Selection, training, and support of relief workers: an occupational health issue

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> Courage rather than cowardice, compassionate human concern of one for the other; and resilience in the face of overwhelming stress.[1]

Many of today's violent conflicts can be characterised as "complex humanitarian emergencies." Complex humanitarian emergencies are defined by Leaning as "Crises in life support and security that threaten large civilian populations with suffering and death and impose severe constraints on those who would seek to offer help."[2] Lauttze interprets these emergencies as "complicated disaster situations that have political, military and humanitarian dimensions and are often associated with natural disasters, especially drought."[3] Kosovo, Rwanda, Sudan, and Afghanistan are recent examples.

The rapid growth, in capacity and number, of humanitarian relief organisations in response to complex humanitarian emergencies has created concern about the professionalism of their relief workers. The risk to the psychological wellbeing of relief workers caused by exposure to traumatic events is a particular worry and has been studied little.[4] Research on the psychological sequelae to trauma has focused on primary victims,[5–7] domestic rescue workers,[8 9] military personnel,[10] and psychologists.[11]

Complex humanitarian emergencies may generate more stress among relief workers than "natural" disasters for several reasons. Firstly, an element of physical insecurity, with the risk of violent personal assault or injury, is increasingly present.[12] Secondly, work in these situations necessarily involves moral and ethical dilemmas—for example, negotiating with warlords; witnessing human rights abuses, but being constrained from responding by operational considerations; and concern that humanitarian aid may perpetuate conflicts.[13–16] Finally, caring for people with serious injuries caused by violence, witnessing unnatural deaths, and handling dead bodies or body parts are highly traumatic experiences in themselves.[17]

Codes of practice have been drawn up to improve technical standards and accountability.[18–20] Furthermore, many universities and relief organisations (including Harvard University, Johns Hopkins University, London School of Hygiene and Tropical Medicine, University of Hawaii, Université de Louvain in Belgium, the International Committee of the Red Cross, and Médecins Sans Frontières) are responding by developing training courses in humanitarian relief. However, individual relief organisations still carry the ultimate responsibility for preparing new recruits for field work. The broad range of current organisational practice in this regard—and particularly practice related to psychological issues—is of concern to all those with an interest in developing a cadre of resilient, professional, humanitarian relief workers.

Summary points

- Although emergency relief workers are at considerable physical and psychological risk, their mental health has been studied little
- Procedures for recruitment, selection, training, field support, and follow up of relief workers vary widely
- Preventive mental health measures for relief workers receive little attention
- Discounting the effects of psychological trauma on workers reflects disregard for their wellbeing and that of the populations they seek to serve
- Relief organisations should develop a coordinated and cooperative approach to training and managing field workers

Survey

We undertook a survey of leading relief organisations to capture and describe a cross section of practice for selecting, training, support, and follow up of relief workers. The survey focused on medical staff and on psychological aspects of relief work. A questionnaire, developed from a search of published reports and from interviews with returned relief workers, formed the basis for semistructured telephone interviews. The 16 questionnaire items were open ended and centred on five themes (box). Interviews were conducted with headquarters staff from 12 of the leading international humanitarian relief organisations. They were completed over a two month period in 1997. Respondents were chosen from the human resources departments or from staff health services. Confidentiality was crucial to obtaining an honest appraisal of organisational practice and is maintained here.

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Questionnaire themes

- Selection and training of relief workers
- Characteristics and qualities of relief workers
- Psychological support available to workers
- Awareness of the risk of post-traumatic stress disorder[20]
- Development of an experienced workforce

The 12 organisations (non-governmental, governmental, and intergovernmental), based in the United States, United Kingdom, and other countries in Europe, deployed medical and other relief personnel to complex humanitarian emergencies in as many as 25 countries and territories in 1996. They have provided a minimum of 14 years to over 70 years of service. All rely heavily on volunteers, most have national offices throughout the world, and all but one governmental organisation have several sources of funding.

Findings

Selection and training

The formal process for selection and training of relief personnel varied widely between organisations. Selection procedures ranged from a single telephone interview to a multiple stage process of individual and group interviews lasting a full day as well as phone contact or personal visits to the site of the project. In acute emergencies, team members are more often found through less formal channels.

Two organisations have a policy of sending staff to the field only after they have spent at least six months either at headquarters or at a regional office. Most attempt to create their own rosters of screened relief personnel, but financial and personnel constraints were cited as limiting factors in maintaining current lists. Organisations based in the United Kingdom are able to access the databases of aid personnel maintained by the umbrella organisations the Red R and the International Health Exchange.

Pre-departure training programmes for new field staff also suffer from a lack of uniformity. Although different assignments call for different training requirements, training in stress management, conflict resolution, handling the media, working in different cultural settings, and team building are important for all relief workers. These were the areas most neglected in training manuals and programmes, whereas role orientation and maintenance of physical health were more adequately covered.

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Organisations relied on printed materials for preparing workers before deployment. They had little knowledge of how useful their workers found this material or, indeed, whether it was read at all. One organisation coupled a packet of detailed reading material with a briefing by health staff that included information about trauma counselling after a mission. In depth training was generally reserved for team leaders and managers. The most extensive courses included all the topics listed above. One training programme for workers on standby for rapid deployment included such practical topics as minor vehicle repairs and the use of radios.

Workers' characteristics and qualities

Flexibility, adaptability, technical expertise, and extensive work experience in a relief setting were seen as key positive qualities predictive of success in new recruits (table 1). One interesting reply included reference to self destructive behaviour as a positive quality: "Some situations require people who can destroy themselves and thrive on chaos … at times we have employed workaholics and alcoholics."

Most respondents expressed frustration at the lack of a sensitive interviewing instrument for predicting whether potential workers were likely to be successful in the field and admitted that they relied heavily on "intuition." The difficulty of ascertaining candidates' vulnerability to traumatic stress was emphasised. Two respondents stated that they ask specifically about past psychiatric history, and one screened out applicants who had experienced recent stressful life events such as the death of a close relative. Staff health officers expressed concern that their expertise in medical fitness was called for only after candidates had already been selected for positions. This meant that they had virtually no role in the psychological screening of candidates.

Negative attributes among candidates were also difficult to quantify. These included the view of relief work as a "crusade rather than a job" and an unrealistic expectation of possible achievements.

Psychological support

Most organisations admitted that support mechanisms were underdeveloped. Staff were expected to seek help in coping with stress from direct superiors in the field with the option of contacting headquarters if necessary. One organisation used peer support groups for this role. Another organisation asked field workers to nominate respected peers, who were then trained as counsellors, and another made formal mental health support available to relief workers, but only for projects in extremely insecure areas.

The provision of stress debriefing after a critical incident, such as a death in the line of duty, was more common. Uncertainties about the format, effectiveness, timing, and ideal location of these interventions, particularly in the relief setting, and the scarcity of funding have hampered their development.[21–25]

Although some organisations have counsellors in the field, many workers avoid professional assistance. The stigma associated with psychological illness may be heightened among medical professionals, who fear being perceived as incapable of carrying out their professional responsibilities. Anecdotal evidence suggests that alcohol and substance misuse and a tendency to neglect personal hygiene are common in this setting.[26]

Only three of the organisations had specific policies on mental health support. However, all had policies on insurance coverage for counselling after a mission and voluntary access to this. Exit or debriefing processes are listed in table 2. All organisations offered formal counselling on request. As one interviewee illustrated for us, however, debriefing is not always the most appropriate method for resolving psychological distress, particularly for workers from non-Western cultures. For one Nigerian worker who felt defiled by his handling of many dead bodies, the remedy was to return home for ritual cleansing and presentation of appropriate tributes to his religious community.

Table 1 Selection criteria mentioned by 12 humanitarian relief organisations in survey

Selection criteria	No of respondents
Personal attributes	
Relevant postgraduate degree*	3
Sense of humour	3
Ability to admit weaknesses, share emotions	3
Ability to speak more than one language	2
Team player	2
Good communication skills	2
Ability to motivate others; leadership abilities	2
Ability to stay calm under difficult circumstances	2
Cultural sensitivity	2
Maturity, emotional solidity	2
Sensitivity to gender issues	1
Well developed mechanisms for coping	1
Ability to tolerate frustration	1
Ability to maintain professional distance	1
Understanding of progression from relief aid to development	1
Ability to make decisions quickly	1
Christian values	1
Self destructive behaviour (people who can "destroy themselves and thrive on chaos")	1
Other criteria	
Creation of geographically diverse workforce (does candidate complement existing worforce?)	1
Positive discrimination towards female candidates	1

*For example, a masters degree in public health.

Table 2 Humanitarian relief organisations with exit or debriefing process at end of contract or project

Process*	No of organisations
No exit process	1
Information on symptoms of post-traumatic stress disorder and how to get help	2
Telephone interview:	
About details of programme (no inquiry about personal issues)	2
Including inquiry about some personal or emotional issues	1
Face to face exit interview:	
Compulsory	6
Optional	2
Medical or psychological screening examination:	
Optional	1
Compulsory after critical incident	1

*Some organisations used more than one process.

Awareness of post-traumatic stress disorder

Although there is a large body of formal research on post-traumatic stress disorder[20] in primary victims and emergency rescue workers,[4–10] we know of no studies of this disorder in relief workers. In contrast to military and rescue workers, aid workers are usually deployed individually and do not benefit from the support of a cohesive group of colleagues who may have longstanding relationships; their preparation and training may be vastly inferior; and their mandate much less clear.[27] Unlike the domestic rescue worker, he or she may also have to deal with continuing "low intensity" trauma over a period of years, rather than discrete traumatic incidents.

All but one of the respondents indicated that there was a definite awareness that post-traumatic stress disorder was a risk for relief workers. Considerable anecdotal evidence reported to us supported the importance of a "stress reaction" as a common cause of morbidity, but there was little formal documentation of this. Collecting data on post-traumatic stress disorder in relief workers is difficult as medical records are confidential and held separately from personnel files and virtually no tracking of returned workers is undertaken.

A few informants voiced the opinion that post-traumatic stress responses may be less likely in medical workers because of their professional training and familiarity with trauma. "They are brought up on blood and gore" was one response. Another representative stated that her organisation was more concerned with the psychological sequelae of the local population living through the crisis.

Developing an experienced workforce

Although many organisations stated that a high proportion of their workers returned for further assignments, no data were kept on this. Return rates were estimated to be in the range of 30-75%. Most organisations had little formal contact with past workers after the debriefing process. Two respondents stated that it was more important for their organisations to staff the head office with experienced personnel and that field workers were easily replaced.

Few organisations had any formal mentoring or career advancement strategies. All had some opportunity for those with leadership potential to access leadership and management training, but a scarcity of resources was the limiting factor.

Discussion

Although the immense suffering of the victims of complex humanitarian emergencies will always be of primary concern for relief organisations, discounting the effects of traumatic events on the relief workers reflects disregard not only for their wellbeing but, more importantly, for the impact of distressed aid workers on the population they seek to serve.

One of the consequences of the apparent ad hoc nature of current practices may be an unnecessarily high prevalence of psychological morbidity (ranging from "burn out" to classic post-traumatic stress disorder) that is as yet inadequately documented and

Recommendations for improving practice

- Standards for selecting relief workers should be drawn up
- Methods of detecting psychological vulnerability and "resiliency" factors must be developed
- Field workers should participate in the development and evaluation of useful training methods and materials
- Integration of stress management training and awareness of psychological risks should be included in the preparation for a mission
- Effectiveness of debriefing methods and the optimal location and timing for debriefing must be studied further
- Records on retention rates of staff and development of methods for the anonymous tracking of psychological morbidity among returned staff must be improved

awaits further research. Recommendations stemming from our research and survey are detailed in the box.

Conclusion

Relief work in complex humanitarian emergencies exposes individuals and organisations to new dilemmas and challenges. One such challenge is the increasing recognition of stress related illness as a problem that can no longer be neglected.

In our view, one of the crucial elements in the achievement of the humanitarian goal is the development of a stable and experienced workforce whose talents are effectively harnessed and maintained through enlightened organisational policies. It is important that these policies are based on evidence that is both qualitative and quantitative. This survey brings to light the need for organisations to develop a coordinated and cooperative response to research and policy formation for the selection, training, and support of relief workers.

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Memorable advice

Doctor suggests a young woman should smoke

In 1941 I was 17 years old—my grandmother was ill and dying after a stroke. My mother was an invalid, and as my grandmother was being cared for at home, it was my job to sit with her through the night. When I told the family doctor that I was having trouble staying awake he suggested that I start smoking a cigarette to keep me awake.

So I did. It took a minor stroke 50 years later, and the concern of my daughter, to make me see sense and stop for good.

Irene Ibison, *retired medical records supervisor*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.