Mitigating Psychological Distress Among Humanitarian Staff Working With Migrants and Refugees: A Case Example

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Abstract: Ongoing acute stress in humanitarian work leads to psychological distress among humanitarian workers. Stress management within humanitarian agencies requires responses at both the individual staff member and agency levels. Stress management is often conceptualized in four categories: stress that can be accepted; stress that can be altered; stress to which individuals can adapt; and stress that can be avoided. Humanitarian workers accept the stress created by the environment in which they choose to work. They can manage stress by altering their own behaviors through improved communication skills and the implementation of self-care plans. They can adapt, with the help of staff care plans such as counseling and peer support, to the stress created by their own histories of trauma or mental illness. The stress created by the workplace can be avoided. However, without a comprehensive support plan for mitigating psychological distress, both the individual humanitarian worker and the agency overall suffer. This article reviews current literature regarding the impact of avoidable stress and the impact of adaptation programs such as staff care and stress management plans on humanitarian work, and illustrates these impacts with a case example from the Danish Refugee Council, an international non-governmental organization with approximately 300 employees working in Greece.

Keywords: Humanitarian workers; refugee; migrant; self-care; stress management; Greece

Self-care is a core principle of social work (Cox & Steiner, 2013), and is critical for effective work with traumatized populations (Lipsky & Burk, 2009). Refugees are people who are forced to flee their homes because of war or persecution. By definition, a person who is labeled a refugee has experienced trauma. Yet, self-care is not universally practiced within humanitarian agencies serving these vulnerable populations (Porter & Emmens, 2009). People categorized as refugees have experienced the trauma of forced migration and as many as 37% may be suffering from PTSD and 75% may be suffering from depression (Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan, 2015). Thus, working with traumatized individuals requires that those providing services understand the unique aspects of stress to which they are exposed.

Humanitarian workers, also referred to as aid workers, are those working with an agency that is responding to a humanitarian crisis. Both humanitarian work and social work are helping professions that seek to protect and promote human dignity. The International Association of Social Workers (IFSW) defines social work as a profession that "promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work" (IFSW, 2014, para. 1). Social workers conduct

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professional activities under the guidance of the Code of Ethics, which outlines the core values of the profession as: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2017).

Humanitarian work is defined through the Geneva Conventions. The International Committee of the Red Cross (ICRC) delineated the role, specifically in the 4th Geneva Convention, which outlines the protection of civilians during war. The ICRC (2014) further defines a humanitarian mission as the delivery of necessary assistance that protects the dignity of the person receiving aid. Just as social work activities are guided by a Code of Ethics, humanitarian work is guided by four key principles: humanity, neutrality, impartiality and independence. Together these principles oblige aid workers to provide assistance that protects the rights and vulnerabilities of every person in need (Rysaback-Smith, 2015).

Both social workers and humanitarian workers choose a profession of providing assistance to people in need. However, social workers are more homogenous in their roles, whereas the humanitarian field is made up of people with a variety of backgrounds. Some aid agencies specialize in health care, such as Doctors without Borders or Doctors of the World, and their staff is often made up primarily of health care providers. Other aid agencies, such as the Danish Refugee Council, focus on the needs of the entire refugee community. They set up and manage camps, create shelters, and provide sanitation services. They also provide protection monitoring, ensuring that people entering the camp are screened for special needs. In many ways, humanitarian workers create and administrate a city. Their backgrounds may be in fields such as engineering, to ensure that housing needs are addressed, or international relations, to ensure that they have a macro understanding of the crisis.

Because not all roles require the same type of education, not all aid workers have the type of training that is considered standard among social workers, such as an understanding of human development, trauma, or the importance of clinical supervision. Although these staff come from a variety of disciplines, many work directly with the affected population and very few, outside of those in specialized organizations, have a background in social work or mental health. Similar to social workers, humanitarian workers are often responsible for conducting assessments to identify needs and assist beneficiaries in accessing basic necessities, such as food and shelter. For humanitarian workers, unique stressors are often present in locations that in and of themselves are stressful. Stress management requires responses at both individual and agency levels. A review of stress management and staff care techniques among international aid agencies (Curling & Simmons, 2010) revealed that 74% of staff members felt moderately or extremely stressed.

In the human service sector, it is well-known that burnout, vicarious trauma, and secondary traumatic stress are occupational hazards (Mathieu, 2012). The criteria for burnout are met when a person working in human services experiences emotional exhaustion, depersonalization, and a reduced sense of accomplishment (Maslach, Schaufeli, & Leiter, 2001). Vicarious trauma is the change in worldview that takes place as the result of hearing an accumulation of traumatic stories over time. Arising from the

helper's engagement with the traumatized client, vicarious trauma involves distress, specifically a change in the worker's cognitive schemata (Nimmo & Huggard, 2013). As with Post-Traumatic Stress Disorder, the change in worldview seen with people suffering from vicarious trauma may be a shift from altruism into pessimism. For example, an aid worker may generally see the world as a place with good people trying to help each other, but over time may begin to see it as a place where people torture and harm each other, instead of help each other. The worker may or may not be aware of these effects. Secondary traumatic stress is experienced when the helper begins to display trauma responses similar to those of persons directly exposed to trauma (Pearlman & Saakvintne, 1995). Secondary traumatic stress symptoms are very similar to those of PTSD, such as hypervigilance and intrusive thoughts, except that the exposure to trauma is secondary rather than primary (Bride, Robinson, Yegidis, & Figley, 2004). A worker's secondary traumatic stress reactions may or may not reflect the client's actual responses.

All three of these types of staff stress manifestations impact the quality of care provided to people in need. But for humanitarian aid workers, much like social workers, a significant piece of their sense of purpose and identity is associated with their work, which means the consequences of burnout, vicarious trauma and secondary stress can be very high.

This article will apply the lens of common stress management techniques to a review of the challenges facing humanitarian workers and their agencies as they work to meet the needs of refugees and migrants. The article will further apply this stress management lens to a case example based on the first author's experience providing a psychosocial support program to staff of the Danish Refugee Council delivering humanitarian services to refugees in Greece. The case example will draw upon the author's case notes, records of services provided, and anecdotal observations.

Conceptual Framework

Stress management is often conceptualized in four categories, or four "A's": (1) accepting stress; (2) altering stress; (3) adapting to stress; and (4) avoiding stress (Mayo Clinic, 2016; Robinson, Smith, & Segal, 2017). Humanitarian workers accept the stress created by the environment in which they choose to work. Aid workers can manage stress by altering their own behavior through improved communication skills and the implementation of self-care plans. They can adapt to the stress created by their own histories of trauma or mental illness and the stress created by the workplace with the help of staff care plans such as counseling and peer support (Mayo Clinic, 2016; Robinson et al., 2017). However, when the majority of staff are experiencing psychological distress due to acute stress, without a support plan, the stress reactions can create a toxic environment (Glasø & Vie, 2010). This toxic environment is avoidable through the application of the other "A's" in stress management.

The Four "A's" in Humanitarian Work

Accepting Stress

As in the field of social work, there are some stressors that are an inherent and accepted part of humanitarian work. Accepted stress in the humanitarian workplace can come from many different sources: a worker's own history of trauma or mental illness; ongoing exposure to people who have been traumatized and are suffering; and high-risk work environments. Social workers are taught, throughout their training, to know themselves and the environment that they are entering. By understanding the physical and emotional risks, social workers can recognize their strengths and limitations and learn how to manage challenging work environments. Humanitarian work takes place in similarly stressful environments, both physically and mentally, but the training and support these workers receive while on mission often lacks this fundamental aspect. Although aid workers are aware of the types of environments in which they will work, they are often unaware of the level of emotional distress this type of work can have on them.

Humanitarian aid is provided to people who have experienced manmade and natural disasters. The profession itself requires that aid workers accept stress, including witnessing the impacts that war, violence, and disasters have on people (Curling & Simmons, 2010). Aid workers' own safety may be at risk while deployed in unstable and dangerous situations (Connorton, Perry, Hemenway, & Miller, 2011; Curling & Simmons, 2010; Ehrenreich & Elliot, 2004). In addition, aid workers are continuously exposed to the traumatic experiences of the people they are supporting (Blanchet & Michinov, 2014). However, studies find that stress and burnout are not correlated with higher-risk or higher-stress environments (Cardozo et al., 2012; Eriksson et al., 2009). While being exposed to these stressors, aid workers are often separated from the support of their families and other social networks (Connorton et al., 2011; Ehrenreich & Elliot, 2004).

Aid workers who have experienced personal trauma or mental illness may be unaware that working with traumatized individuals may trigger their own memories of trauma (Cardozo et al., 2005; Ehrenreich & Elliot, 2004). This type of stress can impede judgment and reduce coping skills (Sommers-Flanagan, 2007). It can also increase the risk of depression, anxiety, and burn-out (Cardozo et al., 2012). Aid workers with a history of anxiety and depression are at greater risk of experiencing anxiety, depression and overall emotional exhaustion in the field (Cardozo et al., 2012).

Over the past few years, several surveys have found high rates of stress, along with symptoms of depression, PTSD and anxiety among staff working within the humanitarian sector. In a 2010 study, 74% of aid workers surveyed were found to be moderately or severely stressed (Curling & Simmons, 2010). Severe stress places a person at increased risk of depression. A 2011 study reported that up to 43% of aid workers have experienced PTSD, 20% have experienced depression, and 29% have experienced anxiety (Connorton et al., 2011). A longitudinal study found that rates of anxiety in expatriate aid workers increased from nearly 4% to nearly 12% from pre-deployment to post-deployment, while rates of depression nearly doubled from 10.4% to 19.5% (Cardozo et al., 2012).

Studies often find higher rates of emotional distress among national staff, or staff coming from the host country, in comparison to international staff, or expatriate staff coming from other countries. National staff often face a unique burden. In many crises, they share a similar culture, language, heritage and history as the refugees they are assisting. They themselves may also have experienced forced migration (Cardozo et al., 2012). The burden of accepted stress is higher in these humanitarian staff members. A 2008 study found Sudanese aid workers had higher levels of stress and burnout than their international counterparts (Musa & Hamid, 2008). A 2009 article found that 42% of national staff in Guatemala experienced symptoms of PTSD (Putman et al., 2009). A 2012 study found that 68% of national staff in Uganda had symptoms of depression, while 53% had symptoms of anxiety, 26% had symptoms of PTSD, and 50% had symptoms of burnout (Ager et al., 2012). Notably, each of these studies found that the aid workers as a group had experienced both primary and secondary trauma, corroborating the unique burden of national staff in regard to their frequent exposure to the same traumas as their clients.

The risks of emotional distress are well known and documented, but often aid workers themselves are unaware of the impact that this work could have on their overall wellbeing. A 2009 longitudinal survey of aid workers revealed that 40% of participants stated that the work environment was more stressful than expected (Dahlgren, DeRoo, Avril, Bise, & Loutan, 2009). And, perhaps more importantly, these workers are often unaware of some of the factors that could protect them from emotional distress.

Without knowing these risks, the emotional distress experienced by aid workers often goes untreated, which can have a significant impact on not only the individuals experiencing these symptoms but the quality of the work they provide. For example, in a Sri Lanka study, over half of humanitarian workers experienced traumatic stress symptoms and nearly one-third avoided working with certain clients (Cardozo et al., 2013).

Altering Stress

The types of stress that can be altered are those that individuals have some control over. Self-care strategies along with assertive and open communication skills are ways in which people can alter their experience to decrease stress (Mayo Clinic, 2016; Robinson et al., 2017). Aid workers employ numerous positive and negative coping skills. Positive coping skills can include journal writing, open communication with friends, exercise, the use of mindfulness and meditation, and counseling. Although aid workers are often separated from their families and support networks, a new support network is frequently formed with colleagues, who are often their friends and sometimes their roommates as well. A 2016 study of Serbian medics in the Democratic Republic of the Congo measured the impact that open communication had, in comparison to the use of avoidance, and found that it had a positive correlation with reduced stress levels (Jokovic, Krstic, Strojanovic, & Spiric, 2016). The same study highlighted how connection with work, regular communication with family, and regular exercise can help lower stress levels. In a 2012 study, strong social support was related to lower levels of depression and burnout (Cardozo et al., 2012). The converse has also been found to be true; depression rates were higher among aid workers with lower family and social support (Cardozo et al., 2005). Mindfulness trainings for aid workers are now being successfully introduced into the field (Pigni, 2014).

The impact of psychological distress on the individual may elicit negative coping skills such as emotional dysregulation, cynicism, and self-destructive behaviors. Aid workers often respond to emotional distress with anger, avoidance, or distancing (Connorton et al., 2011; Ehrenreich & Elliot, 2004). One study found that 27% of aid workers engaged in risk-taking behaviors such as speeding, drinking and driving, unprotected sex, frequent change in sex partners, and excess use of alcohol and other drugs as ways of coping (Dahlgren et al., 2009). A similar study found that 16% of aid workers met the criteria for alcohol abuse (Connorton et al., 2011).

The coping skills that people employ to respond to stress can have a significant impact on the quality of work they provide. Negative coping skills can lead to accidents involving injury (Dalhgren et al., 2009). Aid workers rely on their communication skills to assess and respond to the needs of their refugee clients. Emotional avoidance, cynicism and distancing can impact the relationships staff have with their clients, as these defense mechanisms may reduce the amount of information workers receive from their clients.

Avoiding Stress

Some stress can be avoided altogether with advance planning. Within the context of humanitarian work, avoidable stress is that which is caused by the dynamics within an office environment. Stress management is not only the responsibility of the individual; it is also an agency responsibility. Typical signs of agency burnout include high turnover, clique formation, frequent conflicts, scapegoating, lack of initiative, increased sick leave, and lower output (United Nations High Commissioner for Refugees [UNHCR], 2001). One study found that the top five sources of stress within humanitarian work were not associated with related trauma or safety factors; they were all agency-related. The stressors included workload, ability to achieve work goals and objectives, hours, status of contract, and feeling undervalued (Curling & Simmons, 2010). A similar study in Sri Lanka found that when staff members felt supported by their agency they experienced lower levels of depression and anxiety symptoms (Cardozo et al., 2013). Another similar study found that 56% of participants identified the office environment as the most frequent stressor experienced by humanitarian workers (Dahlgren et al., 2009). Likewise, among the various stressors listed in a 2004 study were lack of adequate resources (i.e. personal time or logistical support to meet expectations), excessive bureaucratic demands, lack of leadership and recognition from the employer, and interpersonal conflict among team members (Ehrenreich & Elliot, 2004).

Although aid work is provided in high-stress environments, the agencies themselves do not need to be high-stress. High-stress agency characteristics include unclear boundaries, over-identification with clients, uncoordinated services, lack of clinical supervision and coaching for leaders, workaholism, self-sacrifice and inadequate self-care. Low-stress agencies include care-for-caregiver programs, coaching for leaders, and clear definitions of roles and boundaries (Pross & Schweitzer, 2010). Unsupportive administration, lack of professional challenge, and difficulties in providing client services are predictive of high burnout rates (Bell, Kulkarni, & Dalton, 2003). Low-stress environments, on the other hand, have been identified as having strong boundaries, having good leaders that utilize internal resources and delegate responsibilities to staff according

to their skills and experience, providing opportunities to learn and improve skills, and providing space for reflection to build self-awareness. Clinical supervision, in particular, has frequently been associated with lower agency stress (Bell et al., 2003; Jones, Muller, & Maercker, 2006). Staff members feel valued when they have the opportunity to provide feedback on agency decisions (Brooks et al., 2015; Curling & Simmons, 2010; Halbesleben & Buckley, 2004).

Because aid work is provided in an emergency context, not everything can be planned. Emergency work, which is usually characterized by deadlines and short-term contracts for management staff, may lead to competing procedures and overall frustration in the field (Francis, Galappatti, & van der Veer, 2012). Decisions are made quickly, and roles and expectations are continuously evolving (Blanchet & Michinov, 2014). However, just as aid agencies are able to plan for the setup of a camp and the number of tents needed, they can anticipate and plan for the certain aspects of internal stress. Protective planning can assist with team cohesion, inter-office communication, and sense of efficacy.

An unstable work environment with unclear roles has a direct impact on transactive memory, that is, the memory that allows a team to function successfully (Blanchet & Michinov, 2014). The transactive memory is a shared cognitive process that helps a team know which person to rely on for what task. When staff members change teams or leave, it is difficult for the remaining team members to adjust unless the incoming staff member has the same skill set and strengths. As the transactive memory decreases, so does the degree to which individuals rely on their colleagues, and they become more likely to keep their work to themselves.

Humanitarians are often much more patient with their refugee clients than they are with each other and the way that this cohort of colleagues interact with each other acts as a catalyst to spread stress. Ongoing exposure to trauma can have a cumulative effect; people may not feel the impact of the first or second exposure to trauma but after several experiences they may begin to show symptoms (Curling & Simmons, 2010). As it is cumulative, the overall impact can appear in subtle changes. According to studies, seasoned aid workers are less likely to experience high rates of stress or burnout than more inexperienced workers, but it has been noted that this conclusion may be inaccurate (Eriksson et al., 2009). Surveys assessing rates of burnout and secondary stress use time limits, with questions framed as, "In the last two weeks have you…?" People who have experienced an accumulation of stress may simply have adjusted to the cynicism and depersonalization used in reaction to their stress (Eriksson et al., 2009). Therefore, seasoned workers, now in leadership roles, may have adapted to the depersonalization and the cynicism common in burnout, but the impact of burnout can still be seen in the way they treat their work and their colleagues. Emotional dysregulation and cynicism impact the office environment by leading to outbursts of anger and blame. In addition, work takes longer to complete when someone is dealing with the emotional exhaustion and depersonalization of burnout (Halbesleben & Buckley, 2004). As stress and burnout spread, team cohesion and work effectiveness decrease as much as 50% (McCormack & Joseph, 2012; Nilsson, Sjöberg, Kallenberg, & Larsson, 2011). Burnout is more likely to spread from management to staff than vice versa (Maslach et al., 2001). Eriksson et al.

(2013), in their work on locally recruited staff in Jordan, recognized that managers can be five times more likely than non-managers to experience burnout.

Inexperienced aid workers often develop burnout due to growing recognition of the limited scope of services that humanitarians provide (Cardozo et al., 2012). Aid workers start their careers imagining how they will help people, but the limitations of what can be done to help can create feelings of inadequacy, and if not managed correctly, burnout. Many people who choose humanitarian work are perfectionistic and highly motivated. Humanitarians are people who expect to make a difference in the world through their work (Eriksson et al., 2013). The reality of the work and its limitations can cause cognitive discord when those who thought they would make a difference now feel that none of it matters. They may focus more strongly on the failures of the work than on its successes, and internalize the failures as their own. This often causes feelings of inferiority and shame in humanitarian workers (McCormack & Joseph, 2012). This type of stress can cause serious challenges for the agency. According to studies, it can impede recruitment and retention of good staff (Nilsson et al., 2011). When dysfunction sets in, no matter how hard people work, the quality of services delivered suffers.

One challenge to ensuring that staff feel valued is the way in which programming is evaluated and funded. Funding priorities lead agencies to value service delivery to high numbers of beneficiaries over capacity building within staff. However, staff feel valued when they are given the opportunity to improve their skills and grow within an agency (Halberson & Buckley, 2004). The decrease in sense of value or ability to contribute to the agency impacts the sense of self-efficacy and the overall feeling of burnout. Increased stress causes people to leave rapidly. The dichotomy in agencies' priorities creates a rise in the number of beneficiaries and a simultaneous drop in service quality (Goncalves, 2011).

Adapting to Stress

Adaptation in stress management refers to changing one's expectations or standards. Within this context, humanitarian aid agencies adjust their standards regarding the type of care and support they provide to their staff. People in Aid, an organization founded by humanitarians to improve organizational effectiveness, identifies the objective of staff care to create wellbeing among staff and improve the quality of their work (Goncalves, 2011). In addition, aid agencies have a *Duty to Protect* principle with regard to staff. The *Duty to Protect* often refers to the duty to keep someone safe from physical harm. But given that decreased emotional well-being increases risk of accidents and decreases quality of service, agencies also have a duty to protect staff against burnout, secondary stress, and vicarious trauma. Measures that can be taken by agencies to decrease exposure to these occupational hazards include providing emotional support, physical safety, and a respectful environment (Cripe & Nyssens, 2017).

Study after study recommends that agencies offer access to counseling and/or peer support models. A 2005 study of Kosovar aid workers (Cardozo et al., 2005) found that existing support services provided to staff were characterized as poor by the participants, and recommended staff support to attenuate the emotional distress experienced. Another

study noted that the key to protecting staff from secondary traumatic stress is recognizing it and treating it early through mental health services (Bilal, Rana, Rahim, & Ali, 2007). In a study of Guatemalan aid workers, the authors noted a need for emotional support (Putman et al., 2009). A study in Sri Lanka recommended ongoing training regarding stress along with increased support for staff (Cardozo et al., 2013).

Emotional support programs provided to staff should include two primary aspects: training and ongoing support. Other programmatic initiatives such as counseling and peer support models have also been shown to be helpful (Curling & Simmons, 2010). Studies have identified having someone to talk to, and training regarding the emotional distress that is common in aid work, as essential to protecting staff against severe emotional distress and burnout (Jokovic et al., 2016). Trauma-specific training has been found to decrease the potential for vicarious trauma (Harr, 2013). Curling & Simmons's (2010) study on support programs for aid workers found that 77% of participants identified training on stress and trauma reactions as necessary and 64% of staff saw access to counselors as helpful. Furthermore, a study of International Red Cross delegates found that participants who had someone to talk to, such as a counselor or a peer support person, were 28% less likely to feel emotionally exhausted (Dahlgren et al., 2009).

More and more agencies are recognizing the need to support their staff through onsite or outsourced counseling, emergency assistance programs, and peer support programs. The World Health Organization has developed a promising pilot program called *Problem Management Plus* that utilizes paraprofessional counselors to deliver short-term crisis counseling (Rahman et al., 2016). Although this program is envisioned to provide direct support to beneficiaries, it could also be a promising model for peer support. Through the use of peer support or counseling, agencies have the opportunity to help not only those who seek counseling, but the entire agency. However, it is important to note that programs that respond to the emotional needs of aid workers must take into account the types of individuals they seek to support. Aid workers are often people who would be considered "non-traditional" clients. Many come from cultures and backgrounds for whom counseling carries a heightened sense of stigma, and those coming from western backgrounds often deny a need for counseling and use emotional distancing as a coping mechanism (Brooks et al., 2015).

Case Example: The Greek Context

Greece is a major transit point for Middle Eastern migrants and refugees, particularly those from Syria. Syrian refugees constitute the largest community of displaced people in the world. Over 5 million Syrians have sought safety worldwide (UNHCR, 2017a). Over 1 million refugees crossed through Greece between 2015 and 2016 (European Civil Protection and Humanitarian Aid Operations, 2017). Refugee camps in Greece are now home to over 60,000 people (UNHCR, 2017b). In response to the crisis, the United Nations, the European Union and humanitarian aid organizations, such as the Danish Refugee Council, have established refugee camps and related services throughout Greece. However, in Greece, the normal stressors that are common in refugee crises are exacerbated by the country's economic crisis and lack of government preparedness to respond to the crisis.

The first author provided psychosocial support services to the Danish Refugee Council in Greece starting in 2016, shortly after the agency began operations in that country, through 2017. At the time, the agency had approximately 300 staff in Greece. The psychosocial support program developed for the Danish Refugee Council in Greece included four components: training on burnout, secondary traumatic stress and vicarious trauma; clinical supervision/case consultation; group counseling; and individual counseling. The overall approach was influenced by a trauma-informed self-care framework (Salloum, Kondrat, Johnco, & Olson, 2015).

This case example is based on the initial nine months of the psychosocial support program, from September 2016 through June 2017. The program was developed in response to a high rate of burnout seen among staff and was initially intended to focus on the needs of one area of humanitarian work, protection. Protection staff are responsible for conducting vulnerability assessments with each refugee. Their assessments assist in informing their colleagues about vulnerabilities that an individual refugee may have and that may need to be accounted for with each aspect of the work, from food distribution to medical support to housing accommodations. The psychosocial support program consisted of live programming, delivered during five visits to each of four program sites, and remote support delivered via Skype. In September of 2016, protection staff from four sites across Greece – Athens, Thessaloniki, Larissa and Lesvos – were invited to a multi-day intensive training. Six hours of this training was dedicated to the concepts of trauma, vicarious trauma, and staff care. Following the training, each protection team was provided monthly clinical supervision/case consultation. In addition to the ongoing clinical supervision, each team was provided with the opportunity to participate in an open group session.

During the initial visit to each office, the scope of work expanded from protection staff to all staff in the agency, based on staff requests. Although only protection staff were provided with clinical supervision/case consultation, all staff were invited to participate in trainings, group sessions, and individual sessions. Staff participating in some portion of the psychosocial support program ranged in age from 22 to 60 years old and came from over a dozen countries in Europe, North America, and the Middle East. Staff at each of the four sites mirrored the population make-up of the surrounding refugee camps, to ensure that communication between staff and refugees could be easily facilitated. During the initial nine-month period of the psychosocial support program, 21 training sessions were provided to approximately 120 aid workers (approximately 40% of the agency personnel) on signs and symptoms of mental health crises along with burnout. Each training lasted approximately two hours and introduced the signs and symptoms of PTSD, depression, anxiety, burnout, vicarious trauma, and secondary traumatic stress. Also during this period, 262 individual counseling sessions were provided to approximately 70 people (23% of the staff), and seven counseling groups were held.

Accepting Stress in the Greek Context

As noted earlier, national staff often have higher rates of emotional distress. National staff are often the people to hear the needs of the refugee first hand; they then interpret them to international aid workers. However, in Greece, it is not national staff that play

these roles but international staff. These expatriate staff often come from refugee-producing countries, and some have first-hand refugee experiences.

In Greece, the Danish Refugee Council's staff accepted the stress of working with traumatized individuals, although many were unaware of the impact that may have had on their own personal wellbeing. However, the environment itself is not a war zone. With the exception of working with a disturbed or violent client, these aid workers are physically safe while conducting their work. Nonetheless, the physical safety did not seem to mitigate the level of emotional distress. As described previously, training was provided to the staff on the signs and symptoms of PTSD, depression, anxiety, burnout, vicarious trauma and secondary traumatic stress. This information was new for the vast majority of participants. Even seasoned aid workers were surprised to learn that the emotional distress they were experiencing individually was common among aid workers.

Altering Stress in the Greek Context

Among the staff members who received individual counseling over the nine-month period in Greece, 34%, or 24 people, found themselves becoming avoidant. As noted previously, social support within the aid worker community most often comes from co-worker relationships. This can create a certain level of support, but it can also isolate the workers from other aspects of their social networks. Avoidant behaviors impacted their personal and professional lives.

Within the counseling sessions, one of the questions the therapist (first author) often asked was, "What generally makes you feel better when you're upset?" Staff members frequently responded that talking to their families and their friends outside of aid work was helpful. But as stress increased, the level of engagement with such friends and family decreased. Most had gone weeks or months without talking to anyone outside of their co-workers. Participants often expressed worry about "burdening" their loved ones with their stress, and exhaustion at even the thought of trying to explain how they were feeling. However, the reverse was also true; when participants reached out to their families and friends they often returned to counseling the following week citing a lower level of stress.

In group counseling sessions, each group discussed the challenges of working and socializing together. When socializing together, the groups found that they often talked about work. But this only served to heighten their stress levels. Each group discussed ways in which they could change this pattern of behavior. One group found a creative solution in the decision to create a list of conversation topics and cut them up into little strips of paper and put them in a plastic bag. That way when they were out, they could choose a non-work related topic, from those included in the plastic bag, to discuss.

Avoiding Stress in the Greek Context

Low-stress and high-stress qualities were seen within the Danish Refugee Council in Greece. The agency responded to needs of staff for training regarding topics such as boundaries, active listening, and psychological first aid, providing opportunity for staff to increase their skills. In addition, some staff were invited to participate in case consultations/clinical supervision to allow staff to receive feedback and assess the

successes and challenges of their work. However, the spread of burnout and overall stress had a significant impact on the personal experience of the work. Common conversations during individual counseling sessions included interpersonal experiences with colleagues. Frustration often stemmed from the feeling that colleagues didn't know how hard a person was working, or the strengths that person had. Individuals experiencing conflict within the workplace often felt alone in their work, or as if they could rely on only a few people.

Adapting to Stress in the Greek Context

The author used a flexible approach in designing and delivering a psychosocial support program for the Danish Refugee Council in Greece. Particular attention was paid to the needs of these "non-traditional" clients through activities and trainings that normalized conversations about feelings and challenges. The programmatic approach utilized strategic timing of services offered. The initial introduction to the psychosocial support program was a training using psychosocial and stress-relief activities to highlight the commonality of the feelings of distress individuals often feel. Participants were then invited to participate in psychosocial groups around stress management. Finally, individual counseling was made available. Sessions focused on past experiences of trauma, grief and loss, along with the everyday stressors of humanitarian work. Through programming and training on burnout, the aid workers became more likely to seek services as needed, once familiar with the service provider.

Discussion

The body of research reviewed earlier provides ample evidence that humanitarian work can cause burnout, vicarious trauma, and secondary traumatic stress among aid workers. The environment of the work, the nature of the work, and organizational stressors create barriers to the provision of quality humanitarian services to vulnerable populations. The experience of humanitarians working with the Danish Refugee Council in Greece mirrors the prior research regarding trauma and stress in this field. Viewing the stressors faced by humanitarian workers through the lens of the four "A's" of stress management provides a roadmap to assist agencies and aid workers both in decreasing the emotional distress and the impact it has on beneficiaries.

Implications for Humanitarian Workers and Agencies

Although aid workers accept the inherent stressors of the job, they need training and education about how those stressors may impact them. With information regarding the emotional impact the work will have, aid workers can alter some of their behaviors to increase their overall wellbeing. Aid agencies can avoid the internal stress that the office dynamic creates through planning and developing staff recognition and support programs. Finally, aid agencies can further decrease the rates of burnout, vicarious trauma, and secondary traumatic stress through adaptation programs such as counseling or peer support.

Limitations

This article presented a case example of a psychosocial support program implemented by the Danish Refugee Council in Greece. The description provided was based on the first author's case notes and anecdotal information, thus limiting scientific rigor. Further, a case example based on one agency in one country prohibits generalization. Finally, this program was provided both through in-person and remote support; the relative effectiveness of the two approaches cannot be determined.

Recommendations for Future Research

To further support or refute the observations made in this case example, replications in other humanitarian settings should be conducted. More rigorous quantitative and qualitative evaluations are needed to examine the impact of psychosocial support programming on the stress experienced by humanitarian workers. The authors are presently conceptualizing means to include such evaluations in future research endeavors. Moreover, further research regarding the accumulation of trauma exposure among seasoned aid workers is needed. Often, seasoned aid workers ignore symptoms of psychological distress within themselves, sometimes for years. In these cases, assessment tools may not adequately identify the distress, as the adaptive functioning, including pessimism and acting out behaviors, has become normalized. Finally, further research regarding the efficacy of remote-based psychosocial support for humanitarian workers would be valuable.

Conclusions

This article has highlighted the unique role that social workers can play in supporting humanitarian work. Social workers have the benefit of academic training that provides skills in the areas of interviewing traumatized individuals, boundary-building, and understanding personal triggers. In addition, social workers have the benefit of ongoing clinical supervision to help hone those skills. These social work skills are foundational elements of good self-care and provide support to both the worker and the program beneficiary; however, humanitarian workers often do not have the benefit of these types of training and supervision.

Aid workers often fear the stigma of mental illness, coming from communities where counseling is considered abnormal. They often feel that they took a job that is defined by emotional and physical intensity and that asking for help undermines their self-image of their ability to do the work. The employment cycle of an aid worker is often divided into three phases: pre-deployment, during mission, and post-deployment. Each of these phases offers an opportunity for prevention of burnout, vicarious trauma and secondary traumatic stress (Hearns & Deeny 2007). However, many international non-governmental organizations find themselves responding to instead of preventing burnout, vicarious trauma and secondary traumatic stress. Agency culture, the accumulation of stress that may be present in seasoned aid workers, and stigma all create barriers to creating programs that can prevent and respond to existing psychological distress.

The refugee crisis in Greece, for many aid workers, was envisioned as a light mission. Instead of working in a war zone, they would be working in Europe. However, as the volume of requests for psychological support in this program suggests, working with traumatized people is always strenuous, regardless of the setting.Yet, as demonstrated by this program, when support is made available and seeking support is normalized as a common response to the types of occupational hazards experienced by aid workers, it is often highly utilized and well-received.

References

Ager, A., Pasha, E., Gary, Y., Duke, G., Eriksson, C., & Cardozo, B. (2012). Stress, mental health, and burnout in national humanitarian aid workers in Gulu, Northern Uganda. *Journal of Traumatic Stress, 25*, 713-720. doi: https://doi.org/10.1002/jts.21764

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84,* 463-471. doi: https://doi.org/10.1606/1044-3894.131

Bilal, M., Rana, M., Rahim, S., & Ali, S. (2007). Psychological trauma in a relief worker: A case report from earthquake-struck areas of Northern Pakistan. *Prehospital and Disaster Medicine, 22*, 458-462. doi: https://doi.org/10.1017/S1049023X00005215

Blanchet, C., & Michinov, E. (2014). Relationships between stress, social support and transactive memory among humanitarian aid workers. *International Journal of Emergency Management*, *10,* 259-275. doi: https://doi.org/10.1504/IJEM.2014.066484

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, *14*, 27-35. doi: https://doi.org/10.1177/1049731503254106

Brooks, S., Dunn, R., Sage, C., Amlot, R., Greenberg, N., & Rubin, G. (2015). Risk and resilience factors affecting the psychological wellbeing of individuals deployed in humanitarian relief roles after a disaster. *Journal of Mental Health*, *24*, 385-413. doi: https://doi.org/10.3109/09638237.2015.1057334

Cardozo, B., Crawford, C., Eriksson, C., Zhu, J., Sabin, M., Ager, A.…Simon, W. (2012). Psychological distress, depression, anxiety, and burnout among international aid workers: A longitudinal study. PloS One, *7,* 1-13. doi: https://doi.org/10.1371/journal.pone.0044948

Cardozo, B., Holtz, T., Reinhard, K., Gotway, C., Ghitis, F., Toomey, E., & Salama, P. (2005). The mental health of expatriate and Kosovar Albanian humanitarian aid workers. *Disasters, 29*, 152-170. doi: https://doi.org/10.1111/j.0361-3666.2005.00278.x

Cardozo, B., Silvilli, T., Crawford, C., Scholte, W., Petit, P., Ghitis, F., & Ager, A. (2013). Factors affecting mental health of local staff working in the Vanni region, Sri

Lanka. *Psychological Trauma: Theory, Research, Practice and Policy, 5,* 581-590. doi: https://doi.org/10.1037/a0030969

Connorton, E., Perry, M., Hemenway, D., & Miller, M. (2011). Humanitarian relief workers and trauma-related mental illness. *Epidemiologic Reviews*, *34,* 145-155. doi: https://doi.org/10.1093/epirev/mxr026

Cox, K., & Steiner, S. (2013). *Self-care in social work: A guide for practitioners, supervisors, and administrators.* Washington, DC: NASW Press.

Cripe, L., & Nyssens, O. (2017, August 3). Aid Worker Wellbeing: The Duty of Care. Mental Health and Psychosocial Support Network (MHPSS.net). Video retrieved from www.youtube.com/watch?v=q-pwpv0CoO8

Curling, P., & Simmons, K. (2010). Stress and staff support strategies for international aid work. *Intervention*, *8,* 93-105. doi: https://doi.org/10.1097/WTF.0b013e32833c1e8f

Dahlgren, A., DeRoo, L., Avril, J., Bise, G., & Loutan, L. (2009). Health risks and risk-taking behaviors among International Committee of the Red Cross (ICRC) expatriates returning from humanitarian missions. *Journal of Travel Medicine*, *16*, 382-390. doi: https://doi.org/10.1111/j.1708-8305.2009.00350.x

Ehrenreich, J., & Elliot, T. (2004). Managing stress in humanitarian workers: A survey of humanitarian aid agencies' psychosocial training and staff support. *Peace and Conflict: Journal of Peace Psychology, 10,* 53-66. doi: https://doi.org/10.1207/s15327949pac1001_4

Eriksson, C., Bjork, J., Larson, L., Walling, S., Trice, G., Fawcett, J., Abernethy, A., & Foy, D. (2009). Social support, organizational support and religious support in relation to burnout in expatriate humanitarian aid workers. *Mental Health, Religion & Culture, 12*, 671-686. doi: https://doi.org/10.1080/13674670903029146

Eriksson, C., Kemp, H. V., Gorsuch, R., Hoke, S., & Foy, D. (2001). Trauma exposure and PTSD symptoms in international relief and development personnel. *Journal of Traumatic Stress, 14,* 205-212. doi: https://doi.org/10.1023/A:1007804119319

Eriksson, C., Lopes Cardozo, B., Ghitis, F., Sabin, M., Gotway Crawford, C., Zhu, J., Rijnen, B., & Kaiser, R. (2013). Factors associated with adverse mental health outcomes in locally recruited aid workers assisting refugees in Jordan. *Journal of Aggression, Maltreatment & Trauma, 22*, 660-680. doi: https://doi.org/10.1080/10926771.2013.803506

European Civil Protection and Humanitarian Aid Operations. (2017, July 27). *Greece.* Retrieved from http://ec.europa.eu/echo/where/europe-and-central-asia/greece_en

Francis, F., Galappatti, A., & van der Veer, G. (2012). Developing a responsive model to staff care beyond individual stress management: A case study. *Intervention, 10*, 74-78. doi: https://doi.org/10.1097/WTF.0b013e328351bc4b

Goncalves, P. (2011). Balancing provision of relief and recovery with capacity building in humanitarian operations. *Operations Management Research, 4*, 39-50. doi: https://doi.org/10.1007/s12063-011-0045-7

Glasø, L., & Vie, T. L. (2010). Toxic emotions at work. *Scandinavian Journal of Organizational Psychology*, *2*, 49-54.

Halbesleben, J., & Buckley, M. (2004). Burnout in organizational life. *Journal of Management, 30,* 859-879. doi: https://doi.org/10.1016/j.jm.2004.06.004

Harr, C. (2013). Promoting workplace health by diminishing compassion fatigue and increasing compassion satisfaction. *Social Work and Christianity, 40*, 71-88.

Hearns, A., & Deeny, P. (2007) The value of support for aid workers in complex emergencies: A phenomenological study. *Disaster Management and Response,* 5, 28-35. doi: https://doi.org/10.1016/j.dmr.2007.03.003

International Committee of the Red Cross. (2014). The Geneva conventions of 1949 and their additional protocols. Retrieved from https://www.icrc.org/en/document/geneva-conventions-1949-additional-protocols

International Federation of Social Workers. (2014). *Global definition of social work.* Retrieved from http://ifsw.org/get-involved/global-definition-of-social-work/

Jokovic, D., Krstic, D., Stojanovic, Z., & Spiric, Z. (2016). Experience of the air medical evacuation team of Serbian armed forces in the United Nations mission in the Democratic Republic of the Congo: Deployment stress and psychological adaptation. *Vojnosanitetski Pregled*, *73,* 188-191. doi: https://doi.org/10.2298/VSP140114145J

Jones, B., Muller, J., & Maercker, A. (2006). Trauma and posttraumatic reactions in German development aid workers: Prevalence and relationship to social acknowledgement. *International Journal of Social Psychiatry, 52*, 91-100. doi: https://doi.org/10.1177/0020764006061248

Lipsky, L. V. N., & Burke, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler.

Maslach, C., Schaufeli, W., & Leiter, M (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422. doi: https://doi.org/10.1146/annurev.psych.52.1.397

Mathieu, F. (2012). *Routledge psychosocial stress series. The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization.* New York, NY, US: Routledge/Taylor & Francis Group.

Mayo Clinic. (2016). *Need stress relief? Try the 4 A's*. Retrieved from http://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress-relief/art-20044476

McCormack, L., & Joseph, S. (2012). Psychological growth in humanitarian aid personnel: Reintegrating with family and community following exposure to war and genocide. *Community, Work, and Family, 16*, 147-163. doi: https://doi.org/10.1080/13668803.2012.735478

Musa, S., & Hamid, A. (2008). Psychological problems among aid workers operating in Darfur. *Social Behavior and Personality, 36*, 407-416. doi: https://doi.org/10.2224/sbp.2008.36.3.407

National Association of Social Workers. (2017). *Code of ethics.* Retrieved from https://www.socialworkers.org/about/ethics

Nilsson, S., Sjöberg, M., Kallenberg, K., & Larsson, G. (2011). Moral stress in international humanitarian aid and rescue operations: A grounded theory study. *Ethics & Behavior*, *21*, 49-68. doi: https://doi.org/10.1080/10508422.2011.537570

Nimmo, A., & Huggard, P. (2013). A systematic review of the measurement of compassion fatigue, vicarious trauma, and secondary traumatic stress in physicians. *Australasian Journal of Disaster and Trauma Studies, 1,* 37-44.

Pearlman, L.A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary stress disorders. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized* (pp. 150-177). London, UK: Brunner-Routledge.

Pigni, A. (2014). Building resilience and preventing burnout among aid workers in Palestine: A personal account of mindfulness based staff care. *Intervention, 12,* 231-239. doi: https://doi.org/10.1097/WTF.0000000000000043

Porter, B., & Emmens, B. (2009). *Approaches to staff care in international NGOs.* Retrieved from http://www.chsalliance.org/files/files/Resources/Articles-and-Research/approaches-to-staff-care-in-international-ngos.pdf

Pross, C., & Schweitzer, S. (2010). The culture of organizations dealing with trauma: Sources of work-related stress and trauma. *Traumatology*, *16,* 97-108. doi: https://doi.org/10.1177/1534765610388301

Putman, K., Lantz, J., Townsend, C. C., Gallegos, A., Potts, A., Roberts, R…Foy, D. (2009). Exposure to violence, support needs, adjustment, and motivators among Guatemalan humanitarian aid workers. *American Journal of Community Psychology, 44,* 109-115. doi: https://doi.org/10.1007/s10464-009-9249-5

Rahman, A., Riaz, N., Dawson, K. S., Usman Hamdani, S., Chiumento, A., Sijbrandij, M.,…Farooq, S. (2016). Problem Management Plus (PM+): Pilot trial of a WHO transdiagnostic psychological intervention in conflict-affected Pakistan. *World Psychiatry, 15*, 182-183. doi: https://doi.org/10.1002/wps.20312

Robinson, L., Smith, M., & Segal, R. (2017). *Stress management: Using self-help techniques for dealing with stress*. Retrieved from https://www.helpguide.org/articles/stress/stress-management.htm?pdf=true

Rysaback-Smith, H. (2015). History and principles of humanitarian action. *Turkish Journal of Emergency Medicine*, *15*, 5-7.

Salloum, A., Kondrat, D., Johnco, C., & Olson, K. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers.

Child and Youth Services Review, 49, 54-61. doi: https://doi.org/10.1016/j.childyouth.2014.12.023

Slewa-Younan, S., Uribe Guajardo, M. G., Heriseanu, A., & Hasan, T. (2015). A systematic review of post-traumatic stress disorder and depression amongst Iraqi refugees located in western countries. *Journal of Immigrant and Minority Health, 17*, 1231-1239. doi: https://doi.org/10.1007/s10903-014-0046-3

Sommers-Flanagan, R. (2007). Ethical considerations in crisis and humanitarian interventions. *Ethics & Behavior, 17,* 187-202. doi: https://doi.org/10.1080/10508420701378123

United Nations High Commissioner for Refugees [UNHCR]. (2001). *Managing the stress of humanitarian emergencies.* Retrieved from https://drc.ngo/media/2113528/unhcr-booklet-on-stress-management.pdf

UNHCR. (2017a, August 6). *Syrian regional refugee response.* Retrieved from http://data.unhcr.org/syrianrefugees/regional.php

UNHCR. (2017b, August 10). *Greece.* Retrieved from https://data2.unhcr.org/en/situations/mediterranean/location/5179

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