Photo: Siddharth Shah

Laughter yoga therapy with Indian NGO.

Addressing Stress in National Staff

Secondary traumatic stress and burnout can affect national staff too.

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THE GEOGRAPHIC CURE. R&R. Regular alcohol use with compatriots in an end-of-day cathartic ritual. Phone calls to family. Many readers will recognize these NGO worker attempts to deal with humanitarian aid stress. Although these interventions might mitigate the stress and workplace difficulties that accumulate into burnout, they leave untouched an important category of occupational stress: secondary traumatic stress (STS) – the neurobiology that humanitarian workers develop in the process of working with other people's trauma. Given that STS is such a massive topic and that it has been dealt with in the humanitarian literature in a general sense, I want to focus on the untold opportunities for humanitarian efforts when we engage with the stress vulnerability and resiliency of national staff.

In 2002, I began providing trainings on identifying, mitigating and preventing secondary trauma stress to humanitarian organizations headquartered in India, Pakistan and Sri Lanka. Translating a validated instrument from the scientific literature into Gujarati, I designed a quantitative public health study for four organizations working with victims of violence. Out of the nearly 100 workers studied, *every single person identified a negative, vicarious traumatic consequence of their work.*

That means that every national staffer acknowledged that their work hurts their mind. The staffers responded to the simple 17-item instrument with STS symptoms such as, "Due to the trauma content of my work, in the last week I have found myself:

- Re-living the trauma experienced by my client.
- Having trouble sleeping.
- Being easily annoyed.
- Having trouble concentrating.

STS makes its imprint on buried regions of the brain and there is no one classic form of STS. It could be chronic insomnia as a result of working with refugee populations; or it could take the form of memory gaps in an otherwise fresh, new worker who starts listening to the testimonies of rape survivors. STS often means an affected person feels stuck or frozen in seemingly irrational feelings and behaviors.

STS also occurs in headquarters staff or back office staff who may never go to the field. When an organization works with what have been called "traumascapes," the whole organizational chart begins to vibrate with trauma. People do not have to work in the field to absorb enough crisis, grief, anxiety and pain to be impacted by STS. After all, regions of our brain with their specialized neurons are built to suffer vicariously.

I was warned that humanitarian organizations would be reluctant to delve into STS. However, in my experience, South Asian NGO leadership is not hindered by a cowboy machismo denial mindset or a slowness to acknowledge that their work has mental health costs. South Asian groups ask me for cheap, low-tech, adaptable and portable interventions to mitigate traumatic stress. I give them a menu of 20 to 30 options from which they can pick and choose including:

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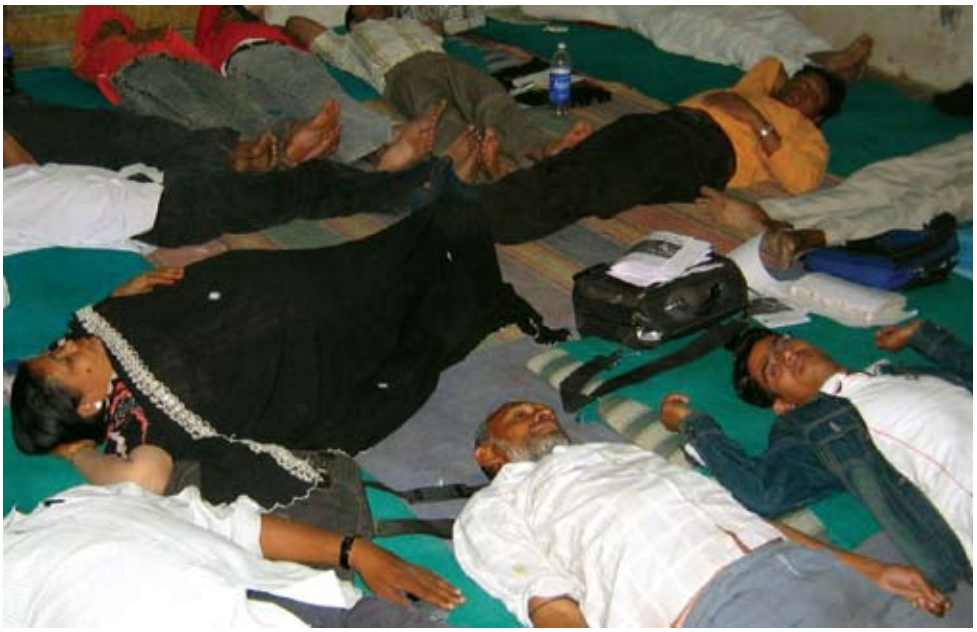
- Intra-agency, horizontal (peer-to-peer) and vertical (throughout the hierarchy) "neuropsychoeducational" exchanges. Learning together how the brain is wired for vicarious trauma, their occupation's sector-wide vulnerability and signs of difficulty reduces stigma for everyone in an agency.
- Inter-agency meetings in which staffers share mental notes and cross-pollinate concerning stress mitigation techniques. This method reduces the need to adapt techniques foreign to ▷



Guided meditation with Indian aid workers.

Photo: Siddharth Shah

the culture (e.g. psychodynamic or cognitive-behavioral therapy or exposure therapy – all powerful evidence-based therapies, but which require painstaking adaptation).

- Mind-body therapies such as breath modulation (pranayama, breathwork) and meditation have been popular.
- With the proper framing, systematic shaking, trauma-sensitive yoga, dance and other movement therapy can be powerful given the trauma literature's recognition of how animals bounce back from horrifying events through shaking and engaging the body purposefully.
- Laughter yoga, a sequence of activities systematized by an Indian physician, although not appropriate for the acute or subacute phase of recovery, can be used to build group resiliency, to engage the body, and frankly, to have fun while promoting wellness.

What doesn't work? One-size-fits-all protocols. People do not have identical cognitive styles. So while yoga and meditation may work for some workers, journaling and poetry will work for others. Referring a worker to a mental health professional, while it may seem like the diligent and scientific thing to do, is useless if the worker does not accept the basis of psychotherapy. Prayer works great in organizations, but it must be done in a way that ensures that those who do not believe in prayer will not feel ostracized.

While the geographic cure (a trip away from fieldwork to somewhere nice or home) can help with the stress leading to burnout, it does nothing to reach the neurobiological changes that occur in traumatic stress. In fact, the *geographic cure can actually do more harm than good* by allowing the trauma to simmer in someone's brain. As the psychiatrist who helped develop trauma-sensitive yoga explains, "Trauma is not like fine wine. It does not get better with age."

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National staff can be especially open to creating interventions that are essentially a re-tooling of familiar cultural or spiritual practices. For example, in Pakistan, I took a generally accepted reverence of *Noor* ("Divine Light") and developed a guided meditation that we packaged in mp3 files that could be easily emailed from peer to peer. When accepted practices are re-tooled, workers will more easily buy into a menu of interventions for de-stressing themselves daily (i.e., *while* the work is in progress) and not only at workshops or trainings. In fact, as a form of South to North learning, we in Northern nations have an important opportunity to learn specific resiliency factors from abroad and adapt them to our settings and mindsets.

As a physician who sees multiple opportunities for prevention, I take a hard-nosed view of what we are dealing with here. Burnout and secondary traumatic stress are both *bona fide* occupational hazards in this industry. There is an ethical responsibility to mitigate these hazards, just as we have a responsibility to safeguard people who work near asbestos or tuberculosis because, otherwise we are putting them in harm's way without providing the means to avert the harm. We know there is harm in working near trauma. The medical and humanitarian literature is rife with the evidence. Is there any doubt that there are costs to such work? No doubt at all.

As mentioned, reluctance from South Asian NGO leaders in acknowledging "our work has its costs" has not been a barrier. There are opportunities in both directions: provide training to national staff in a way that meets them halfway, and reduce current barriers to adequately training headquarters and expatriate staff. Is it possible that in the West we are more nervous about addressing this subject because if STS were discussed regularly as an occupational hazard a lot more due diligence from legal departments would be necessary? Do managers fear that workers would ask for more psychotherapy benefits? Would donors have to come face-to-face with the reality that in the process of doing good in the world we put humanitarian workers in harm's way? When it comes to STS, it will take strong leadership to capitalize on our opportunities. MD

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