related stress, her experience highlights the kinds of pressures or stressors faced by staff in large international aid and relief agencies. On the other hand, it is also true that her work, as she has sometimes admitted, has provided her with a *raison d' etre*, and at the same time, the support and guidance provided by the staff counselor have been important elements in her recent recovery. Paradoxical as it appears, the IGO while partially responsible for her emotional deterioration has also provided her with an important support system and has helped Sonia to get over the

worst of her illness. It is also perhaps significant that the Organization has not to date given her an assignment of more than a few weeks duration overseas, nor to the frontline of war or famine etc. This may be partly a function of the nature of Sonia's job, and partly a reluctance on the part of the Programme to send on assignment someone who has already shown vulnerability under stress.

In conclusion, the Case Studies served to illustrate that emergency work is extremely stressful, whether it be at the field level or even in dealing with logistics from the safety of Headquarters. At the same time, risks to physical and mental health are very real, and are likely to have some kind of side-effect, anything from nightmares and flashbacks (even if only transitory) to severe depression and breakdown which may prevent temporarily and in the long term affected staff from continuing to work. While several of the organizations mentioned by interviewees showed consideration and support for their staff, there appears to be little recourse for staff to appeal and or take action to mitigate the effects of work-induced stress as well as exposure to trauma. Only when their situations have become so critical that the staff member can no longer function normally is the organization likely to take remedial action.

CHAPTER VII. CONCLUSIONS, RECOMMENDATIONS AND A REVIEW OF THE RELEVANT LITERATURE

Incidence of Post-traumatic Stress Disorder (PTSD)

On the basis of the definition of symptoms, most notably flashbacks, sleeping problems, emotional instability, avoidance and withdrawal, alcohol and drug abuse, none of the respondents surveyed indicated that they had suffered from all or even a majority of the symptoms. Further, when compared with the definition applied in the fourth edition of the American Psychiatric Association Manual of Mental Disorders (DSM-IV), which stipulates that events must produce an intense emotional response such as fear, hopelessness and horror[59], none of the respondents expressed similar feelings.

While many admitted to having sleeping problems, feeling stressed, irritable, frustrated, depressed and or angry, and several indicated that they had been experiencing severe emotional problems, these may be regarded as normal reactions to stress not necessarily indicative of PTSD. Moreover, all but three of the respondents indicated that they were able to cope despite family, health and administrative/organizational problems. Of the remaining three, the worst that could be said was that they were suffering from chronic stress.

Further, since all the respondents were currently still employed on field missions or at headquarters as part of their relief assignments, the answers did not indicate whether the symptoms had developed after a certain amount of time (i.e. either weeks, months or years) after having undertaken field work. Since definition of the timing of onset of symptoms is intrinsic to a definition of PTSD, it is impossible to assert that any of the respondents, especially in the absence of a significant number of symptoms, were cases of PTSD.

On the other hand, some of those interviewed and included among the Case Studies (Case Studies One, Two, Three, Four and Five), qualified as having experienced

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[59] Op. Cit., UN Peacekeepers and Humanitarian Personnel, p.11.

PTSD symptoms and other reactions to severe stress induced by witnessing and or being victims of highly traumatic events.

Obviously, a major constraint to the survey was the small size of the sample. Further, from the author's own experience and conversations with colleagues who have worked for FAO Special Operations Service, WFP, UNDP, UNICEF emergency services, USAID, Concern, Doctors without Borders, and CARE International, the majority of relief workers, especially those who are geniunely suffering symptoms such as severe sleep disorders, flashbacks, emotional disturbance, and alcoholism do not tend to be willing to complete questionnaires.

According to Reid, in studies of generalized disaster victims,

"refusal rates (i.e. refusal to take part in surveys and or be questionned) can vary greatly across studies. As an extreme example, Jackson and Mukergee (1974) studied reactions to earthquakes in two cities using the same recruitment strategy. In San Francisco they experienced a refusal rate of nearly 80 percent, in Los Angeles, only 10 to 15 percent. One can only get so much information from victims, and choices probably have to be made about which variables to assess and which to forego."[60]

Reid also remarks that

"in the case of a person's recollection of past adjustment after a devastating experience, it is possible that the recollections of past problems are biased to fit the person's current adjustment problems, as shown in Vaillant's (1983) classic longitudinal study of alcoholism. A related problem concerns ethical or practical considerations. Survivors of a disaster or trauma are not always excited about the chance to participate in research forcing them to deal with a personal tragedy, its sequelae, and the way things used to be. Not only have they likely discussed these issues extensively with their family and various friends, investigators, bureaucrats, Red Cross workers, medical helpers, and counselors (which in itself probably affects the integrity of subsequent interview

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[60] John B. Reid (1990), *A Role for Prospective Longitudinal Investigations in the Study of Traumatic Stress and Disasters*, Oregon Social Learning Center, Journal of Applied Social Psychology, 20(20), p. 1696.

and report data), **but the victims most seriously affected may be the least anxious to cooperate.**"([61]bold inserted by author).

Further, the lack of significant response in quantitative terms does not mean that organizations, at least those directly concerned, can afford to assume that lack of "reported"incidence of PTSD among respondents is indicative of (a) the overall picture in the institution as a whole, and (b) the fact that adequate preventative measures should not be taken for, as observed by Myers

"any symptoms that seem acutely intense, disturbing, or out of control to the worker may require professional assistance. In particular visual or auditory hallucinations, extremely inappropriate emotions, phobic or panic reactions, antisocial acts, serious disorientation, or suicidal or homicidal thoughts should receive mental health assistance."

Moreover,

"any symptoms that seriously interfere with an individual's functioning at work, at home, or in social relationships should be considered for mental health assistance."[62]

Given that PTSD is especially difficult to diagnose, relief organizations may be as well to assume that incidence is possible and even likely, with emphasis on new volunteers or very experienced staff - at risk of over-exposure due to repeated and or back-to-back assignments. As Salama notes "Unlike domestic rescue workers who are periodically exposed to short stressful events, relief workers may suffer exposure to chronic low levels of stress by, for example, residing in insecure environments for many years. It is in this setting that stress may be cumulative."[63]

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[61] Ibid.

[62] Op. Cit., Myers p. 92.

[63] Op. Cit., Salama p. 12.

Ursano et al also observe that "in a review of the literature on disaster responses, several groups (including rescue workers, the injured, heroes and children) emerge as being at greater risk for traumatic stress-related sequelae". [64] They observe that "exposure to death and the dead is part of most disasters and one of the risk factors for the development of psychiatric illness. The number of dead and injured and the sight and smell of dead bodies were among the most stressful aspects of the Granville, Australia rail disaster…"[65] One example of this was that of Case Study Three, whose handling of dead bodies during the Goma emergency caused her to suffer from flashbacks.

Ursano et al further note that

"disaster workers who do not participate directly in the disaster recovery are also frequently overlooked. And heroes are part of nearly every disaster. Empirical observations suggest that they are often overlooked as a highly stressed group. Heroes are expected to carry the burden of idealization placed on them by the community. They are required to be away from their homes and families, always to be good, and to be able to tell a story that brings hope and courage to those around them. They are rarely allowed to express their own despair, worry, and fear or to recall the feelings that they overlooked in order to perform their heroic acts."[66]

Interestingly enough, even those who have suffered most markedly, among the Case Studies included, when asked if they would continue to do emergency work, most have answered in the affirmative. The exception was someone who whilst working for an IGO in the field, found the first experience so traumatizing that she did not want to continue, at least not undertaking field assignments. Despite the risk to physical and emotional health, it appears that there is a degree of fulfillment and excitement, both among those working for NGOs and IGOs which transcends the negative aspects of the experience.

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[64] Robert J. Ursano, M.D., Carol S. Fullerton, Ph.D, Ann E. Norwood, M.D. (1999), *Psychiatric Dimensions of Disaster: Patient Care, Community Consultation, and Preventive Medicine*, in http://www.psych.org/pract_of_psych/disaster.html, p.12

[65] Ibid.

[66] Ibid p.13.

While this study cannot demonstrate empirically from among the questionnaire respondents alone, that there is an incidence of PTSD among either the employees of the IGO or NGOs surveyed, the Case Studies plus a number of tendencies among the questionnaire respondents **indicate not only the potential for development of PTSD but also the existence of more general tendencies and policies in the organizations themselves which give cause for concern. Moreover, there did appear to be a strong correlation between those who had developed illnesses and conditions such as malaria, hypertension, typhoid and anaemia and their vulnerability to emotional and psychological disturbance.**

According to the survey of respondents, as indicated by the eight cases which showed several of the symptoms associated with severe stress, **a correlation exists between the amount of time involved in emergency relief and the onset of symptoms.**

Further, the lack of job security works as a stressor which causes additional tension and may even encourage those who might otherwise not accept such assignments to do so for fear of jeopardizing their future prospects with the organizations. Interestingly, there did not appear to be any difference between staff working for the IGO or the NGOs in this respect. Respondents of both kinds of organizations appeared to believe that non-acceptance of an assignment put them at risk. The issue therefore is, to what extent do staff who may be basically unsuited whether by nature or due to specific circumstances occurring at the time of being offered or sent on assignment, feel pressured to accept assignments which could risk either or both their physical and mental wellbeing.

In Case Study Four, and to a lesser extent in studies Three and Six, together with the eight questionnaire respondents who indicated that they were feeling severely stressed, and had stated that they suffered from one or a number of illnesses and or symptoms of stress and exposure to trauma (such as somatic disorders, hypertension, palpitations etc), the victims were apparently suffering from burnout following repeated emergency missions, and stress resulting from general work pressure. For the purposes

of this study **the issue is therefore whether the organizations have a responsibility to prevent over-exposure from becoming chronic (or as it appears endemic).**

One way of doing this might be to a) prevent staff from being given assignments in rapid succession without ensuring that adequate leave is taken; b) screen staff who have been given multiple, and especially back-to-back assignments by requiring that they meet the staff counselor and or medical officers and that their working relations with colleagues are normal (many organizations have already begun to institute annual staff evaluations, some version of an evaluation to highlight in particular potential problems of work pressure and stress might be designed and tested). Further, should organizations establish a cut-off point at which staff are given less stressful tasks, and not sent to the field, at least for a sufficient period of time to allow them to unwind and synthesize their experiences. This is particularly true for those suffering from illnesses and conditions or those with a history of substance abuse, which may make them more vulnerable to experiencing stress-related symptoms and eventually less able to perform effectively at work.

Admittedly, **many of these checks rely on value judgements and are prey to subjective opinion. It might be that organizations would have to carry out evaluations based partly on their own staff evaluations together with evaluations undertaken by independent sources outside the organizations.**

Proportionately, there was a much greater number of symptoms reported by those working for NGOs than for the IGO considered. If the examples taken from the Case Studies are added, the figure is higher still. An explanation for this might be that staff of the IGO were simply less exposed to direct stressors than their NGO counterparts. Since it has been established that the IGO was the World Food Programme (WFP), it is also true that such staff, while working in emergency relief, are generally sent to emergency zones sometime after the initial disaster has occured. They therefore have limited or no direct exposure to, for example death and dying, on a large scale. Those involved in true frontline relief, like employees of CARE, the Red Cross and Concern Worldwide are more likely to have witnessed more immediately traumatic scenes than their counterparts in WFP, UNICEF emergency services and UNHCR, for

example. Workers in IGOs tend to appear on the scene after the initial death and destruction has occured.

The most evident stressor, and that indicated by both questionnaire respondents and those included in the Case Studies as being the most worrisome was **risk to personal security**, rather than exposure to human suffering. Included among these were the longest serving relief workers, the shortest serving, and or those who had been exposed to direct threat to their personal security and or felt emotionally insecure, due in part to uncertain contractual status and or personal emotional problems. The exceptions were among the case studies, the NGO-worker who had returned from Goma where she had witnessed and been part of the relief effort to clear and bury the dead and assist those dying of cholera, and the IGO-worker who was suffering from ongoing depression exacerbated by simple overwork as opposed to exposure to excessive traumatic stimulae while in the field.

Green notes that

"..certain types of experiences may have more long-lasting effects than other types and, therefore, put people at higher risk for chronic and long-lasting problems. For example, Grace, Green and Lindy found that extended exposure to the elements, injury, being blocked in one's escape, and loss of a household member all predicted PTSD 14 years after the dam collapse in the Buffalo Creek disaster. In a study of Viet Nam veterans, loss of a buddy, injury and general combat predicted developing postwar PTSD, whereas exposure to grotesque death and to dangerous special assignments predicted continuing, or chronic PTSD (Green, Grace, et al., 1990a)...General stressor factors that increase the risk for PTSD and other stress-response syndromes include violent loss, life threat, exposure to grotesque death, receipt of intentional harm, injury, witnessing violence, exposure to noxious agents, and being responsible for the death of another person (Green, 1990)."

Staff of IGOs and others less involved in immediate frontline relief appear to be more affected by

" post-disaster disruptions or additional traumatic events that might arise in the immediate post-disaster period that are possibly associated with recovery efforts. These latter events might be conceptualized as environment-recovery factors that affect outcome rather than as part of the event itself….. or by the shere repetition over time of widespread suffering in the wake of an emergency. Thus the study found that symptoms appeared to increase with the greater number of years in service as noted by Kramer and Green (1991) "because multiple trauma events may put individuals at higher risk for developing PTSD."(Green).

At the same time, a report on NGO and UN agency personnel working in conflict zones, notes, disturbingly that

"The conditions of contract within many NGOs are not generous in relation to long term conditions which impair the productivity of their personnel. Often, the individuals concerned may opt to leave the agency and return home where they continue to suffer the condition in private, isolated from their former colleagues and friends within the agency and geographically distant from others experiencing similar conditions."[67]

Certainly, several staff of NGOs – the exception being the Salvation Army – implied in their responses to the questionnaire that they were concerned about their contractual status and displayed relatively high levels of general anxiety. Recognizing similar phenomena, the report cited above of the Humanitarian Practice Network, noted that "a cooperative support network for NGO personnel working in, or returning from, zones of conflict is being established simultaneously in the Netherlands and the UK with support from NOVIB and Oxfam." It is called the 'Rainbow Network' and is involved in developing and testing appropriate mechanisms and forms of support for agencies and their personnel in addressing PTSD and burn-out.

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[67] From an article entitled, *Support Network for Relief Workers Returning from Zones of Conflict* January 1994, on http://www.odihpn.org/report.asp/ReportID=1179, p.2.

Limitations of the methodology used

In terms of the methodology employed in collecting a sample, the poor (though not unusually low turnout in responding to the questionnaire) indicates that surveying by questionnaire alone is largely ineffective and should only be done together with, if possible, one-on-one interviews. By contrast, interviews on their own can lack structure, and if too formalized risk intimidating the interviewee.

In retrospect, it might have been more effective to have used an approach which was more direct, and addressed the issues head-on. For example, direct questions should have been included as to whether respondents had experienced flashbacks, and if so whether they believed these were a cause for concern. What was the frequency of occurence? Relating to any of the symptoms, the questionnaire should have determined when such symptoms had begun to show themselves. This was a piece of basic information which is vital to a diagnosis of PTSD as opposed to chronic or acute stress or other psychological disorders. In hindsight such information is essential. However it also depends on the overall approach adopted. As noted above, mental health is a sensitive issue. The stigmas attached to it, personal and professional sensibilities frequently mitigate against using a very direct approach, especially in the impersonal form of a questionnaire.

On the question of response rates, the author corresponded with Dr. Teri L. Elliot, an Assistant Professor at the Disaster Mental Health Institute of the University of South Dakota who remarked with regard to a mental health survey that was being undertaken by the Institute, that while they "didn't have any clear data on response rates, we predict it to be quite low." He observed however that "there are mixed opinions on this. First, the questionnaire is long which will obviously reduce compliance. But, trauma workers are often seen as invested in bettering society etc., and so the response rate is expected to be higher." Response rates for this study were around 16 percent on average among the organizations surveyed.

Support, assistance and information - briefing and debriefings

It might have been useful to ask what if any suggestions respondents could themselves have offered to improve the conditions under which humanitarian staff worked. Certainly, little information was gleaned in terms of support services offered by organizations to their staff from the responses received. In general, however, the respondents indicated that little background information had been provided (i.e in terms of risks, security conditions, existence of assistance to field staff) or direct support received from employing institutions. Neither briefings nor debriefings were common.

In the few instances where respondents had received debriefings, these were generally thought to be useful. However, no attempt was made to differentiate between educational debriefings i.e. provision of supplementary information to victims following an event that may be needed for simple logistical/administrative purposes and pyschological debriefings the purpose of which are inter alia, "providing emotional disclosure, detecting high-risk individuals[68] and to provide "the catharsis of emotional release, by allowing individuals to test their perceptions of the experience against those of others, and by enabling them to actively review the experience and thus gain mastery."[69]

Briefings on the other hand, were almost exclusively concerned with risks to personal security and in all but two cases had not dealt with stress management and trauma. And yet, Salama (1999) observes that "studies in various settings have shown that untrained, poorly briefed staff suffer most from stress-related illness (Ursano & McCarroll, 1994). Briefing and debriefing should be mandatory and in person..It should cover the individual's personal and emotional reaction to their work environment, not merely the programmatic" aspects.[70]

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[68] Arieh Y. Shalev, *Post-traumatic Stress Disorder among Injured Survivors of a Terrorist Attack. Predictive Value of Early Intrusion and Avoidance Symptoms*, The Journal of Nervous and Mental Disease (1992), Volume 180, No. 8, Williams and Wilkins, p.505.

[69] Beverley Raphael (1986), *Victims and Helpers, When Disaster Strikes: How individuals and communities cope with catastrophe*, Basic Books Inc. Publishers, New York, p242.

[70] Op. Cit., Salama, p.13.

More specifically,. Salama states that

"Strategies for improving briefing, training and debriefing need to take
place in the context of organizations developing clear, written and
comprehensive policies on the psychological health of their employees. Within
the framework of institutional policies, mechanisms to support relief workers in
the field need more detailed elaboration. A formal mentoring system for new
personnel or the designation of a particular individual chosen by his peers in the
field to act as the support person for that particular area are two examples of
current practice."[71]

Van Brabant argues[72] that "critical incident debriefing and follow-up requires
special training and preparation." He notes that "when a staff member shows symptoms
of acute distress after having experienced or witnessed a critical incident, and is
therefore vulnerable to PTSD, you should call in specialist expertise." He cautions that
"the survivor may deny the depth of the distress and oppose the calling-in of a specialist,
for example, following a relatively short period of abduction without serious
mistreatment, or after a rape that the survivor does not want other people to know
about." But in arguing for the benefits of victim's long term health, an initiative should
be taken to obtain specialist services.

On the other hand, another study notes that

"research on the efficacy of psychological debriefing suggests, on the
one hand, that 50-90 percent of debriefing recipients are convinced that this
intervention facilitated their recovery from the acute emotional distress caused
by the stressful event. On the other hand, there is little evidence that
psychological debriefing prevents PTSD (Bisson et al., in press; Neria &
Solomon 1999)."

The same source, observes in parallel that **Frontline Treatment** may be an
alternative to psychological debriefing.

"Frontline treatment was developed in a military context and is

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[71] Ibid.

[72] Op. Cit, Van Brabant, p288.

extensively utilized by many UN member nations during peacekeeping deployments. There is no reason why this approach couldn't also be utilized by humanitarian personnel…it has always emphasized the importance of administering psychological interventions as close to the front as possible..the three major principles are Proximity, Immediacy and Expectancy (PIE)."

In this context, the authors note that "evidence favouring the effectiveness of frontline treatment is stronger than that favouring psychological debriefing (Neria and Solomon, 1999; Solomon and Benbenishty, 1986). The difference may be due to more individualized and intensive attention to emotional reactions provided by frontline treatment in comparison with psychological debriefing."[73]

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[73] Op. Cit, <u>UN Peacekeepers and Humanitarian Personnel</u>, p. 22.

Recommendations

What the organizations can do to prevent or treat PTSD and other stress-related disorders

Recognition is half the problem: An immediate requirement is that the organizations themselves need to acknowledge their responsibilities towards their staff in terms of recognising the potential for, and assisting in the prevention and treatment of serious stress disorders including PTSD (the latter being, as noted earlier one of the most difficult to diagnose). As observed in the recent WHO study "there is a growing understanding that the responsibility of employers of humanitarian relief workers should be seen within the framework of international occupational health practices. The basic principles of occupational health build on the WHO definition of health as a "state of physical, mental and social well-being' that allows individuals to conduct a 'socially and economically productive life."[74]

Moreover, "ILO Convention No. 161 on Occupational Health Services..states that the primary responsibility for health and safety at work, and for occupational health services in the workplace, rests with the employer."

A review of the,albeit scant literature, on organisational responsibility and mechanisms which may be used by relief organizations to mitigate the effects of exposure to traumas and their associated stressors revealed the following.

Van Brabant in his recently published work on operational security management, believes that "managing stress is an individual and an organisational responsibility....Organisations and managers need to talk about stress, and organisations need to have an appropriate rest and relaxation policy."[75]

Myers observes that "early identification and intervention with stress reactions is the key to preventing worker burnout." [76]She therefore recommends that a review be

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[74] Op. cit., *Occupational Health*....WHO (1999), p.7

[75] Op. cit., Brabant, p.280.

[76] Op. cit, Myers, p.94.

undertaken of stress symptoms with relief workers before they go into the field and provide handouts for staff on stress management and self-care. Other actions include:

1. assessing workers' appearance and level of functioning regularly. It is not uncommon for workers to deny their own level of stress and fatigue. For example, workers may say they are doing "just fine" but may be exhibiting multiple stress symptoms and appear very fatigued;

2. trying to rotate workers among low-stress, moderate stress, and high-stress tasks. Limit workers' time in high stress assignments… and providing breaks and personal support to staff; and

3. supervisors should ask workers to take breaks if effectiveness is diminishing: order them to do so if necessary.[77]

As regards the first point, results obtained from the survey indicate that there was more than a degree of the "I'm feeling fine" syndrome[78] in several of the answers received from respondents who for one reason or another, did not wish to reveal emotional or for that matter physical weakness. Moreover, as Myers herself asserts

"most people do not see themselves as needing mental health services following disaster, and will not seek out such services. Many people equate mental health services with being crazy."[79]

In the second instance, strategic planning is an obvious prerequisite prior to rotating workers. As observed earlier in this study, much emergency work is still carried out on a largely ad hoc basis which involves assigning staff randomly, according to availability and sending them to the field based on proven track record, regardless of whether or not they have completed one or a number of assignments back-to-back, or as good as. It may be this very element which is the key to an effective preventative strategy. **Ironically, forward planning and provision for additional human resources to be trained and available at short notice is likely to improve the organization's overall effectiveness in the field. To date however, most**

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[77] Ibid.

[78] Carmen C. Moran, *Individual Differences and Debriefing Effectiveness,* The Australasian Journal of Disaster and Trauma Studies, Volume 1998-1, p.1

[79] Ibid, p.3.

organizations appear reluctant, in the event to operate on anything but a crisis management basis, which some justify in terms of not knowing in advance their budgets for long-term planning purposes and or the nature and duration of emergencies before they happen.

As mentioned above, a critical issue appears to be that of time constraints. Relief organizations work under severe time limitations, due first and foremost to the nature of emergency work. There is little time for planning and strategizing as relief planning must often be carried out in the field simultaneous with the provision of immediate assistance. Nevertheless, since such crises are the mainstay of relief organizations measures may be taken to prepare staff in advance with a view to reducing, to the extent possible, the negative effects of exposure to emergencies and the stresses of emergency work. These include information on stress and its management, ensuring that staff have a peer group or other collegial support from the time they start working in an organization, in addition to peer groups that may develop spontaneously during the various phases of emergency work. Repeated confirmation from the organization itself that the job they are doing is important and that their sacrifices (in terms of hours worked, sleep lost, degree of hardship witnessed and or experienced, aspects of their personal lives such as their relationships with spouses and family) are appreciated by the organizations.

With respect to the third point, many of those interviewed, in particular but not necessarily the senior staff, both those who completed the questionnaire and some of those included in the Case Studies, were not working under supervision. Either they directed the operations themselves or were acting alone on the mandate of the Organization.

Van Brabant states that

"in volatile environments, expectations of field-level managers tend to be unrealistic – probably in terms of the many tasks that need to be performed with skill, and certainly in terms of what can be done in a working week that more often than not amounts to 55 hours or more. Overall authority also brings overall responsibility which in itself can be a source of significant stress, as the

responsibility does not stop at night or on weekends or during official holidays. The staff need to feel that their manager is strong and solid and reliable, and therefore a source of stability. A senior manager who shows signs of severe stress, or who continues in post although burned out, is likely to demoralize staff and add to their sense of insecurity and stress. But the expectation that the manager will always be sound and solid, and his/her attempts to meet that expectation, adds to the stress."[80]

Special provision should therefore be made in planning support to relief staff to include measures which relate to Heads of Operations and semi-autonomous workers. Actions could include periodic visits by medical staff at Headquarters to field staff and or regular written and e-mail correspondence by counselors and or peers, with relief workers to provide psychological support and a chance for such staff to vent their feelings in an informal manner.

Van Brabant also suggests a number of approaches including:

1. delegating or sharing tasks with a deputy representative, an office manager, a senior medical officer, or a security focal point:

2. trying to create and stimulate a 'senior management team' around you that shares in the responsibility, although the manager remains the ultimate decision-maker; and

3. finding a "sounding board"or 'buddy' in a peer from another agency.[81]

As noted above, certain groups of individuals are likely to be more predisposed to developing severe stress reactions including PTSD. These include alcohol and drug-dependent personalities; those with physical injuries and or emotional problems and women more than their male counterparts. One universally acknowledged indicator, as confirmed by the Head of the FAO Medical Service, Dr. Pille, is that of an existing history of psychiatric problems. This being the case, it would appear only logical that organizations employing staff and consultants for emergency work take measures (such as one-to-one interviews with the staff counselor and or evaluations by supervisors and or colleagues, self-tests such as a questionnaire which individuals

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[80] Op. Cit., Van Brabant, p. 288-89.

[81] Ibid, p.289.

complete to determine their own level of risk, or a mix of these) to prevent the occurrence of PTSD or other severe stress disorders.

This of course implies that the organization concerned is prepared to accept responsibility for work-stress related disorders.

One of the primary mitigating factors against increased organizational assistance to staff is the current economic reality of many organizations. UN agencies, in particular, are accountable to donors. Recent zero nominal growth budgets and general down-sizing and administrative and organizational streamlining measures put the organizations under increasing pressure to minimize administrative, including staff, costs. **Persuasive arguments must therefore be made to show that well-invested resources, namely an effective and efficient workforce, yields much better short as well as long-term results including enhancing the efficacy of staff.**

Many organizations, despite what appear to be carefully planned programmes of work and budgets (often promulgated and approved as much as two years in advance of the biennium to which they apply) at the practical level appear to make many *ad hoc* decisions. Nowhere, is this more apparent than in emergency relief. The sudden calls on time and resources mean that many decisions tend to be last minute - with maintaining low administrative costs and expeditiousness forming the basis of decision-making, i.e. determining how many people and who to send on a field mission may be largely a question of who is available, whether such persons are already known to the organization, their/the organization's remuneration expectations and the level of experience of staff (i.e. priority tends to be given to those with the most experience, regardless of how often they have been sent on assignment).

Beyond a general physical health examination, and a generally acceptable personal history form or curriculum vitae, questions are rarely asked of employees regarding their emotional suitability i.e. have they experienced a personal tragedy or crisis in the recent past? How often have they been posted in the last 12 to 24 months? Do they have a personal preference?

A number of sources have cited the high cost of insurance as a possible deterrent for organizations to provide staff with more comprehensive support to prevent the development of stress-related illnesses. However, for most UN agencies at least, employees are covered by comprehensive health insurance which also covers at least 50 percent of psychiatric health care. One of the staff members of a large NGO reported that the organization was affiliated with a healthcare network specifically dealing with verifying the physical health of staff returning from field assignments. During the physical examination, questions had also been asked about emotional state and ability to cope.

The problem is more the availability of appropriate and effective counseling and psychiatric services either in-house or readily available through the concerned organization, and of course the willingness and or recognition by victims of the need for assistance, preferably before the condition becomes chronic.

Certainly NGOs have recently been forced to consider the issue of costs associated with insurance cover due to the "increase in the number of conflicts and the greater willingness of relief agencies to work in conflict zones."[82] Several years ago, "a staff member of an American NGO was seriously injured, losing a leg in a landmine accident in Somalia. The costs of repatriating the worker, and the subsequent medical bills, totalled more than one million US dollars."[83] The same article noted that a "quick review of the situation amongst relief organizations in the UK has revealed that no common policy exists regarding the provision of insurance cover for overseas workers. Some organisations not only have no special coverage for war risk, but have no accident insurance at all, one of the rationales being that in an average year, the costs of the premiums would be greater than the costs of any medical treatment required.[84]..The coverage cost being approximately pounds sterling 2 500 per annum per named individual. However, even where cover appears to be adequate, complications can arise. In the Somalia incident, the NGO concerned had war risk insurance but, due to a loophole in the cover, the insurance company refused to pay.. The same report also

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[82] Alistair Hallam, *War-risk insurance cover for aid workers*, RRN Newsletter (February 1997), p.1
[83] Ibid
[84] Ibid

notes that "another complicating factor is that insurance companies may try and shift responsibility by claiming that security guidelines were not adequate, and unnecessarily exposed staff to risk, or that security guidelines were not being enforced properly."[85]

Further, the study warns that "insurance claims may not be met where it can be shown that the injured employee had been acting under the influence of alcohol and drugs."[86] This would seem to be difficult to prove, unless and even if a past history of substance abuse were recognised.

Security and risk

While increasing pressure is being brought to bear on the UN as a whole to protect its civil servants, much of this refers to protection of UN peacekeepers. For example, a recent article[87] on the subject reported that,

> " If the United Nations is to avoid the tragedies of the past, peacekeepers must be better-trained,better-equipped, with greater support from UN Headquarters and member states, and authorized with "sufficiently robust" mandates to protect lives. A new report commissioned by Secretary-General Kofi Annan on peacekeeping says the UN has repeatedly failed to meet the challenge, and it can do no better today."

The recently published study undertaken by the Humanitarian Practice Network (HPN) of Britain's Overseas Development Institute (ODI) notes that

> "although many agencies operate in violent environments, few have a strong organisational culture of safety and security. **There is an excessive confidence in the immunity of humanitarian workers and foreigners.** A perceived increase in risk is gradually changing that. But there remains a gap

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[85] Ibid, p.4

[86] Ibid.

[87] Inter Press Service (IPS) daily journal, entitled *Robust Peacekeeping Needed to Protect Innocents*, Thursday, 24 August 2000, Vol. 8 No. 150.

between rhetoric and practice and great scope for improvement at both field and headquarters level."[88]

Further, the author notes that frequent weaknesses in practice include a "total absence of and/or inappropriate/incomplete security guidelines at field level; reactive rather than proactive thinking about security; reliance on a 'personal sense of security' rather than proper risk assessment; the allocation of responsibility for security management to managers who lack the requisite skill or competence; insufficient preparedness, briefing and training for all staff; security measures undermined by poor discipline; and security considerations overridden by the interests of programme expansion and implementation." Even with respect to peacekeepers, the following gives some idea of the low priority accorded to security generally.

> *"Only now, after the paralysis of U.N. peacekeepers was echoed in Bosnia and, most recently, in Sierra Leone, is the world beginning to take a serious look at how to make peacekeeping more effective. A panel of experts commissioned by Kofi Annan reported in August that the peacekeeping department was stretched to the breaking point and ill informed about the conflicts into which it was sending soldiers, and that it suffered from poor coordination between military and political tasks and a misguided neutrality that often made peacekeepers treat victims and victimizers alike.*
>
> *At the U.N. summit in New York last month, world leaders gave the recommended changes an unusually strong endorsement. The experiences of Dallaire speak eloquently of the need to make U.N. peacekeeping operations more effective and resolute."[89]*

Within the last two years, a group of four NGOs (Action contra la faim, Disaster Relief Agency, Intersos and Médecins du monde) have united to work together under the aegis of a European NGO consortium, the Voluntary Organisations Cooperating in

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[88] Koenraad Van Brabant (June 2000) *Operational Security Management in Violent Environments: A Field Manual for Aid Agencies,* Humanitarian Practice Network (HPN), Overseas Development Institute (ODI), DS Print and ReDesign, London.

[89] Op. Cit. Tina Rosenberg (October 15, 2000).

Emergencies (VOICE) to initiate a project to build up a database to "record, analyse and identify the principal trends in security incidents which should make it possible to identify patterns of violence and their appropriate response."[90]

Treatment or beyond 'referral'

In all organizations approached, the answer to the question, what, if any institutional means exist for recognising and treating PTSD and other extreme reactions to stress? The answer was invariably "we use a system of referral." This means that the staff counselor or medical unit attached to the organization will refer staff members who either identify themselves or in extreme cases are found to be suffering from severe stress or other essentially mental conditions, to psychological practitioners. If the problem manifests itself as alcohol or drug abuse the same is true. Early in 2000, the FAO took the unusual step of issuing a staff bulletin on substance abuse (see Appendix III).

At the beginning of this paper, the Fact Sheet of the American Psychiatric Association was mentioned in defining the symptoms and prevalence of PTSD. It is especially interesting, given the tentative approaches by some organisations to consider, albeit largely preventative measures, such as the setting up of peer groups, and the institutionalization of counselors on staff, and briefings; to consider briefly the treatments recommended in the Fact Sheet. These are:

- **Behaviour therapy** (which focuses on correcting the painful and intrusive patterns of behaviour and thought) by teaching people with PTSD relaxation techniques and examining and challenging the mental processes that are causing the problem;
- **Psychodynamic psychotherapy** (which focuses on helping the individual examine personal values and how behaviour and experience during the traumatic event affected them);
- **Family therapy** which is recommended precisely because the behaviour of spouses and children may result from and affect the victim;

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[90] *Project for a humanitarian security network*: RRN Newsletter, February 1998.

- **Discussion groups** or peer-counseling groups which helps participants realize that many people have done the same thing and felt the same emotions;

- **Medication** (most notably antidepressants especially for treating 'intrusive' symptoms). [91]

To date, to the extent that a problem is being acknowledged, we know that the discussion groups correlate with the World Food Programme's (WFP's) recent efforts to build up peer support groups and a system of regional professional counselors. The peer groups function as a first line of assistance following which staff can also consult the staff counselor or if on assignment, the regional professional counselor. The Programme also undertook to send regional counselors to areas where traumatic events had occurred. The Programme was further developing a system of emergency response training in which certain trained staff were sent to an emergency zone as a first response.

FAO's Dr. Pille cited the recent example of the killing of two FAO staff members in Iraq. Following the attack, a medical team had been sent to the office of the FAO Representation in Baghdad and a second team was fielded several months later to interview staff to determine levels of staff morale and coping. In general, he acknowledged that only recently were UN organizations approaching the problem and as yet the approach still lacked coordination.

Moreover, Dr. Pille stated that according to United Nations regulations, UN organizations were required to employ one full-time staff counselor for every 2000 employees, plus support staff. FAO, with over 4000 permanent staff, employed only on staff counselor part-time. The same was true of IFAD and WFP. It is hardly surprising, given the lack of adequate counseling staff, that mental health and severe emotional problems appear to go largely unnoticed by the organizations. Further, whatever rhetoric may exist, the facts speak for themselves, many organizations are neither structurally nor administratively organized to carry out preventative or curative services.

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[91] Op. cit., *What is Post-traumatic Stress Disorder*, p.2.

Beyond these more general, and often ineffectual indications of approaches to treatment of stress, a number of new methods developed within the past 20 years, were identified and tested within the context of a project known as the Active Ingredients Demonstration Project[92]. Four new methods were reviewed in the project which are: Eye Movement Desensitization and Reprocessing (EMDR, Shapiro 1995); Visual/Kinesthetic Dissasociation (VKD, Bandler and Grinder, 1979); Traumatic Incident Reduction (TIR, Gerbode, 1989); and Thought Field Therapy (TFT, Callahan, 1985). According to the report "four to six month follow-ups revealed that all of the approaches yielded sustained reduction in subjective units of distress".

According to the authors, Bessel A. van der Kolk et al (1999), the

"goal of treatment is to find a way in which people can acknowledge the reality of what has happened without having to re-experience the trauma all over again. For this to occur, merely uncovering memories is not enough: they need to be modified and transformed, i.e. placed in their proper context and reconstructed into neutral or meaningful narratives."[93]

Prevention

The writer believes however that a first step which might be taken by all relief organisations is to consider options for prevention of PTSD and other manifestations of severe stress. Currently, for example, all staff (including consultants) undertaking contracts on behalf of a UN organization, are required to undergo a full health examination before being given a new assignment with the organisation. No such psychiatric examination is however required or even considered. One possibility would be to institute a system of self-examination or collegial evaluation and or visit with the staff counselor in tandem with the required medical examination.

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[92] The findings of the Project were presented in 1995 at the Active Ingredients in Efficient Treatments of PTSD Conference held at Florida State University, May 12-13, 1995, see *Reflections on Active Ingredients in Efficient Treatments of PTSD, Part I*, The International Electronic Journal of Innovations in the Study of the Traumatisation Process and Methods for Reducing or Eliminating Related Human Suffering, article in, http://www.fsu.edu/-trauma/art2v2il.html.

[93] Op.Cit, Bessel A. van der Kolk et al (1999) pp.2-3.

A novel approach has also been formulated by the Rainbow Network for NGO personnel working in or returning from field assignments. The programmes can be offered confidentially to individuals who choose not to inform their employers of their condition. The approaches being considered are:

"1. Programmes of rest and recreation, either within the region or in the country of origin of the affected individuals;

2. The provision of appropriate counselling;

3. The provision of training in stress management and personal coping strategy;

4. The provision of advice to agencies on the preparation and training of personnel before taking up posts in zones of conflict and appropriate forms of support during and after their posting;

5. The possibility of loaning computers and modems to returning personnel to enable them to communicate with others in the Network, to share their problems with a sympathetic, but geographically distant, group and to reduce their sense of isolation."[94]

At the very least, all organisations which assume the responsibility for sending staff into emergency situations should have an adequate *Employee Assistance Program(EAP).* As was seen in the replies given by the respondents to the questionnaire, and from asking those interviewed for the Case Studies, none of the organisations considered appears to have developed a cogent EAP, although WFP would seem to be working towards this.

In considering the effectiveness of EAPs, the Web site for Therapy on Psychology claims that EAPS are needed because:

♦ "Thirty percent of all absenteeism and 66 percent of all terminations are related to employees personal problems (National Institute of Mental Health);

♦ Twenty-five percent of workers are substance abusers (National Institute of Drug Abuse);

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[94] Op. Cit., http://www.odihpn.org/report.asp?ReportID=1179, p.1.

♦ The economic impact of alcoholism showed a loss of US$ 117 billion (1987) and this amount was expected to have doubled by 2000 (US Department of Health and Human Services)."[95]

Even without undertaking surveys of emergency relief organizations, it is clear that a pro-active and cautious policy would be to institute an EAP, as part of an overall prevention-based strategy.

According to the same source, an EAP is designed to assist in the "identification and resolution of productivity problems associated with employees impaired by personal concerns, including but not limited to health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect their job performance."[96]

Salama (2000) also claims that

"A briefing or debriefing by a psychologist or counsellor **should represent the standard for all emergency assignments** (Bold added by author). Mental health professionals working in this role should themselves ideally have experience of humanitarian emergencies." The author goes on to state that training courses should cover stress management techniques (types of stress, coping strategies, how to access help within the organisation), cross-cultural issues, team building/conflict resolution strategies, as well as ethical frameworks and moral dilemmas of humanitarian relief."[97]

Further, Salama notes that at the social level, for example, organizations should be more willing to accommodate couples on assignment, particularly if both have relevant skills. In the Case Studies, Case Study One presented an example of the positive effect of a husband and wife team. Responses to the questionnaire also indicated a significant preoccupation among relief workers about their spouses' welfare.

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[95] See http://www.psychology.com/resources/ Why an EAP works? pp.1-2.

[96] Ibid.

[97] Op.Cit. Salama (2000) pp.4-5.

Two examples of current (though not necessarily widespread) practice are, according to Salama "a formal monitoring system for new personnel or the designation of a particular individual chosen by his peers in the field to act as the support person for that particular area."

As referred to at the beginning of the study, special conditions often apply to locally-recruited staff who may have to reconcile themselves to living with trauma for many years, particularly in some of the poorest developing countries and or those where civil conflict is, or is likely to be, prevalent for a number of years. Unlike their expatriate colleagues, they may have no real escape. Moreover, in conditions where local medical and psychiatric services are limited and of poor quality, special steps should be taken to ensure that such staff have the support of their organizations, and especially in the aftermath of a critical emergency or disaster.

Van Brabant suggests that discussions be held with "some sensitive and trusted local staff members" to review questions such as:

- "Is there a concept of stress and trauma in their culture; how do they experience it, identify it, and describe it?
- How has it been dealt with traditionally and historically, and who would deal with it?
- What is the nature of stress and trauma today and how has it changed from before?
- What coping strategies are currently being pursued and why, and how effective are they perceived to be?
- What resources can be recovered, remobilised or developed to address current needs?
- Is there a role for an international agency, or is it rather a role for the local community, for example, and /or indigenous social institutions?"[98]

As evidenced in the first Case Study, religious beliefs and rituals can also have a significant and therapeutic effect in dealing with stress and exposure to trauma. Doherty (1999) for example, also observes that

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[98] Op. Cit. Van Brabant, p.292.

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"primary mental health benefits of ritual are closely tied to the relational aspects of the ritual process. These act to validate and encourage the healthy expression of a wide range of human emotions. Jacobs (1992) concludes that religious ceremony and ritual functions mitigate anxiety and deal effectively with other problematic emotional states. Religious rites have a cathartic effect as emotions are released and expressed through attachment and connection to significant others. Reeves (1989,1990) suggests that ritual can be used to assist individuals to move from a maladaptive to an adaptive style of grieving."[99]

The importance of recognizing cultural differences both in terms of reactions to stress and exposure to trauma and their treatment, should be built in to all policies and strategies developed by international humanitarian relief agencies. International organizations which are founded on the principle of equal opportunity and employing staff from as many member states as possible should be especially sensitive to this issue. In reality they are not always so, the tendency being to give the cultural 'melting pot' concept the benefit of the doubt, without a prior consideration of whether certain cultures react better or less well to particular working practices, including high levels of stress.

As noted by Doherty "sensitivity to the culturally appropriate needs for ritual in responding to grief and providing for privacy and personal needs are paramount. Imposing a "one size fits all" grief model on people, however well intentioned, may cause more harm and ill feeling than good. Respect for the beliefs, rituals and desires of those affected can accomplish far more than unwanted attention and interventions."[100] In fact, Doherty notes that the Vail Conference on Clinical Psychology elevated the knowledge of the cultures of one's clients to an ethical imperative. "As a result doing therapy or counseling without cultural sensitivity, knowledge or awareness is not just problematic, It has been declared unethical."[101]

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[99] George W. Doherty, *Cross-cultural Counseling in Disaster Settings*, The Australasian Journal of Disaster and Trauma Studies, ISSN: 1174-4707, Volume: 1999-2, p.9.

[100] Ibid. p.10.

[101] Ibid. p.3.

Training

Some organizations have employee training programmes such as peer counseling and or peer support systems. Myers however, notes that "para-professional staff without prior human service experience will need training in communications and peer counseling skills…Topics should include:

- Basics of crisis intervention
- Establishing rapport
- Active listening and responding skills
- Attending to feelings
- Interviewing techniques
- Paraphrasing and interpretation
- Cognitive reframing techniques
- Non-verbal communication
- Group dynamics
- Helpful and unhelpful styles of assistance
- When and how to refer to mental health
- How to link clients with resources."

Myers goes on to advise that

"close clinical supervision should be part of the organizational structure. Training should provide peer counselors with information regarding how and when to consult with their supervisors and how and when to refer to individuals. They should be provided with specific indicators of when they are becoming overinvolved with a client(colleague), and how to overcome this professional vulnerability."[102]

At the very least, all staff should be provided with sufficient pre- and post assignment information on personal security risks which include managing stress. Succumbing to stress responses should not be stigmatised as weakness or incapacity but as a normal response in the face of difficult conditions. One

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[102] Op.Cit., Myers, p.13.

prerequisite for this to be effective is to make basic briefings compulsory for all staff at all levels. Given that time constraints are a major limiting factor, as relief staff are frequently sent to the field at very short notice, appropriate briefings should be scheduled on a regular basis and certainly made compulsory prior to departure on assignment as well as shortly upon return. Such briefings/debriefings should be considered no less important than for example, producing a Back-to-Office report upon returning from field missions. Were organizations to approach briefing and debriefing from this perspective they might achieve more success in terms of preventing long-term stress responses from developing while simultaneously identifying at an early stage specially vulnerable individuals.

One of the survey respondents commented that **"nobody seemed to care what had happened to you when you return from the field"**. While not a common complaint in so far as staff generally expect their work to be taken for granted simply because field assignments are part of the normal terms of reference in humanitarian agencies. There is however a difference between the business-as-usual approach which risks ignoring potential problems including debilitating personal problems (which could have a bearing on personal stress management) and which may in turn adversely effect performance, and providing staff with psychological and emotional incentives to perform the task at hand to the best of their ability.

Finally, much of the literature cited throughout this study, and the author's own experience and that of colleagues, suggest that there is an organizational responsibility towards staff who are exposed to excessively high levels of job-related stress. This includes not only responsibility for their physical wellbeing but also for their mental and emotional health. The reasons are not just ethical. Not only is employee performance likely to improve if preventative measures are taken which help to mitigate against burnout in whatever form it might take – nervous breakdown, substance abuse, PTSD etc., and its resultant hindrance to individual ability - but job satisfaction is likely to be enhanced and staff efficiency improved.

Moreover, organizations may need to carefully consider whether they can afford the potential expense of costly law suits, should employees who have suffered from

excessive work-related pressure manifest as reactions to exposure to severe stress and trauma, decide to seek refuge in the law courts. With increasing publicity being given to conditions such as PTSD and the issues of organizational responsibility receiving similar examination by researchers and the media, the consideration of effective preventative strategies and policies would appear to be both timely and essential to maintain credibility and efficiency.

Questionnaire

In completing the questions, if completing the form electronically please write "yes" on the right hand side next to the question. If filling out by hand please either circle or tick your response on the right hand side. If the question does not apply to you please write N/A in these cases.

Age cohort

20-25
25-35
35-45
45-55
Over 55

Sex   Female   Male

Country of origin   _____

Education type/level)   University Degree or Diploma (specify

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No post-high school education:

Training/skills   (List briefly any special skills or formal training undertaken (including academic, languages, technical, other)

Title of current post/job

Field assignments undertaken to date (Explain nature/place/length of assignment)

_____

Medical history
(health problems if any, indicate how long you have had problem)

_____

Before taking assignments were you given a medical examination?

Yes/No

Were you given a medical kit prior to departure?

Yes/No

Did you find it useful?_____

Were your vaccinations updated before departure?   Yes/No

Have you had malaria?   Yes/No

If you have had malaria how long were you ill for/how many times?

_____

Have you been briefed about malaria risks and symptoms by the Organization you work for?

Yes/No

Have you been informed about accident risks in the field?

Yes/No

Have you been briefed about security arrangements in the field?

Yes/No

In light of your experience, do you think your briefing was sufficient?

Yes/No

If not, indicate what dangers/risks you were exposed to (if any) and how these might have been avoided or any measures that could have been taken by the Organization to minimise these risks?

If you are a woman, do you think you were more vulnerable than your male colleagues?   Yes/No

If yes, explain
why_____

Were you breifed about risks before your departure?
Yes/No

Were you given the choice not to take the assignment?   Yes/No

If you had not accepted the assigment do you believe it might have influenced future work prospects/career with the Organization?

                                                                    Yes/No

If you answered yes explain briefly how

Counseling (are you or have you received counseling of any kind in the past 5 to 10 years, if so, indicate duration of sessions and freqency/reason if any)

When on duty in the field do you take regular rests?	Yes/No
Are rest periods required?	Yes/No
When not in the field how many hours do you work normally	0-6 hours 6-9 hours 9-11 hours more than 12 hours?
When in the field how many hours do you work	0-6 hours 6-9 hours 9-11 hours more than 12 hours?

When you finish your work in the field do you discuss with colleagues?
Yes/No

Or do you prefer to remain
alone?_____

Do you discuss your experiences in the field with spouse/family/friends/colleagues?

Yes/No

If so specify in order of who you speak with most frequently about your
experiences, if anyone__

colleagues, spouse, friends?

Do you live alone?   Yes/No

Do you have a close group of friends or family?

Yes/No

Psychological well-being

Do you feel stressed?
Yes/No

If so, how does it affect you?

Irritability_____
Sleeplessness_____
Bad or recurrent dreams_____
Headaches_____
Palpitations_____
Feeling overwhelmed_____
Difficulty in concentrating_____
Depression_____
Anger_____
Frustration_____
Difficulty in coping_____
Feeling of losing control_____
Change in eating habits_____
Increase in smoking_____
Increase in drinking_____
Feeling of detachment_____
Feeling of helplessness_____
Feeling of guilt or
remorse_____
Conflicts with
family/friends_____

Do you take anti-depressents?   Yes/No

If so for how long have you taken them?

_____

How do you cope with
stress?_____

Do you exercise regularly?   Yes/No

How do you cope with stress in the
field?_____

Were you given a briefing before departure?   Yes/No

Were you briefed about risks before your departure?

                                                                 Yes/No

Are you given debriefing(s) upon return?
Yes/No

If yes indicate how many and if they were useful

_____

Are you given briefing/debriefings whilst in the field? Specify type and frequency:

_____

If yes, would you benefit from taking a rest break immediately upon return?

                                                                 Yes/No

If so, what would be the minimum amount of time needed?

                                                      3 – 5 days
                                                      5 – 10 days
                                                      two weeks
                                                      three weeks
                                                      one month
                                                      more (specify)?

Were you given a medical checkup on returning from the field?
Yes/No

Were you given counseling upon returning from the field?
Yes/No

If yes, was such counseling satisfactory?
Yes/No

<u>**General concerns**</u>

Are you worried about:	your contractual status	Yes/No
	Your personal security	Yes/No
	Your family	Yes/No
	Health and diseases	Yes/No
	Interpersonal relations in the team	Yes/No
	Other	

Respondent answers to questionnaire

Age cohort	Sex	Nationality	Education	Organization (IGO or NGO)	Work experience	Lives alone	Illness or injuries	Average hours worked on post	Admits feeling stress	Sleeping problems (insomnia, bad or recurrent dreams)	Feeling of being overwhelmed	Other (irritability, frustration, anger, helplessness, headaches, palpitations, difficulty in concentrating)	Increase in smoking	Increase in alcoholic consumption	Worried about: family, health & diseases, personal security, interpersonal relations	Received counseling upon return	Medical check up on return	Worried about contractual status	Would like counseling	If had not accepted assignment could have influenced future work prospects?	Comments	Coping strategy
25-35	F	USA	MA& BA in social psychology	NGO	Four years incl.Rwanda	Yes	Goiter but healthy	Over 12	Maybe due to long hours	No	No		No	No		No	Yes	No	Not mentioned	Yes	Robbed at gunpoint in Haiti. Slight feeling of loneliness, fear of being raped	Reads books, letters & e-mails to friends
45-55	M	Philippines	MD	NGO	Proj. Manager	No	Hypertension for 3 years	6 to 9	Yes	No	No	Irritability	Yes	No	Family	No		Yes		No	Risks exposed to include gun battles, ambush, kidnapping,	Sex and singing with guitar
35-45	F	Canada	MA	IGO	7 years field, FS adivsor	No	No	9 to 11	Sometimes	Yes, sleeplessness and bad dreams	No	Feeling of helplessness & frustration	No	No	Family		No	No		N/A	Fear of being car jacked.	Writing, turns stressful situations into humorous ones, talking to partner, exercise
45-55	M	Denmark	LLB	IGO	5 years, emergencies, Unit Chief	No	No	Over 12	No	No	No		No	No		No	No	No		Yes	Good fortune to be calm under stress.	
35-45	M	UK	High School	NGO	4 years, captain relief services	No	No	9 to 11	Yes	Sleeplessness, bad or recurrent dreams			No	No		Yes	Yes	No				Prays and talks with spouse
35-45	F	Canada	MSC	IGO	1 month	No	No	9 to 11	Sometimes	Yes		Sometimes overwhelmed, irritable,angry	Yes	No	Personal security, health and diseases	No	No	No		Yes		Meditation and relaxation techniques, swimming
35-45	M	USA	BSC	IGO	9 years, Head office	No	No	Over 12	No				No		Health and diseases	No	No	No		No		Exercise
45-55	F	USA	BA	IGO	2 years emergencies, Office head	Yes	Hypertension for 3 years, anaemia	6 to 9	Yes	No			No	No	Family, health, interpersonal relations	No	No	No		Yes	Hypertension since field assignments	
Over 55	F	Peru	Phd	IGO	7 years field, senior prog.advisor	No	Mononucleosis, kidney infections, typhoid, cervical anthrosis	9 to 11	yes	Yes	Yes	Change in eating habits	no	No	Health and diseases	No	No	No		Yes		Gardening, TV, cooking
35-45	F	Malaysia/Malta	Diploma Business	IGO	3 postings as admin.assist	Yes	None	9 to 11	Sometimes			Irritability, anger, frustration	No	No	Family,health, relations with team	No	No	No		Yes	Nobody cares when you return from field	Yoga, exercise as fitness instructor
25-35	F	UK	BA	IGO	7 postings, P-3, trained as counselor by WFP	No	Typhoid recently	9 to 11	Yes	Yes	some	Depression, difficulty in concentrating, change in eating habits, slight feeling of detachment	Yes	Yes	Marriage and future	No	No	No		Yes	Would have been considered less committed if hadn't accepted job	Horseriding, massage, plan things on the weekends
35-45	F	France	MA(2)	IGO	3 years, Emergency coordinator	Yes	Malaria, back pains, anaemia and skin infections	Over 12	Yes	Sometimes	Some	Headaches, palpitations, difficulty concentrating, anger, frustration	N/A	N/A	Family, health, interpersonal relations	No	No	Yes		Yes	Only one short & poor stress management session organized.	Exercise

Respondent answers to questionnaire

Age cohort	Sex	Nationality	Education	Organization (IGO or NGO)	Work experience	Lives alone	Illness or injuries	Average hours worked on post	Admits feeling stress	Sleeping problems (insomnia, bad or recurrent dreams)	Feeling of being overwhelmed	Other (irritability, frustration, anger, helplessness, headaches, palpitations, difficulty in concentrating)	Increase in smoking	Increase in alcoholic consumption	Worried about: family, health & diseases, personal security, interpersonal relations	Received counseling upon return	Medical check up on return	Worried about contractual status	Would like counseling	If had not accepted assignment could have influenced future work prospects?	Comments	Coping strategy
35-45	M	Bangladesh	Dip. Civil Eng.	NGO	3 assignments total 101/2 years (plus disaster-related training and TOT)	No	None	Over 12	Yes		Yes	Feeling of losing control, helplessness, frustration	No	No	Contractual status, personal security, family, health	Yes				No		
35-45	M	Finland	MSC	IGO	Five years in field as programme/logistics officer	No	None	9 to 11				Depression and anger	No	No	Family, health, interpersonal relations, personal security	No	No	Yes		Yes, noted that short contracts and no expression of continuity/safety nets was one of the biggest occupational hazards	Received counseling after witnessing a massive traffic accident (one session). Selected as a 'peer support volunteer'.	Socializing, taking breaks, distancing onself
35-45	F	Bangladesh	MA	NGO	6 years, Coordinator Disaster Mgt.	No	None	Over 12	Sometimes		Yes	Depression and anger	No	No	Personal security, family, health and diseases, interpersonal relations	No	Yes			Yes	Received about 5 debriefings said they were useful.	Singing and discussing with staff
25-35	F	Kenya	MA & BA Psychology	IGO	Two years	Yes	None	6 to 9	Sometimes	Bad or recurrent dreams	Yes	Irritability, difficulty concentrating, anger, detachment, helplessness, difficulty in coping, frustration.	No	No		Yes de-brief		Yes		Yes		Exercise, friends, films
35-55	M	Guinea	MSC & military instructor	IGO	Five years in field as security officer (Burundi)	Yes	Repeated malaria	9 to 11	Yes	Yes			Yes	No	Family, health, interpersonal relations, personal security	Yes/de-brief	No	Yes			No coping strategy for stress but admits to exercising regularly	
35-45	M	France	MBA	IGO	1 three-year, P-3/4, Logistics, procurement,	No	No	9 to 11	No	No	No		No	No		No	No	Yes		Yes	You can have contract terminated if no alternative posts are vacant.	Exercise, parties

Policy and Procedures for Dealing with Alcohol-Related and other Substance Abuse Problems in the Work Place (Staff Circular, FAO, March 2000)

1. Introduction

The objectives and procedures set out below are based on those developed by the World Health Organisation and adopted by other UN organizations regarding employees and their possible misuse of alcohol and other substances, which may affect their work performance and their well-being and that of their families. They apply to the staff of the Organization at all levels. The social use of alcohol and other drug-related substances does not pose a major problem for most people. However, their misuse can affect mental and physical functions, particularly coordination, speed of reaction, judgement, emotional behaviour and human relations inside and outside the Organization. Alcohol dependence or alcoholism is a serious health problem in which the responsibility of the individual plays an important role with regard to rehabilitation. The use of alcohol and other drug-related substances becomes a problem in the work place only when it affects the conduct and/or impairs the performance of the staff member in the function of his/her duties. In addition, excess use of alcohol or other drug-related substances may lead to dependence, causing serious health problems that need to be addressed as such. Consequently, confidentiality and privacy will be preserved when a staff member seeks assistance with any alcohol or drug-related problem. Nor will he/she suffer career discrimination or disadvantages while actively seeking treatment.

2. Policy Objectives

All those intervening in an alcohol or an other substance abuse problem should be guided by the primary objective of assisting staff members so that their illness is treated and they recover their normal health and productivity instead of facing disciplinary/administrative action. Further objectives of the policy are:

- to inform staff members of the dangers of alcohol and other substance abuse and thereby increase awareness of alcohol and drug-related problems;
- to inform staff members that alcohol and drug-related problems can be treated and that the Medical Service is available for advice, including counselling;

- to encourage and help any staff member who has an alcohol or drug-related problem to seek professional help and treatment in order to overcome the problem;
- to provide information on the steps that should be followed to deal with the problem;
- to support the Medical Service in the identification of alcohol and other substance abuse problems as well as treatment and rehabilitation methods;
- to ensure that appropriate treatment and rehabilitation are adequately covered by relevant health insurance schemes.

3. Intervention Procedures

All those responsible for taking action should clearly understand the sequence of procedures to be applied in respect of an alcohol or drug-related problem concerning a staff member. These are set out in the following three steps.

Step 1. Recognition of problem. In some cases, individuals may themselves recognise that they are manifesting an alcohol or other substance abuse problem and may volunteer to receive appropriate treatment. In other cases, such problems may be revealed in the course of a medical examination, in which case it will be possible to proceed directly to Step 3. Finally, individuals in the workplace may become aware of an alcohol or drug-related problem affecting performance and/or conduct. In such cases, the procedure under Step 2 should be followed.

Step 2. Referral for medical/psychological/social assessment. The supervisor may refer the individual to the Chief Medical Officer in order to ensure that a skilled and objective assessment of the problem has been obtained. The individual will also be given the opportunity to obtain an outside professional opinion. If no alcohol or drug-related problem is diagnosed by both medical experts during this assessment, this intervention procedure is terminated.

Step 3. If the existence of an alcohol or drug-related problem is confirmed. Every effort will have to be made by all concerned to ensure professional reintegration. Two alternative scenarios with corresponding steps may be appropriate

Rehabilitation. The staff member successfully modifies his/her problem behaviour or agrees to be referred to appropriate treatment and rehabilitation. If treatment is accepted by the staff member, it will still be necessary to ensure that the case is monitored by the Medical Unit, and if appropriate, by the supervisor. Every effort will have to be made by all concerned to ensure professional reintegration in order to facilitate the normal resumption of duties. In the case of relapse, the procedure outlined above will still apply.

Refusal. The staff member does not modify problem behaviour and refuses to accept treatment with the result that work performance and conduct continue to be seriously impaired. In such cases, the staff member may become subject to administrative action in line with the relevant provisions of the Manual.

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