



USAID
FROM THE AMERICAN PEOPLE

ASSESSMENT REPORT

Stress and Resilience Issues Affecting USAID Personnel in High Operational Stress Environments

September 2015

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Greenleaf Integrative Strategies, represented by Lee R. Briggs, Siddharth Ashvin Shah, Mary-Katherine Howell, Deepak Shenoy, Marci Moberg and Kate Burke.

ASSESSMENT OF STRESS AND RESILIENCE ISSUES AFFECTING USAID PERSONNEL IN HIGH OPERATIONAL STRESS ENVIRONMENTS

September 2015

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ACRONYMS

AD	Adjustment Disorder
AEF	Annual Evaluation Form
ASD	Acute Stress Disorder
CDC	Centers for Disease Control & Prevention
CIRP	Critical Incident Response Protocol
CLO	Community Liaison Office
COR	Contracting Officer's Representative
CPC	Critical Priority Country
CS	Civil Service
DEC	Development Experience Clearinghouse
DHS	Department of Homeland Security
DLI	Development Leadership Initiative
DOS	Department of State
DSMP	Deployment Stress Management Program
EAP	Employee Assistance Program
ECHO	European Community Humanitarian Aid Office
EFM	Eligible Family Members
EISF	European Interagency Security Forum
FS	Foreign Service
FSI	Foreign Service Institute
FSL	Foreign Service Limited
FSN	Foreign Service National
FSO	Foreign Service Officer
FY	Fiscal Year
GS	Civil Service
HCTM	Human Capital Talent Management
HHS	Department of Health & Human Services

HPG	Humanitarian Practice Group
HRM	Human Resource Management
THE	High Threat Environment
IASC	Interagency Standing Committee of the UN
ICRC	International Committee of the Red Cross
ILO	International Labor Organization
iNGO	International Non-Governmental Organization
LEC	Life Events Checklist
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
NIMH	National Institute of Mental Health
NIOSH	National Institute of Occupational Safety and Health
NPE	Non-Permissive Environments
PASA	Participating Agency Service Agreement
PFA	Psychological First Aid
PSC	Personal Services Contractor
PTS	Post Traumatic Stress
PTSD	Post-Traumatic Stress Disorder
OAPA	Office of Afghanistan and Pakistan Affairs
OCHA	United Nations Office for Coordination of Humanitarian Affairs
ODI	Overseas Development Institute
OFDA	Office of Foreign Disaster Assistance
OIG	Office of Inspector General
OTI	Office of Transition Initiatives
OU	Operating Unit
QDDR	Quadrennial Diplomacy & Development Review
RMO/P	Regional Medical Officer (Psychiatrist)
SAG	Senior Advisory Group
SOW	Statement of Work
StaffCare	The USAID Staff Care Program and associated services

TBI	Traumatic Brain Injury
TCN	Third Country National
TDY	Temporary Duty
TSS	Traumatic Stress Syndrome
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USAID	U.S. Agency for International Development
USDH	United States Direct Hire
USG	United States Government
USPSC	United States Personal Services Contactor
WHO	World Health Organization

EXECUTIVE SUMMARY

“USAID personnel are the most stressed population from among the various agencies at post.” – State Department Health Practitioner in the field

The USAID workforce is currently exposed to severe and unsustainable levels of stress that (a) are adversely impacting the health of the workforce, (b) very likely are reducing the mission effectiveness of the Agency, and (c) require a coordinated, holistic institutional response. This report elaborates on these three points, based on interviews and a survey conducted with USAID personnel. The conclusions have been validated through an extensive review of the literature and consultation with leaders from similar agencies.

No one could have foreseen the national security concerns and operational demands that would become commonplace in the post-9/11 era. Exposure to conditions that increase vulnerability to operational stress and trauma are an inherent part of USAID’s mission today. Postings of USAID staff in austere, demanding, restrictive, and hostile locations have steadily increased due to national security priorities and stabilization objectives undertaken by USAID. In a section entitled *Adapting Our Organizations to Take Care of Our People*, the QDDR notes, “As the number of dangerous posts has grown, increasing numbers of our Foreign Service, Civil Service, local staff, and contractor workforce have served in challenging locations.”¹ “Nearly half of the countries where USAID operates are at risk of conflict, or present direct threats to Americans...”² More than 3 out of 4 USAID personnel who responded to a survey conducted as part of this assessment reported they have been assigned to a location designated as a CPC, NPE, or HTE (76.4%).

Multiple deployments, exposure to threat, unprecedented workloads, accelerated promotions, role ambiguity, separations from family, inadequate rest, delayed stress effects, stigma over invisible wounds, and gaps in mental health support are issues we typically associate with military personnel.³ However, research conducted for this assessment shows that USAID personnel are experiencing similar issues, which will be elaborated in detail in this report.

USAID’s practices have not kept pace with the challenges of difficult operating environments. As one USAID officer stated, “Times have changed. The staffing model USAID is using does not reflect the current operational reality.” If USAID does not improve its operational approach, untreated stress will continue to contribute to increased absenteeism, turnover, burnout, presenteeism (when staff is present but not fully functioning), demoralization, increased mental and physical illness with related leaves of absence, and operational errors. Unaddressed stress imposes great costs on all organizations, as well as great personal and financial costs on individuals. These costs borne by USAID are not sustainable if the Agency is to continue its mission safely or effectively.

¹ U.S. Department of State. “Quadrennial Defense and Diplomacy Review.” 2015. pp. 77-78

² Ibid. p. 60.

³ Army, U. S. *Health Promotion, Risk Reduction, Suicide Prevention Report*. Army's Suicide Prevention Task Force. Washington, DC: 2010.

To meet the requirement that “employees will...have the tools and the skills required to do their jobs right,” the QDDR explicitly specifies the need to “focus on taking care of our people.”⁴ USAID has therefore commissioned this assessment of stress and resilience* issues affecting Agency personnel to do exactly what the QDDR directs: “identify obstacles to our operations and programs...devise better options for operating in these environments, and maximize field input to inform high-level policy deliberations.”⁵

This Executive Summary includes key *Findings* and *Conclusions*. These sections support the *Recommendations* that were developed through a gap analysis, mapping the current USAID stress management framework against ideal practices (as detailed in *Section 12* of this report). These recommendations have been sharpened through continuous engagement and consultation with USAID personnel.

Key concepts that were used to inform this document throughout are drawn from an extensive literature that applies to a range of organizations operating in demanding environments:

- *Stress Awareness* – the non-stigmatizing understanding by staff and managers that stress is biopsychosocial and has specific consequences that affect health, work performance and interpersonal behavior.
- *Stress Responsiveness* – an organization’s adoption of practices that mitigate stress and care for staff; in other words, practices that eliminate avoidable adaptation challenges (stressors), minimize exposure to unavoidable adaptation challenges, mitigate current stress effects, care for distressed personnel, and reduce strain on the organization as a whole.
- *Stress Mitigation* – Interventions that either prevent or reduce the prevalence/severity of adaptation challenges.
- *Staff Care* – Interventions that provide relief, support or treatment for personnel that have been negatively affected by adaptation challenges.

The recommendations this assessment contains aim to ensure the best quality of Stress Aware and Stress Responsive training and evidence-based care is available for all USAID staff who have operated, are currently operating, or will operate in high-stress environments into the future.

DATA AND RESEARCH METHODS

This study was conducted between December 2014 and September 2015, and presents extensive data on USAID staff perceptions and self-identified sources of stress. Site visits and interviews were conducted in four USAID Missions: Jordan, Pakistan, Afghanistan, and Kosovo, and also with personnel evacuated from Yemen and staff posted in Washington, DC. 171 USAID personnel were interviewed. Health officers from State/MED and staff of numerous implementing organizations were also interviewed. An online survey of USAID personnel resulted in 556 responses.

This analysis is informed by an extensive review of the medical, psychological, and academic literature on stress, trauma, and occupational stresses common in international relief and development. USAID policy documents, systems and support services were reviewed as well.

⁴ Ibid. p. 68. The full quote reads: “Our employees will pursue learning and professional development and will have the tools and the skills required to do their jobs right. To achieve such a workforce, we will focus on: 1) Increasing agility; 2) Investing in training, diversity, and leadership; and 3) Taking care of our people.”

* See Glossary in Annex 2 for working definitions of all terminology.

⁵ Ibid. p. 60.

USAID personnel, both civil service and foreign service, were integrated into the research processes throughout the assessment. Evolving findings and conclusions were shared and discussed with USAID assessment principals, a Working Group made up of USAID officers, a Senior Advisory Group made up of USG leaders and knowledgeable subject matter experts, and a group of senior USAID leaders attending two separate Mission Directors' Conferences.

I. FINDINGS

Overall, the primary sources of stress identified by USAID personnel were related to institutional factors rather than external contextual factors, reflecting “the discrete set of challenges, many internal, that if effectively tackled will advance the effectiveness of American diplomacy and development,” as noted in the QDDR.⁶ Threat vigilance, critical incidents, and near misses outside the wire were also reported as causes of stress. Although USAID’s StaffCare Program is providing a number of important stress mitigating services in support of USAID personnel, numerous gaps exist (detailed further in *Conclusions, Section 13*).

I.1. FINDINGS: USAID INTERVIEWS AND REPORTED STRESSORS

The sources of stress reported by USAID personnel in interviews include:

1. Heavy Workload/Tempo
2. Leadership, Management, and Supervision⁷
3. Organizational, Bureaucratic and Interagency Interactions
4. Human Resources Management and Administrative Support Issues
5. Family Stress
6. High Turnover/“Churn”
7. Severe Contextual Factors
8. Critical Incidents, Traumatic Stress, and PTSD

“There is a pervasive feeling or vibe, of anxiety, due to the high pace of work. Everything’s a crisis or an emergency, and this is chronically destructive, it’s toxic.” – USAID Officer

“Leadership matters. It is the single biggest variable that relates to stress.” – SAG Member

“People get ‘crispy’ after being here too long. This leads to damaged relationships.” – USAID Officer

Institutional and organizational stressors synergistically interact to intensify the already severe stress faced by staff living and working in difficult operational environments. *Section 8* includes direct quotes and supporting analysis in the eight thematic areas outlined above.

I.2. FINDINGS: STAFF SURVEY RESULTS

The survey was delivered to serving Foreign Service Officers (FSOs), as well as Personal Services Contractors (PSCs) and people separated from the Agency. 556 people responded, of which 64.5% have been employed by USAID for over 5 years. Full Survey Results are available in *Section 9*, with three most significant findings highlighted here:

“I feel as though I am on my own.”
– USAID Officer

⁶ U.S. Department of State. “Quadrennial Defense and Diplomacy Review.” 2015. pp. 78.

⁷ Leadership is also identified as a key area of focus in the QDDR. See pp. 71, and 73-74.

*Perception of Staff Care:*⁸ Only 22% of the 453 respondents perceive that USAID staff care policies and programs at USAID are adequate. And only 23% of the 453 find that USAID programs to support staff are mostly or completely accessible. Of those 126 respondents who did utilize the StaffCare Center, 74% found support to be useful. Stigma was found to be a significant barrier in utilization.

Training/Resources Interest: Of the respondents, nearly 70% believe that they would benefit from further training or coaching in stress management or psychological wellness techniques. A quarter of those who had received training characterized the training as not useful.

Assessment of Stressors: Institutional and general work context stressors are the most frequently named stressors for USAID personnel in general. However, of those serving in CPC/NPE/HTEs, 74% say that “dangers/threats” make these posts particularly stressful, and 62% say “workload/tempo” make these posts particularly stressful.

“You’ve got incoming rockets that were happening at least a few times a week and some getting rather close. We had one that went off around 0630, I’d say about 100 feet for so outside my bedroom window, and it blew gravel into the room. I remember getting back to the cafeteria in the evening and sat down with the senior civilian, and he was shaking like a leaf. He exhibited obviously just a tremendous shaking. He could hardly control himself.”
– USAID Officer

I.3. FINDINGS: USAID STAFFCARE CENTER SERVICES

Author’s note: All data on StaffCare was either retrieved from the StaffCare website, or was provided by the StaffCare COR, with no hard data to back this information up. The researchers were provided with no StaffCare information products or tools/systems. All requests for hard data, work products, tools and templates, raw data from StaffCare M&E processes, or to conduct interviews directly with personnel in Staff Care went unanswered. Questions sent to StaffCare are provided in Annex 9. The assessment team cannot factually verify much of the description provided, nor can we with full confidence assess the overall quality of StaffCare products and services.

USAID’s StaffCare Service Center became fully operational in 2012 after a consultative process involving USAID personnel. Deployment overseas began in 2014. Services are detailed in Section II.

⁸ NOTE: Staff Care as used here refers to the general suite of staff care services, not ONLY those specific to the USAID Staff Care Center (Staff Care Center is referred to as StaffCare throughout in this document). Specific StaffCare services are, however, included in the general suite of services as mentioned above.

1.4. FINDINGS: LITERATURE REVIEW

The causes and effects of stress are extremely well researched and well understood across a broad range of organizations and contexts, in the public sector, the private sector, and the social sector. Untreated psychological injuries, resulting in temporary or longer-term anxiety or depression, are shown to have a disability cost to employers greater than the cost of many other feared illnesses (Nash, 2010 and Gifford, 2014). *Sections 6 and 7* of the full report examine the evidence base for causation and consequences of occupational stress in more detail.

In contrast to physical risk mitigation, addressing psychological stress risks and associated harm is not highly developed among international development organizations. Objective standards for stress mitigation among such organizations are not fully developed either- although standards and practices are highly developed in other sectors. The international development sector is moving towards this.

The evidence for psychological injury is extensive. These injuries are biopsychosocial in origin, and they also manifest in biopsychosocial ways. There is ample evidence that such injury is not solely caused by exposure to traumatic incidents, but can also be caused by protracted exposure to chronic high stress with inadequate opportunity to recover.⁹ Very frequently these stress injuries are caused by inadequate organizational mitigation and care. From a neurobiological standpoint, it is **factually inaccurate as well as counterproductive to interpret personnel stress injuries as character flaws, weakness, willful complaining or poor performance.**

Duty of Care. In the United States, the primary statute governing duty of care is the Occupational Safety and Health Act of 1970. There are two types of potential harm to staff that an ethical employer needs to consider:

- Physical injury and/or death
- Psychological or psychosocial injury

In addressing these potential harms, there are two rationales:

- Legal liability -- motivated by aversion to the risk of financial costs for litigation or compensation.
- Moral duty -- revolves around taking care of people because it is the right thing to do.

There are positive political and reputational implications of duty of care, regardless of motivation, as well as benefits in staff morale/retention due to a sense of “being taken care of.” These implications apply to all employers, and are not unique to USAID. *Section 10* provides more detailed information about the duty of care principle.

2. CONCLUSIONS

There are numerous gaps that have been identified in terms of USAID institutional management practices, and the resources and services offered to support USAID personnel to mitigate stress. Multiple synergistic and mutually reinforcing sources of stress constitute a high-stress environment that is negatively impacting the health and performance of the USAID workforce. This situation has serious

⁹ For a very brief and simple overview, see: “Adult Stress— Frequently Asked Questions: How it affects your health and what you can do about it.” Factsheet produced by the National Institutes of Mental Health. http://www.nimh.nih.gov/health/publications/stress/Stress_Factsheet_LN_142898.pdf.

potential to degrade long-term USAID mission effectiveness. Unaddressed stress may also constitute a security risk due to stress-related impaired judgment, maladaptive coping behaviors, or disgruntlement.¹⁰

Numerous standards, good practice examples, and lessons learned exist that USAID can draw upon to develop and implement a systematic, evidence-informed response that will mitigate stress and bolster resilience of USAID personnel. This assessment details many of these.

2.1. CONCLUSIONS: PERSONNEL EXPERIENCES WITHIN USAID

1. **The USAID workforce is currently exposed to severe levels of stress and is at risk for developing numerous stress-related health conditions and/or disorders.** Every adaptation challenge and stress effect reported by USAID personnel is mirrored in an extensive body of literature with similar findings across similar institutions. While USAID has unique configurations of adaptation challenges and stress effects, the problems appear to be widespread throughout the U.S. government, the development sector and international relief organizations.
2. Given the **consistency of response across Missions and DC**, as well as across management levels and employment categories, it is concluded that **USAID's stress levels are indicative of systemic, Agency-wide challenges that require a coherent, systemic, Agency-wide response.** Providing additional training and stress management tools to USAID personnel, or making incremental adjustments to improve the fielding process, is unlikely to significantly alter the stress conditions affecting USAID personnel.
3. **Major sources of stress as reported by USAID personnel are related to institutional management practices.** These institutional stressors are:
 - Excessive workload: overlong days, overlong weeks, and inadequate time to recover.
 - Leadership deficits, including lack of defending USAID institutional interests in interagency forums, lack of defending USAID personnel interests (prioritization of tasks and reasonable workload), lack of personnel management/supervisory skills, and lack of team-based management skills.
 - Inadequate HR management and personnel support practices.
 - Poor and unsupportive assignment/fielding practices.
4. **These institutional stressors are exacerbated by the threat exposure**, operational tempo and political pressure of CPCs/NPEs/HTEs and result in unhealthy stress loads.
5. With the current model of staff support being purely voluntary, **lack of awareness of the need for support, an agency culture of stoicism, and significant stigma to seeking support**, many personnel do not elect to receive assistance. As a result, many USAID personnel who would benefit from focused stress support **remain untreated**, which further intensifies the stress environment affecting the workforce as a whole, due to **social contagion of stress.**
6. The mindset and engagement of USAID personnel is profoundly affected by **family concerns and family stress.** Relationship strain substantially drains situational awareness and morale.
7. Through **provision of services through the StaffCare Center**, USAID is responding to people dealing with stress reactions. Of those who have used it, the data shows 74% have found it useful; at the same time, the data shows close to half (45%) of USAID respondents

¹⁰ This issue was mentioned by a USAID/SEC officer during an interview, and is a recognized concern among security managers. For more detailed discussion, see: Humanitarian Practice Network. "Operational Security Management in Violent Environments. Good Practice Review, Number 8 (New Edition)." December 2010. pp. 123-125.

found **service was not available** to them and/or did not utilize the services. There are numerous gaps, which limit the overall effectiveness of the StaffCare intervention:

- **Lack of expeditionary approach** for a consistently perceptible field presence.
- **Lack of routine psychosocial health maintenance approach**, including periodic individual level stress assessment and tracking.
- **Unfavorable restrictions** (too low caps to session quantity and period of availability) to providing on-going and long-term support to people with stress reactions and other conditions traceable to occupational or traumatic stress exposure.
- **Lack of systematic M&E** for quality assurance and organizational learning.

2.2. CONCLUSIONS: SYSTEMS WITHIN USAID

1. **USAID as a whole is not adequately in alignment with identified standards and best practices for managing the stress of its workforce.** There are numerous gaps that require USAID attention if it is to successfully mitigate the negative consequences of stress.
2. **USAID lacks a set of coherent, overarching, and multi-tiered policies** for stress mitigation across USAID.
3. USAID currently does not possess **data systems or technology to track chronic or acute stress** among personnel, Missions/OUTs, and the Agency as a whole. Additionally, there is a lack of analytic capacity to determine where preventive measures may be taken or extra support may be necessary.
4. **USAID lacks a “permanent organizational development” approach to stress management.** This includes processes that focus on leadership development, coaching and mentoring of inexperienced officers, developing skills in team-based management, and developing specific USAID tradecraft. USAID also lacks systems of accountability and performance management related to stress responsive management and supervision.
5. **This situation has long-term implications** for the performance/effectiveness of USAID personnel, physical and psychological health, total workforce management, and the achievement of USAID’s mission.
6. There are special opportunities to reduce risk at CPCs/HTEs/NPEs and positively affect the cadre of personnel operating in these high stress environments. **USAID warrants targeted policies and practices to address stress exposure throughout the entire CPC/HTE/NPE deployment cycle.**

2.3. CONCLUSIONS: GENERAL KNOWLEDGE AND BEST PRACTICES

1. **Stress is biopsychosocial.** Stress causative factors reside not just in the environment, but in the biological, psychological, and social milieu of individual persons. Stress also produces disruptions and alterations in each of these elements, and an integrated approach of stress responsiveness must operate within and address each of these dimensions as well.
2. Members of the workforce who carry a heavy stress burden due to high levels of chronic stress exposure, as a result of the **cumulative nature of stress** and allostatic load, have a **diminished ability to be resilient** when exposed to the potentially traumatic stress of a critical incident. Therefore, the likelihood that a critical incident will result in traumatic stress — or a stress-related psychological injury — is markedly increased (Nash, 2010).
3. There are **well-established standards and best practice templates for managing occupational stress** in general, and specifically for managing occupational stress in international relief and development organizations.

3. RECOMMENDATIONS

Our recommendations are divided into two areas. First, there are a number of high-level institutional support factors that are needed as an “umbrella” of support across USAID. Second, there are specific recommendations for addressing sources of stress at each stage of the job cycle.

Each of the recommendations listed in this executive summary are summarized. The detailed recommendations are described in *Section 14*.

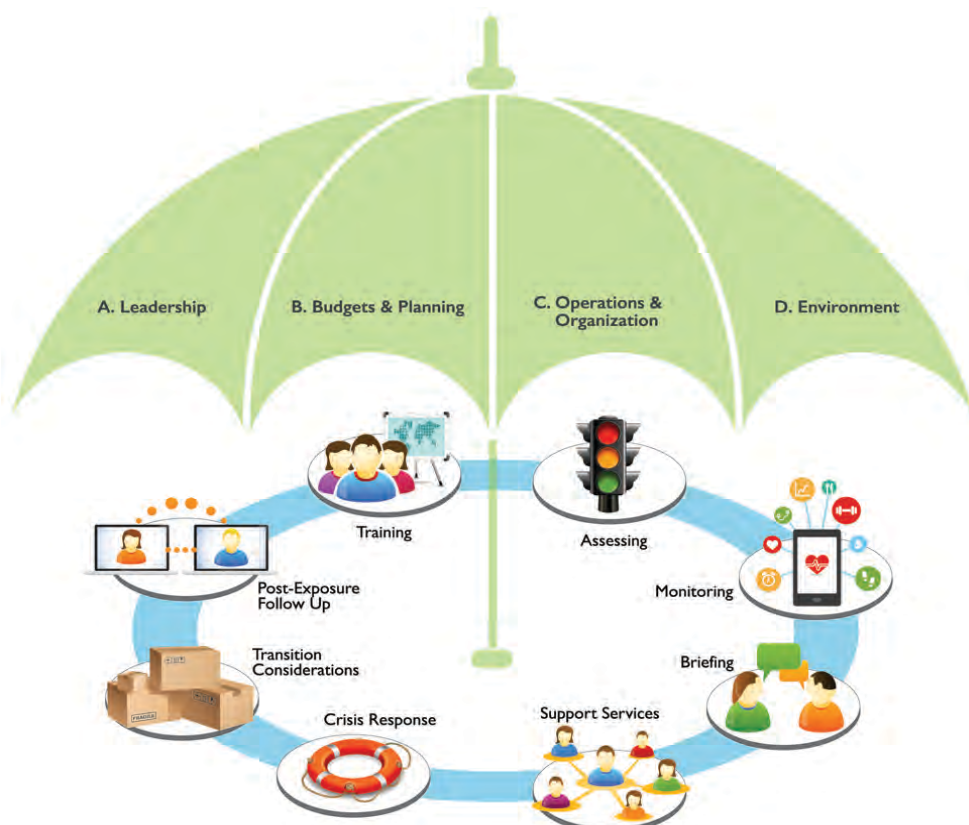


Figure 1. Recommendations Organized as Institutional Umbrella and Assignment Cycle

3.1. RECOMMENDATIONS FOR INSTITUTIONAL SUPPORT



- A. Leadership:** Support, validate, and implement organizational change focused on Stress Awareness and Stress Responsiveness. This entails the highest levels of leadership providing direction and oversight to the various OUs that have a role in the implementation of Stress Responsive policy, leadership, and interventions. This would be supported by the creation of additional policies focused on staff mitigation and care, both in the ADS and on the level of individual Operating Units.
- B. Budget and Planning:** Plan and budget for stress mitigation initiatives and staff care programs agency-wide, coordinating with and building on pre-existing stress mitigation programs at the Operating Unit level. Implement monitoring and evaluation measures to track the investment, inform learning, and guide continuous improvement.

- C. Operations and Organization:** Institutionalize USAID's commitment to stress responsiveness by strengthening coaching/mentoring programs, professional development, and ensuring access to an anonymous mechanism for raising stress concerns.
- D. Environment:** Create an environment of healthy stress mitigation and a network of supportive staff care resources for Agency staff, their families, and foreign nationals staff. As per QDDR, commit to engage interagency partners regarding stress mitigation. Become an exemplar of best-practice stress mitigation and staff care for the international development community.

3.2. RECOMMENDATIONS FOR JOB CYCLE

The job cycle refers to the process by which USAID staff are placed on assignments of various lengths. For many staff, assignments involve foreign travel.

However, some USAID staff do not have discrete assignments, but rather ongoing tasks. For those staff, the recommendations listed under transition and post-assignment follow-ups (e.g. checking in with a supervisor about stress) should be repeated on a periodic basis (e.g. annually) or when they change roles.



- A. Training:** Create and deliver trainings for staff and managers to reach the necessary level of Stress Awareness and Stress Responsiveness.
- B. Assessing:** Assess the suitability of individuals for specific assignments based on an individual's vulnerability and the assignment's risk profile.
- C. Briefing:** Brief staff on the specific stress risks they can expect to face on their assignment.
- D. Monitoring:** Provide tools for individuals to self-monitor. Utilize data to conduct regular institutional monitoring of workforce stress.
- E. Support Services:** Improve services provided to staff and increase their utilization. This includes expanding/improving StaffCare Center operations, identifying and vetting external care providers, and promoting care resources internally (e.g. use of Champions).
- F. Critical Incident and Crisis Response:** Establish a policy for characterizing a CI or a crisis, a protocol for response, and expand the roster of specialists available to provide CI or crisis support.
- G. Transition Considerations:** Proactive transitions and handoffs should take stress into account for operational out-processing and in-processing.
- H. Post-Exposure Follow Up:** Due to the prevalence of delayed stress reactions in individuals previously exposed to high-stress assignments, conduct additional check-ins to detect negative stress reactions and provide additional, ongoing support as may be indicated.

I. INTRODUCTION AND BACKGROUND

The 2014 Quadrennial Diplomacy and Development Review (QDDR) states that “Our diplomats and development professionals advance American interests in dangerous environments; those interests certainly do not diminish when threats increase.”¹¹ These environments require the Department of State and USAID to adapt their organizations “to manage and mitigate risk.”¹² One of the most substantial risks in demanding, dangerous environments is the exposure to operational stress. The science around operational stress is growing and decisive -- the risks are wide-ranging and enormous: poor performance on mission objectives, burnout, low morale, trauma, high staff turnover, security lapses, maladaptive coping (e.g. alcohol and substance abuse), and severe family problems. Increasing numbers of personnel who have suffered emotional distress during their tenure with USAID has prompted many at USAID to question how the Agency can do better in terms of preparing staff and supporting them to adapt to the difficult, often challenging operating requirements of dangerous environments. Fulfilling the QDDR’s imperative to adapt USAID to function in situations of “risk and unpredictability”¹³ makes robust and effective operational stress mitigation an urgent priority for USAID.

USAID recognizes that unique professional and personal problems come with the territory of working in high stress postings, including critical priority countries (CPCs), non-permissive environments (NPEs), and fragile or post-conflict development environments. As an organization, USAID is interested in/committed to finding ways to mitigate these problems. USAID personnel across multiple categories (USDH- FS and CS, as well as FSN, FSL, USPSC, and PASA) and USAID as an institution simultaneously face diverse challenges associated with providing appropriate and effective staff care support in fluid, up-tempo operating environments. In order to ensure that the best quality of care is available, to provide necessary support to safeguard a healthy and productive workforce, and to meet Duty of Care requirements, USAID has commissioned this assessment of current support provided to such staff. This assessment includes a broad survey of staff perceptions and self-identified sources of stress; a review of the medical and psychological literature on stress; a review of the academic and normative standard-setting literature on occupational stress in general, and specifically occupational stress in the fields of international relief and development; and finally, a gap analysis of policies and practices to include a map of the current USAID stress management framework.

Current issues affecting USAID personnel in these environments include: threats of physical harm that are present when living and working in high-threat environments; the personal challenges that emerge when adapting to, and living and working in severe/austere, uncomfortable, or remote locations; the psychological effects that emerge from living and working in chronic and acute high-stress environments; the secondary trauma that is experienced by staff responding to the human suffering that occurs during crises and natural disasters; and the emotional toll of being separated from family, friends, and social support systems. There is wide recognition, in particular among the people who do similar work to USAID, of the hardships such work entails:

¹¹U.S. Department of State "Quadrennial Diplomacy and Development Review (QDDR)." 2014. p. 58.

¹²Ibid. p. 60.

¹³Idem.

“The humanitarian and development sector continues to grow rapidly and increasing attention has been given to the wellbeing of the international aid worker. Several researchers and policy planners in the field of relief and development have given attention to the treacherous life and work of aid personnel, and management of major iNGOs have been quickly responding to the growing concerns.

Personnel working in more stable environments may not face the same ‘traumatic’ experiences, but issues of work-related stress, foreign culture, harsh climate, isolation, illness/disease, professional stagnation, poor management, and dilapidated infrastructure can easily lead to distress, burn-out, and mental and physical deterioration. Whether chronic or acute, staff in humanitarian and development organizations work in emotionally demanding environments and need appropriate support...”¹⁴

Numerous other authors echo this awareness. For example, in April 2009, the Humanitarian Policy Group/ Overseas Development Institute and the Centre on International Cooperation wrote an update on the status of humanitarian workers. Their report “Providing aid in insecure environments: 2009 Update. Trends in violence against aid workers and the operational response,” indicated that 2008 experienced the highest levels of attacks, kidnappings, and deaths yet recorded: “The absolute number of attacks against aid workers has risen steeply over the past three years, with an annual average almost three times higher than the previous nine years.”¹⁵

“Aid workers continue to work in some of the most insecure environments in the world. They witness atrocities, handle dead bodies, encounter destitute poverty, and receive threats, among others. “There was a time when the aid worker was sacrosanct, when the work was seen as detached from political agenda. This is ancient history and the truth of the matter is that we are more and more vulnerable either because we are seen as more easily available targets representing our governments or because we are now confused with a military insistent on doing ‘development’ work...”¹⁶



U.S. Army 1st Lt. Robert Wolfe, right, escorts Jim Otwell, left, a USAID officer, to the Directorate of Education in Farah City, Afghanistan, Feb. 26, 2013. Both are assigned to the Provincial Reconstruction Team (PRT) Farah. Credit: U.S. Navy photo by Lt. j.g. Matthew Stroup

Postings of USAID and other organizations’ staff in severe/austere, demanding, restrictive, and hostile locations have steadily increased as a result of the heightened national security priorities that have ensued from the global war on terror and associated stabilization objectives taken on by USAID and other donors. As noted in the Aid Worker Security Report 2014:

¹⁴Porter, Benjamin and Ben Emmons. “Approaches to Staff Care in International NGOs.” InterHealth/People in Aid: September, 2009. p. 11.

¹⁵Stoddard, et. Al., 2009.

¹⁶Porter and Emmons: 2009. Idem. Attributed to Donna Read, Devex.com, 2009.

“The year 2013 set a new record for violence against civilian aid operations, with 251 separate attacks affecting 460 aid workers. Of the 460 victims, 155 aid workers were killed, 171 were seriously wounded, and 134 were kidnapped. Overall this represents a 66 per cent increase in the number of victims from 2012.”¹⁷

Postings in unstable or high-threat environments appear likely to continue into the foreseeable future, and this trend very likely constitutes “the new normal.” Given USAID’s mandate to “promote resilient, democratic societies,”¹⁸ as well as respond to complex emergencies and natural disasters with humanitarian assistance, the need to provide appropriate care to staff who may be exposed to work-related chronic or acute high stress will continue.

Derived from this commissioned assessment, USAID seeks a set of recommendations to improve staff care provided to all USAID personnel – particularly those fielded into high-stress environments – based upon the following:

- Sensitive and thorough analysis of the stress-related issues currently affecting USAID personnel;
- Integration of evidence-based practices emerging from within the field of stress management and clinical response to the psychological conditions of acute and chronic stress management (i.e. a scientifically grounded, evidence-driven approach);
- Alignment with best practices identified from other USG agencies’ and other international development actors’ established approaches to ensuring staff care and supporting wellness.

KEY CONCEPTS IN THIS REPORT

USAID is not alone in facing the risks surfaced in this report. In the absence of a sensitive and thorough analysis; integration of evidence-based practices; and alignment with best practices in similar organizations, responses to stress are more likely to be chaotic, unfounded, instinctive (perhaps wrongly so), and, at best, guided by good intentions. A management dilemma exists: one does not know what constitutes an effective, or even legally-permissive management response, to stress. This leads to ineffective responses and ultimately untenable circumstances. Leaders resort to making their best guess. Supervisors avoid sticky situations. Managers improvise where they have no guidance. None of these otherwise understandable, even predictable, responses belong in a consequential organization with a workforce that is exposed to extraordinary stress.

Where organizations are confronted with the issues currently affecting USAID, a systematic response is warranted. How do we build this systematic response? The following interlocking key concepts will be used throughout this document to identify gaps and inform conclusions and recommendations.

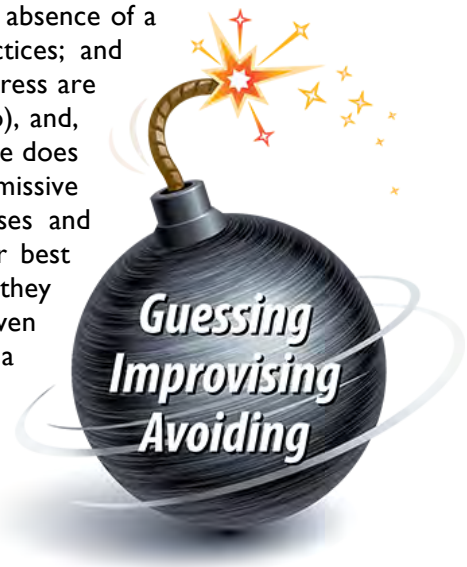


Figure 1.1. Ineffective Management Responses

¹⁷Stoddard, Abby, Adele Harmer, and Kathleen Ryou. “Aid Worker Security Report 2014. Unsafe Passage: Road attacks and their impact on humanitarian operations.” Humanitarian Outcomes. August 2014.

¹⁸ USAID Mission, Vision, and Values, as stated on the USAID website. <https://www.usaid.gov/who-we-are/mission-vision-values>.

1. *Stress Awareness*: The non-stigmatizing understanding by staff and managers that stress is biopsychosocial and has specific consequences that affect health, work performance and interpersonal behavior. Furthermore, the knowledge that stress can be managed and moderated with positive self-care and benevolent stress-supportive management systems, and is exacerbated by unskillful management practices and dissonant organizational systems.
2. *Stress Responsiveness*: Based on an objective understanding of stress (*Stress Awareness*), an organization's adoption of practices that mitigate stress and care for staff; in other words, practices that eliminate avoidable adaptation challenges (stressors), minimize exposure to unavoidable adaptation challenges, mitigate current stress effects, care for distressed personnel, and reduce strain on the organization as a whole.
3. *Stress Mitigation*: Interventions that either prevent or reduce the prevalence/severity of adaptation challenges. For example, management might mitigate stress by providing clarification on the relative urgency of tasks so that staff is not frantic with the perception that everything is important and must be completed immediately.
4. *Staff Care*: Interventions that provide relief, support or treatment for personnel that have been negatively affected by adaptation challenges. For example, an organization with occupational exposures to trauma might provide a counseling center providing trauma-informed services.



Figure 1.2. Stress Awareness Driving Stress Responsiveness with its Two Components Stress Mitigation and Staff Care

Simply put, policies based on Stress Awareness are realistic, higher-yield and have a better “do no harm” profile that can substantially lower risk. Stress Aware policies lead to better guidance on Stress Responsiveness and the institutional practices such policies establish, which in turn produce better outcomes for staff and, as a consequence, for the organization as a whole.

In summary, with the current recognition of the impact of stress on USAID officers and their families, a window of opportunity has opened that will allow USAID to take action and adapt strategically to the current situation in which the Agency finds itself. Using the objective, scientifically validated, and evidence-based analyses contained in this assessment report, USAID has the information it needs to put in place a multi-tiered and integrated system that addresses both current and future needs of the USAID workforce.

2. ASSESSMENT PURPOSE

USAID requires specific, actionable, evidence-informed recommendations for how best to enhance, maintain, or establish systems for staff care and meet all Duty of Care obligations to USAID personnel. This study provides a multi-tiered, multi-perspective analysis of the sources of stress affecting USAID personnel working in high-operational stress environments, as well as the effects of stress USAID personnel are currently enduring. Understanding this stress ecology informs the development of solutions necessary to make that stress load more manageable, both from individual and institutional perspectives.

The audience for this assessment is senior management at USAID, including senior USAID leaders in Washington, USAID Mission leaders worldwide, and managers within the Office of Human Capital/Talent Management (HCTM).

The assessment team has reviewed medical and academic literature related to the biology and psychology of stress, as well as academic and normative standards-setting literature related to occupational stress in general and, specifically, occupational stress focused on personnel working in international relief and development. This fully evidence-informed perspective allows USAID to interpret the relative utility of each recommendation.

To ensure that the assessment accurately and sensitively reflects the lived experience of USAID personnel, rather than being merely an academic exercise, the assessment team has conducted extensive interviews with USAID personnel. To ensure that USAID can locate the challenges and experiences of its personnel within a larger field of practice, the assessment team has also interviewed others working in the field of international relief and development, as well as representatives from other federal agencies that have personnel dealing with intense, workplace-related stress exposure.

The assessment team has reviewed internal policy documents and USAID systems meant to support personnel dealing with work-related stress, mapping the USAID policy environment and the various services provided. Personal perspectives and experiences of USAID officers as they interacted with these systems have also been recorded, to identify self-articulated needs and reflections on access, adequacy, and quality of services provided. The assessment team has also reviewed USAID StaffCare Center services to determine if they adequately support staff resilience in volatile, uncertain, complex, and ambiguous conditions.

This assessment inventories, categorizes, and evaluates the impact of current staff care systems, services, and resources, as provided by multiple operational nodes within the Agency. This study also locates USAID within the standards and practices of similar organizations working in high-stress environments.

All of this information has been collected, reviewed, and analyzed in order to inform recommendations USAID can use to implement a multi-layered institutional framework for staff care that is appropriate to provide. This study identifies what USAID should do differently, and compares current USAID practices with analogous services available from other agencies and best practices in the wider field of international assistance. Finally, this study establishes, given the current state of knowledge and practice in this evolving and highly specialized discipline, objective requirements and applicable best practices to prescribe an appropriate institutional response for USAID.

3. RESEARCH METHODS

This USAID assessment was implemented between December 2014 and September 2015.

This study is a multi-level, mixed-methods study, making use of both qualitative and quantitative evaluation methodologies, with an emphasis on qualitative methods.

The assessment began with a review of literature in the fields of stress physiology and psychology, trauma psychology, general occupational stress, and occupational stress in the field of international relief and development. In parallel with this ongoing literature review, group interviews and key informant interviews were conducted with USAID personnel. Many of these interviews were conducted in Washington with staff working in Washington, both face-to-face and via telephone. Phone interviews were also conducted with staff from numerous USAID Missions abroad. Site visits along with face-to-face interviews were conducted overseas in four USAID Missions: Jordan, Pakistan, Afghanistan, and Kosovo. Personnel recently evacuated from Yemen were also interviewed in Washington. A total of 171 USAID personnel were interviewed, 87 in individual key informant interviews, and 84 USAID officers in 17 separate group interviews. Trauma-informed principles of interviewing were employed so as not to re-traumatize subjects.

Where possible, US Department of State (State/MED) health officers with familiarity with psychosocial support systems at post were interviewed, including on-site social workers in Pakistan and Afghanistan, the Embassy health unit in Kosovo, and senior officers at State/MED in Washington. Key informant interviews were also conducted with numerous implementing organizations that do work similar to that of USAID; in many cases, interviews occurred with staff in organizations located outside of Washington. These implementing organizations included several large international NGOs or Washington-based consulting firms. Additionally, staff from the following agencies (results from selected agencies in Annex 8) were interviewed either in person, by Skype or by phone:

- United Nations High Commission for Refugees (UNHCR)
- United Nations Office for Coordination of Humanitarian Affairs (OCHA)
- United Nations Office for Project Services (UNOPS)
- The World Bank
- US Department of State (DOS)
- US Department of Defense (DOD)
- US Department of Homeland Security (DHS)
- Centers for Disease Control and Prevention (CDC – Atlanta, GA) and National Institute of Occupational Safety and Health (CDC/NIOSH – Washington, DC)
- U.S. Public Health Service
- U.S. Peace Corps

Finally, an online survey was conducted via SurveyMonkey. This survey was sent to over 1,400 serving USAID Foreign Service Officers (FSOs), as well as many who were either Personal Services Contractors (PSCs) or who had separated from the Agency prior to the time the survey was delivered. Most of these were invited to participate both through an Agency Notice that contained the web link to the survey and individual invitation emails generated by SurveyMonkey. Additional snowball sampling requests were sent out as well. 556 people overall responded to this survey.

DOCUMENT REVIEW

More than 300 publications and external documents were reviewed. A wide variety of internal USAID documents were reviewed as well, including Agency Notices and various ADS Chapters, a USAID Incentives Survey, various StaffCare program description documents, and assorted documents or informational materials related to education on stress awareness or pre-deployment preparation for USAID personnel. The complete list of documents reviewed is attached as Annex I.

The document “Managing Stress in Humanitarian Workers-Guidelines for Practice,” 3rd edition (March, 2012), published by the Antares Foundation, was used as a tool for establishing the normative frame for USAID comparison against established best practice standards. Several additional standards or ideal practices have been identified through the course of research; all of these are presented in the Ideal Practices Matrix, which begins on page 72. The Antares Guidelines focus on eight core principles that constitute a cyclical representation of the various stages in a deployment cycle, and these eight principles contain 34 associated indicators. This set of indicators, and other practices contained in the Ideal Practices Matrix, constitutes the set of ideal stress management practices that USAID practices were assessed against. These ideal practices were cross-analyzed and triangulated against the specific stress-related themes that emerged through interviews, and were further quantified through the USAID survey.

A review of USAID policy documents was used to initially determine conformity with these indicators. Analysis was conducted on an extensive set of documents provided by USAID and the results of various key informant interviews held with USAID personnel responsible for implementation management of various stress management functions within USAID. Key Informant Interviews were conducted with staff from USAID/HCTM (Human Capital and Talent Management, USAID’s human resources management unit); USAID’s StaffCare Center; the staff concerned with providing stress management resources, knowledge, or support to USAID’s Office of Foreign Disaster Assistance (OFDA) and Office of Transition Initiatives (OTI); and a representative from USAID’s Security Office. The assessment team’s description of current USAID practices, procedures, and resources, and analysis for conformity with the frame of ideal practices is based on the documents and other information products that were provided to the team, information provided through face-to-face interviews, written information provided via email communication, and findings emerging from the USAID survey. The accuracy of all statements provided by USAID personnel were not, in general, rigorously and independently verified. However, all information provided by USAID staff was triangulated across multiple sources, using multiple methods.

In the case of current ideal practice examples emerging from other organizations, specific program elements have been highlighted that comply with the Matrix of ideal practices. These are described in this report as illustrative examples that could be used for USAID learning purposes, or that could serve as noteworthy examples to facilitate rapid internal design and adoption by USAID. However, no review and analysis for conformity to the matrix overall was conducted for other organizations.

KEY INFORMANT INTERVIEWS WITH USAID AND EXTERNAL STAKEHOLDERS

All participants in this assessment were assured of anonymity, to encourage frank and candid discussion. Many interviewees specifically agreed to speak only on condition of strict anonymity. A number of the implementing organizations contacted also requested their information not be provided in any identifiable way. This assurance of anonymity was especially important for information shared during individual interviews, focus groups, and surveys with USAID, due to the ongoing stigma associated with needing or receiving psychosocial support services, and the mistaken assumption that revealing this could result in damage to one's security clearance. As a result, the names of those interviewed are not provided in this document and care has been taken to ensure any quotes used have been suitably anonymized by removing any personally identifiable information.

There were, broadly speaking, two general patterns to key informant interviews conducted. The first sought to identify sources and effects of stress for USAID personnel and obtain feedback on services accessed, as well as identify recommendations for improvements to USAID's stress management offerings. These interviews used very loosely structured, open-ended, elicitive questions focused on: 1) sources of stress; 2) effects of stress noted in self and others; 3) feedback on access, adequacy, or quality of services accessed; and finally, 4) recommendations for improving USAID stress responsiveness. This allowed USAID personnel to steer the discussion to whatever seemed most of interest from their perspective, and allowed interviewees to establish the course and content of the discussion based upon their own understanding, personal interest, and self-identified priorities. This design was selected to allow for the broadest range of perspectives and issues to emerge so that the team could fully map the themes and categories of interest to USAID personnel.

The second pattern aimed at capturing a detailed and accurate description of policies, practices, procedures, and resources. These descriptive interviews were far more structured, and aimed to extract information that mapped against the content areas consistent with the Antares framework's eight good practice principles, as well as the additional ideal practices in the Matrix mentioned previously. For USAID staff concerned with managing stress reduction programs or resources, and personnel from other organizations who are responsible for staff welfare and/or stress management, questions were tailored to elicit detailed descriptions of the policies, resources or services they were responsible for. Additionally, at the tail end of the loosely structured interviews described in the previous paragraph, feedback was also elicited that spoke to this more structured and descriptive area of research interest.

The assessment team conducted 87 randomly selected key informant interviews with USAID personnel, most of which were USAID Foreign Service Officers serving at four USAID Missions abroad, and one Mission recently evacuated with personnel resident in Washington. These specific Missions were selected based upon an understanding that they were either Critical Priority Countries (CPCs) or Non-Permissive Environments (NPEs), i.e., Pakistan, Afghanistan, or Yemen; were likely to receive personnel in follow-on postings from CPCs/NPEs, as was the case with Kosovo; or were for some other reason likely to be high operational stress posts, as is the case in Jordan, where a protracted refugee crisis has been ongoing since the 2003 Iraq war and has been severely exacerbated by the ongoing civil war in Syria, and the emergence of ISIS in Syria and Iraq.

The study methodology required that a minimum number of interviewees at Missions were randomly selected. Additionally, there were non-randomly selected interviews conducted with staff care and wellness personnel with other implementers, and a small number of interviews with USAID personnel

that were referred to the assessment team due to previous CPC experience. In Washington, a call went out to senior managers and former Mission Directors working in Washington, and those who had time available participated.

USAID interviewees cut across all management levels, including interviews with Assistant Administrators, former and current Mission Directors and Deputy Mission Directors, Office Directors, and staff at all Foreign Service Levels. The team also interviewed a number of Personal Services Contractors (PSCs), Third-country Nationals (TCNs), and Foreign Service Nationals (FSNs). Interviews were also conducted with representatives of external agencies, including several UN Agencies and US Government agencies with similar operational requirements, and various private and non-profit implementing partners of USAID.

GROUP INTERVIEWS WITH USAID

17 Group Interviews were conducted with a total of 84 USAID personnel; 13 occurred in the field and 4 were conducted in Washington. Group size varied between two and eight persons, with most sessions being between 6-8 persons. Separate interviews were conducted with FSOs, PSCs, FSNs, and TCNs. As with Key Informant Interviews, all Group Interviews began with obtaining informed consent, and included a guarantee of anonymity for all information provided. Focus groups were facilitated by the assessment team leader. The structure of the organizing questions asked in each group discussion was consistent and based upon three broad, open-ended questions. Each group discussion followed a course that was dynamic and emergent.

First, group members were asked about the common causes of stress, from their perspective, and then allowed to discuss this between themselves. When this discussion had proceeded to a point where discussion was trailing off, and the group seemed ready to move on, or when time pressure required it, group members were next asked to describe the effects of stress they noticed in themselves and/or in others. After an initial discussion, a list of common stress effects extracted from the literature on occupational stress in general and humanitarian aid work in particular was provided. Participants were asked to review the list and then identify any stress effects they felt were noteworthy. Finally, participants were asked for any recommendations they could provide to help USAID better address the causes and effects of stress they had previously identified. If any discussion points related to access, adequacy, or quality of staff care resources/services emerged, clarifying questions were asked.

All focus groups and individual interviews were analyzed by the lead researcher for thematic content based upon interview notes, and this analysis was shared with a second and third researcher who participated in many of the interviews, for validation. Themes were assembled into broader categories to identify any patterns, and these categories were quantified to establish the frequencies with which they emerged, although no score was utilized to rate them for relative intensity.

USAID STAFFCARE AND STRESS EXPOSURE SURVEY

Themes and categories that emerged from USAID interviews were used to establish the frame of response categories for an online survey of USAID staff that followed. This survey was intended to generate quantitative breakdowns and distribution of these themes across the USAID survey population. Additionally, survey content was developed based upon a desk review of research in the field of mental health and psychosocial well-being issues that affects humanitarian aid workers, including review of

previous staff stress survey instruments (for example, the InterAction Darfur study¹⁹ and the UNHCR Staff assessment);²⁰ and finally, subject matter expertise and prior experience from the assessment team.

Once the initial draft of the survey instrument was completed it was shared with USAID for review and comment, and then a slightly modified version was tested by a number of personnel at USAID. The final version of the survey incorporated all feedback received from USAID testers.

The survey link was sent out by USAID in an all-staff Agency Notice, with a cover letter from the USAID Counselor, emphasizing the importance of staff perceptions and the anonymous nature of the survey. Several reminders were sent, and the survey closed at the end of June. The online survey resulted in a response of 556.

(Author's Note: One USAID officer raised a question about — and an objection to — the use of the “militarized” term ‘deployment’ in the survey delivered to USAID personnel, rather than the terms ‘assignment’ or ‘posting’ that have a less explicitly martial tone. This officer wondered if this use of the term was further evidence of the blurring of differences between development and military activity. This is a valid point. However, from the authors’ perspective, deployment has some additional meaning that makes it a more precise term, and this is why it has been chosen and is used throughout this report. Deployment refers to assigning people to serve in various locations, in a more mandatory way than simple posting or assignment. Deployments might be war related- but can also be for the purposes of a peaceful mission. When the word deployment is used, the reader knows people are being required to go somewhere for a specific mission).

¹⁹Augsburger, Rick, William Sage, Lisa McKay, Laurie Pearlman, Jim Guy, Bree Hulme, and Alicia Jones.

“NGO Staff Well-being in the Darfur Region of Sudan and Eastern Chad.” Headington Institute. November 2007.

²⁰Welton-Mitchell, Courtney E. “UNHCR’S Mental Health and Psychosocial Support for Staff. PDES 12/2013.” UNHCR. July 2013.

4. METHODOLOGICAL LIMITATIONS AND MITIGATION MEASURES

All researchers involved in the research process have extensive and complementary experience in the subject matter of this assessment. The team includes researchers with extensive experience in the design and implementation of program evaluations and applied social science research; the medical and psychological dimensions of stress and trauma; experience working for similar implementers, including UN agencies and NGOs, on conflict programs; and experience working on conflict programs inside USAID, both from Washington and in the field. All members of the team regularly met and shared their observations, discussed and checked each other's emerging analysis, contributed to data collection, data analysis, and drafting of the report.

Self-reporting through survey questionnaires or qualitative interviews are a common and widely-accepted approach to stress assessment that is validated throughout the literature on stress.²¹ However, there is one overarching issue related to the qualitative methods used, and that is difficulty in accurately self-assessing and/or self-reporting. Various self-reporting biases may interfere with an accurate assessment of the true causes of stress, as well as the extent and severity of stress effects, as stress effects masquerading as other conditions may be “misdiagnosed” by those reporting them.

Internet surveys can be problematic for several well documented reasons.²² Chief among these is bias associated with self-selection: there is no way to ensure that the people who responded to the survey did not do so for reasons that would bias the data, such as being among the most stressed or the most emotionally reactive due to their experience of stress. The survey instrument was not validated as a psychometric instrument might be, nor was it delivered in a consistent structured manner by a trained survey enumerator. There is a possibility, as a result, that diverse understanding and subjective interpretations of questions by respondents distorts some responses, and there is no way to estimate this error. Additionally, the survey response rate overall is possibly due to any of several factors that cannot be determined. These may include cynicism, lack of trust in management, frustration with perceived institutional indifference, etc., and each of these might affect the ultimate accuracy, and thus reliability, of the survey. It could also be that people are just too busy, and when prioritizing tasks, a survey takes less precedence than day-to-day duties and so becomes one task that gets neglected. If people systematically chose not to take the survey for any of these unverifiable reasons, an important and significant sub-population at USAID may not be represented in the survey and this might distort the data. Analysis based on a survey that has a low response rate, and is therefore not fully representative of

²¹ See, for example, “Stress at Work.” NIOSH: Publication 99-101. p. 17. See also, “Psychological health and Safety: An Action Guide for Employers.” Mental Health Commission of Canada: 2012. p. 13; and numerous chapters that outline assessment approaches in, Murphy, Lawrence R., and Theodore F. Schoenborn. “Stress Management in Work Settings.” CDC/NIOSH. May 1987.

²² See, for example, Jansen, Karen J., Kevin G. Corley, and Bernard J. Jansen. “E-Survey Methodology.” Chapter 1, in “Handbook of Research on Electronic Surveys and Measurements,” by Rodney A. Reynolds, Robert Woods and Jason D. Baker. IGI Global. 2007.

the population, must be undertaken with recognition of this uncertainty. However, when considered in combination with data emerging from interviews, and reinforced by additional data that resides in the literature, the survey data becomes one piece of information that, in combination with all the others, allows the assessment team to construct a reasonably reliable picture of the causes and effects of stress that currently impact USAID staff.

Due to the loosely structured and open-ended nature of the interviews, many of the themes inserted into categories were interpreted and then assigned by the researchers. Because of the dynamic and emergent nature of the interviews, each interview varied widely in terms of content, including the words and phrases used to describe personal experiences of stress causes and effects. Due to the need to identify patterns in the data, they were necessarily coded by the researchers in a way that required subjective interpretation, which can result in various forms of researcher bias. In qualitative research such as that conducted during the course of this assessment, the personal assumptions, interpretations, and observations of researchers inevitably influence the analysis, including emphasizing which data constitutes relevant findings, and how to interpret this data to formulate conclusions and associated recommendations.

To control for all of the above methodological limitations, triangulation was used throughout the research process. Information obtained from multiple sources, using multiple methods, can be assumed to be more reliable where the data converge. This triangulation included the use of multiple research methods, multiple data sources, and regular and continuous peer review of findings, analysis, and conclusions. In addition, USAID data collectors or research observers were integrated into the research team, and attended most interviews, and all findings were regularly shared and discussed with assessment managers inside USAID as they emerged, to aid in validation and analysis. Beyond that, emerging conclusions were shared with and further developed by a Working Group made up of USAID personnel, as well as a Senior Advisor Group made up of knowledgeable subject matter experts convened by USAID, and a group of senior USAID managers attending two separate Mission Directors' Conferences.

Every attempt has been made to ensure that all analysis and associated conclusions, and recommendations that flow from these are objectively based on the data and reasonable, given USAID understanding of the issues, and to minimize potential bias or distortions emerging from the subjective interpretations of the researchers.

5. RESEARCH QUESTIONS

The study seeks to answer the following descriptive and normative research questions, some of which are precursors to accurately understanding the perceived causes of stress at USAID, which is essential in order to prescribe appropriate institutional responses. The careful reader will note the specific formulation of the research questions listed below differs from the format, arrangement, and phrasing as documented in the SOW (for the full SOW as originally received, see *Annex 4. SOW*). This was done to streamline the research process.

RESEARCH QUESTIONS

1. What are the causes or sources of stress as attributed by USAID personnel?
 - 1.a. What stress effects do USAID personnel notice in themselves and others?
2. What is currently provided by USAID in terms of staff care (including training)?
 - 2.a. How adequate is this care according to staff perceptions?
 - 2.b. What is the utilization of this care?
3. What can be learned from the current medical literature related to the psychosocial dimensions of managing the effects of high-stress?
 - 3.a. How adequate is USAID care according to what is currently known in the medical literature?
4. What are similar agencies doing in regards to providing staff care in high stress environments?
 - 4.a. USG agencies, including Dept. of State, DOD, Peace Corps, etc.
 - 4.b. International assistance agencies, including UN agencies, other bi-lateral development agencies, and international NGOs
5. What objective standards of care are there?
 - 5.a. What legal “Duty of Care” standards are there, if any?
 - 5.b. What other normative standards may exist in terms of identified best practices?
6. What services, resources, policies and practices currently exist at USAID?
 - 6.a. What specific gaps can be identified in terms of the care provided?
 - 6.b. Quality gaps?
 - 6.c. Quantity or access gaps?
7. What specific recommendations can the assessment team provide to ensure USAID meets or exceeds minimum standards and best practices in terms of ensuring staff have access to quality care?
 - 7.a. Staff management practices/managers capacity building
 - 7.b. Systems, policies, procedures
 - 7.c. Institutional arrangements/structures

Additionally, the following section from the SOW is attached here to establish the information requirements these research questions were meant to address (edited for brevity):

A. USAID seeks to:

1. Collect baseline and historical data on USAID personnel who have served (or currently serve) in high stress posts, i.e. frequency and number, duration of the assignments, types of staff (USDH FSO and CS staff, FSN, FSL, PSC, etc.), for USDH backstop-filled versus actual backstop, and other staffing actions (to include to the degree legally and practically possible, information on persons who have separated from the agency);

2. In collaboration with USAID staff assisting with the assessment, inventory all services related to 'staff care' available to USAID employees;
3. Survey the range of services that are currently being provided to employees working for similar foreign affairs/national security agencies i.e. Department of Defense (DOD), Department of State (DOS), Peace Corp (PC), and also non-US Government entities such as NGOs, UN, etc., active in high stress deployments;
4. Survey of relevant USAID staff on their opinions about the support that is/was available to them during their assignments in high stress countries, including NPEs and CPCs;
5. Assess USAID StaffCare programs interventions to determine if they adequately and sufficiently promote and ensure staff resilience;
6. Identify potential gaps in program resources (regulatory, financial, perceptual, or other); and
7. Make recommendations to Agency senior leadership on improvements in staff care programs writ large (i.e., not limited to current staff care programs).

B. The assessment team will assess and analyze, among others, the following as it pertains to staff assignment, staff care and resilience:

- Selection process (i.e., screening process) for deployment to high stress, NPEs and CPCs;
- Frequency and duration of high stress, NPE and CPC assignments;
- Access and quality of 24/7 services;
- Adequacy and appropriateness of Agency-specific high stress, NPE and CPC incentives;
- Adequacy of pre-deployment training;
- Adequacy of on-site deployment assistance;
- Adequacy of post-deployment (Short/Long Term) assistance;
- Perceived quality and availability of services;
- Current policies and procedures (both helpful and hindering) for assignments to high stress, NPE and CPCs;
- Training gaps; and,
- Review of existing literature and assessment of the other foreign affairs and national security agencies, e.g. State Department/MED, Do D, DHS, PC as well as non-US Government entities' staff care programs, to determine best practices, and to identify potential opportunities for collaboration.

DELIVERABLES

Once the review is completed the assessment team will detail findings and recommendations and provide the following:

1. A description of the working relationship between the SAG and the Operational team, including the procedures guiding them.
2. An inventory of staff who have previously served or are serving in high stress environments, as well as recommendations about keeping such an inventory accurately up-to-date, while protecting PII;
3. Results of interviews and surveys of current and former USAID staff assigned to high stress countries, and an analysis of the staff care offered or provided to such staff?

4. A Gap Analysis that will at a minimum include:
 - a. A comprehensive analysis of staff care issues and concerns affecting USAID personnel in high stress environment;
 - b. The strengths and weaknesses of the current pre- and post-deployment training programs; and
 - c. An inventory of all current staff care resources available to USAID personnel who have previously served or are serving in high stress environments;
5. A list of recommendations to senior leadership for increasing the availability of and access to an improved staff care program for USAID personnel with a focus on staff who currently or have previously been assigned to NPE posts, CPCs or high-stress environment posts. These recommendations will address all the points identified in section III 'Scope of Work', B. The recommendations will also identify the annual resources required to implement such a program.

6. FINDINGS: STRESS, BIOPSYCHOSOCIAL CAUSES AND EFFECTS

OVERVIEW: STRESSORS AND STRESS, STIMULI AND RESPONSES

It is important for the reader to begin with the extremely well researched causes of stress. In general, stress is caused by any significant change or unpleasant conditions in the environment. Of note, positive changes can also produce stress, such as graduation from school, receiving a promotion, being newly married, etc.

Stress has been classically defined as a condition that upsets the physiological and psychological balance of an individual. Stress is defined here by the assessment team as a biopsychosocial response to an 'adaptation challenge,' otherwise known as a stressor. An adaptation challenge is thus any condition or event that activates a stress response, or that challenges a person with a potential threat to well-being and that induces a physiological and/or a behavioral response. The characteristics of that stressor -- as well as the context in which the stressor is experienced -- shape the consequences of the stressful experience and thus can influence the way an individual experiences stress. For example, unpredictability is a reinforcing factor for stress, because a stressor that is unexpected cannot be controlled, prepared for, or avoided; and so its experience leads to more severe stress outcomes.²³

Stress affects everyone differently and in ways unique to each individual: stressors, and the responses of stress physiology, affect diverse people differently depending on a complex interplay between individual psychology, physiology, behavior and personal history. Diverse individuals also possess different constitutional or behavioral characteristics that play out in terms of resilience, adaptability, or coping style. There is clear evidence that cognitive, perceptual and other differences between individuals interact with stressors to create differential interpretations of the relative severity of stressors as well as variations in how stressors are reacted to emotionally.²⁴

²³ Franklin, Tamara B., Bechara J. Saab, and Isabelle M. Mansuy. "Neural Mechanisms of Stress Resilience and Vulnerability." *Neuron*, Volume 75, Issue 5: 6 September, 2012. Elsevier Inc. pp. 747–761.

²⁴ See, for example, Franklin, Tamara B., Bechara J. Saab, and Isabelle M. Mansuy. "Neural Mechanisms of Stress Resilience and Vulnerability." *Neuron*, Volume 75, Issue 5: 6 September, 2012. Elsevier Inc. pp. 747–761. See also, Barbara Lopes Cardozo, Carol Gotway Crawford, Cynthia Eriksson, Julia Zhu, Miriam Sabin, Alastair Ager, David Foy, Leslie Snider, Willem Scholte, Reinhard Kaiser, Miranda Olf, Bas Rijnen, and Winnifred Simon. "Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study." September 2012. *PLOS ONE*, Volume 7, Issue 9, e44948. September 2012. www.plosone.org; and, Kendall, Elizabeth, Patricia Murphy, Veronica O'Neill, and Samantha Bursnall. "Occupational Stress: Factors that Contribute to its Occurrence and Effective Management." August, 2000. WorkCover Western Australia. Pp. 21-30; and, Roth, Susan and Lawrence J. Cohen. "Approach, Avoidance, and Coping with Stress." *American Psychologist*: July 1986. pp. 813-819.

Effects of stress are also equally well-researched and generally understood. There are four broad categories of stress effects consistently identified in the literature, and a fifth mentioned less frequently:

1. Physiological
2. Cognitive
3. Emotional
4. Social
5. Some sources also identify Spiritual, Moral, or Meaning-related stress effects

THE BIOPSYCHOSOCIAL MODEL*

Stress responses are a function of **subcortical** processes (meaning **below** the conscious processes of the brain's cortex). These subcortical processes activate the biological system responsible for producing the cascade of physiological reactions that are a hallmark of the stress response. As with the subcortical brain processes, these physiological processes are not under simple conscious control of will (although there are tried and tested techniques that can be learned that allow conscious influence over certain elements of the stress response). These physiological processes are both visceral and neuro-anatomical, including neurochemical and hormonal changes, and they affect mental processes of perception and cognition as well as the regulatory processes of the body. With prolonged exposure, over time these various processes can become self-reinforcing and counter-productive.

Stress affects both internal psychology and external social relationships, and is also conditioned substantially by the presence or absence of positive social support. As a primary environmental context for most humans is social, this is where many of the most significant environmental challenges occur, and adverse social conditions frequently trigger stress response (as do other environmental factors). Stress affects social relations by altering normal social behavior and generating abnormal behaviors, and positive social connections can be stress reducing or stress mitigating and can also positively reduce stress effects. Stress is also “socially contagious”; in other words, when interacting with people under stress, people pick up stress from each other.

Biological, psychological, and social factors thus all work together in a complex and interdependent ecology that conditions how one experiences and responds to stressors. Additionally, how one conceptualizes stressors affects not only whether or not an event is experienced as distressing, but also may determine how one responds to and deals with stress.²⁵ This complex and interdependent ecology of stress is referred to as the Biopsychosocial Model (See Figure 1). If the mechanism of the stress response is understood as a set of interrelated processes within biological, psychological, and social realms of experiences that affect the individual, then preventative measures against chronic and traumatic stress, as well as provision of support or care for those experiencing distress (ranging from generalized anxiety to burnout to PTSD), will ideally address each and all areas in an integrated and synergistically reinforcing way. Sufficiently comprehensive and effective strategies for managing stress will broadly define “biological” to include neurological and physiological processes and will broadly define “social” to include not only interpersonal, but also organizational sources -- as well as outcomes -- of stress.

* Annex 3 provides more detail to key neurobiological terms used here.

²⁵Engel, George L. “The Clinical Application of the Biopsychosocial Model.” *American Journal of Psychiatry*, Volume 137, issue 5, 1980. pp. 535–544.

ADAPTIVE AND MALADAPTIVE RESPONSES TO STRESS

Stressors are an adaptation challenge, or some element of the inner or outer world an individual inhabits that necessitates change. Stress is thus any biopsychosocial response to an adaptation challenge. Mental and physical health is often the result of the adaptations people make to their unique environments (stressors) with whatever current resources they possess, which may include any genetic or medical predispositions, or diatheses. The spectrum of responses to stressors can be understood to often include both adaptive and maladaptive responses.

For example, one person may choose to deal with a traumatic stress and a demanding job by learning mindfulness meditation techniques and another person may drink more alcohol than in the past. Both responses are understandable because both are being used to alleviate distress. Ultimately, increasing alcohol consumption when someone has traumatic stress does more long-term damage to the brain despite the short-term relief from stress that is obtained through consumption of alcohol. Though the increased alcohol consumption is a maladaptive response to stress in this case, it is still important that it be understood as a rational attempt to relieve or manage stress.



Figure 6.1. The Biopsychosocial Model.

Both examples described above constitute “coping behaviors,” or attempts by an individual to better adjust to or regulate the effects of stress. This understanding of responses selected by individuals in an attempt to regulate or mitigate the effects of stress ideally enables peers and professionals in relationship with “stressed-out” or even traumatized individuals to approach the person in a nonjudgmental manner. Understanding a stressed person with the constructs of ‘adaptation challenge’ and ‘coping behavior’ also shapes the suggestion of how to appropriately fill the real voids left by eliminating maladaptive coping strategies such as substance use. A non-judgmental attitude and recognition of the individual’s need for multiple adaptive coping strategies will make suggestions for the use of more adaptive coping mechanisms more likely to be well-received and thus sustainable.

When an individual’s coping capacity is overwhelmed by adaptation challenges, stress affects all major systems of the body (see Figure 6.2 on the next page). This state of being overwhelmed can lead to physical or psychological illness. Physical, mental, interpersonal, and operational adaptation challenges all trigger stress, but the reaction by the body does not distinguish among these adaptation challenges.²⁶

Additionally, the cost of continual adaptation to uninterrupted chronic or acute stress, without adequate opportunity to recover, is cumulative. Exposure builds up over time in line with the concept of exposure to environmental toxins. There appears to be a “threshold” that can be reached (which varies from person to person) after which negative health effects begin to manifest. Protracted or acute stress exposure that surpasses this threshold can lead to numerous physiological and psychological health problems, which are discussed in greater detail below.

²⁶Sadock, Benjamin J., Virginia A. Sadock, and Pedro Ruiz. “Kaplan and Sadock’s Synopsis of Psychiatry.” Baltimore: Lippincott, Williams & Wilkins. 2014.

In contrast to homeostasis, **allostasis** is the active process that normally maintains physiological and behavioral stability during the changes associated with adaptation, but chronic stress or insufficient allostasis can lead to arrest of the healthy stress response.²⁷ When this process of maintaining stability is overburdened with exposure to stress and lacks sufficient resources or resilience to adapt to the stress, it is known as allostatic overload. The degree to which an individual is carrying cumulative stress within the system is referred to as allostatic load, and this cumulative stress load can diminish an individual's ability to adapt, to cope, or to recover from any given stress exposure.

Optimal conditions for healthy allostasis include limited exposure to stress factors, as well as possessing well-developed resources to cope with stress that can promote adaptive coping and resilience.²⁸

BIOLOGICAL STRESS FACTORS

Nervous system:

Any stress, both positive stress (eustress) and negative stress (distress), involves the autonomic nervous system (ANS) and results in increased responsiveness and activity, or “excitation”. The autonomic nervous system functions largely involuntarily and unconsciously and regulates the human body's most basic regulatory processes, including basic physiological processes such as breathing, heart rate, blood pressure, and digestion, as well as the so-called “fight or flight” response in which the physiological system of an organism is primed to respond to a threat to survival. Increased responsiveness and activity in the ANS include physiological manifestations of arousal such as elevated heart rate, increased blood pressure and re-routing of blood flows to support aggressive defensive action, heightened sensory alertness, and pupillary dilation, among other protective and preparatory measures. When the ANS is chronically overstimulated, adaptive bodily responses that once helped the body prepare to respond to an imminent survival threat may become maladaptive, producing a variety of compromises to physical health (see Table 6.1, on next page).²⁹ When exposed to chronic or acute high-stress, in addition to numerous chronic health problems, people are at increased risk for the emergence or reactivation of major health problems.

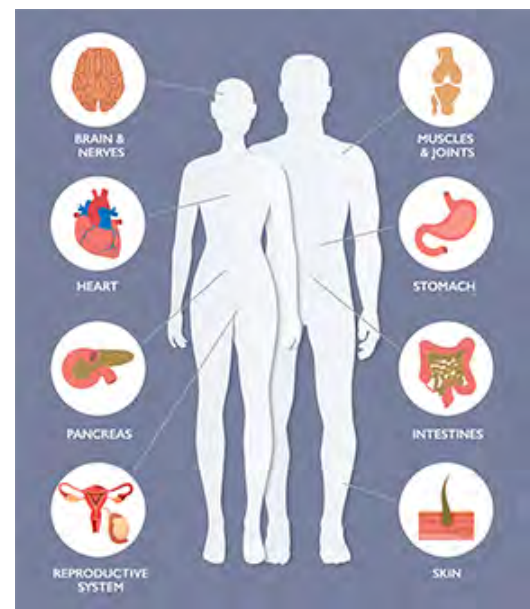


Figure 6.2. Stress Effects on the Body

²⁷The more commonly known term “homeostasis” refers to the internal physiological state that organisms seek to maintain. Allostasis is a process, whereas homeostasis is a state. Therefore, allostasis is the active process that maintains not only homeostasis (physiological stability), but also behavioral stability.

²⁸Sterling, Peter, and Joseph Eyer. “Allostasis: a New Paradigm to Explain Arousal Pathology.” In *Handbook of Life Stress, Cognition, and Health*, S. Fisher, ed. (New York: John Wiley & Sons), 1988. pp. 629–649.

²⁹Jacobs, Gregg D. “The Physiology of Mind-body Interactions: the Stress Response and the Relaxation Response.” *Journal of Alternative and Complementary Medicine*, Volume 7, Supplement 1. pp. S-83–S-92.

Overactivation of ANS contributes to:

- Sleep disturbance such as insomnia and reduced restorative slow-wave sleep
- Gastrointestinal disorders such as irritable bowel syndrome (abdominal pain, constipation and/or diarrhea)
- Musculoskeletal stress connected to recurring headaches, muscle tension, back pain, and chronic pain
- Triggering stress-related skin conditions
- Cardiovascular events such as hypertension, high blood pressure, stroke, cardiac arrhythmias and heart attacks

Table 6.1. Health effects attributable to over-activation of the autonomic nervous system (ANS) due to chronic stress.

NEUROCHEMICAL AND HORMONAL CHANGES

The hypothalamic-pituitary-adrenal (HPA) neuroendocrine axis is activated in any stress response and facilitates what is commonly known as the “fight or flight” response. A pivotal organ in this response is the adrenal medulla, and two catecholamine molecules: epinephrine (adrenaline) or norepinephrine (noradrenaline). Epinephrine is activated in a stress response to perform a variety of functions that are adaptive in short-term “fight or flight” situations, such as increasing arterial blood pressure, increasing oxygen/nutrition to skeletal muscles, and decreasing blood flow to non-essential organs such as the kidneys and gastrointestinal tract. These helpful physiological responses can become maladaptive and produce long-term injury or illness when the HPA axis becomes chronically over-stimulated by sustained stress exposure.³⁰

In more chronic forms of stress, the HPA axis becomes hyperactive, as does the noradrenergic (norepinephrine-responsive) and endogenous opiate (endorphin-responsive) systems in the brain. Although endogenous opiates in our brains serve to modulate the response to painful stimuli and stressors, reward and reinforce, and perform homeostatic adaptive functions, such as regulating body temperature and food and water intake,³¹ upon over-stimulation endogenous opiates have been linked to diverse neuropsychiatric and bodily diseases. People with hyperactive noradrenergic systems exhibit nervousness, increased blood pressure and heart rate, palpitations, sweating, flushing, and tremors. Hyperactivity in the HPA, noradrenergic, and endogenous opiate systems has been repeatedly observed in many people in chronically stressful environments or who are experiencing acute stress disorders or posttraumatic stress disorder (PTSD).³²

Other neurochemicals such as endorphins, cortisol, dopamine, and acetylcholine all play a normal role in the stress response as well. Under stress, levels of these neurochemicals and hormones fluctuate widely from their normal range, causing a ripple effect that affects other neural axes. Stress affects neurochemical interactions in every part of the brain.³³

³⁰Everly, Jr., George S., and Jeffrey M. Lating. “The Anatomy and Physiology of the Human Stress Response.” In “A Clinical Guide to the Treatment of the Human Stress Response.” Springer Science and Business Media, New York: 2013.

³¹Olson, Gayle A., Richard D. Olson, and Abba J. Kastin. “Endogenous Opiates.” In *Peptides*, Volume 11, Issue 6, November–December, 1990. pp. 1277–1304.

³²Sadock, Benjamin J. & Virginia A. Sadock, and Pedro Ruiz. “Kaplan and Sadock’s Synopsis of Psychiatry.” Baltimore: Lippincott, Williams & Wilkins. 2014.

³³ Ibid.

NEUROANATOMICAL AND STRUCTURAL IMPACTS ON THE BRAIN

In addition to hormonal and neurochemical fluctuations involved in responses to stress, research now shows brain structure changes in response to chronic stress. Some neurons die; other neurons take on novel firing patterns. The hippocampus, amygdala, and prefrontal cortex all undergo stress-induced structural alteration (see Figure 6.3).

The hippocampus is the region of the brain associated with learning, memory and emotional processing. The hippocampus also plays a role in shutting off the HPA response. Chronic stress results in damage or atrophy (cell degeneration) of the hippocampus, which impairs this shut off mechanism and leads to prolonged HPA response. Chronic stress also impairs memory functions that are dependent on the normal function of the hippocampus.³⁴

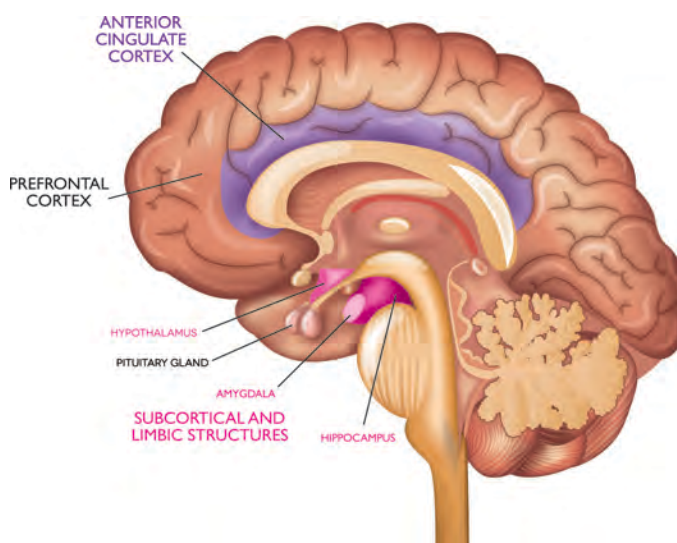


Figure 6.3. Location of Cortical and Subcortical (pink) Structures

Combat veterans with PTSD have demonstrated not only lower average hippocampal density, but also structural changes to the amygdala,³⁵ the area of the brain responsible for processing memory and regulating emotions, primarily fear and aggression.³⁶ By contrast to the hippocampus, the amygdala increases in density due to a hypertrophy (cell enlargement) of amygdaloid neurons when exposed to chronic stress.³⁷

Like the hippocampus, the prefrontal cortex experiences neuronal atrophy under chronic stress.³⁸ The prefrontal cortex is the center of all executive functions (cognitive control, reasoning, problem-solving, planning etc.) in the brain and is also involved in selective attention and decision-making. Persons with decreased prefrontal cortex volume may exhibit impaired decision-making, poor concentration, and attention difficulties.

Due to the above neuroanatomical/structural changes, the ability to learn, remember, and make decisions is compromised by chronic stress, and any of these changes may be further accompanied by increased levels of anxiety and aggression.³⁹

³⁴ McEwen, Bruce S. "Physiology and Neurobiology of Stress and Adaptation: Central Role of the Brain." *Physiological Reviews*, Volume 87, Issue 3, 2007. pp. 873-904.

³⁵ IOM (Institute of Medicine). *Building a Resilient Workforce: Opportunities for the Department of Homeland Security: Workshop Summary*. Washington, DC: The National Academies Press. 2012.

³⁶ Sadock, Benjamin J., Virginia A. Sadock, and Pedro Ruiz. "Kaplan and Sadock's Synopsis of Psychiatry." Baltimore: Lippincott, Williams & Wilkins. 2014.

³⁷ Ibid.

³⁸ Ibid.

³⁹ Ibid.

PHYSIOLOGICAL CHANGES

Stress provokes a non-specific system-wide physiological response, some characteristics of which have been mentioned above in regards to the results of chronic overstimulation of the ANS. The physiological effects of stress are well researched and understood. Common effects are listed in Table 6.2, below.

Physiological Stress Effects:
• Sleep disturbance, problems getting to or staying asleep, disrupted sleep cycles • Metabolic disorders, including diabetes and obesity; appetite and digestive changes • Skin and hair problems, such as acne, psoriasis, and eczema, and hair loss • Persistent fatigue, low energy, feeling tired • Chronic pain, headaches, chronic musculoskeletal problems, back and shoulder pain, clenched jaw or grinding teeth • Immune system dysregulation, frequent and longer-lasting infectious disease given too little activity from particular cells; and autoimmune disease given too much activity from other cells • Cardiovascular problems such as chest pain, rapid heartbeat, and elevated blood pressure, which over time can precipitate cardiovascular disease • Accelerated tissue aging and cell death throughout the body, as well as increased incidence of various cancers

Table 6.2. Stress Effects on Physiology

Many other physiological health conditions are associated with stress exposure, and vulnerability to nearly all disorders and diseases is increased with greater exposure to stress.⁴⁰

⁴⁰ Sadock, Benjamin J., Virginia A. Sadock, and Pedro Ruiz. "Kaplan and Sadock's Synopsis of Psychiatry." Baltimore: Lippincott, Williams & Wilkins. 2014.

PSYCHOLOGICAL EFFECTS – COGNITIVE AND EMOTIONAL

Biological structures and processes are the basis for the cognitive and emotional experiences of stress, “cognitive” referring to our thoughts and “affective” referring to our emotions. The body’s main response to experienced stressors occurs through activation within the ANS, primarily regulated by the hypothalamus and the amygdala. The hypothalamus is a nexus for inputs from the rest of the brain, and serves as a regulatory center for many physical processes and systems, including responses to stress. The amygdala sends signals that activate the ANS and cue multiple other hormonal responses, as described above, but it also plays a vital role in mediating two common responses to stress, fear and

Stress Effects

Because stress affects the systems for generating and regulating conscious thought and emotion, people experiencing stress manifest a host of abnormal thoughts or disrupted cognitive processes, feelings, and behaviors that they might not otherwise display. These include:

Cognitive Effects:

- Pessimism, cynicism, or negativity
- Difficulty concentrating or forgetfulness
- Disorganization and difficulty making decisions or an inability to concentrate or focus attention
- Excessive worrying, preoccupation with stressors, or racing thoughts
- Poor judgment
- Repetitive or intrusive negative thoughts or memories
- Reactivation of previous traumatic or negative experiences

Emotional Effects:

- Difficulty relaxing
- Loss of enthusiasm, listlessness
- Increased moodiness, sudden mood swings
- Fragility, feeling vulnerable
- Numbness, detachment, feeling disconnected from others, alienation
- Low self-esteem or worthlessness
- Loneliness, difficulty connecting with others
- Unusual irritability, anger or hostility, low resistance to frustration
- Feeling unstable, emotionally out of control
- Anxiety
- Depression or grief
- Becoming very alert at times, startling easily
- Feeling frightened or anxious

Behavioral Effects:

- Lowered activity level
- Lower work productivity
- Altered eating behaviors- loss of appetite or comfort eating
- Social relationship disturbances
- Isolating yourself from others
- Increased use of alcohol or other substances (self-medication for depression, anxiety, or to release stress)
- Increased risk taking behavior

aggression.⁴¹ The result is that the prefrontal cortex- and the associated conscious, rational thoughts it produces- may be less focused on information directly related to the stressor at hand due to increased background levels of fear or aggression. Cognitive stress effects (in above text box) are why it can be difficult to think rationally when stressed and also why situational awareness decreases under stress.

In terms of emotional responses to eustress or distress, people can experience either greater emotional exhaustion or numbness or greater emotional hyperarousal or overstimulation (for example, becoming depressed, hyperactive, or irritable, etc.). With chronic stress exposure, these emotional effects may be heightened further and become difficult to self-regulate. Arousal of the structures and systems that regulate emotion, cognition, and perception-- and any breakdown or dysregulation of those systems-- results in a wide range of altered cognitive capabilities, emotions, and behaviors. These altered states characterize what people usually refer to as “being stressed.” For a summary table of these well-documented stress effects, see text box above.

There is a key difference between a severe stressor and a trauma. Trauma is any experience or set of experiences that are so emotionally painful and/or distressing as to overwhelm an individual’s capacity to cope. Trauma can include being a witness to or being involved in a life-threatening accident or violent crime, military combat, violent assault, being kidnapped, being involved in a natural disaster, being diagnosed with a life-threatening illness, or experiencing systematic physical or sexual abuse. Trauma has also been found to include exposure to chronic life adversity (discrimination, racism, oppression, and poverty).⁴² An extremely stressful event that becomes traumatic occurs when the experience of the event overwhelms the individual cognitively and/or emotionally. High levels of chronic stress, even in the absence of a recognizable traumatic event, can nonetheless produce psychological consequences similar to those produced by a traumatic event.⁴³ It is often unclear whether an extremely stressful event or series of events was traumatic for someone until some time has passed after the event or events occurred.⁴⁴

SOCIAL INTERPERSONAL FACTORS

The organizational and occupational factors of stress are detailed in the following section “Findings: Occupational Stress.” In general, the presence of strong and supportive social relations functions as an important stress buffer. The more social support people have, through strong and mutually supportive social relations, the less stress is likely to affect them in a negative way.⁴⁵ The effect goes the other way as well: stress responses are triggered and intensified in the presence of social isolation, or when individuals experience difficult, unpleasant, or conflict-ridden social interactions.⁴⁶

Social support seems to positively affect the balance of hormones in the brain.⁴⁷ Adequate amounts of social support are associated with increases in levels of the hormone oxytocin, sometimes referred to as

⁴¹Southwick, S.M., F. Ozbay, D. Charney, and Bruce S. McEwen. “Adaptation to Stress and Psychobiological Mechanisms of Resilience.” In “*Biobehavioral Resilience to Stress*.” Ed. Lukey, Brian J. and Victoria Tepe. Boca Raton: CRC Press. 2008.

⁴²Rich, John, Theodore Corbin, Sandra Bloom, Linda Rich, Solomon Evans, and Ann Wilson. “Healing the Hurt: Trauma-informed Approaches to the Health of Boys and Men of Color.” Philadelphia: Drexel University School of Public Health and Medical School. 2009.

⁴³Ibid.

⁴⁴Ibid.

⁴⁵Institute of Medicine (US) Committee on Health and Behavior: Research, Practice, and Policy. “Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences.” Washington (DC): National Academies Press (US); 2001. 4, Social Risk Factors. Accessed via: <http://www.ncbi.nlm.nih.gov/books/NBK43750/?report=reader>

⁴⁶Ibid.

⁴⁷ Kumsta, Robert, and Markus Heinrichs. “Oxytocin, Stress and Social Behavior: Neurogenetics of the Human Oxytocin System.” *Current Opinions in Neurobiology*, Volume 23, Issue 1, 2012. pp. 11-16.

the “bonding hormone”, which functions to decrease anxiety levels and stimulate the parasympathetic nervous system, calming various stress responses.⁴⁸ Oxytocin also stimulates our desire to seek out social contact and increases our sense of emotional attachment to people we are in relationships with. People who have adequate levels of social support receive an oxytocin boost, which helps them feel less anxious, more confident in their ability to cope, and more drawn to other people, thus further reinforcing the positive cycle of social support as a mitigator of stress effects.

Oxytocin also helps balance out other stress hormones, such as vasopressin, which is associated with fight-or-flight behaviors such as enhanced arousal, focused attention, increased aggressive behavior, and a general increase in sympathetic nervous system activity.⁴⁹ People who are stressed and withdraw from others, rather than seeking out social support, become more affected by vasopressin rather than oxytocin. They may thus end up having difficulty operating within interpersonal relationships with spouses, children, friends, and co-workers, and ultimately end up becoming more isolated, frustrated and stress affected than they would be otherwise.

Many people experiencing stress do not have adequate forms of social support available. They may not have the self-awareness or comfort level necessary to ask for help or support from others. They may feel depressed and start to withdraw from others (a common symptom of depression), further decreasing the amount of social support available. This social support deficit is both a vulnerability factor for stress reactions, and also a synergistic reinforcer, intensifying stress affects caused by other factors.

DIATHESIS – STRESS MODEL

Stressors can come from a variety of environmental conditions and various life situations. As we have discussed previously, responses to stressors are shaped by biopsychosocial factors. An additional model that explains the individual characteristics of a given stress response is the Diathesis-Stress Model (see Figure 6.4 below). This model describes the recognition that one’s mental health at any one time is the result of two types of influences: 1) existing vulnerabilities and strengths within the person (often biological in nature), called “diatheses,” and; 2) environmental “stresses” and supports. This division of diatheses and stresses parallels the concept in the field of psychology that nature and nurture both play a role in determining psychological aspects of our selves.



⁴⁸ Taylor, Shelley E., Gian C. Gonzaga, Laura Cousino Klein, Peifeng Hu, Gail A. Greendale, and Teresa E. Seeman. “Relation of Oxytocin to Psychological Stress Responses and Hypothalamic-Pituitary-Adrenocortical Axis Activity in Older Women.” *Psychosomatic Medicine*, Volume 68, Issue 2, 2006. pp. 238-245.

⁴⁹ Kumsta, Robert, and Markus Heinrichs. “Oxytocin, Stress and Social Behavior: Neurogenetics of the Human Oxytocin System.” *Current Opinions in Neurobiology*, Volume 23, Issue 1, 2012. pp. 11-16. <http://dx.doi.org/10.1016/j.conb.2012.09.004>.

medication or substance use. “Stress” in this model is defined as various environmental factors that help cultivate mental health and protective factors against mental illness, such as a fulfilling and safe work environment, or supportive, meaningful social relationships (eustress). “Stress” in this model could also be external risk factors for mental illness, such as operating in high threat or demanding environments or being affected by tumultuous, disharmonious, or weak social or institutional relationships (distress). The Diathesis-Stress Model explains that our mental health at any given time is the result of interactions between pre-existing and environmental factors. Both diatheses and stressors can be either helpful for or hurtful to mental health, and people may exhibit a combination of both adaptive and maladaptive responses to those stressors.⁵⁰

For example, one particular person could have diatheses of a family history and genetic predisposition to alcoholism, and current stressors such as safety issues in the workplace, unsympathetic managers, and a professional culture of alcohol use after stressful work events. This set of diatheses and stressors combined may result in alcohol abuse in the individual. In the absence of pre-existing vulnerabilities or in the absence of any triggering stressors, this person may not have ever experienced problems with alcohol, but the synergistic coupling of these two factors may have a significant effect on the person’s mental health triggering a particular substance abuse outcome.

DISTRESS AND HEALTH DISORDERS

Not all distress that people experience following a stressful event, chronic stress, or even a traumatic event(s) results in a diagnosable mental illness. Many people who experience traumatic events may be distressed afterwards for weeks, but their distress eventually resolves, often after the person engages in a variety of supportive activities. These activities may include talking with a trusted friend or family member, meditating or praying, engaging in an appropriate rest and recovery period, restorative physical exercise, reflecting on the meaning of the event, taking precautions to try and prevent the extreme stressor or trauma from happening again, or other stress management activities.

Many people, despite distress, report long-term benefits associated with stress exposure, including a greater appreciation of the value of life, a greater sense of closeness with others, stronger confidence in their ability to cope, a stronger spirituality or religious faith, or stronger working or personal relationships.⁵¹ Nonetheless, signs of psychological distress such as feelings of sadness, irritability, crying, numbness, and fatigue are normal responses to stressful events or trauma. When signs such as these and others persist, seeking professional help may become necessary.



Student Mikila Foster is given medical care after 72 hours under the rubble of the University of Port au Prince after being dug out by the Fairfax County Urban Search and Rescue Team, part of USAID, January 15, 2010. Credit: Paul J. Richards, AFP

⁵⁰Zuckerman, Marvin. “Diathesis-stress Models. Vulnerability to Psychopathology: A Biosocial Model.” Washington, DC: American Psychological Association. 1999.

⁵¹Sadock, Benjamin J., Virginia A. Sadock, and Pedro Ruiz. “Kaplan and Sadock’s Synopsis of Psychiatry.” Baltimore: Lippincott, Williams & Wilkins. 2014.

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, describes several trauma and stressor-related disorders, including Acute Stress Disorder (ASD), Posttraumatic Stress Disorder (PTSD), and Adjustment Disorder. These diagnoses are discussed in greater detail below, but it should also be noted that distress of any kind always adds load to the “stress” side of the equation in the Diathesis-Stress Model and thus in some way affects mental health. Chronic exposure to stress can make a person more vulnerable to developing any mental disorder, including mood disorders such as Major Depressive Disorder and Bipolar Disorder, anxiety disorders such as General Anxiety Disorder and Panic Disorder, and substance use and personality disorders.⁵²

ACUTE STRESS DISORDER (ASD)

ASD, like PTSD, develops in response to a traumatic stressor. One may have directly experienced the traumatic event(s), witnessed the event(s), learned that the event(s) occurred to a close family member, friend, or coworker, or experienced repeated or extreme exposure to aversive details of a traumatic event.

People with ASD experience a combination of several symptoms at a minimum of 3 days and for up to 1 month, including intrusive and distressing memories, flashbacks, dreams, or thoughts, inability to experience positive emotions, an inability to remember part of the traumatic event, avoiding memories, thoughts, or feelings of the event, sleep disturbance, irritability, hypervigilance, problems concentrating, and an exaggerated startle response. If ASD continues for longer than 1 month, it is diagnosed as PTSD.

POST-TRAUMATIC STRESS DISORDER (PTSD)

While continuing to experience the effects of the stress (such as feeling hyperalert, watchful, or even numb), people with PTSD have little reserve power to cope with aversive thoughts, emotions or sensations. The affected person may thus feel flooded (too hot) with memories, thoughts, and emotions related to the trauma, with alternating periods of avoiding (too cold) the same memories, thoughts, and emotions. This “Too Hot and Too Cold” phenomenon wrecks havoc in the lives of PTSD sufferers.

The cognitive theory behind why PTSD occurs is that affected persons struggle to process, or rationalize, the trauma that occurred before the onset of the disorder. Other psychological mechanisms that potentially explain PTSD are learned helplessness, kindling, and sensitization. Learned helplessness is the theory that repeated exposure to unavoidable stress produces a learned sense of futility, as opposed to control.⁵³ Kindling is a process by which one stressful or traumatic event makes another stressful or traumatic event more likely.⁵⁴ Sensitization is a learning process in which repeated exposures to a given stimulus results in the progressive amplification of a response.⁵⁵

Finally, a behaviorist theory of understanding PTSD’s set of reactions to trauma is that new learning has happened that fundamentally changes how the person interprets different potential threats. There are two phases to this “learning”:

⁵² Ibid.

⁵³Southwick, Steven M., Ozbay, F., Charney, D., & McEwen, B.S. “Adaptation to Stress and Psychobiological Mechanisms of Resilience.” In *Biobehavioral Resilience to Stress*. Eds. Lukey, B.J. &Tepe, V. Boca Raton: CRC Press. 2008.

⁵⁴Post, Robert M., Susan R.B. Weiss, and Mark A. Smith. “Sensitization and Kindling: Implications for the Evolving Neural Substrates of Post-traumatic Stress Disorder.” In *Neurobiological and Clinical Consequences of Stress: From Normal Adaptation to Post-traumatic Stress Disorder*. Ed. Friedman, Matthew J., Dennis S. Charney, and Ariel Y. Deutch. Philadelphia, PA: Lippincott, Williams and Wilkins Publishers. 1995.

⁵⁵Ibid.

Phase I of PTSD Development:

The traumatic event (an unconditioned stimulus) produces a fear response, and the event and the fear become paired through classical conditioning, a learning process by which an innate response to a powerful stimulus is repeatedly paired with a neutral stimulus.

Phase II of PTSD Development:

Now, any stimuli associated with the original event(s) elicit the same fear response, along with any associated behaviors to protect oneself, even if independent of the original traumatic event and any objectively real threat.

ADJUSTMENT DISORDER (AD)

Adjustment Disorder (AD) is a widely diagnosed disorder, characterized by an emotional response to a stressful event. Often, the stressor may be financial issues, a medical illness, a challenging workplace, or a relationship problem. As previously stated, negative reactions and distressing emotions in response to a stressor are a normal, healthy part of life, so what makes AD a disorder is when it impairs someone's ability to function normally in social, occupational, or other roles. AD is also marked by distress that is out of proportion to the severity or intensity of the stressor, taking into account context, cultural factors, and any bereavement.⁵⁶

SUB-THRESHOLD TRAUMA

Sub-threshold Trauma is a single symptom or constellation of symptoms that does not meet the diagnostic criteria for ASD or PTSD, but nevertheless affect a person cognitively, emotionally or behaviorally. Examples include:

- Difficulty regulating emotional states
- Physiologic instability
- Feeling “off”
- Chaotic interactions with family and other social relationships
- Job related dysfunctions or incompetence

These symptoms might be transient or only arising in a specific context. Maladaptive as it might be, the individual may be vulnerable to substance abuse in an attempt to remedy the symptoms. These symptoms frequently prompt individuals to seek care. They may be initially diagnosed with depression (which frequently is present in trauma survivors), but the traumatic roots and difficulties may be missed. To the extent that trauma is missed as the source and nature of difficulties, treatment may be suboptimal or filled with miscues.

OTHER STRESS-RELATED HEALTH OUTCOMES

Health outcomes associated with pathological responses to stress (ASD, PTSD, AD), as well as stress reactions that may not meet the strict diagnostic criteria for these disorders, can include:

- High blood pressure/hypertension
- High cholesterol due to arterial inflammation
- Abnormal sleep architecture (insomnia or hypersomnia)

⁵⁶American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - 5* (5th Edition). Washington, DC: American Psychiatric Association. 2013.

- Muscle tightness, tension, or pain
- Fatigue or low energy
- Upset stomach
- Chest pain and rapid heartbeat
- Frequent colds or infections
- Sexual dysfunction
- Nervousness and shaking, cold or sweaty hands and feet
- Dry mouth and difficulty swallowing
- Clenched jaw and grinding teeth⁵⁷

Because of the mental health and physical health risks of unmanaged stress, being proactive about stress management and mental health care is vital. More than just reactive, post-emergence treatment of health effects, in this report the authors discuss a multi-tiered approach to preventative care in-depth (see the next section on Occupational Stress).

Finally, it is important to note that it is not always obvious who may have developed stress-related pathology (PTSD, ASD, etc.), or who is struggling to manage their stress. In social and/or professional relationships, the effects of trauma or poorly managed stress may be well-hidden, disguised, or unrecognizable. Hence, understanding the causes and consequences of stress and trauma is crucial. Increasing awareness of stress causes and effects in non-stigmatizing ways inevitably improves one's ability to identify stress effects and mobilize necessary resources to provide support for those affected by allostatic overload and exposure to high levels of stress or trauma.

⁵⁷ Sadock, Benjamin J., Virginia A. Sadock, and Pedro Ruiz. "Kaplan and Sadock's Synopsis of Psychiatry." Baltimore: Lippincott, Williams & Wilkins. 2014.

7. FINDINGS:

OCCUPATIONAL STRESS

Occupational stress results from the interaction between the worker and the conditions of work. Even a cursory review of the causes and consequences of occupation stress, and more particularly within international relief and development, reveals a broad range of research and anecdotal evidence that indicates occupational stress should not be ignored. Through a quick review of models for addressing occupational stress, this section will consider a tripartite model for interventions.

I. CAUSES AND CONSEQUENCES OF OCCUPATIONAL STRESS

There is an extensive body of literature that examines the causes and consequences of occupational stress, stretching back at least to the mid-1960s. The various causes and consequences of stress listed here are extracted from several guides or manuals published by organizations concerned with worker welfare, including the National Institute of Occupational Safety and Health (NIOSH);⁵⁸ the National Institute of Mental Health (NIMH);⁵⁹ the World Health Organization (WHO);⁶⁰ and the American Psychiatric Foundation;^{61,62} as well as from various other documents⁶³ prepared by governmental and non-profit organizations worldwide. For the complete list of these stress guides and manuals reviewed by the assessment team, see the bibliography in Annex I. The same causes and consequences of occupational stress, with minimal variation between documents, recur over and over again, and the reader should consider this list as well-established in the scientific and academic literature.

Causes - Job Conditions That May Lead to Stress:

- Work Volume: Heavy workload, long working days, and infrequent rest breaks.
- Management Structure or Style: Lack of participation by workers in decision-making, poor communication or lack of consultation in the organization, or lack of family-friendly policies.
- Interpersonal Relationships: Poor social environment and lack of support or help from coworkers and supervisors; harassment or bullying; unsupportive, dysfunctional or abusive relations with direct supervisors or senior leaders; excessive politics in the workplace.
- Work Roles: Conflicting or uncertain job expectations, too much responsibility or too many responsibilities, or responsibilities for which workers lack necessary skills or capabilities.
- The Design of Tasks: Hectic and routine tasks that have little inherent meaning, do not utilize workers' skills, or provide little sense of control.
- Career Concerns: Job insecurity and lack of opportunity for growth, advancement, or promotion; rapid changes for which workers are unprepared.

⁵⁸ NIOSH. "Stress at Work. Publication no. 99-101." HHS/CDC: Undated.

⁵⁹ NIMH. "Adult Stress- Frequently Asked Questions." Factsheet available at: http://www.nimh.nih.gov/health/publications/stress/Stress_Factsheet_LN_142898.pdf

⁶⁰ Bryce, Cyraline P. "Insights into the Concept of Stress." Pan American Health Organization/WHO: 2001.

⁶¹ Spangler, Nancy W., Joy Koesten, Michael H. Fox, and Jeff Radel. "Employer Perceptions of Stress and Resilience Intervention." *Journal of Occupational and Environmental Medicine*. Volume 54, Issue 11, November 2012. pp.1421-1429.

⁶² Attridge, Mark. "Employee Work Engagement: Best Practices for Employers." *Research Works*. Volume 1, Issue 2. June 2009.

⁶³ Gallup. (2013). State of the American workplace: Employee engagement insights for U.S. business leaders. Retrieved from <http://www.gallup.com/strategicconsulting/163007/state-americanworkplace.aspx> or The State of American Well-Being: 2013 State, Community and Congressional District analysis, which reports the most recent findings of the Gallup-Healthways Well-Being Index®

- Environmental Conditions: Unpleasant or dangerous physical conditions that may include threats to safety and welfare, crowding, noise or air pollution, or ergonomic problems.

Consequences - In addition to the list of physiological and psychosocial stress effects listed earlier in this document, occupational stress may produce the following results that are of a specific institutional-behavioral character:

- Increased absenteeism.
- Decreased commitment to work, which may include sabotage behaviors (this is a particularly worrying concern given the high-security contexts in which USAID often works).
- Reduced staff retention and increasing staff turnover.
- Impaired job performance and decreased worker productivity.
- Unsafe work practices and accidents.
- Increased complaints from clients, customers, and staff.
- Adverse effects on staff recruitment.
- Damage to the organization's reputation both among workers and external clients/partners.

2. OCCUPATIONAL STRESS AND INTERNATIONAL RELIEF/DEVELOPMENT

Much of the existing body of academic literature that examines medically recognized psychosocial stress effects focuses on PTSD and emerges from studies examining the effects of stress exposure on survivors of severely traumatic experiences, which includes military personnel,⁶⁴ survivors of natural disasters or other life-threatening events,⁶⁵ or survivors of severe adversity in childhood. As a result of the recent wars in Afghanistan and Iraq and the large number of returned veterans now struggling with stress-related disorders, this body of literature is rapidly developing and advancing insights into the causes and effects of traumatic stress exposure. In terms of the literature of occupational stress exposure and associated stress related conditions or disorders, there is a great deal of research that has been conducted on health care workers and emergency responders such as emergency medical technicians, fire fighters, and police officers, which focuses on burnout, depression, anxiety, and other psychosocial stress effects.⁶⁶ There is also a vast body of literature looking at occupational stress among staff of private, commercial firms and government employees that examines how work organization, work culture, work shifts and workload impact the psychosocial health and productivity of employees.⁶⁷ The American Psychiatric Foundation holds a repository of case studies through their program the Partnership for Workplace Mental Health. A searchable database as well as feature stories are housed on their website www.workplacementalhealth.org. Rigorous study of the occupational stress associated with international relief and development is comparatively thin,⁶⁸ although it appears to be an area of increasing academic interest.⁶⁹

⁶⁴ Nash, W. P. *Combat and Operational Stress Control*. Washington, DC: U.S. Navy. 2010.

⁶⁵ MacGregor, Susan. "Burnout: Why do People Suffer, and why do International Relief Workers Suffer more than Domestic Response Workers and First Responders?" 2008. p.2

⁶⁶ Idem.

⁶⁷ This body of literature is too vast to cite here, but a number of excellent practical summaries of this literature exist, produced by both academics and by the CDC/NIOSH, the World Health Organization, as well as various others, and these are cited elsewhere in this document.

⁶⁸ MacGregor: 2008. Idem.

⁶⁹ See, for example, Connorton, Ellen, Melissa J. Perry, David Hemenway, and Matthew Miller. "Humanitarian Relief Workers and Trauma-related Mental Illness." *Epidemiologic Reviews*, Volume 34. 2012. pp. 145–155. See also Shah, Siddharth A., Elizabeth Garland, and Craig Katz. "Secondary Traumatic Stress: Prevalence in Humanitarian Aid Workers in India." *Traumatology*, 13(1), 59. 2007.

For the purposes of the current assessment of USAID, it is worth noting that, in general, practitioners of international relief and development “share the workloads, exposure to traumatic events and often prolonged exposure to stressful situations”⁷⁰ that characterize the stress environments generating negative stress effects among the aforementioned, well-studied populations. Although the comparison is not exact for many reasons, it is reasonable to infer that sources of stress previously identified — and thoroughly validated through academic and clinical research — that apply to these other populations apply also to workers in the fields of international relief and development. Perhaps even more so because, as noted in Connorton, et. al., “Assignment to complex emergencies entails multiple stressors resulting from the work environment and separation from normal sources of psychological and social support.”⁷¹ While for emergency medical personnel and domestic first responders there are clear and often mandatory standards in terms of protections from overlong shifts, requirements for routinized psychosocial care and peer support, and mandatory leave requirements, international relief and development practitioners operate for the most part without these sorts of required protections designed to minimize stress exposure and allow adequate time off for recovery.



Kristin Dadey, an aid worker with the International Organization for Migration (IOM), and Senior Chief Aviation Structural Mechanic Ray Adams, assist an injured Indonesian man medically evacuated from a coastal village on the island of Sumatra, Indonesia, after the Indian Ocean tsunami of December 26, 2004. Photo Credit: U.S. Navy.

There are a number of specific stressors that definitively apply to, or are unique to, international relief and development. Although we have relied heavily upon a few well-cited sources below, it is important to note the sources of stress identified below recur consistently across the literature. Sources of stress that uniquely or particularly affect international relief and development workers may include:

- Heavy workload and long working hours, without sufficient resources available to do the job properly.^{72, 73}
- Inadequate or unskilled leadership, management, or supervision.^{74, 75}

⁷⁰ MacGregor: 2008. Idem.

⁷¹ Connorton: 2012. Idem.

⁷² Augsburg, Rick, William Sage, Lisa McKay, Laurie Pearlman, Jim Guy, Bree Hulme, and Alicia Jones. “NGO Staff Well-being in the Darfur Region of Sudan and Eastern Chad.” Headington Institute: November 2007. Idem.

⁷³ Welton-Mitchell, Courtney E. “UNHCR’S Mental Health and Psychosocial Support for Staff.” UNHCR: July 2013. p. 53.

- Moral dilemmas related to humanitarian work.⁷⁶
- Loss of social networks and relationships; being separated from family and friends.⁷⁷
- Loss of customs and routines; new culture, habits and customs resulting in “culture shock.”⁷⁸
- Witnessing poverty, cruelty, and unfair and unjust treatment of people or animals without being able to intervene.^{79,80}
- Problems with local bureaucracy, politics, or corruption.⁸¹
- Threats, provocations, robbery, blackmail, and unrealistic demands. These may occur directly or indirectly (upon the friends/communities with whom one works).⁸²
- Being a direct target of aggression and concern that traumatic events may recur.⁸³
- Negative emotional and social experiences.⁸⁴
- Short R&R time or difficulties finding the time and place to relax and recover from work-related stress.⁸⁵
- Troubles at home complicated by a lack of ability to respond due to separation and distance.⁸⁶
- Exposure to unfamiliar environmental hazards of various types including pathogens, parasitic illnesses, dangerous road conditions, lack of medical infrastructure, etc.⁸⁷
- Travel stress, frequent uprooting and sleep cycle disturbance.⁸⁸

⁷⁴ Augsburger, Rick, et. al. 2007. Idem.

⁷⁵ Welton-Mitchell, Courtney E. July 2013. p.28.

⁷⁶ Augsburger, Rick, William Sage, Lisa McKay, Laurie Pearlman, Jim Guy, Bree Hulme, and Alicia Jones. “NGO Staff Well-being in the Darfur Region of Sudan and Eastern Chad.” Headington Institute: November 2007. p.19.

⁷⁷ Augsburger, Rick, et. al. 2007. Idem.

⁷⁸ Porter, Benjamin and Ben Emmens. “Approaches to Staff Care in International NGOs.” InterHealth/People in Aid: September 2009. p. 11.

⁷⁹ Idem.

⁸⁰ Pfefferbaum, B. J., Reissman, D. B., Pfefferbaum, R. L., Klomp, R. W., & Gurwitsch, R. H. Building resilience to mass trauma events. In *Handbook of injury and violence prevention*. Springer US. 2001. pp. 347-358.

⁸¹ McFarlane, Colleen A. “Risks Associated with the Psychological Adjustment of Humanitarian Aid Workers.” *The Australasian Journal of Disaster and Trauma Studies*. Volume 2004, Issue 1. ISSN: 1174-4707. Retrieved from: <http://trauma.massey.ac.nz/issues/2004-1/mcfarlane.htm>.

⁸² Idem.

⁸³ Connorton, Ellen, Melissa J. Perry, David Hemenway, and Matthew Miller. “Humanitarian Relief Workers and Trauma-related Mental Illness.” *Epidemiologic Reviews*, Volume 34, 2012. pp. 145–155, p. 145.

⁸⁴ IASC. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Inter-Agency Standing Committee. 2007. p. 68.

⁸⁵ Antares Foundation. “Managing Stress in Humanitarian Aid Workers- Guidelines for Good Practice.” 3rd edition. March, 2012. p. 7.

⁸⁶ Danieli, Yael (ed.) “Sharing the Front Line and the Back Hills: Peacekeepers, Humanitarian Aid Workers and the Media in the Midst of Crisis.” United Nations; Baywood Publishing Co., Amityville, New York: 2002. p. 245

⁸⁷ Porter and Emmens: September 2009. Idem.

⁸⁸ McKay, Lisa. “On the Road Again: Coping with Travel and Re-entry Stress.” Headington Institute: 2007.

3. MODELS FOR OCCUPATIONAL STRESS

There are multiple models for occupational stress that are used in academic literature.^{89,90} These models can be broadly generalized into three categories: the Stimulus-Response Model, the Interaction Model, and the Transactional Model.⁹¹ For the purposes of this assessment, we believe the most applicable model to use to inform analysis of stress causes and consequences, and to inform appropriate and most likely effective interventions to address employee stress at USAID, is the Transactional Model, as the following definitions support.

When stress is conceived primarily as a Stimulus-Response process, the emphasis for causal analysis and stress reduction intervention is on the “characteristics of the environment” that “have the effect of causing strain reactions in the individual exposed to such external...factors.”⁹² This conceptual approach to stress management seeks to reduce the unpleasant or disturbing environmental factors that are seen to be triggering the stress reaction.

When stress is conceived in the Interaction Model, the emphasis for causal analysis and stress reduction intervention is on “an individual’s psychological reactions to stressors.”⁹³ This management approach seeks to bolster the individual’s biopsychosocial resilience profile, or to assist the individual to develop more effective coping skills and behaviors.

The Transactional Model is in many ways a “consolidation of both earlier definitions” and rests on the observation that “stress is an interaction between the individual and sources of demands... the consequences of a structural lack of fit between the needs and demands of the individual and his/her environment.”⁹⁴ Transactional theory integrates awareness of “the appraisals and coping frameworks” that determine “how individuals initially evaluate stressful encounters in terms of potential risk through an initial assessment (i.e. primary appraisal), which then informs the processes that frame an individual’s development of coping strategies (i.e. secondary appraisal) utilized to accommodate, reduce or remove impending stressors...”⁹⁵

The Transactional Model, therefore, allows for nuanced interventions that address both bolstering individual worker characteristics and their stress-response resources, while also seeking to reduce the sources of stress that arise from institutional systems and culture. There is clear evidence that cognitive and perceptual differences between individuals interact with stressors to create differential reactions based upon the perceived relative severity of stressors.⁹⁶ This model accommodates the fact that diverse individuals possess different constitutional, perceptual, or behavioral characteristics that play out in terms of resilience, adaptability, or coping style.⁹⁷ Emphasizing that the primary cause of job stress can

⁸⁹ NIOSH. “Stress at Work. Publication no. 99-101.” HHS/CDC: Undated.

⁹⁰ Spangler, Nancy W., Joy Koesten, Michael H. Fox, and Jeff Radel. “Employer Perceptions of Stress and Resilience Intervention.” *Journal of Occupational and Environmental Medicine*. Volume 54, Issue 11, November 2012. pp.1421-1429.

⁹¹ Idem.

⁹² Idem.

⁹³ Idem.

⁹⁴ Babatunde, Akanji. “Occupational Stress: a Review on Conceptualizations, Causes and Cure.” *Economic Insights-Trends and Challenges*. Volume 65, Issue 3, 2013. pp. 73-80.

⁹⁵ Idem.

⁹⁶ Kendall, Elizabeth, Patricia Murphy, Veronica O’Neill, and Samantha Burnsnall. “Occupational Stress: Factors that Contribute to its Occurrence and Effective Management.” August, 2000. WorkCover Western Australia. pp. 21-30

⁹⁷ Roth, Susan and Lawrence J. Cohen. “Approach, Avoidance, and Coping with Stress.” *American Psychologist*. July 1986. pp. 813-819.

vary between either worker characteristics or working conditions, or additionally, the complex and dynamic interplay between both factors, suggests different ways to address stress. These different strategies are referred to in the literature as Primary, Secondary, and Tertiary Interventions.⁹⁸ Each of these interventions are discussed in greater detail below.

4. TRIPARTITE INTERVENTIONS⁹⁹ TO ADDRESS OCCUPATIONAL STRESS: STRESS REDUCTION, STRESS PREVENTION AND MANAGEMENT, AND STRESS MITIGATION

To directly address the environmental causes and dispositional factors of workplace stress, the framework of Primary, Secondary, and Tertiary Interventions can inform a comprehensive and systematic response.

Primary interventions aim to eradicate or reduce the sources or causes of stress within the organization in order to lessen its negative effects on individuals. These strategies may focus on changing the demands related to tasks and roles (work overload, role ambiguity and conflicts, etc.), improving interpersonal relationships, or improving organizational communication, among others.¹⁰⁰

Secondary interventions focus on addressing consequences of stress for the individual and aim primarily at prevention, seeking to develop or improve personal resilience factors or coping behaviors that help workers adapt better to their work environment, such as developing personal coping mechanisms or self-care practices and reducing personal vulnerability.¹⁰¹

Tertiary intervention aims to address stress effects after they have emerged and reduce the suffering of individuals who have a work-related health problem caused by stress; it aims at treating or mitigating stress effects after they occur.¹⁰² These effects being treated may include physical health problems, behavioral or work-performance problems, or mental health problems. A form tertiary intervention often takes is providing critical incident intervention or Psychological First Aid after a severe stress exposure, or providing access to health treatment or psychosocial counseling after exposure.

If individual characteristics such as personality, job-related skills, and coping style are seen to be most (or solely) important in determining stress effects, then prevention strategies focus on workers and ways to help them develop capabilities to better cope with demanding job conditions.

However, it should be noted here that certain working conditions are stressful to even those people with optimal coping abilities and, under certain circumstances, even these people will succumb to stress effects. This recognition clearly argues for an emphasis on addressing stressful working conditions as

⁹⁸ See, for example, Spangler, Nancy W., Joy Koesten, Michael H. Fox, and Jeff Radel. "Employer Perceptions of Stress and Resilience Intervention." *Journal of Occupational and Environmental Medicine*. Volume 54, Issue 11, November 2012. pp.1421-1429. Numerous other sources describe the same three-tiered intervention model.

⁹⁹ Spangler, Nancy W. "Employer Practices for Addressing Stress and Building Resilience." Arlington, VA: Partnership for Workplace Mental Health. 2013. Available at www.workplacementalhealth.org.

¹⁰⁰ Chair in Occupational Health and Safety Management, Université Laval. "Solving the Problem: Preventing Stress in the Workplace." *Mental Health at Work Series, Booklet 3*. 2005. pp. 3-5

¹⁰¹ Mental Health Commission of Canada. "Psychological Health and Safety: An Action Guide For Employers." January, 2012. pp. 26-30.

¹⁰² Blaug, Ricardo, Amy Kenton, and Rohit Lekhi. "Stress at Work." *The Work Foundation*. February, 2007. pp. 77-79.

well as seeking to optimize the coping ability of personnel. Reducing the work-related causes of stress may entail job redesign, clarification and adjustment of roles and responsibilities, changing management practices or organizational culture, or other changes in institutional structure or function as a primary prevention strategy.

4.A. PRIMARY INTERVENTION: STRESS REDUCTION THROUGH ORGANIZATIONAL DEVELOPMENT OR CHANGE

In order to reduce occupational stress by eliminating stressors, it is often necessary to redesign jobs or make other organizational changes.¹⁰³ Among changes likely to be required are the following measures:

- Ensure that the workload is in line with workers' capabilities and resources. This can be accomplished either through reducing workload, increasing work force, or training staff to better accomplish work objectives.
- Develop necessary capacities among workers based upon actual job requirements, ensuring all employees are capable of meeting job requirements.
- Clearly define workers' roles and responsibilities.
- Give workers opportunities to participate in decisions and actions affecting their jobs.
- Improve internal organizational communication and create transparent decision-making processes.
- Reduce uncertainty about career development and future employment prospects.
- Provide opportunities for positive social interaction among workers.
- Ergonomically address stressful workplace environmental factors.

The development and application of strategies that may result in changes in work methods or development of work skills to reduce excessive demands is a common approach to reducing stress that adversely affects staff and is related to organizational dynamics.¹⁰⁴ These skills-building processes may be delivered through targeted adult learning products, or peer-to-peer learning and/or mentoring provided by more experienced staff. Some examples of learning content that may be useful:

- Development of specific applicable technical work skills, or "tradecraft".
- Training in utilization and application of organizational systems.
- Soft skills and personnel management skills for supervisors.
- Leadership skills development .
- Time management or self-organizational skills development.
- Interpersonal or conflict resolution skills development.

Successful organizational development stress interventions have several things in common:¹⁰⁵

- Significant commitment from top management and buy-in from middle management for stress interventions.
- Adequate resources provided.

¹⁰³ Idem. pp. 79-87.

¹⁰⁴ Babatunde, Akanji. "Occupational Stress: a Review on Conceptualizations, Causes and Cure." *Economic Insights-Trends and Challenges*. Volume 65, Issue 3, 2013. pp. 73-80.

¹⁰⁵ Spangler, Nancy W., Joy Koesten, Michael H. Fox, and Jeff Radel. "Employer Perceptions of Stress and Resilience Intervention." *Journal of Occupational and Environmental Medicine*. Volume 54, Issue 11, November 2012. pp.1421-1429, p.1426.

- Involving workers at all stages of the intervention.
- Providing workers with the authority to develop, implement, and evaluate the intervention.
- An organizational culture that supports and validates stress interventions.
- Periodic evaluations of the stress intervention.

Without these components — in particular, senior management commitment and middle management support — it is not likely that the intervention will succeed.¹⁰⁶

In order to identify issues, develop remedies, and obtain support, the most commonly implemented organizational interventions typically include one or more of the following:¹⁰⁷

- Team-based problem-solving processes.
- Multidisciplinary team building processes.
- Expert assessment and organizational redesign processes.

Team process or worker-participatory methods give workers opportunities to participate in decisions and actions affecting their jobs. Workers receive clear information about their tasks and roles in the organization that reduces conflict, confusion and redundancy. Team-based approaches to redesigning work systems may be successful in improving job satisfaction and reducing occupational stress by reducing job frustration, which may also reduce job turnover and absenteeism, as well as increasing organizational efficiency and effectiveness. Teams can accomplish the following:

- Compress time requirements for completing work (a team can perform activities concurrently that one worker would need to perform sequentially).
- Generate deep insight by integrating multiple perspectives.
- Promote innovation by exchanging and refining a diversity of creative ideas.
- Analyze, integrate, link, and synthesize information in ways that individuals cannot.

4.B. SECONDARY INTERVENTION: STRESS PREVENTION AND MANAGEMENT THROUGH IMPROVED EMPLOYEE RESILIENCE AND COPING

Occupational stress interventions that focus on the worker often seek to improve resilience or coping as a way of preventing stress effects. Worker-focused preventive interventions often consist of providing training or resources that improve individual stress management techniques or develop innovative coping skills, such as the following:¹⁰⁸

- Raising stress awareness, including how to self-identify or self-diagnose stress.
- Training in coping and self-care strategies.
- Progressive relaxation, Biofeedback, or other Mind-Body integration techniques.
- Cognitive-behavioral techniques for adjusting perception or reducing emotional reactivity.

¹⁰⁶ “Psychological health and Safety: An Action Guide for Employers.” Mental Health Commission of Canada. 2012. p. 7.

¹⁰⁷ Multiple sources describe variations of participatory or team-based approaches to addressing the work-related causes of occupational stress. See, for example: Blaug, Ricardo, Amy Kenton, and Rohit Lekhi. “Stress at Work.” The Work Foundation. February, 2007. pp. 79-88; see also, Mental Health Commission of Canada. “Psychological Health and Safety: An Action Guide for Employers.” January, 2012. p. 8; and, NIOSH. “Stress at Work. Publication no. 99-101.” DHHS/CDC: Undated. pp. 16-19.

¹⁰⁸ Chair in Occupational Health and Safety Management, Université Laval. “Solving the Problem: Preventing Stress in the Workplace.” Mental Health at Work Series, Booklet 3, 2005. pp. 6-7.

The goal of these techniques (further developed in section below “Positive Self Care Practices and Paradigms”) is to help the worker reduce the causes of stress that result either from personal attributes or workplace demands, including dealing more effectively with the effects of occupational stress, more skillfully managing inter-personal dynamics in the workplace, or developing specific applicable work-skills that improve effectiveness. Worker focused interventions have been the most common form of stress reduction in U.S. workplaces.¹⁰⁹ Although worker-focused interventions can help workers deal with stress more effectively and organize their work more effectively, in some cases they do not remove the sources of workplace stress that reside outside individual perception or behaviors, and thus may lose effectiveness over time.¹¹⁰

4.B.1. SELF-ASSESSMENT MECHANISMS

Self-assessment is any practice that provides information to individuals to help them gauge how well (or how poorly) they are doing in a stressful environment. In turn, self-assessment influences both self-care decisions and practices and may be used to inform help-seeking behavior.

Self-assessment can occur in three basic ways:

1. Ad hoc: Mentally checking in with oneself and answering the question “How am I doing?” This unstructured approach may be problematic in that it requires people to remember to check in when they may be distracted or overwhelmed by cognitively disruptive or stressful circumstances.
2. Standardized Tool: An instrument designed for a specific condition and/or population. For example, the *Schedule of Recent Experience*¹¹¹ and *How Stressed Are You?*¹¹² are pre-existing tools that can be easily distributed among the USAID population. They are user-friendly, requiring little or no focused training to be used. They could also be easily revised or adjusted to be very USAID-specific.
3. Validated Standardized Tool: A standardized tool with reasonable academic agreement that it truly measures in specific populations what it purports to measure. These are frequently used for clinical or research purposes, although with increased availability through mobile applications for smart phones there is increased availability and utility for wider public use. For example, the *PTSD Checklist (PCL)*,^{113,114} *Maslach Burnout Inventory*,¹¹⁵ *Secondary Traumatic*

¹⁰⁹ Richardson, Katherine M., and Hannah R. Rothstein. Effects of Occupational Stress Management Intervention Programs: A Meta-Analysis. *Journal of Occupational Health Psychology*. Volume 13, Issue 1. February, 2008. pp. 69-93. pp. 70.

¹¹⁰ Ricardo Blaug, Amy Kenyon, and Rohit Lekhi. “Stress at Work.” The Work Foundation. February 2007. p. 72

¹¹¹ Davis, Martha, Elizabeth Robbins Eshelman, and Matthew McKay. “The Relaxation and Stress Reduction Workbook.” New Harbinger Publications. 2008. pp 4-6.

¹¹² Headington Institute. “How Stressed Are You?” Web accessed 3 August, 2015. http://www.headington-institute.org/files/test_how-stressed-are-you_edited_00549.pdf

¹¹³ Bliese, Paul D., Kathleen M. Wright, Amy B. Adler, Oscar Cabrera, Carl A. Castro, and Charles W. Hoge. “Validating the Primary Care Posttraumatic Stress Disorder Screen and the Posttraumatic Stress Disorder Checklist with Soldiers Returning from Combat.” *Journal of Consulting and Clinical Psychology*, 76, 272-281. 2008. doi: 10.1037/0022-006X.76.2.272.

¹¹⁴ Norris, Fran H. and Jessica L. Hamblen. “Standardized Self-report Measures of Civilian Trauma and PTSD.” In J.P. Wilson, T.M. Keane and T. Martin (Eds.), *Assessing Psychological Trauma and PTSD* New York: Guilford Press. 2004. pp. 63-102.

¹¹⁵ Ravalier, Jermaine M., Andrew McVicar, and Carol Munn-Giddings. “Public Service Stress and Burnout over Twelve Months.” *Occupational Medicine*, Volume 64, Issue 7, 2014. pp. 521-523.

Stress Scale,¹¹⁶ *Hamilton Rating Scale for Depression (HAM-D)*, *Beck Anxiety Inventory*, and *Professional Quality of Life Measure (ProQOL)*^{117,118}

A validated standardized tool — dependent on how utilized, ease of use, and if adequately relevant to the population using them — can provide robust data to individuals on the following parameters: severity of stress effect, degree of improvement/degradation in stress effects over time, and which effects are prominent for any given time period. This data can then motivate the user to take specific self-care steps, as well as, if applicable, motivate the user to seek assistance.

4.B.2. POSITIVE SELF CARE PRACTICES AND PARADIGMS

Individuals have varying attitudes towards self-care practices. If self-care is not actively performed, then one's diathesis stress state is simply the sum of prior life experiences and personal reactions. This might be termed a *passive* approach to self-care. Most individuals cannot be said to have a completely passive approach. In fact, the choice of work with the humanitarian ethic and interest in international living that motivates many if not all relief and development workers among the USAID population implies recognition of some existing resilience or protective factors. Everyone does something to relieve stress -- using coping mechanisms of one form or another. Even smoking a cigarette is an active self-care practice to the extent that it relieves stress; however, since cigarettes have several deleterious effects on health, including altering physiological processes that may result in greater resilience, smoking cigarettes would not constitute a *positive* self-care practice.

Positive self-care practices include a vast number of biopsychosocial activities that improve mood, reduce mental tension, engage social support, and improve physical health. In the arenas of humanitarian and federal agency staff care, several categories and examples of positive self-care are as follows:

Category	Examples
Cognitive	Attention Control, Cognitive Reappraisal, Positive Thinking
Physical	Walking, Time in Nature, Weight-lifting, Fitness Classes, Nutrition
Mind-Body	Yoga, Progressive Muscle Relaxation, Tai Chi, Breath Regulation
Contemplative	Mindfulness, Meditation, Prayer, Guided Imagery
Rest	Play, Unstructured Time, Adequate Sleep
Interpersonal ¹¹⁹	Family, Pets, Unit/Team Support, Peer Support

Table 7.1. Positive Self Care Practices

¹¹⁶ Shah, Siddharth A., Elizabeth Garland, and Craig Katz. "Secondary Traumatic Stress: Prevalence in Humanitarian Aid Workers in India." *Traumatology*, 13(1), 59. 2007.

¹¹⁷ Lawson, Gerard, and Jane E. Myers. "Wellness, Professional Quality of Life, and Career-Sustaining Behaviors: What Keeps Us Well?" *Journal of Counseling and Development*, 89(2), 2011. pp 163-171.

¹¹⁸ Potter, Patricia, Teresa L. Deshields, Julia A. Berger, Marty Clarke, Sarah Olsen, and Ling Chen. "Evaluation of a Compassion Fatigue Resiliency Program for Oncology Nurses." In *Oncology Nursing Forum*. Volume 40, No. 2, March 2013. pp. 180-187.

¹¹⁹ Interpersonal practices are "self"-care insofar as they are pursued by an individual who believes that social contact will be supportive and positive. If the contact with others is a result of a program (e.g. peer support program), then it would be considered "programmatic" care.

All of the above have been scientifically validated as stress-reducers and resiliency-builders (bolstering protective factors). Depending on the scientific rigor of any study used to validate the stress relieving effect of any particular practice, some evidence will be deemed by some to be so weak that the practice could seem disreputable, and thus could be discredited by those detractors. On the other hand, the same practice may also be connected to strong scientific evidence that members of the population at large are not aware of.¹²⁰ Much of this perception of credibility likely rests more on the personal disposition, preferences, and belief patterns of the individual than on any objective measure of actual effectiveness. Examples of reputable institutions that have found positive results in mind-body and contemplative practices include: Benson-Henry Institute for Mind Body Medicine, Consortium of Academic Health Centers for Integrative Medicine, National Institutes of Health: National Center for Complementary and Alternative Medicine, Samuels Institute, University of Massachusetts Medical School Center for Mindfulness, and the Waisman Center for Brain Imaging and Behavior.

Ideally, given the dispositional variation that exists within any population as large and diverse as the USAID workforce, a wide spectrum of potential self-care techniques, and associated tools and resources, should be offered, allowing individuals to tailor a self-care strategy to their own unique preferences from among a variety of evidence informed options.

4.B.3. EMPLOYEE ASSISTANCE PROGRAMS (EAPS)

Another alternative approach to secondary stress reduction interventions is to provide Employee Assistance Programs (EAPs), which often provide resources either to minimize the influence of life and family stressors, or provide active stress-relieving services to employees.¹²¹ These may include, for example, making fitness equipment available or providing on-site massage therapy sessions for employees. Additionally, on-site or off-site counseling services may be made available¹²² to allow employees to process stress effects before the manifestation of more severe stress effects. There are a wide range of models of EAPs as well as various studies on their effectiveness.^{123,124} Research indicates the need for better data, to understand more. A free, while copyrighted, tool called the Work Outcomes Suite, can be used to measure employee outcomes along five scales:¹²⁵

1. Work Absenteeism: number of hours absent due to the employee's personal concern(s).
2. Work Presenteeism: decrements to productivity even though the employee is not physically absent but nonetheless is not working at optimum due to unresolved personal problem(s).
3. Work Engagement: extent to which the employee is passionate about his or her job.
4. Workplace Distress: the employee's feelings of distress about being at the work site.
5. Life Satisfaction: the employee's general sense of well-being.

¹²⁰ For a very interesting discussion of the scientific legitimacy of various practices, such as those mentioned in the table above, as effective techniques for stress reduction, see: Gregg D. Jacobs. "The Physiology of Mind-Body Interactions: The Stress Response and the Relaxation Response." *The Journal of Alternative and Complementary Medicine*, Volume 7, Supplement 1, 2001. pp. S-83–S-92.

¹²¹ Babatunde, Akanji. "Occupational Stress: a Review on Conceptualizations, Causes and Cure." *Economic Insights-Trends and Challenges*. Volume 65, Issue 3, 2013. pp. 73-80. p. 78.

¹²² "Psychological Health and Safety: An Action Guide for Employers." Mental Health Commission of Canada. 2012. p. 33.

¹²³ Attridge, Mark, Terry Cahill, Stanford W. Granberry, and Patricia A. Herlihy. "The National Behavioral Consortium Industry Profile of External EAP Vendors." *Journal of Workplace Behavioral Health*, Volume 28, Issue 4, 2013. pp. 251–324. doi: 10.1080/15555240.2013.845050.

¹²⁴ Pompe, John C., David A. Sharar, and Monica Ratcliff. "Caterpillar's Employee Assistance Program: Evaluating the Workplace Effects of EAP Services." *Mental Health Works*. 2015, Q1. Partnership for Workplace Mental Health. Retrieved from http://www.workplacementalhealth.org/mhwq1_2015.

¹²⁵ The measure can be downloaded online at www.eapresearch.com

4.C. TERTIARY INTERVENTIONS: CRISIS RESPONSE, THERAPEUTIC SERVICE DELIVERY OR MEDICAL TREATMENT

Medical or mental health treatment or support may be required by personnel in the event of a significant work-related event — such as a critical incident affecting an individual or the Mission as a whole — or after long-term exposure to high levels of chronic stress. Tertiary interventions provide care after stress has produced medical or psychological conditions or illnesses.¹²⁶ This sort of intervention may take the form of:¹²⁷

- Personal counseling to alleviate anxiety, depression, sub-threshold trauma, TSS, ASD, PTSD, or other stress-related mental health conditions.
- Medical treatment for various stress-related physiological health conditions.
- Psychological First Aid (PFA) through peer debriefing processes or Critical Incident group debriefing session.

¹²⁶ Babatunde, Akanji. "Occupational Stress: a Review on Conceptualizations, Causes and Cure." *Economic Insights-Trends and Challenges*. Volume 65, Issue 3. 2013. Pp. 73-80. p. 78.

¹²⁷ Spangler, Nancy W. "Employer Practices for Addressing Stress and Building Resilience." Arlington, VA: Partnership for Workplace Mental Health. 2013. Available at www.workplacementalhealth.org. pp. 11-14.

8. FINDINGS: USAID INTERVIEWS

One of the most striking observations to emerge from interviews -- an observation further validated by the data that has emerged through the survey -- is how much the sources of stress, as perceived and reported by USAID personnel, align with sources of stress identified throughout the academic and normative literature on occupational stress. The sources of stress reported by USAID personnel related to the overall institutional and organizational factors, while particular to working in the USG,¹²⁸ are true of any/all organizations. Each of the specific stressors that emerged through data collection with USAID personnel is so thoroughly researched and well documented in a wider body of literature on stress in the workplace that they are, for all intents and purposes, beyond question. While these organizational stressors affect all USAID staff, it is important to understand that they synergistically exacerbate the severe and traumatic stress factors faced by staff living and working in difficult operational contexts (e.g. the unique demands that accompany operating in CPCs, NPEs, and HTEs).

A second observation is the striking consistency of reported sources of stress among USAID personnel across USAID Missions and in Washington, and across management levels within the organization. The following recurrent categories emerged, and will be described further below: 1) Workload/Tempo, 2) Management and Leadership, 3) Organizational, Bureaucratic, and Interagency Politics, 4) Human Resources Management and Administrative Support Issues, 5) Family Obligation, 6) Turnover/"Churn", 7) Severe Contextual Factors, and 8) Critical Incidents, Traumatic Stress, and PTSD. There is such consistency of response that the assessment team can reach no conclusion other than that these stressors are indicative of systemic, Agency-wide challenges that, if they are to be successfully addressed, require a coherent, systemic, Agency-wide response.

When disaggregating sub-groups of staff, the relative severity of these various stressors shifts, and certain stressors are of course more impactful on some groups than others. For example, senior managers are more concerned with the weaknesses of inexperienced or junior staff and the management dilemmas this often produces; PSCs are deeply and particularly affected by the failures of the human resources management function and admin support systems to meet their somewhat unique situations and needs, and the stark inequities they frequently encounter in relation to USDH staff; and FSNs are particularly sensitive to issues of poor personnel management skills in USDH supervisors. However, merely providing additional tools and training to enhance resilience of USAID personnel individually, or making some incremental adjustments to the fielding process, is unlikely to significantly alter the stress conditions affecting USAID personnel. As noted by Blaug, Kenyon and Lekhi in the Work Foundation's "Stress at Work":

"Individual worker-focused interventions typically involve techniques such as cognitive reappraisal, relaxation guidance, education about exercise and nutrition, and training in developing coping skills. Such approaches have been shown to result in short term improvements in the levels of stress experienced by employees, but have been criticized for wrongly laying responsibility for preventing and treating stress with the individual, rather than requiring employers and organizations to take action to prevent their workplaces from being stress-provoking environments for their employees. In the long term, if work-related stress is to be

¹²⁸ IOM (Institute of Medicine). Building a resilient workforce: Opportunities for the Department of Homeland Security: Workshop summary. Washington, DC: The National Academies Press. 2012.

controlled, it is not enough to equip individual workers with the techniques with which to deal with potentially stressful situations; it is also necessary to bring about fundamental changes to the organization to try to diminish the stress-inducing aspects of the job, and to address the sources of work stress that are located in the culture and climate of the organization.” (P. 72)

CATEGORIES AND THEMES EMERGING FROM USAID INTERVIEWS

The section includes correlation to the complete survey results (in separate Survey Data Annex to this report), direct quotes from the interviews, general grouping information from the assessment team, and a sample of supportive research for each category that emerged from USAID interviews.

I. Heavy Workload/Tempo

Interview Findings

“Times have changed. The staffing model USAID is using does not reflect the current operational reality.”

Correlated to Survey
Data ANNEX:
Q9, 10, 11

“USAID needs to get the battle rhythm right.”

In every location where interviews were conducted, interviewees identified heavy workload as a significant source of stress, and many people unambiguously asserted this to be the single most important source of stress. Heavy workload was mentioned 30 times in Focus Groups, and 61 times in Key Informant Interviews.

“There is a crushing number of working hours. If necessary, do less- we should do no more than 40-60 hours a week, rather than 10-12 hours a day 7 days a week. This is not healthy and it’s not good- this is abuse. The number of initiatives is too much...just stop it!”

“The main issue is heavy workload and long working hours. 10-14 hours a day, 6-7 days a week, 60+ hours a week. There is limited ability to detach from work, and a shortage of US staff to manage the workload. USAID needs to reduce the workload or properly staff the Mission.”

“USAID tells us they care about work-life balance, but actions don’t support this. Having meetings late in the day, pressuring us to not take home leave, or work while on leave. Bad management is the primary cause of stress.”

“Workload is huge- not 40 or 60 hours a week, but 100 or more...”

“We lack the bandwidth to do it all...”

In addition, the workload issues were often seen to be omnipresent, not just to be a factor when posted to a CPC.

“Every post I have served in has been high-stress. Operational tempo is the issue.”

“It’s not just CPCs...it’s anywhere.”

“There is a pervasive feeling or vibe, of anxiety, due to the high pace of work. Everything’s a crisis or an emergency, and this is chronically destructive, it’s toxic.”

There were numerous explanations given for why this workload exists, primary among them being inadequate staffing levels. This came up 16 times in Key Informant Interviews and 6 times in Group Interviews.

“There is a vast budget inadequately staffed to properly manage. Low staff numbers but a high budget portfolio, because the USG wants to reduce the footprint.”

“Programs don’t get put on hold. When there is a security related evacuation, even though staff are gone, the program goes on. Oversight requirements remain the same, even when staff are displaced.”

10 times tight, arbitrary, or unrealistic deadlines were mentioned, and 9 times people specifically mentioned taskers from Washington.

“Arbitrarily decided internal deadlines are killing us. Everything is urgent all the time.”

“In Afghanistan, I felt safe. It was the workload, the lack of work-life balance, with pressure to respond to DC, with bosses who expect you to work all the time...”

“There is a constant workload coming from Washington, but it’s often much ado about nothing. Pace and volume is the main stressor.”

“There should be appropriate staffing levels, so we don’t have to work on a Saturday. Reduce the taskers coming in on a Thursday night. When everything’s a priority, nothing’s a priority.”

In addition, interviewees discussed arranging visits for high level delegations as significant contributors to heavy workloads and stress 5 times.

Supportive Research – Heavy Workload/Tempo

Heavy workload and extended working hours are identified as a validated source of occupational stress again and again throughout both the academic and the normative literature. As but one example, the CDC/NIOSH document entitled “Overtime and Extended Work Shifts: Recent Findings on Illnesses, Injuries, and Health Behaviors” (HHS/NIOSH Publication no. 2004-143: April 2004), identifies, through a broad meta-analysis of the peer-reviewed academic literature, numerous negative stress effects related to overlong working hours. These effects include increased illness, increased work-related injuries, and impaired cognitive performance. Numerous other manuals on occupational stress exist, produced in other countries, either by governmental or non-governmental standards setting organizations,^{129, 130} and including the ILO and WHO,¹³¹ and these also mention heavy workload as a key source of occupational stress.

When reviewing documents concerned with stress and international relief and development, again, heavy workload and long working hours, coupled with inadequate time off, serving as a cause of occupational stress, occurs again and again. As noted by People in Aid: “Workload is consistently top of the complaints list for those working in our sector. This is often due to decreased staff capacity and

¹²⁹ As but one example, see: Chair in Occupational Health and Safety Management, Université Laval. “Solving the Problem: Preventing Stress in the Workplace.” Mental Health at Work Series, Booklet 3. 2005.

¹³⁰ Another example: Safety Institute of Australia. “Psychosocial Hazards and Occupational Stress: Core Body of Knowledge for the OHS Professional.” 2012.

¹³¹ Leka, Stavroula, Amanda Griffiths and Tom Cox. “Work Organisation and Stress: Systematic Problem Approaches for Employers, Managers, and Trade Union Representatives. Protecting Workers’ Health Series no. 3.” Institute of Work, Health and Organisations, University of Nottingham. World Health Organization. 2003.

increased work.”¹³² As another example, “UNHCR’s Mental Health and Psychosocial Support for Staff” (Welton-Mitchell: July 2013) reports staff survey results for both UNHCR and UNICEF (page 53), with heavy workload being identified as the top stressor in both organizations. In the UNICEF document “Caring for Us: Stress in Our Workplace” (undated), on page 4 the authors note “Long working hours, an intense workload, and the insecurity of employment contracts can undermine even the most dedicated and talented staff.” The ICRC, in their handbook entitled “Stress Management in the Field (Fourth Edition, 2009) notes “heavy workload” as a “commonly reported cause of stress in the field” on page 5. The Antares Guidelines for Managing Stress in Humanitarian Workers also discusses the issue on page 7, and the SPHERE standards identifies “supporting aid workers to manage their workload and minimize stress” on page 72, as a Key Action under Core Standard 6.¹³³ This list could go on and on.

2. Leadership, Management, and Supervision

Interview Findings

“There are no tools for managers to support them in addressing serious performance issues.”

“Work was a high-threat environment.”

“Threats are internal.”

Correlated to Survey
Data ANNEX:
Q9, 10, 11, 59

Leadership and Management issues were mentioned in focus groups 35 times, while the discussion came up 48 times among key informants. A lack of sensitive personnel management skills among supervisors was reported overwhelmingly.

“DC is the same as Kabul. The system is pretty broken. The HR system is dysfunctional, initiatives were not prepared for, and I have not been impressed by most of my supervisors, they are not good managers. USAID and DOS have the worst managers I have ever seen, although I have had some good bosses, too.”

“The biggest stressor is non-supportive or even abusive supervisors.”

“There is a failure of HR and the AEF process to cull out the terrible managers...”

“Lack of gratitude and appreciation among senior managers and irritable managers with aggressive expectations. USAID managers need skills and training in human management.”

“Inexperienced staff lack capabilities in key skill sets of human resources management.”

“USAID needs to prepare personnel to be successful leaders. They need people skills, and a team-based management approach.”

“High pressure and responsibility, but with no experience- that’s what is normal. This Mission is severely understaffed, with junior and inexperienced officers, dealing with challenging, complex, high-volume workloads.”

“USAID commits ‘forced errors.’ Some things can’t be helped, but some things we do to ourselves. Management failures intensify the stress.”

¹³² People in Aid. “The State of HR 2014: A Question of Impact.” 2014. p. 60.

¹³³ The SPHERE Project. “Humanitarian Charter and Minimum Standards in Humanitarian Response.” 2011.

“The idea of leadership is woven through the whole organization. It has a huge effect on morale and a huge effect on your ability to win. The issue of your boss should not be marginalized- leadership makes a huge difference.” (A quote from a SAG member at the second SAG meeting held June 12, 2015).

“Even the death of colleagues was not the worst thing. We are professionals, and we need that [professional] environment. If they want people to stick around, USAID needs to be more professional, and needs to develop personnel management capabilities in their technical work force.”

“Leadership matters. It is the single biggest variable that relates to stress.”

A number of additional themes emerged, including issues related to a large number of new or inexperienced officers who have not yet learned their “tradecraft”, were very ambitious, had unrealistic expectations, and lacked personnel management skills. Senior managers were also seen to be selected based upon technical competence, rather than management skill and experience, especially when it related to personnel management skills. Several people mentioned a lack of qualified staff, lack of role clarity, and lack of support for work-life balance. Many people mentioned the need for leaders to establish boundaries and defend the interests of USAID personnel at the interagency, especially vis-à-vis DOS.

“No-one at USAID will challenge or stand up to the dysfunction [that exists when DOS has control over issues that affect USAID personnel or interests].”

Several mentioned the need to develop stress awareness as critical management skills. And the issue of the need to link stress aware and responsive management practices to an objective system for performance appraisal re-occurred.

“It’s not just skills in leadership and good management- training is not the answer. We need incentives, too.”

“Lack of role clarity is a major issue. Many young, inexperienced officers, coupled with a lack of sufficient leadership and mentorship, is a key source of institutional dysfunction and a source of stress.”

“There is a lack of a culture of performance, of working together and getting the job done. There is little reward for people who do well and perform and no consequences for bad behavior. There are no tools to support managers in addressing serious performance issues. They’re not getting help- so what do we do? The people who really care, leave.”

Stress aware and responsive performance management of supervisors- often explicitly coupled with recognition that the current AEF process does not adequately create accountability for these key management skills- was mentioned separately 11 times in Key Informant Interviews and 7 times in Group Interviews.

Supportive Research – Leadership, Management, and Supervision

Stress aware and responsive performance management of supervisors is an especially noteworthy theme because it aligns with a normative principle for organizational stress management established in the literature. For example, the Antares Guidelines even posits a specific indicator under Principle 3: Preparation and Training:

“[Indicator] 3. Managers are adequately trained and evaluated in stress management skills and capacities. They are able:

- a. to recognize and monitor signs of stress in themselves and in those working under them;
- b. to recognize the signs of stress at the team level;
- c. to promote activities that help reduce stress in individuals, manage conflict in teams, and promote team cohesion;
- d. to arrange support for individual staff as and when required.”¹³⁴

People in Aid identifies a similar need in their Code of Good Practice, under Principle Three, Managing People:

“Good support, management and leadership of our staff is key to our effectiveness. Our staff have a right to expect management which prepares them to do their job so we can, together, achieve our mission. Our management policies, procedures and training equip our managers to prepare and support staff in carrying out their role effectively, to develop their potential and to encourage and recognize good performance.

Indicators:

- 1. Relevant training, support and resources are provided to managers to fulfill their responsibilities. Leadership is a part of this training.
- 2. Staff have clear work objectives and performance standards, know whom they report to and what management support they will receive. A mechanism for reviewing staff performance exists and is clearly understood by all staff.
- 3. In assessing performance, managers will adhere to the organization’s procedures and values.
- 4. All staff are aware of grievance and disciplinary procedures.”¹³⁵

While this People in Aid best practice is not explicitly linked to stress management, it nonetheless produces a stress management result.

The Department of State has also explicitly identified the need for performance management processes and metrics that track leadership performance:

“Even leaders judged by OIG inspectors to be good to excellent could benefit from an assessment or feedback mechanism.

OIG therefore reiterates the importance it places on adopting an effective assessment and performance improvement system for ambassadors, deputy chiefs of mission, and principal officers. OIG continues to believe that a confidential survey of personnel at post is an essential element of such a system. While such a survey cannot yield precise rankings, our experience has shown that it is an excellent diagnostic tool that can reveal serious problems as well as identify strong performances.”¹³⁶

¹³⁴ Antares Foundation. “Managing Stress in Humanitarian Aid Workers- Guidelines for Good Practice.” 3rd edition, March 2012. p. 19.

¹³⁵ People in Aid. “The People in Aid Code of Good Practice in the Management and Support of Aid Personnel: Principles and Indicators.” 2006. p. 4.

¹³⁶ US Department of State, Office of the Inspector General. “Memorandum Report, Improving Leadership at Posts and Bureaus (ISP-I-12-48).” Dated September 19, 2012.; but see also, “Implementation of a Process to Assess and Improve Leadership and Management of Department of State Posts and Bureaus, Report Number ISP-I-IO-68.” Dated June 29, 2010; and, “Special Review of the Accountability Review Board Process, Report Number ISP-I-13-44A.” Dated September 2013.

There are examples of specific performance management mechanisms and metrics that USAID can draw upon to inform the design of such a process. One such toolkit is the suite of Stress Management standards, and associated indicators and instruments, produced by the Health and Safety Executive, the UK counterpart to NIOSH in the United States.¹³⁷

The importance of skilled, capable leadership to stress re-occurs again and again. As another example:

“Managers are both key agents of stress and potentially vital “stress busters”, according to a study by Industrial Society, which suggested that managers’ unrealistic expectations and poor quality of work were important causes of stress. Yet 94% of those questioned said that the help of supportive managers was the most successful means of reducing stress.”¹³⁸

Also, the very first Key Action under Core Standard 6 (Aid Worker Performance), from the SPHERE Handbook, states that international organizations must “Provide managers with adequate leadership training, familiarity with key policies and the resources to manage effectively.”¹³⁹ The People in Aid Code of Good Practice in the Management and Support of Aid Personnel (People in Aid: 2003), in Principle Three: Managing People (pp. 12-13), also notes:

“Although [managers] are often recruited on the basis of competence in a particular discipline, most managers have people management responsibilities. Therefore ensuring they are adequately supported in their role and able to manage effectively is vital. This will usually entail providing them with viable management development and training opportunities... Where appropriate, leadership qualities should be nurtured and developed...”

Finally, on page 20, the Antares Guidelines for Managing Stress in Humanitarian Workers notes:

“Managers are central to the stress management process. First, managers play a key role in supporting stress management efforts by the staff they supervise. They educate staff about stress and train them in stress management techniques; monitor the impact of stress on their staff; are alert to signs that stress may be having a negative effect on individuals or teams; work to resolve frictions in the team; and provide a good role model for those working under them. Research also suggests that middle managers are themselves at especially great risk of suffering the adverse effects of stress. Agencies should provide specific and culturally sensitive training in stress and stress management techniques for project leaders or managers. This should include development of the skills needed to monitor staff stress and help staff manage their own stress, as well as skills in personal stress management for managers themselves.

¹³⁷ See, for example: Health and Safety Executive. “HSE Stress Management Competency Indicator Tool.” 2009. See also: Kerr, Robert, Marie McHugh and Mark McCrory. “HSE Management Standards and Stress-related Work Outcomes.” *Occupational Medicine*, Volume 59, Issue 8, 7 October 2009. pp. 574–579. doi:10.1093/occmed/kqp146.

¹³⁸ People in Aid. Newsletter, “Cut Your Stress Levels with People in Aid.” January 2002.

¹³⁹ The SPHERE Project. “Humanitarian Charter and Minimum Standards in Humanitarian Response.” 2011. p. 71.

In addition, managers who have good managerial skills and provide good leadership reduce the stress experienced by staff from all sources. Conversely, poor management practices add to the stress staff experience. Ensuring that managers have good, culturally appropriate managerial skills helps reduce stress on the staff they supervise. Specific training, mentoring, and peer support can all be used to accomplish this.”

The Department of State Office of Inspector General also recognizes the critical importance of skilled leadership when it comes to managing the stress of personnel, noting that “leadership deficiencies resulted in reduced productivity, low morale, and stress related curtailments.”¹⁴⁰

3. Organizational, Bureaucratic and Interagency Politics

Interview Findings

The concept of “organizational politics” as used by the assessment team to organize emergent themes into a category is admittedly somewhat imprecise. To establish the working definition the team is using, a useful discussion emerges from the organizational behavior researcher Eran Vigoda:

“Studies generally agree that organizational politics refers to the complex mixture of power, influence, and interest-seeking behaviors that dominate individuals’ activity in the workplace. Ferris, Fedor, Chachere, and Pondy (1989a) suggested that organizational politics is a social-influence process in which behavior is strategically designed to maximize short-term or long-term self-interest. As they pointed out, the self-interest may be consistent with or at the expense of others’ interests.”¹⁴¹

For the purposes of this analysis, politics is understood by the researchers to mean: Any behaviors that relate to influencing organizational actions, policies, resource distribution, or getting and keeping power within an intra-

PEPFAR and Stress

An excellent example of the stress challenges presented by ‘initiatives’ is PEPFAR (President’s Emergency Plan for AIDS Relief). PEPFAR was mentioned as a significant source of stress at the Mission Director’s conference, in the survey, and was described in a focus group. PEPFAR was originally an emergency programmatic response, initiated in 2004, for HIV/AIDS prevention, care, and treatment. Since that time, it has been expanded with DOS imposed planning and reporting requirements, and with an operational tempo that has yet to abate. The stressors experienced by USAID officers when managing PEPFAR are a microcosm of other issues described in interviews and captured in the survey. PEPFAR entails inter-agency collaboration, primarily between USAID and CDC, coordinated by DOS. But clear inequities exist between USAID and CDC: staff to budget ratios at CDC are far more optimal; CDC country directors have a seat at Country Team and a direct relationship with the Ambassador, while USAID Health offices are represented more tenuously by the Mission Director. Leadership deficits among senior USAID personnel complicate this dilemma. As one USAID officer put it, “Who has your back? Who’s willing to go to bat at post and in Washington to support USAID officers and USAID process?” Additionally, USAID personnel must comply with Agency policy and regulations in program management, audit requirements, and oversight processes that do not apply to CDC. CDC can directly fund the government and pay, for example, salary top offs that result in political influence over a country approach that USAID cannot match. CDC also does not operate as a development agency, which can lead to problematic approaches and sub-optimal outcomes from a development perspective. All of these together frequently create overly ambitious expectations at the interagency along with great amounts of frustration that ultimately result in a heavy stress burden for USAID officers responsible for managing PEPFAR.

¹⁴⁰ Department of State, Office of the Inspector General. “Memorandum Report, Improving Leadership at Posts and Bureaus (ISP-I-12-48).” Dated September 19, 2012.

¹⁴¹ Vigoda, Eran. “Stress-related Aftermaths to Workplace Politics: the Relationships among Politics, Job Distress, and Aggressive Behavior in Organizations.” *Journal of Organizational Behavior*, Volume 23, Issue 5, August 2002. pp 571–591, p. 572.

or inter-organizational environment. This often takes the form of actual or perceived competition or conflict between self-interested individuals or groups over power or leadership status, and this may take the form of seeking or exerting control over decisions, activities, policies, or resources.

Organizational politics, as defined above, includes tensions between different organizations, such as DOS and USAID (although other actors in the Interagency, such as USDA, DOD, Treasury, and CDC were all mentioned) at post; but also between USAID headquarters and the field, and among operational units within a Mission. It also includes conflicts that create tensions with the values and ethical concerns of relief and development workers, such as when political considerations trump development best practices or work at cross-purposes to values-conditioned development outcomes.

55 people mentioned some issue that constitutes organizational politics in group interviews, while it emerged 54 times in key informant interviews. The primary source of stress was relations between USAID and DOS at post, explicitly occurring 16 times among Key Informants and 13 times in group interviews. There were several key themes that emerged, including resource allocation, specifically approval of staff complements, and assignment of office space and housing allotments, on joint compounds, or when embassy GSO functions are provided to USAID.

Again, the most significant sources of stress reported were not the safety risks related to operating in non-permissive or high-threat environments- contextual factors and dangers related to the unique demands placed upon personnel working in non-permissive and high-threat environments- but were instead the challenges and issues that arise from working within competing priorities, or in “High-political environments,” a descriptive meme that occurred at least 3 times in separate interviews.

“Workload and bureaucracy challenges are the main stressors. Safety issues contribute- but these are present no matter where we are- but they are all more acute in politically intense environments.”

“High political environments are the source of stress. It’s never Pakistan- it’s always the USG. Taskers, irrational security policies and procedures, high-pressure workload.”

One State Department Health Practitioner in the field noted, “USAID personnel are the most stressed population from among the various agencies at post.”

Another significant issue frequently discussed was the security procedures and constraints imposed by Regional Security Officers (RSO) impacting engagement with partners and off-the-compound access to program activities, and safety updates.

Differences in prioritization, or work assigned and program decisions made between USAID/Washington and the field were mentioned 12 times by key Informants and occurred 4 times in group interviews, with Washington based initiatives identified 6 times and short turnaround taskers emerging frequently (it is important to note that many of these themes can also be categorized as workload related). Issues with audits from the various Inspectors General (both USAID/OIG and SIGAR/SIGIR) were also mentioned multiple times.

Supportive Research - Organizational, Bureaucratic, and Interagency Politics

Organizational politics as a source of stress is, once again, a well-researched and documented phenomenon. There are numerous scholarly articles examining the issue from the perspective of organizational psychology or other specialized academic fields.¹⁴² This issue is also of concern to international development and relief workers, and permeates the literature related to stress management in the field of relief and development.

“Elements of the hierarchy, bureaucracy, allocation of resources and also the mission may be responsible for this [stress] effect.”¹⁴³

“The Most stressful events in humanitarian work have to do with the organizational culture, management style, or operational objectives of an NGO or Agency, rather than external security risks or poor environmental factors. Aid workers, basically, have a pretty shrewd idea of what they are getting themselves into when they enter this career, and dirty clothes, gun shots at night and lack of electricity do not surprise them. Inter- and intra-Agency politics, lack of teamwork, and unclear or conflicting organizational objectives, however, combine to create a background of chronic stress and exposure that over time wears people down and can lead to burnout or even physical collapse.”¹⁴⁴



Dan Gedacht (U.S. Embassy Baghdad), Mike Rothe (Provincial Reconstruction Team Diyala), LTC Ricardo Singleton (PRT Diyala), and Greta Holtz (U.S. Embassy Baghdad) in Aruba Market, Muqaddiya, Iraq, December 2009. Mike Rothe served as a consultant with USAID in Baghdad, and also worked for the State Department on the Diyala PRT and for USAID on the Babil PRT. Credit: State Department Photo/Public Domain.

This is a very brief and illustrative list of references that could be far more extensive.

Again, the most significant stressors reported by USAID personnel are related to institutional management and USAID business processes, and bureaucratic politics. This perspective is echoed throughout the literature related to the occupational stress of international development and relief workers. People in Aid provide a pertinent example:

“Humanitarian workers do not have easy jobs, nor are they particularly safe. During the last 15 years intentional violence has become the leading cause of death for humanitarian relief and

¹⁴² See, for example, Goodman, Joseph M., W. Randy Evans, and Charles M. Carson. “Organizational Politics and Stress: Perceived Accountability as a Coping Mechanism.” *The Journal of Business Inquiry*, Vol. 10, Issue 1, 2001. Pp 66-80. See also, for example, Valle, Matthew and L. A. Witt. “The Moderating Effect of Teamwork Perceptions on the Organizational Politics-Job Satisfaction Relationship.” *Journal of Social Psychology*, Vol. 141, issue 3, 2001. pp. 379-388.

¹⁴³ UNHCR. “Managing the Stress of Humanitarian Emergencies.” August 2001.

¹⁴⁴ McKay, Lisa. “Building Resilient Managers in Humanitarian Organizations.” *People in Aid*. January 2011. p. 27.

development workers in complex humanitarian emergency situations, and kidnapping is on the rise. Humanitarian workers already confronted with the realities of poverty, conflict, starvation, and disease must also face the reality that their work is dangerous. Being shot at or bombed; being assaulted, kidnapped or carjacked; being threatened at a checkpoint by a child toting a gun – in many parts of the world these are not infrequent occurrences.

Most of the humanitarian workers I know, however, don't pinpoint this sort of danger as the most stressful aspect of their work. Most humanitarian workers who leave the developed world and head for the developing world expect (on some level, anyway) to run certain risks. Fewer expect to find...organizational challenges related to bureaucracy, management, and communication quite so frustrating and wearisome. Perhaps even fewer expect to have their fundamental ideals and beliefs about meaning and purpose challenged, reshaped, and sometimes shattered during the course of their work.

Some of those who decide to pursue humanitarian work don't make it past two years before burning out – spent, disillusioned, or traumatized. Some people survive for much longer than that, but do it at cost to their closest relationships and while flirting (or worse) with alcoholism or other addictions.”¹⁴⁵

In support of the perception by some that the RSO creates stress by failing to understand USAID operational requirements, the DOS/OIG has also identified performance issues related to the RSO:

“OIG identified seven inspection reports from 2010-2012 that highlighted problematic RSO performance. The reasons behind substandard RSO performance varied, and in some cases RSOs were poorly prepared for their positions. But all seven reports showed that DCMs and principal officers did not understand the responsibilities of RSOs. In addition, lack of familiarity with security programs hampered the ability of OCMs or principal officers to effectively lead and supervise RSOs and to properly evaluate their performance.”¹⁴⁶

The DOS/OIG-mentioned issue above, compounded with the distinctive operational culture of USAID that requires a different tolerance for risk in order to program development assistance effectively, may be mitigated with more tactical dialogue between RSOs and USAID. The goal would be to find middle ground between DOS safety and security priorities and USAID development assistance priorities.

4. Human Resources Management and Administrative Support Issues

Interview Findings

Issues related to inadequate HRM and admin support were mentioned 51 times by Key Informants and emerged 35 times in group discussions. Many of these discussions centered on problems with the assignment and bidding process that emerged 10 times among the two different methods.

**Correlated to Survey
Data ANNEX:
Q33, 34, 35**

“I feel as though I am on my own.”

¹⁴⁵ Lisa McKay. “Building Resilient Managers in Humanitarian Organizations.” People in Aid: January 2011. p. 9.

¹⁴⁶ U.S. Department of State, Office of the Inspector General. “Review of Oversight and Management of Security Programs and Operations (ISP-I-13-02).” Dated October 26, 2012.

“The Agency’s policy towards CPCs and assignment priorities is a recurring source of stress. There is a narrowing of options that is not family friendly.”

“Staffing is not really a priority for the Agency. CPCs or Africa get first pick, the rest get insufficient staff or inexperienced and unqualified staff. We do not get our choices when it comes to staff...”

“The bidding and assignment process is very stressful. It would be nice if people at USAID recognized you put your life on hold to go to a CPC. It would be nice if someone from HCTM would reach out once we’re assigned...from a human perspective, show some support.”

Feeling that posts were not accurately characterized, and that people did not really know what they were getting into with any given assignment, also came up 11 times. This issue as a source of stress is frequently identified in the literature.¹⁴⁷ There was an assumption among many that postings following a high-stress CPC tour would be less stressful and thus allow recovery from CPC-related stress exposure, and also represent a more relaxed tour that would allow reintegration with family.

“How do posts get characterized? Not just for post-diff, but also for the stressful living environment. This should be accurate and realistic...”

“USAID needs to give a realistic presentation of what to expect- the situation, challenges, priorities, expectations. They were not transparent with me- they did whatever they could, by hook and by crook, to get me to post. They need to be honest, and provide accurate information for informed consent.”

Finally, there was a very consistent generalized expression of dissatisfaction with the lack of a customer service orientation at HCTM that was frequently accompanied by expressions of cynicism, frustration, anger, and resentment.

“Don’t send anything to HR- you’ll never get an answer. Their main job is to support FSOs in the field, but Washington fails. I call it “fishing for humans”- HR doesn’t answer phones, and there is a total lack of customer service. These issues trickle down and are compounded in NPEs, like the butterfly effect. HR cares about liability- they don’t really care about you.”

“The Agency does not acknowledge they beat us up and that we are completely on our own. It all has to be employee driven, rather than HCTM doing their employee support function. These experiences affect loyalty and performance.”

“The HR system has not a clue about life in the field...”

“If HR were run well, this would be a massive bump to morale and a reducer of stress...”

Supportive Research - Human Resources Management and Administrative Support Issues

Given the degree of disconnect from HQ that on-the-go and on-the-road international workers are likely to experience, variations in Human Resources Management support are felt acutely. As one USAID interviewee put it:

*“The day to day bull***t is the most significant source of stress, things like payroll and basic admin issues...”*

¹⁴⁷ For example, the Antares Guidelines for Managing Stress explicitly discusses the need for adequate briefing (on page 17, Principle 2: Screening and Assessing, Indicator 2.b.) “The awareness of the staff member about the possible risks of their potential assignment with respect to their emotional and physical wellbeing, and with respect to the kinds and levels of support the agency is able to provide.”

This is due to the fact that, when being exposed to all the other stressors that characterize international development work, lack of effective or supportive administrative systems synergizes in a way that intensifies all the rest. When being fielded into difficult, demanding or harsh operational environments, when removed from family and other social support systems, when dealing with the dislocation and culture shock of operating in foreign settings alongside being exposed to danger and working long and intense hours; when also then having to deal with delays in payroll processing or arrival of personal effects, or any one of a thousand other minor administrative frustrations, it can seem unendurable. As one example of the recognition of the importance of HRM to international relief and development, the UK-based human resources management support organization People in Aid, which focuses on providing technical guidance and support to the international NGO sector, has extensive publications which specifically aim to improve and professionalize the HR workforce for humanitarian organizations, and to objectively establish key indicators and process templates to ensure quality standards of HR are consistently met. People in Aid, in partnership with Cranfield University, have also produced a document specifically addressing this issue entitled, “The Importance of HR Management in Supporting Staff Working in Hazardous Environments.”¹⁴⁸ As another example, the SPHERE standards, which “define the minimum level of response to be attained by humanitarian agencies”, explicitly note the importance of HR, management, and admin support in order to ensure effective delivery of assistance.¹⁴⁹

5. Family Obligation

Interview Findings

Issues related to the stress of family obligations were mentioned 6 times in group interviews and 29 times by key informants. In addition to the unavoidable stressors that occur simply as a result of separation, and due to the challenges associated with managing family issues remotely, a consistent theme emerged related to the perception that USAID fails to fully appreciate the costs of an unaccompanied posting that are borne by spouses and children, and the need for USAID to provide support to families as well as USAID personnel.

Correlated to Survey
Data ANNEX:
Q12, 66, 67

“USAID needs to demonstrate a sense of loyalty, of care and concern, for USAID personnel- and their families. Where is the safety net?”

“A big part of the stress was worrying if something happened to me, would my wife and children be taken care of?”

“USAID needs to take seriously the effects of separation on families and spouses.”

“People get ‘crispy’ after being here too long. This leads to damaged relationships.”

“Make sure kids understand what’s happening, why USAID has to take their parents away.”

“USAID always pressures people to accommodate an urgent timeline, with no allowance for R&R with family, even when there is accumulated leave to take. There is a lack of valuing a work-life balance. On leave, he is never really available. He’s wiped out and then always on his blackberry. There is no real

¹⁴⁸ Williamson, Christine and Dr. Roger Darby. “The Importance of HR Management in Supporting Staff Working in Hazardous Environments.” People in Aid: 2011.

¹⁴⁹ Specifically, see Core Standard 6, in “Humanitarian Charter and Minimum Standards in Humanitarian Response.” The SPHERE Project: 2011. pp. 71-73.

system for spouse and family support, except through the CLO. The last seven years have been continuous high stress.”

“My wife had the harder job, raising three kids with no support. Spouses and partners can no doubt describe a spillover effect...”

Supportive Research – Family Obligation

This category and the following category of Severe Contextual Factors of reported stressors are also consistent throughout the literature on stress among international relief and development workers and are intuitive enough they do not need to be cited. Separation from family and other social support,¹⁵⁰ plus exposure to hazardous and dangerous working environments as sources of stress, are going to contribute to allostatic load, and very often cause synergistic problems.¹⁵¹

6. High Turnover/“Churn”

Interview Findings

High turnover as a source of stress was mentioned 13 times among both group and individual interviewees. Lack of continuity, lack of institutional memory, high turnover related to curtailments, and poorly designed programs due to inadequate familiarity with local development context were all seen to contribute to the presence of this stressor.

“Legal and fiduciary oversight is a big stressor. Skeletons from previous personnel on a 1 year tour come back to haunt you.” To which another interviewee replied, “Except they’re not just skeletons- they’re zombies.”

“With short tours, it’s a problem because we want to see impact, but we can’t take a project to fruition. People pay a heavy price with no visible outcome.”

Supportive Research – High Turnover and “Churn”

Again, this is a phenomenon that has been researched and documented within the larger field of international relief and development.¹⁵²

Short-term postings and churn is also recognized in the literature as a source of stress.¹⁵³ This primarily is a result of the effect high turnover has on institutional effectiveness¹⁵⁴ and the frustration that occurs when highly motivated, values-driven professionals are confronted with programs that do not perform as intended, either in terms of achieving outcomes and objectives, or in terms of meeting applicable accountability requirements.

¹⁵⁰ Lovell-Hawker, Debbie. “Debriefing Aid Workers: A Comprehensive Manual.” People in Aid. 2004. pp. 35.

¹⁵¹ As but one example, see: Lopes Cardozo, Barbara, Carol Gotway Crawford, Cynthia Eriksson, Julia Zhu, Miriam Sabin, et al. “Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study.” PLoS ONE, Volume 7, Issue 9, 2012. e44948. doi:10.1371/journal.pone.0044948

¹⁵² For a very interesting discussion of the institutional management and stress related causes and programmatic consequences of high turnover in the field, see: Loquercio, David, Mark Hammersley and Ben Emmons. “Understanding and Addressing Staff Turnover in Humanitarian Agencies. Network Paper Number 55.” Overseas Development Institute/Humanitarian Practice Network. June 2006.

¹⁵³ Idem.

¹⁵⁴ For an interesting discussion on how staffing churn affects organizational effectiveness, see: Breslin, Scott. “Shooting Ourselves in the Foot: A Look at the Humanitarian Sector’s Self-inflicted Wounds.” 10 February 2015. Downloaded from: <http://www.peopleinaid.org/pool/files/pubs/ScottBreslin-Self-inflicted-Dilemmas.pdf>.

7. Severe Contextual Factors

Interview Findings

“USAID should recognize and identify regions and countries that are difficult and allow greater flexibility, a sort of ‘notwithstanding authority’ for certain Missions, where we can expedite program design, respond rapidly to changing conditions, use more flexible M&E...”

Correlated to Survey
Data ANNEX:
Q6, 7, 8, 13, 15, 16,
27, 28, 60

Twenty-one individual mentions of quality of life issues occurred, and the unique difficulties associated with “fishbowl living”, as one interviewee termed it.

“Bad working conditions: crowded offices, tiny cubicles, no windows, lousy bathrooms. It is dusty, noisy, crowded, dirty. It’s a construction zone with no green spaces...”

Challenges around the unique requirements for operating in CPCs, NPES, and HTEs were discussed 12 times in group interviews and 42 times among key informants. This included discussion of the perception of danger and threats to personal safety, mentioned 14 times overall, but also frequently mentioned were overly restrictive security requirements imposed by the RSO (discussed also above, under Organizational, Bureaucratic, and Interagency Politics). One interviewee used the phrase “nervous in the service” to describe DOS risk aversion related to security threats and how this prevented USAID from operating in a way that would lead to programmatic success. Several people mentioned the need for greater flexibility in terms of program design, implementation and M&E requirements, with a number explicitly identifying the flexibilities OTI operates under as a model for USAID programs in unstable and dynamic stabilization contexts.

Finally, many interviewees discussed the various meaning-related stressors that can challenge the ethics and values that typically drive professionals working in the relief and development sector. This issue has been identified consistently in the literature, most notably on how burnout affects international relief and development workers.¹⁵⁵

“There is a loss of meaning for me, when a project you’ve really invested yourself in gets cancelled due to contextual factors...”

8. Critical Incidents,* Traumatic Stress, and PTSD

Interview Findings

“You’ve got incoming rockets that were happening at least a few times a week and some getting rather close. We had one that went off around 0630, I’d say about 100 feet for so outside my bedroom window, and it blew gravel into the room. I remember getting back to the cafeteria in the evening and sat down with the senior civilian, and he was shaking

¹⁵⁵ See, for example, McKay, Lisa. “Resilience- Building Resilient Managers in Humanitarian Organizations: Strengthening Key Organizational Structures and Personal Skills that Promote Resilience in Challenging Environments.” People in Aid. January 2011; see also, MacGregor, Susan. “Burnout: Why do People Suffer, and why do International Relief Workers Suffer more than Domestic Response Workers and First Responders?” April 1, 2008. Web download: <http://www.peopleinaid.org/pool/files/pubs/burnout,-susan-macgregor-april-2008.pdf>; and, Pearlman, Laurie. “What to do about Burnout: Identifying your Sources.” Headington Institute: dated November 13, 2012. Webpage: <http://www.headington-institute.org/blog-home/206/what-to-do-about-burnout-identifying-your-sources-part-1>

* Defined on next page immediately following interview findings.

like a leaf. He exhibited obviously just a tremendous shaking. He could hardly control himself.”

“I remember for several weeks after that waking up with what I thought was an explosion. I would then be wide-awake.”

“I was just leaving Kunar going down to Jalalabad. We were caught in a complex attack again. This time there apparently were RPG’s and AK-47’s. I’m kind of surprised looking back that [the military] actually took those missions anyways when so many times, like almost every time we were told we were going to get hit... we got hit. ...[I was] always thankful and glad when I could get back to my room and take off my body armor and say, ‘I survived another day.’

Critical incident: an event or series of events that: 1.) seriously threatens the welfare of personnel with massive injury, violation of bodily/psychological integrity, or death; and, 2.) is so stressful to an individual as to cause an immediate or delayed emotional or psychological reaction that surpasses available coping mechanisms.

Figure 8.1. Critical Incident definition

It is impossible to know exactly how representative the survey sample is of the entire USAID community in terms of exposure to traumatic stressors or critical incidents. Many people who suffer from traumatic stress reactions do not necessarily recognize the various symptoms as being evidence of traumatic stress, and so have not received a formal diagnosis, nor are they seeking treatment. Also, given the stigma associated with needing or seeking treatment for psychiatric disorders that is widespread among USAID personnel, many people with traumatic stress reactions are treating their diagnosis discreetly- or not at all- and are unwilling to openly discuss it when asked. Nonetheless, during the course of this research, a number of interesting data points emerged that bear emphasis:

1. It is clearly the case that numerous USAID personnel have been exposed to critical incidents as defined above, as the assessment team heard many personal stories to this effect, and survey results corroborated a variety of critical incidents (see Heat Map in Table 9.1);
2. It is also clearly the case that many if not all USAID personnel are currently exposed to extremely high levels of chronic stress that would, in combination with exposure to a critical incident, in any given population the size of USAID, result in a certain number of individuals with diagnosable traumatic stress reactions. A smaller proportion of these would likely develop traumatic stress disorders;
3. Numerous people interviewed by the team manifested signs of acute or traumatic stress reactions but did not disclose having received treatment or formal diagnosis of specific stress-related disorders. In the opinion of the authors- one of whom is a medical practitioner with expertise in traumatic stress- it is likely many of these people are suffering from undiagnosed acute stress reactions, and it is likely that at least some of these are experiencing diagnosable stress disorders including traumatic stress disorders;
4. A number of courageous people wanted to tell their story to the team. These interviewees felt strongly enough about the stress exposure they had received through the course of performing their official duties, along with a perceived generally inadequate response from USAID, that they wanted to speak out. Out of 171 randomly assigned people interviewed during the course of

this assessment, 8 people (almost 5%) specifically mentioned that they had received diagnosis and treatment for the symptoms of PTSD. This number is almost certainly under-representative due to the aforementioned lack of awareness of stress reactions many people may be experiencing, and the stigma associated with needing or seeking psychiatric care leading to unwillingness to reveal diagnosis and treatment.

There are several definitions of what constitutes a ‘critical incident’ that were found in the literature.

1. “A critical incident is any incident so unusually stressful to an individual as to cause an immediate or delayed emotional reaction that surpasses available coping mechanisms. Critical incidents take many forms, including all emergencies that cause personnel to experience unusually strong reactions.” (USAID/OFDA Field Operations Guide, version 4; page I-13)
2. “A critical incident is any security incident severe enough that it leads to a situation with potential to cause significant disruption to operations or even discontinue them.”¹⁵⁶
3. “A critical incident (CI) is an event or series of events that seriously threatens the welfare of personnel, potentially resulting in death, life-threatening injury or illness. Most critical incidents—although they may have potentially severe impacts on individual staff and programs—do not have wider implications for the organization as a whole and are thus managed by regular management structures, with additional support from headquarters if required.”¹⁵⁷

From the authors’ perspective, the first definition (the only definition the researchers could find that is in use by USAID), while succinctly capturing the stress-related psychosocial impacts such incidents often have, fails to fully validate the threats (as opposed to risks) that USAID personnel currently must accommodate in many of the places USAID works. The second definition, while certainly valid from a security management perspective, fails to adequately capture the stress-related psychosocial consequences of a critical incident. The third definition, while recognizing that critical incidents concern *people*- not only institutions and program operations- nonetheless fails to adequately represent how people might be *affected* by such an incident.

For the above reasons, we have developed our own working definition of a critical incident (earlier, in Figure 8.1.) that we feel addresses all dimensions necessary to understand the term in the context of this study.



The Ebola victim burial site at Disco Hill Cemetery in Morgibi County, Liberia, is supported by USAID and operated by Global Communities, with trained burial and disinfection teams made up of local community members. Since the Ebola epidemic began, USAID has helped support nearly 200 burial teams. Credit: Neil Brandvold, USAID

¹⁵⁶ International Federation of Red Cross and Red Crescent Societies (IFRC). “Stay Safe: the International Federation’s Guide for Security Managers.” 2007. p. 56.

¹⁵⁷ European Interagency Security Forum (EISF). “Crisis Management of Critical Incidents.” 2010. p. 4.

Vicarious trauma: In certain circumstances, such as the consequences of civil unrest and armed conflict or natural disasters, the illness, injury, or death in question may not be directly occurring to personnel, but may nonetheless cause secondary or vicarious stress reactions among affected personnel. Vicarious trauma and secondary traumatic stress refer to the frequently observed, and scientifically described, phenomena that individuals can be negatively affected by the trauma of others. Symptoms of vicarious trauma and secondary traumatic stress can mirror the symptoms of primary, or direct, trauma (e.g. numbing, irritability, intrusive memories). Furthermore, the constellation of symptoms in vicarious trauma and secondary traumatic stress can masquerade as burnout; however, one may find that interventions for burnout do not adequately resolve the condition. It is for this reason that special expertise may be warranted to discern the true factors and manifestations of occupational stress.

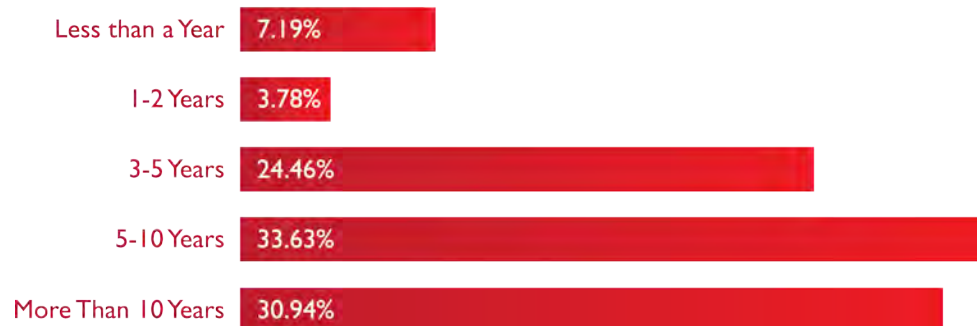
It is important to note that in many emergency or crisis situations that USAID responds to, “unusual” circumstances (for example, large numbers of fatalities; large numbers of displaced persons; widespread or violent protests and civil disturbances; or large-scale acts of violence, human rights abuse, and atrocities, etc.) are in fact frequent, widespread, or of long duration. This makes them hardly “unusual” in terms of the exposure to such events that any given USAID officer is likely to receive; they are unusual only in that they fall outside the range of normal human experience that someone brings when hired by USAID.

9. FINDINGS:

USAID SURVEY RESULTS

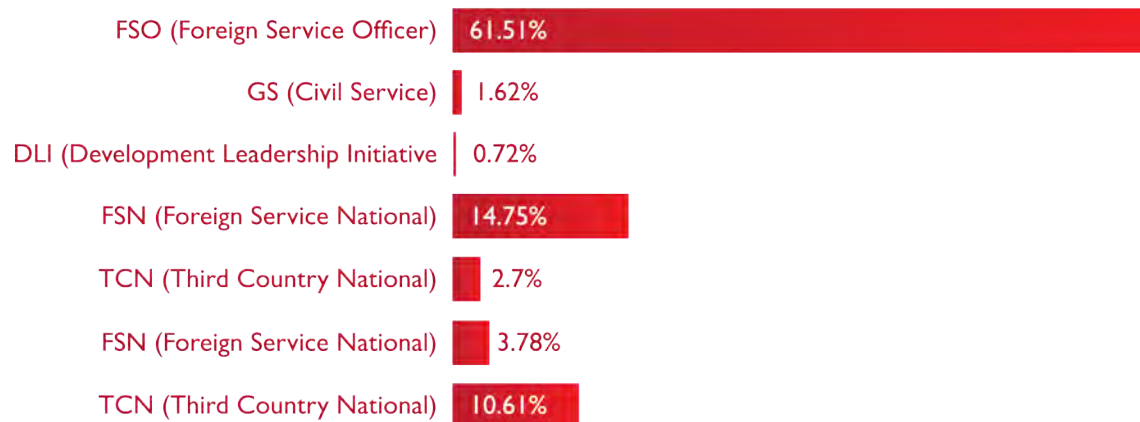
The full complement of Survey Results is available in a separate annex. As mentioned in the methodology section the assessment team delivered a Staff Care Needs and Stress Exposure survey to serving USAID Foreign Service Officers (FSOs), as well as many who were either Personal Services Contractors (PSCs) or who had separated from the Agency prior to the time the survey was delivered. This section discusses and provides analysis of key findings.

Years Employed by USAID



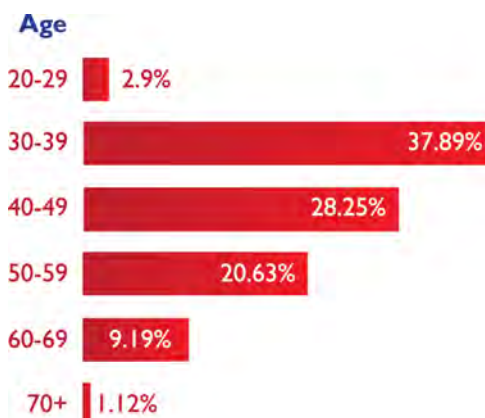
556 people responded to the survey. Of those 556, most have been employed by USAID for over 5 years - 33.6% have been employed 5-10 years and 30.9% have been employed by USAID for over 10 years. 11 were no longer employed by USAID (2.0%). 61.5% of respondents self-identified as Foreign Service Officers currently employed by USAID. A table describing the current designations of survey respondents is below.

Current Designation with USAID



RESPONDENT DEMOGRAPHICS

Just over half of respondents were male (227, or 50.9%), and respondents' ages were widely distributed. The majority of respondents were married or in a civil union (66.8%), while 20.4% identified as single, and another 7% identified as not married but in a committed relationship. 1 in 2 respondents had children (54.9%), and 1 in 2 also endorsed having family members that were dependent on them for care during a deployment (54.3%).



RESPONDENT DEPLOYMENT EXPERIENCE

The vast majority of survey respondents (76.4%) have been assigned in a location designated as either a critical priority country (CPC), a non-permissive environment (NPE), or a high-threat environment (HTE). The 556 respondents have been assigned to a cumulative 1,432 posts in 89 different countries, including the United States, seen below in Figure 9.1. Survey respondents have been deployed 2.58 times for 20.52 months, on average.



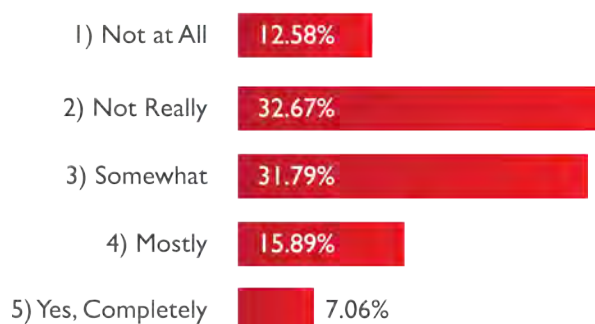
Figure 9.1. Respondent Deployment Distribution

RESPONDENT PERCEPTION OF STAFF CARE

In addition to creating an inventory of USAID's services related to staff care (for this description of services, see the section entitled USAID Policies and Practices), the evaluation team also assessed the perceptions of USAID staff regarding these services in terms of access, adequacy, and quality.

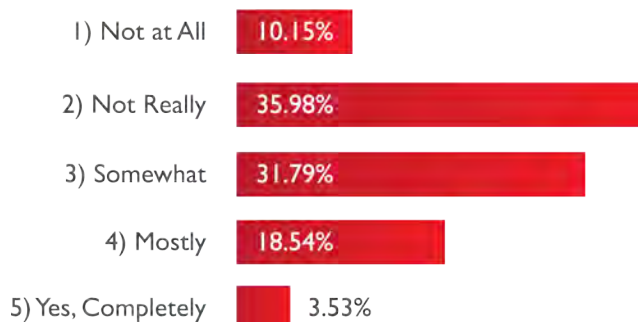
Regarding perceptions of **accessibility**, 12.6% attested that programs to support staff have been “not at all” accessible. Another 32.7% of respondents attested that programs were “not really” accessible, and another 31.8% attested the programs were “somewhat” accessible. 15.9% stated they were “mostly” accessible, and only 7.1% stated they were “completely” accessible. See chart below.

Accessibility



Regarding perceptions of the **adequacy** of programs, 10.2% attested that programs to support staff were “not at all” adequate. Another 36.0% of respondents attested that programs were “not really” adequate, and another 31.8% attested the programs were “somewhat” adequate. 18.5% stated they were “mostly” adequate, and a paucity of respondents, only 3.5%, stated services were “completely” adequate.

Adequacy



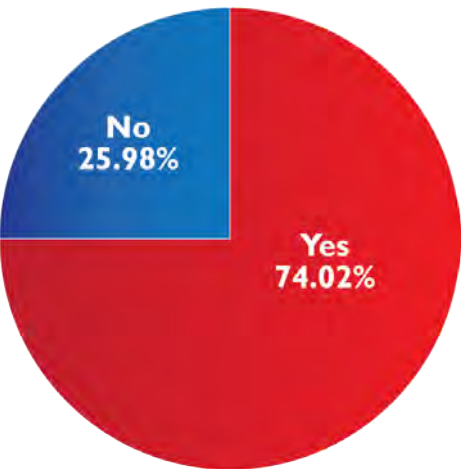
While the overwhelming majority of respondents were aware that they had access to the USAID StaffCare Center support on demand in DC or remotely by hotline or VTC (72.6%), only 27.8% of respondents had ever accessed any USAID StaffCare Center support.

The data shows close to half (45.3%) of USAID personnel respondents found service to be unavailable and did not utilize the services. Although according to StaffCare the suite of support services are available 24/7, these services are only available to field personnel via the StaffCare website or telephone. This likely creates a perceptual disconnect that renders them inaccessible, and also degrades their perceived quality and adequacy. As one survey respondent stated, “I would have preferred to speak to someone in person instead of over the phone, and I wasn't comfortable going to a local professional about my issue. I felt the cultural differences would impede the level of trust I needed.”

RESPONDENT UTILIZATION OF STAFFCARE

In contrast, 57.5% reported that information about support was easily available, and 48.8% said that support itself was easily available. Overall, out of 127 people who answered this question, respondents found the StaffCare Center support they accessed “inviting” (56.7%) and “excellent, helpful throughout” (26.0%). A few found the StaffCare Center “initially awkward, but ultimately engaging” (15.0%).

Correlated to Survey Data ANNEX:
Q34, 36, 37, 38, 39, 40, 41

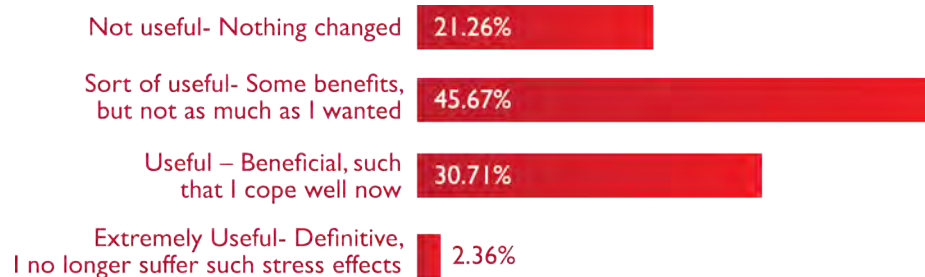


Q37: Did you find the StaffCare Center support to be helpful?

Q40: Overall, what was the nature of the StaffCare Center support you were able to access? (check all that apply)



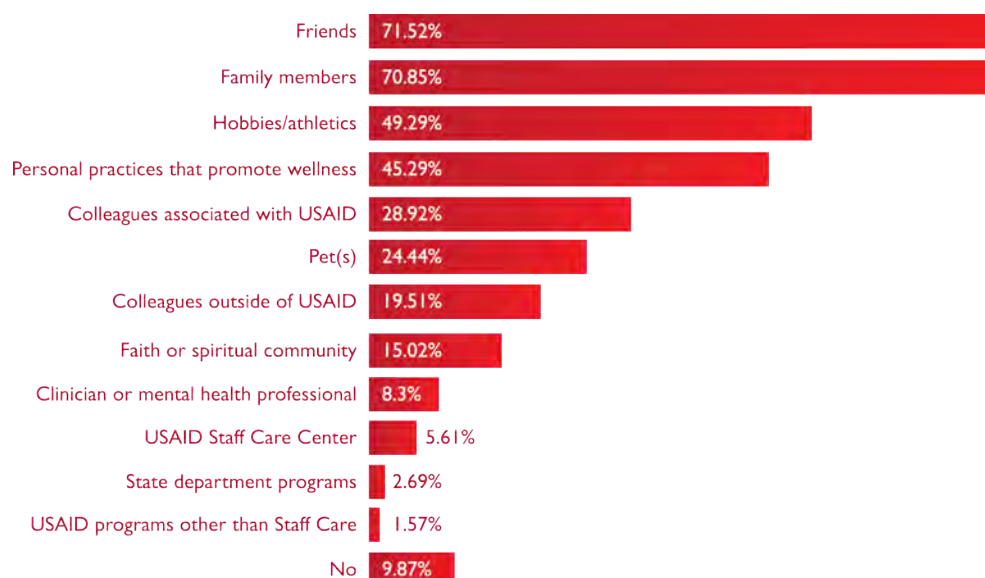
Q41: How useful was the StaffCare Center support to you in coping with stress and reducing the effects of stress in your life?



RESPONDENT RESOURCES FOR WELLNESS

USAID staff receives support and gains wellness from many different sources. Most stated they are supported by friends (71.5%) and family members (70.9%). Many others identified supports outside of USAID, such as hobbies or athletics (49.6%), other personal practices that promote wellness (45.3%), pets (24.4%), colleagues outside of USAID (19.5%), and faith or spiritual community (15.0%). Some are currently accessing support associated with USAID, **including engaging with USAID colleagues (28.9%), USAID StaffCare Center (5.6%), State Department programs (2.7%), and USAID programs other than StaffCare (1.6%). Nearly 1 out of 10 are receiving support from a clinician or mental health professional outside of USAID (8.3%).**

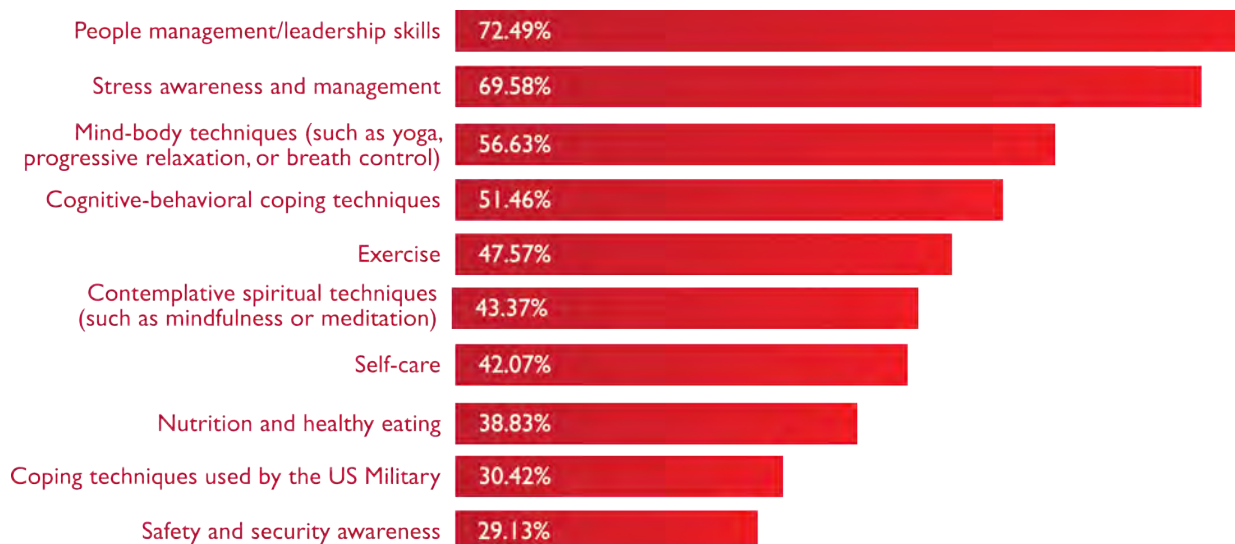
Q58: Do you presently gain wellness or receive support from the following sources? (check all that apply)



RESPONDENT TRAINING/RESOURCES INTEREST

67.5% of survey respondents believe they could have personally benefited from further training or coaching in stress management or psychological wellness techniques. Out of the 309 respondents that answered this question, most listed several trainings they would like to have had. For a breakdown of percentages requesting these additional training content areas, see Q21 below.

Q21: What topics for training or coaching would you be interested in receiving? (check all that apply)



In line with the significant finding that leadership and personnel management skills are key conditioning variables that either mitigate or constitute sources of stress, the most requested training content area was “people management and leadership skills.”

Respondents offered many suggestions for psychosocial support they would like to have accessed but that was not available during deployment. Recommendations that appeared several times included, “more counseling,” “marriage counseling,” “psychosocial professionals as part of the med units,” “exercise programs,” and “social workers.”

Correlated to Survey
Data ANNEX:
Q55, 56

Over half of all respondents (57.7%, n = 267) stated that they received no training in psychological wellness or stress management. Another 25.7% of respondents characterized the training they did receive as not useful. Among the various open-ended responses received, respondents stated that training, “was absolutely useless, too general, not focused,” “meaningless,” “did not focus on how to deal with internalized USAID institutional stressors,” “only one day,” and “made me angry.” Of the 16.6% that identified the training as useful, one noted that “it served as a reminder of services available,” and another observed, “they tried to give us tools for coping.”

RESPONDENT COPING SKILLS AND METHODS

The majority of respondents (69.7%) identified feeling personally able to cope with the stressors they encountered in their work with USAID (55.7% - “Reasonably well,” 14.0% - “Perfectly well”). Of those who coped well (n = 319), the vast majority attributed their successful coping to family and friends (73.7%). These respondents also endorsed **team cohesion and support** (41.4%), active coping work on their part (40.4%), and personal faith or spirituality (27.0%) as contributing to their successful coping. Less than 10% endorsed pre-deployment training or post-deployment and HQ accessibility to resources as being helpful.

Of those who struggled to cope (30.4% marking “Somewhat,” “Not very well,” or “Terribly,” n = 139), **over half attributed their difficulty to managers and leaders that did not support their needs** (65.5%) and deficits in HR processes (54.0%). Other impediments to coping that over 1 in 3 respondents identified were surprise stressors at post they did not expect (38.8%), unsupportive or non-cohesive teams (34.5%), and stress unrelated to work (33.1%).

During deployment, USAID staff utilized a variety of psychosocial support services, but many accessed no psychosocial support during deployment (36.2%). **Only 43.9% of respondents stated that they had been provided with the name(s) and contact information for someone to speak to for psychosocial support.** 33% said they were not provided with such basic information. Some did access USAID resources, with 36.6% relying on peer support, 25.6% receiving psychosocial support from the Embassy health unit or medical staff, and 14.1% receiving support from a seasoned manager. Only 9.5% of respondents indicated accessing support from the RMO/P (State Department Regional Medical Officer/Psychiatrist), and only 8.8% accessed support from the Community Liaison Office (CLO).

USAID staff expressed several perspectives on support. Most found formal support from USAID to be “Inviting and engaging” or “Excellent--it was very helpful throughout” (51.1%), while 17.9% described it as “initially awkward, but ultimately engaging.” 27.2% found the support to be “pro forma, just checking a box.”

Respondents identified a range of impressions about how useful the support they received was, but only 2.8%- or 8 people out of 290 who answered the question- were able to say that they found the support “Extremely useful” and that they no longer suffer from stress.

Respondents offered many suggestions for psychosocial support they would like to have accessed during deployment but that was not available. Recommendations that appeared several times included, “more counseling,” “marriage counseling,” “psychosocial professionals as part of the med units,” “exercise programs,” and on-site “social workers.”

One of the most important potentially mitigating factors from a stress management perspective is the time spent in a recovery mode between high operational stress assignments. Not all respondents have had multiple overseas assignments; some are still working at their first assignment, and others have always been based in Washington. But of those survey respondents that have had multiple deployments overseas, 32.9% indicated that they have not had sufficient time to recover from a previous assignment before they were deployed elsewhere. Many (48.3%) of those that reported not having had enough time to recover between assignments identified this as happening frequently.

RESPONDENT ASSESSMENT OF POST-DEPLOYMENT SUPPORT

47.9% of respondents stated that, at the conclusion of a deployment, they were not provided with contact information for any psychosocial support resources or providers they could use for addressing stress from work experiences. Respondents who did recall being given contact information stated that this was the USAID StaffCare hotline number, and wished that they had been given a “list of vetted psychiatrists and clinical psychologists that specialized in trauma.”

The majority of respondents (56.8%) stated that they did not access any psychosocial support after deployment. The largest percentage stated they utilized peer support (16%). Others accessed USAID StaffCare (12.9%), State/MED staff (8.2%) or an outside psychotherapist (7.3%) or psychiatrist (5.1%). Similar to support accessed during deployment, respondents reported a mix of impressions about post-deployment support. **Many found formal support from USAID to be “Inviting and engaging,” (39.9%)** “Excellent--it was very helpful throughout” (14.5%). 19.2% described it as “initially awkward, but ultimately engaging.” **Around 1 in 4 (25.4%) found the support to be “pro forma, just checking a box.”** One respondent shared that, after seeking assistance from the Regional Medical Officer/Psychiatrist, “I was told I would be fine in 2 or 3 years and to carry on. Ridiculous.”

Respondents were evenly split in their opinions on the usefulness of the post-deployment support that they received. A third asserted that post-deployment support was not useful and that nothing changed, while another third stated that the support had some benefits, and a further third described support as beneficial, reporting that they sustained the lessons learned on how to cope.

For post-deployment support, in open-ended comments, respondents recommended that, in addition to providing more counselors and social workers that are specialized in high stress and traumatic environments, they would also like to see more “logistics and HR help in navigating home leave and communicating with my onward assignment,” and communication with others in the form of “peer groups as a place to share thoughts and ideas,” “discussing my CPC experience with my new Mission Director and Office Director, but neither showed any interest,” and also “reaching out to military support as they have a better understanding of working in combat related environments.” Many emphasized that a one-day out briefing is not enough, and that multi-day processing should be required. Many people mentioned the need for some variation or another of mandatory engagement with a routine psychosocial health maintenance framework. One respondent said, “I think it needs to be required at some level even for non-CPCs. I needed to be forced to consider issues that I had been subduing during my time because I had to be focused on my program, and felt I couldn't afford to confront things I was feeling.”

Several respondents identified that assistance during and post deployment should be routine (and focused on health maintenance as much as crisis mitigation), emphasizing the strict confidentiality of any access to assistance and clear communication that this does not affect security clearance. Others discussed the need for a mandatory amount of time off post-CPC, including, if necessary, providing additional leave time, or even leave without pay allowances when required.

RESPONDENT ASSESSMENT OF STRESSORS

USAID staff who responded to the survey identified many general work context stressors that negatively affected them during their period of employment at USAID. Respondents identified **dysfunctional organizational policies and procedures (65.3%)**, HR processes that seemed unsupportive of personal needs (55%), a lack of sufficient rest (47.3%), **a lack of appreciation (45.2%)**, relational difficulties with supervisors (41%), and a program, project, or initiative not performing as intended (32.8%). **Nearly a third of employees identified moral and ethical dilemmas related to their work as a stressor that negatively affected them (26.7%)**. 1 in 10 respondents noted the significant negative effects of alcohol use on colleagues and on the Mission.

Related to general work context stressors, survey respondents also indicated stressors related to operational tempo that had negatively affected them. Many attested that taskers and overly-burdensome reporting requirements were stressful (58.8%), as well as understaffing (54.2%), **feeling that supervisors had no idea of how taxing their requirements were (43.1%)**, and that the workload was “heavier than I could have imagined” (37%). Strikingly, around a third of respondents indicated that there was a culture of “work ‘til you drop” (30.7%) and an **“unspoken norm that sleeping well, regular exercise, or hobbies are for ‘people who do not work hard enough’” (23.9%)**. Also, quick turnarounds after stress exposure were reported by respondents, such as pressure to work immediately following severely stressful incidents (17.9%), and following “duck and cover” situations (9%).

USAID staff who responded to the survey identified an overwhelming number of security stressors that they felt (1) there was a risk of for themselves; (2) that had occurred to someone they knew; or, (3) that had actually happened to them. See Table 9.1’s Heat Map on next page for frequencies of security-related stressors reported in response to Q13.

Color	Percentage
Red	Above 50%
Yellow	20-50%
Blue	Below 20%

SECURITY-RELATED STRESSORS SUSTAINED BY SURVEY RESPONDENTS			
	Felt there was a risk of	Occurred to someone known to me during my deployment	Personally experienced during my deployment
Natural disaster (for example, flood, hurricane, tornado, or earthquake)	48%	27%	43%
Combat related bomb, IED, fire, or explosion	54%	43%	52%
Non-combat related fire or explosion	49%	36%	48%
Caught in civil unrest or political violence	59%	30%	46%
Caught in armed conflict or active combat operations	60%	46%	35%
Maneuvers intended to preserve life (e.g. "Duck & Cover")	36%	27%	82%
Captivity (e.g. being kidnapped, abducted, held hostage, prisoner of war)	78%	35%	3%
Transportation accident (e.g. car accident, boat accident, train wreck, plane crash)	67%	48%	21%
Exposure to endemic diseases, environmental pathogens, or toxic substances	60%	36%	45%
Physical assault (e.g. being attacked, hit/kick, beaten up)	65%	55%	9%
Assault with a weapon (e.g. being shot, stabbed, threatened with a knife, gun)	72%	45%	12%
Sexual assault (e.g. rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	72%	37%	4%
Criminal victimization, not specified above	68%	44%	18%
Life-threatening illness or injury without adequate medical facilities	68%	45%	13%
Sudden, intentional/violent death (i.e. homicide, suicide)	54%	53%	13%
Sudden unexpected, death of someone close (e.g. family member)	47%	34%	44%
Serious injury, harm, or death you caused to someone else (e.g. accidental, combat-related)	68%	36%	9%

Table 9.1. Security Stressors Heat Map

Respondents also indicated several USAID or institutional stressors that have affected them negatively. More than half of all respondents indicated that constraints on traveling freely within the country of assignment was an issue, with reasons stated including the Regional Security Officer's warnings, protocols, or requirements (57.8%), tension between the US Embassy and USAID about priorities (52.9%), and **insensitive leadership (51.9%)**. Respondents also identified tension and conflict within USAID as a major stressor, **tension with USAID Washington (33.6%)** and **tension between offices over resources, etc. (32.8%)**.

Respondents also noted that personal stressors not necessarily related to their work added to their negative stress load. Many respondents stated that lack of leisure time or social opportunities (41%), stress in family relations (37.4%), family obligations (36.6%), softening the worries of family due to news of violence or other events in country (36.3%), and issues with living situation or housing (30.7%) were of concern to them. A small but significant group of respondents also identified that amorous relationships or the sexual milieu present at post were stressful and negatively affected them (6.7%).

Overall, USAID or institutional stressors bothered respondents the most (145 out of 476), and general work context stressors were a close second for most stressful elements of their experience (113 out of 476). Although 35.6% of respondents endorsed experiencing a Critical Incident (any event or series of events that seriously threatens the welfare of personnel, potentially resulting in life-threatening illness or injury, or death) while serving with USAID, most respondents rated security-related stressors, as compared to other categories, as the least stressful element of their stress experience (144 out of 476).

Of those who reported experiencing a critical incident, respondents indicated a broad spectrum of responses, which is to be expected given the wide variation in response patterns that exists among individuals. Many felt worried or anxious (50.6%), **constantly on guard, watchful, or easily startled (46.4%)**, had trouble falling or staying asleep (43.5%), and had **trouble concentrating on things (33.3%)**.

Around the time that respondents were completing the survey, or “in the past two weeks,” most identified that they felt “fine” (58.9%), and yet many also endorsed feeling tired and having too little energy (31.5%), feeling worried or anxious (29.4%), and **continuing to have trouble falling or staying asleep (27.4%)**.

On the other hand, many respondents reported benefits associated with their stress exposure. Some respondents affirmed that their stressful experiences with USAID have caused them to change priorities about what is important in life (41.5%), to learn how supportive and helpful other people can be (34.4%), and to better cope with difficulties (32.9%).

Respondents indicated some ambivalence and lack of clarity about whether they were connected to adequate ongoing mental health services. 35.9% said they did not know whether their current access was adequate, and only 19.5% insisted that they were not inclined to use mental health services. Others stated that their access was very good (16.1%) or somewhat adequate (19.1%)

Q57: How adequate is your current access to ongoing mental health services, if needed?



10. FINDINGS: DUTY OF CARE

“As the risk to staff rises, so does the risk to organizations. Clearly organizations have ethical, moral, and legal responsibilities when it comes to staff care...”¹⁵⁸

In general, when considering the risks that personnel fielded into difficult or hazardous environments face, there are two types of potential harm that an ethical employer needs to consider. These are:

- Physical injury and/or death; and,
- Psychological or psychosocial injury.¹⁵⁹

In addressing these potential harms that may occur, as a direct result of being fielded into a risky environment by an employer, there are two rationales that underlie the concept of Duty of Care:

- Legal liability
- Moral duty

Legal liability revolves around the danger of being held legally liable and the risk is primarily financial costs for litigation as well as for compensation. Political and reputational costs also need to be considered, if the Agency is required to provide compensation (or does so without being required, such as through an out of court settlement with no admission of liability) due to failing to ensure minimum standards of safety and security are met, or being perceived to fail in this, and these reputational costs can include effects on recruitment, staff morale and retention. A perception that safety and security is not adequately provided is likely to represent a stressor for staff who perceive themselves to be at risk, but also, given the social contagion aspect of stress, to affect other staff as well.

Moral duty revolves around taking care of people because it's the right thing to do, with similar political, reputational, and staff morale/retention consequences, although liability is not a concern. Again, a perception by staff of an absence of care and concern likely constitutes a stressor.

Physical safety and security standards are based upon MOSS (Minimum Operational Safety and Security) standards, and the principles of MOSS are highly developed. The general standard is the “reasonable person” and the obligation is to provide at least the minimum necessary to ensure safety and security, when risks were known or should have been known. MOSS standards are objective and are clearly defined in a variety of normative documents produced by the UN as well as by multi-member standard setting organizations such as ECHO (European Community Humanitarian Aid Office), IASC (Interagency Standing Committee of the UN), EISF (European Interagency Security Forum), InterAction, RedR, People in Aid, and ODI/HPG (the Humanitarian Practice Group of the Overseas Development Institute). Additionally, most bi-lateral agencies and large international development organizations have robust policies in place for field safety and security that are MOSS compliant.

¹⁵⁸ Porter, Benjamin and Ben Emmons. “Approaches to Staff Care in International NGOs.” InterHealth/People in Aid: September, 2009. p. 11.

¹⁵⁹ Dunigan, Molly, Carrie M. Farmer, Rachel M. Burns, Alison Hawks and Claude Messan Setodji. Out of the Shadows: The Health and Well-Being of Private Contractors Working in Conflict Environments. Santa Monica, CA: RAND Corporation, 2013. p. 19. http://www.rand.org/pubs/research_reports/RR420

Understanding of psychosocial risks, and associated costs and harm, are not as highly developed- nor are they objectively standardized- in the practices and normative literature of international development, but the evidence for psychological injury is extensive. In 2010, for the first time the ILO has recognized psychosocial injury in the List of Occupational Diseases, under the category of mental and behavioral disorders. This includes “2.4.1. Post-traumatic stress disorder”, but also “2.4.2. Other mental or behavioral disorders not mentioned in the preceding item where a direct link is established scientifically, or determined by methods appropriate to national conditions and practice, between the exposure to risk factors arising from work activities and the mental and behavioral disorder(s) contracted by the worker.”¹⁶⁰ It is important to note that there is ample evidence that such injury is not solely caused by exposure to traumatic incidents, but can also be caused by protracted exposure to chronic high stress with inadequate opportunity to recover.¹⁶¹ Both types of stress exposure appear clearly to result in:

- Psychological injuries such as anxiety disorders, traumatic stress syndromes and disorders, and depression,¹⁶² as well as increased incidence of suicide and attempted suicide.¹⁶³
- Physiological injuries related to the biopsychosocial nature of stress and protracted over-excitation of the neuro-anatomical system for identifying and responding to environmental stressors.¹⁶⁴
- Activation/intensification of non-psychosocial, purely physiological illnesses, many of which are life-threatening.¹⁶⁵
- Disruption and sometimes destruction of key supportive social relationships, especially spousal relationships and families.¹⁶⁶

¹⁶⁰ International Labour Office. “List of Occupational Diseases. Revised 2010. Occupational Safety and Health Series, 74.” p. 4.

¹⁶¹ For a very brief and simple overview, see: “Adult Stress— Frequently Asked Questions: How it affects your health and what you can do about it.” Factsheet produced by the National Institutes of Mental Health. Available at: http://www.nimh.nih.gov/health/publications/stress/Stress_Factsheet_LN_142898.pdf

¹⁶² In addition to the numerous sources referenced elsewhere in this document, the interested reader can find additional information at the following websites:
<http://psychology.about.com/od/abnormalpsychology/ss/A-List-of-Psychological-Disorders.htm#step13>
<http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>
<http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp>

¹⁶³ As but one example, see: Sanders, Robert. “New evidence that chronic stress predisposes brain to mental illness.” Available at: <http://news.berkeley.edu/2014/02/11/chronic-stress-predisposes-brain-to-mental-illness/>; as another, see: Bergland, Christopher. “Chronic Stress Can Damage Brain Structure and Connectivity. Chronic stress and high levels of cortisol create long-lasting brain changes.” Available at: <https://www.psychologytoday.com/blog/the-athletes-way/201402/chronic-stress-can-damage-brain-structure-and-connectivity>

¹⁶⁴ Idem.

¹⁶⁵ In addition to the numerous sources referenced elsewhere in this document, the interested reader can find additional information at the following websites:
<http://www.indiana.edu/~engs/hints/stress1.htm>
<http://www.healthline.com/health/stress/effects-on-body>
<http://www.stress.org/stress-effects/>

¹⁶⁶ See, for example: <https://www.ncfr.org/ncfr-report/focus/couples/stress-bad-couples-right>; see also, Buck, April A., and Lisa A. Neff. “Stress Spillover in Early Marriage: The Role of Self-Regulatory Depletion.” *Journal of Family Psychology*, Volume 26, Issue 5, Oct 2012. pp. 698-708; and, Riggs, David S., Christina A. Byrne, Frank W. Weathers, and Brett T. Litz. “The Quality of the Intimate Relationships of Male Vietnam Veterans: Problems Associated with Posttraumatic Stress Disorder.” *Journal of Traumatic Stress*, Volume 11, No. 1, 1998.

In the United States, the key statutory provision that underpins Duty of Care is the Occupational Safety and Health Act of 1970. This law, passed by the US Congress, created the Occupational Safety and Health Administration to prevent employees from being injured or contracting diseases in the course of their employment.

Employers covered under the OSH Act must abide by the General Duty Clause at 29 USC 654 that speaks to a workplace free from “recognized hazards”. In the context of the OSH Act, the recognized hazards seem to deal exclusively with physical harm, but it is worth noting this law is now 45 years out of date, and at the time it was written there were no scientifically validated and generally recognized stress-related health conditions to speak of. As argued previously, this is no longer the case.

The relevant section from 29 USC 654 is presented below:¹⁶⁷

SEC. 5. Duties	
a. Each employer --	
1. shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees;	
2. shall comply with occupational safety and health standards promulgated under this Act.	

Table 10.1. General Duty Clause from U.S. Occupational Safety and Health Administration

¹⁶⁷ The Occupational Safety and Health Act of 1970 (29 USC 654). Full text available at: https://www.osha.gov/pls/oshaweb/owasrch.search_form?p_doc_type=OSHACT&p_toc_level=0&p_keyvalue=&p_status=CURRENT

Section 5, “Duties”, referenced above, is available at: https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=3359&p_table=oshact

II. FINDINGS: USAID STAFFCARE CENTER SERVICES

Author's note: All data on StaffCare reported below was either retrieved from the StaffCare website, or was provided by the StaffCare COR, either verbally or in written response to questions from the assessment team. Most of the information was received via StaffCare verbal assertions, with no hard data to back this information up, and some minimal responses in writing that are all somewhat vaguely descriptive of what StaffCare does. Some of the information, in the view of the assessment team, is self-promoting and thus considered unreliable. The researchers were provided with no StaffCare information products or tools/systems, even though these were repeatedly requested. All requests for hard data, work products, tools and templates, raw data from StaffCare M&E processes, or to conduct interviews directly with personnel in StaffCare, went unanswered. (Questions to StaffCare are provided in Annex 9). As a result, the team has received no data with enough detail to be able to reliably critique overall quality or appropriateness of StaffCare services from the perspective of comparison with established standards, or in relation to the access, quality, and adequacy of those services. Many of the points of discussion below are assumptions, derived from disjointed bits of information from a variety of sources. As a result, at this point the assessment team cannot factually verify much of the description provided, nor can we with full confidence assess the overall quality of StaffCare products and services.

USAID has made substantial progress in creating a Stress Responsive institutional environment with the creation of the StaffCare Program delivered through the StaffCare Service Center. It is a relatively recent addition to the suite of services and systems designed to mitigate stress, having become fully operational only in 2012 after a robust consultative process involving USAID personnel; the StaffCare website itself notes that StaffCare is a “work in progress.”¹⁶⁸ Deployment overseas only began in 2014.

The StaffCare program is separate from and subordinate to the Department of State Medical Unit (State/MED) but is responsive to guidance provided by State/MED, including State/MED oversight of the credentials approval of StaffCare counselors. All StaffCare activities are overseen by USAID, implemented by independent contractors under the direct supervision of a USAID COR. StaffCare does not provide medical services per se, but instead provides support to USAID staff in navigating a range of work place issues. Consultations with StaffCare professionals are protected information of the third party contracted provider and are not entered into USG systems. All categories of USAID's workforce (e.g. PSCs, institutional contractors, etc.) have access to StaffCare services, including those USAID staff who have previously served or currently serve overseas in high stress, CPC, or NPE posts.

USAID's StaffCare Program promotes a range of programs and initiatives that are modeled on a fairly standard Employee Assistance Program (EAP). For example, the federally mandated child care subsidy program; providing assistance to employees dealing with child and elder care issues; providing assistance to the Agency's workforce in addressing a range of day-to-day life and resiliency issues that include promotion of healthy lifestyles, fitness, and improved lactation facilities; and providing and managing in-

¹⁶⁸ USAID Staff Care Program website. Available at: <https://staffcare.usaid.gov/>

“Ten Guiding Principles for the Staff Care Program.” Available at: <https://staffcare.usaid.gov/principles.html>

house and externally referred employee counseling services. The purpose of StaffCare is to promote a vibrant, healthy and diverse workforce and, in so doing, to contribute to positive employee morale and to reduce negative effects of employees struggling with work-life issues in a way that impacts their ability to be optimally productive members of the USAID workforce. In this way, *all* StaffCare services can correctly be viewed as being stress mitigating and thus as being Stress Responsive.

In addition, StaffCare offers a number of services that are *not* strictly classical EAP-type activities, and these represent an “expeditionary” approach well-suited to a number of the particular stress factors that exist in high-operational stress environments, and the issues these produce. These expeditionary services respond to many of the distinctive contextual factors that make the stress environment at USAID unlike that within other organizations that do not field staff abroad. Of particular interest to this study are the StaffCare services that are specifically targeted at stress prevention or stress management in CPCs/NPEs/HTEs, and that fall conceptually within the deployment cycle outlined by the Antares Foundation¹⁶⁹. These also fit within the matrix of resources and services- some in addition to the Antares standards- that the assessment team has identified. All of these services are relevant from the perspective of supporting staff deployed to or returning from postings in CPCs/NPEs/HTEs and other high-operational stress environments.

The authors received descriptions of the following USAID StaffCare services (the same services are included in the gap analysis found later in the report):¹⁷⁰

- I. Pre-deployment Stress and Resilience in High-Threat Environments training. This is an eight-hour, full day workshop provided to USAID personnel prior to deployment, through the Office of Afghanistan-Pakistan Affairs (OAPA). Training objectives are:
 - a. To understand the impact of stress on health and wellbeing in the NPE context;
 - b. To learn how to assess need for greater care for self and others and build resilience;
 - c. To understand the cognitive, affective, and physical impact on health and wellbeing after a critical incident;
 - d. To learn and practice the basic tenets of Psychological First Aid; and
 - e. To learn about available USAID StaffCare Resources and how to access them.

These resilience and stress-awareness training programs are expanding beyond solely being provided pre-deployment. Training is being provided to “emerging leaders” and through the Center for Professional Development.

2. Confidential counseling services provided to all employees (including FSNs and institutional contractors) experiencing psychosocial distress, as well as all Eligible Family Members (EFMs). These services are limited to 6 counseling sessions provided to employees under the Employee Assistance Program, and 8 sessions under the Employee Resilience Program, per incident/per year, although in some situations this support can be extended up to 36 months. External referrals are provided for longer-term care if required. StaffCare provides a hotline service that is available 24/7, 365 days a year, for assisting USAID personnel who may be in crisis. With the exception of situations in which a StaffCare team is deployed to a Mission at the request of Mission management to respond to a Critical Incident or some other management identified crisis situation (see number 8 below), personnel posted abroad must access these DC-based counseling services remotely or when they are on TDY in Washington. Referrals can be

¹⁶⁹ “Managing Stress in Humanitarian Aid Workers- Guidelines for Good Practice.” Antares Foundation. 3rd edition, March, 2012.

¹⁷⁰ Based upon information provided by the Staff Care Program.

provided to local external service providers as well, but in many locations where USAID works local service provision is weak or non-existent, and local service providers may not be seen as credible to many American expats.

StaffCare also provides access to confidential, no-cost financial counseling by telephone, and no-cost legal consultations with US attorneys. Referrals for international attorneys are also provided.

3. Personalized Pre-deployment Consultations, voluntary check-ins while on assignment, and voluntary Post-deployment Consultations.
 - a. Creation of a Resilience Action Plan. An individualized Resilience Action Plan aims to help individuals to build awareness of resilience factors, define balance and identify choices as these relate to bodies, brains, beliefs, and behaviors.
 - b. Creation of a Personalized Transition Plan. A Personalized Transition Plan allows an employee to think through likely issues and pro-actively produce an objective response that enables them to anticipate and better respond to likely challenges. It allows staff to more systematically address any work-life issues that will likely arise, prepare for and pro-actively mitigate stress, and orient themselves to available resources.
4. Work-life Support provided across the assignment cycle. Work-life support includes providing expert guidance and personalized referrals, online tools and discounts, breastfeeding support, arranging backup care for children and older adults if unexpected interruptions in care occur, and live and virtual presentations on work life topics.
5. Wellness Support provided across the assignment cycle. Wellness support includes wellness and health education and disease prevention initiatives, and promotion of healthy lifestyles. It also supports a Mission in developing a lactation program and quiet rooms, or other customized programs, if deemed to be appropriate. Prior to departure, staff can obtain a Health Risk Assessment and educate themselves about disease prevention and self-care. Staff can also obtain Bio-metric screenings such as checking blood pressure or checking other information about the status of their personal health. StaffCare also supports On-site Challenges, formation of Running/Walking groups, and Weight Management Groups. All employees have no-cost access to headquarters fitness facilities and the RRB health unit.
6. Temporary duty to provide psychosocial support to Missions during Evacuations or after Critical Incidents. Support is provided to individuals, to couples/families, or groups, as may be appropriate. When responding to a critical incident, support is usually 100% clinical focused. During these events, at least one behavioral health professional is deployed to ascertain need. If their assessment determines more robust support is required, StaffCare fields additional clinical support while working to identify on-going local clinical support.

StaffCare is typically required to provide clinical support to the entire U.S. Mission, regardless of Agency affiliation. TDYs must have State/MED clearance and work in tandem with and under the direction of the Embassy Health Unit. Clinicians who are deployed can consult and refer to other components of the StaffCare Program, as may be necessary, when meeting with USAID personnel.

7. Temporary duty support may also consist of assistance in dealing with other institutional issues that are creating psychosocial distress or creating management challenges within the Mission. This service was initiated in mid-2014, and entails conducting comprehensive behavioral health and psychosocial “stress assessments”¹⁷¹, through delivery of surveys customized to the needs and concerns expressed in the statement of work (SOW) as submitted by a Mission. Typically, an Assessment Team includes four professionals, two addressing individual and organizational resiliency, one addressing wellness, and one addressing work-life issues. Also typically at least one clinician accompanies the team to provide one-on-one and group therapeutic support and referrals, if required.
8. Survey assessments are used by StaffCare to tailor interventions, including customized questions that address the particular needs outlined in the SOW provided to StaffCare prior to deployment, and information collected through these surveys is used to custom design the engagement. The data collected is a starting point for further conversation in designing an appropriate and relevant engagement to strengthen individual and organizational resilience, and draw from all resource components and services offered through the StaffCare Program.

Surveys are disseminated to staff through Survey Monkey and all responses are anonymous. Surveys are live for approximately 1-2 business weeks, and participation is encouraged by Mission leadership.

Standard questions that address standard StaffCare services and resources

All surveys contain standard demographic questions, as well as questions addressing each of the StaffCare program components. Standard questions include:

- Gender
- Age
- Hiring mechanism
- Number of years at post/with the team
- Whether or not employee has supervisory responsibilities
- Exercise, dietary, and sleep habits
- Personal stress levels over the last three years
- Ability to cope with stress
- Caregiver status of employee
- Types or causes of stress experienced

Customized Questions

These customized questions relate to topics Mission personnel feel would be useful to address or to build skills around, such as managing stress and developing resilience; managing change and complexity; improving health and wellness; communication skills, teamwork and cooperation; personal morale or overall Mission morale; and sensitivity to diversity.

¹⁷¹ Quotation marks added by the authors, as this approach to assessment appears to be in alignment with one of the best practices identified in our review of the literature.

9. Customized Organizational Resilience Interventions support USAID groups of any size that may be located anywhere in the world. These services complement StaffCare's work with individuals by supporting the development of skills, dynamics, systems and settings that are conducive to health and effectiveness. Organizational Resilience includes, among other things, understanding and addressing systemic issues, creating and supporting positive group dynamics and processes, and equipping leaders and managers to recognize, model and reward resilient behaviors and practices.



An unnamed USAID rescue worker inspects the site of a building that collapsed in the 25 April, 2015 earthquake in Kathmandu, Nepal, on May 12, 2015. Credit: Niranjana Shrestha, Associated Press.

StaffCare's organizational resilience services include:

a. Assessments

Through surveys, focus groups, interviews, and other processes, StaffCare assists teams, Divisions, Bureaus, Offices and Missions seeking to identify strengths and improvement opportunities. Assessment methodologies are chosen, in consultation with those being served, to best suit the group's interests and assessment goals.

b. Group Process Design and Facilitation

StaffCare designs and facilitates retreats and other group processes to support collective learning, growth and effectiveness. The planning process begins with gathering information, often through surveys and/or individual interviews, to gain an understanding of the group's needs, and to clarify process objectives. StaffCare then collaborates with leadership and planning teams to design a group process that will engage all participants in achieving the objectives identified.

Frequently, groups focus on a combination of issues that may include team dynamics, communication, conflict management, change management, and diversity, among others. As appropriate, individual and team assessments (e.g., strengths, team performance, personality, communication and conflict styles, etc.) are completed to enhance the individual and collective learning experience. Agendas typically include a combination of reflective, interactive, dialogue, and planning processes.

c. Change Management

StaffCare helps leaders, managers and staff members navigate the human transitions that are part of any change process, an issue that is often confronted inside USAID due to rapid

transitions that frequently occur. Through guided processes, participants gain self and other awareness, and the capacity to manage transitions more effectively. By structuring a systematic approach to change, individuals and groups can steer change, develop the desire and capacity to support change initiatives, and ensure that changes implemented are sustainable.

d. Coaching

StaffCare coaching enables managers and leaders to refine and develop the knowledge and skills they need so that they can effectively support resilience within their teams and organizations. An individual makes a request to StaffCare and then has an initial intake interview with a StaffCare staff person. Upon completing the intake, and securing supervisory approval and approval from the StaffCare COR, an individual is matched to an experienced coach best suited to meeting their coaching objectives. Coaching services are thus customized to the needs of each manager. Coaching services are provided by credentialed executive coaches. Services are offered virtually for staff posted overseas, while staff based in Washington can access services in person at the StaffCare Service Center.

According to the StaffCare Program COR, these interventions may be triggered by an Operational Unit that realizes it has issues requiring such an intervention, and then reaching out to StaffCare with a request for services. Alternatively, these may be triggered by awareness in StaffCare that a certain Mission or Operational Unit may be having problems of the sort that would be amenable to resolution through an Organizational Resilience Intervention.

10. Mobilizing and developing StaffCare Champions within the Mission. These Champions advocate for and provide Work-Life Support, and/or Wellness Support within Missions, and serve as knowledgeable points-of-contact to connect USAID personnel to useful StaffCare resources.
11. Compassionate Curtailment Support. This involves conducting an assessment of the nature of the situation wherein a USAID employee requests curtailment from a posting on grounds that it imposes an undue hardship on the individual or the individual's family. If appropriate, StaffCare engages with USAID management to provide support for the individual to justify their request.

12. FINDINGS: GAP ANALYSIS

CURRENT POLICY ENVIRONMENT AND MANAGEMENT CAPACITY

A review of current USAID policies was conducted, including ADS 436 “Foreign Service Assignments and Tours of Duty” and key Agency Notices¹⁷² relating to fielding and supporting staff in CPCs and NPEs. As currently configured, written policies at USAID do not fully support a Stress Aware or Stress Responsive culture or an integrated set of institutional practices designed to address stress among the USAID workforce. While a section of the ADS discussing the StaffCare Program is currently being drafted, guidance to establish an agency-wide set of stress management policies is not included in the current draft. Current established guidance is limited to one-off Agency Notices that primarily address questions or specify procedures related to CPC assignments, training, and incentives for serving in a CPC or NPE.

Below is a table of policies and procedures best practices (detailed in the Antares model -- Annex 5) and current USAID alignment or gaps:

Policy/Procedure Best Practices	USAID Implementation? (Yes/No)
Organization culture: Explicit policies to establish and promote a Stress Aware and Stress Responsive culture throughout all levels of the organization.	No.
Training and Education: Regular education of staff about the stress-related risks of their work. Regular training to recognize the signs of stress in self and others and to develop healthy coping mechanisms.	Primarily limited to personal security. Some minor content related to stress awareness and self-care is included, but appears to make a minimal impression on personnel and thus has limited impact.
Accountability: Accountability to ensure that staff members comply with policy and procedures to reduce risk and hold the Agency accountable to uphold these policies and procedures. Management is evaluated for stress management skills and capabilities.	No. The AEF process has no components that focus on compliance with stress management policies, nor to hold managers accountable for creating a stress mitigating working environment.
Personnel matching: Screening for new and current staff with respect to strengths and likelihood of negative responses to risks.	No. OTI and OFDA appear to be an exception, and use a variety of techniques during the recruitment process to ensure they select appropriate candidates.

¹⁷² The assessment team reviewed a pre-selection of Agency Notices and ADS sections provided by USAID. In addition, the assessment team completed several key word searches in the ADS to identify other sections with relevant policies. As a result, there may be other Agency Notices or Agency policies that were not reviewed and could be relevant for future research.

Policy/Procedure Best Practices	USAID Implementation? (Yes/No)
Prepared leadership and management: Necessary management and leadership skills, training in how to handle traumatic incidents as well as mentoring and peer support.	No. OTI appears to be an exception and provides training, information, and ongoing support to managers.
Monitoring and assessment: Multi-tiered monitoring of stress at the individual and team level. Regular assessment of organizational wellbeing and policy and procedures. Performance management of supervisors for stress responsive management practices.	No standard approach exists although there are some isolated examples of some elements of this, such as StaffCare Organizational Resilience Assessment and USAID/Uganda Organizational Diagnostics.
Post-Assignment Support: End of assignment support to ensure staff is supported in a transition out of an assignment or leaving the Agency, and in dealing with stress that may be experienced after deployment.	Limited to CPC de-briefing at FSI, and “personalized transition plans” offered through StaffCare Center. Counseling services provided through StaffCare are currently constrained in terms of number of sessions, and access privileges expire after a certain amount of time passes post deployment.

Table 10.1. Gap Analysis on Policy vis-à-vis Workforce Stress

Pre-deployment requirements, according to Agency policies¹⁷³, state that staff assigned to a CPC or on TDY to a CPC for 30 days or more are required to take the following training courses:

- Security Overseas Seminar and Advanced Security Overseas Seminar
- FACT course
- Specialized Iraq course (if assignment is in Iraq)
- Family members are encouraged to take an online course and a seminar for youth

According to individuals surveyed, when asked, “Prior to your postings, was your training in psychological wellness or stress management useful?” 57.67% suggested they had no stress management training prior to getting to post. One respondent said, “I do not recall specific training,” while another stated, “I was not aware of such training.” A third noted, “I think there was general mention of stress management, but I can’t remember anything useful,” and another stated: “I’m 99% sure we received some kind of training, but frankly I don’t remember anything about it. So it seems not very useful.” Perhaps many of the personnel who reportedly received no stress management training had never gone through mandatory CPC training, but probably at least some of them simply failed to develop the awareness that the small module on stress awareness sought to produce. This is likely due to the current emphasis in pre-deployment training that is primarily focused on- and thus to a degree limited to developing knowledge and skills- related to personal security.

The theme of emphasizing personal security continues when employees arrive at post. But as one survey respondent stated, “*The training assumed there would be sustained support at post, which was not the case.*”

¹⁷³ USAID Agency Notice “Personal Security Training and Practices.” February 20, 2008 issued by USAID/SEC and HR.

According to Agency policy outlined in Agency Notices¹⁷⁴, managers are required to ensure employees have all useful information and policy directives. Managers are encouraged to host regular discussions, but these are to address personal security concerns such as suggesting employees change their ways of getting to work.

Upon completing a CPC assignment¹⁷⁵, employees are required to attend a mandatory out-briefing. This out-briefing, held at FSI and facilitated by State/MED, covers employee benefits, repatriation issues, and how to deal with stress upon returning from assignment. This is only a requirement for individuals who are returning from serving in a CPC post for 30 days or more. Furthermore, the utility of it is questionable, as currently configured. As one survey respondent reported:

“The FSI workshop/Briefing for leaving high stress posts was not only worthless but made me angry. The push by Mission to have me not go to Washington for this was annoying at first (I felt the mission didn't want to pay for it/didn't value FSL) but then, after sitting through it, I wished I hadn't gone as it only made me angry. It was a 'check the box' session, it completely focused on FSOs, not someone leaving, and thus denigrated our service even more.”

In addition, as currently stated, the requirement possibly neglects anyone who has experienced the acute stress of a critical incident, and many of the most highly stressful posts that a USAID officer may serve in are not specifically designated as CPCs.

“I wish there was some sort of follow up to the high stress out brief. I did it right before going on home leave, but should have spent more time (on the spot!) accessing the resources provided. Instead, I ended up going on home leave later that day and not using resources that I probably needed to help me adjust. This would have been very helpful to have...”

Current procedures for selecting candidates, both during initial hiring and for assignment upon being hired into the Agency, do not currently include mandatory psychosocial wellness screening beyond a medical clearance, and any screening that does occur is voluntary and upon request of the staff. Paired with this lack of structured, required psychosocial wellness screening, current incentives both favor staff who have or will serve in a CPC, and require Foreign Service staff to bid on at least one CPC¹⁷⁶ in each bidding cycle regardless of their psychosocial wellbeing. Incentives include priority consideration for a person's onward assignment, less burdensome extension procedures for PSC positions in CPCs,¹⁷⁷ encouragement of Mission Directors to bid on Deputy positions in CPC posts, the opportunity to remain in the field if staff serve in Afghanistan, Pakistan, or Iraq (rather than requiring them to bid on a Washington post),¹⁷⁸ and strong financial and promotion incentives.¹⁷⁹ For example, when USAID

¹⁷⁴ USAID Agency Notice “Personal Security Training and Practices.” February 20, 2008 issued by USAID/SEC and HR.

¹⁷⁵ USAID Agency Notice “Support Sessions (Out Briefings) for CPC Returnees.” October 11, 2006 issued by M/HR/POD.

¹⁷⁶ USAID Agency Notice “Guidance for the 2011 Priority Consideration Bidding Round for Eligible Bidders Completing 12 Months or Longer in CPC Posts.” July 26, 2010 issued by OHR/FSP/SP. and USAID Agency Notice “Senior Management Group 2010/2011 Major Listing — New Bidding Rules, Additional Positions and Corrections.” October 16, 2009 issued by OHR/FSP.

¹⁷⁷ USAID Agency Notice “Approval Policy for Recruitment or Extension of U.S. and Third Country National Personal Service Contractors (US/TCNPSCs).” May 17, 2013 issued by OHR/FSP/SP.

¹⁷⁸ USAID Agency Notice “Senior Management Group 2010/2011 Major Listing - New Bidding Rules, Additional Positions and Corrections.” October 16, 2009 issued by OHR/FSP.

¹⁷⁹ USAID Agency Notice “Correction - Incentives for service in Critical Priority Country Assignments - 2007 Foreign Service Assignment Cycle.” November 9, 2006 issued by M/HR/POD.

designated Yemen as a CPC country in August of 2012, Agency employees were given incentives including four R&Rs, 25% post differential and 30% danger pay, eligible family member employment for personnel wishing to be accompanied by their spouses, and a meal allowance. Incentive structures such as this perhaps unavoidably lead to a culture favoring staff that have served in CPCs,¹⁸⁰ and unremitting organizational pressure to serve in posts with levels of high chronic and traumatic stress exposures, without a strong framework of best practice policies and procedures in place to support staff wellbeing. This culture can drive assignment decisions even in cases where this is clearly not in the best interests of individuals who may already have been exposed to unhealthy or injurious levels of stress.

The Agency has made some strides in recent years to address some family and length of assignment concerns. This has included, upon Chief of Mission approval, an employee going to a CPC assignment while family already stationed overseas are allowed to remain “safe havened”, and staff may complete the CPC under a TDY arrangement. In addition, creative assignment options have been developed, including linking assignments to allow an employee to complete a CPC tour immediately followed by a more desirable overseas location, or twinning assignments to allow two employees to be assigned to a Washington Regional Bureau with alternating six-month TDY rotations to a CPC position.¹⁸¹ However, the fact that these policies are codified in one-off Agency Notices and are not integrated consistently in the ADS represents a challenge, as the ADS is the authoritative policy resource employees first turn to for policy guidance and clarity on Agency procedures. As a result, an employee will only become aware of these options if they read every Agency Notice, or spend extensive time attempting to search the Agency Notices (an exercise which can be very challenging, to say the least), or through word of mouth. It also remains unclear whether Agency Notices serve as authoritative sources of policy and procedures for the Agency, without an end date.

As a result of these many gaps in policy and practice, one of the concerns the assessment team heard during interviews was about the trend of “intervention too late.” This is of concern from a wellness perspective because once a stress injury has been received, an individual’s life can be severely disrupted, the process of recovery is often long, and the cost to the individual, both emotionally and financially, even in a best case situation, is extremely high. Additionally, interviewees from the Office of Security expressed a frustration that issues regarding an individual’s psychosocial wellbeing are often not addressed until the person is considered a “security risk.” This results in potentially dire consequences for the individual, risking their security clearance, as well as security risks to the organization, raising concerns including physical security concerns and the potential for sabotage behaviors.

(Note: While USAID overall as an organization has significant policy and procedure gaps for preventing and mitigating chronic operational and traumatic stress, some units within the organization have taken additional steps to more fully support the psychosocial wellbeing of staff. Examples of positive practices and policy trends within USAID/Uganda, and OTI and OFDA can be found in Annex 6.)

¹⁸⁰ USAID Agency Notice “Message from the Director of Human Resources to AAs, DAAs, Mission Managers, Office Directors, and Other Selecting Officials.” October 6, 2009 issued by OHR/OD.

¹⁸¹ USAID Agency Notice “Correction - Incentives for service in Critical Priority Country Assignments - 2007 Foreign Service Assignment Cycle.” November 9, 2006 issued by M/HR/POD.

GAP ANALYSIS ON PRACTICES: USAID AND OTHER AGENCIES

Phase	Best Practice	Gap Analysis for USAID	USG, UN, Implementers
Institutional Context	Policy providing clear and effective guidance on Stress Management and Staff Care.	USAID has various disjointed ADS chapters and Agency Notices that do not together constitute a coherent policy on Staff Care and Stress Management; Staff care is currently developing an ADS for the Staff Care Center, but this will not penetrate into Agency policies and procedures nor will it be binding on Missions and OUs.	UNHCR, OCHA, UNICEF, ICRC, CDC. The United Nations policy on stress management is being updated in 2015. DOD: All branches of services are required to establish policies and programs based upon overarching DOD Directives, most notably Maintenance of Psychological Health in Military Operations. Details in Annex 4.
	Adequate budget resources assigned for staff care, training, production of resources and materials, etc.	Funds currently applied to services at the USAID Staff Care Center, training at WLC/FEI and outbriefs/trainings at FSI, but there is no integrated budget for stress mitigation.	World Bank, UNHCR, OCHA, World Vision DOD has extensive budget supportive of personnel care and resilience.
	General training for personnel in stress awareness and resiliency, and self-care practices	USAID has implemented this for CRC OAPA Training modules being implemented in select situations, primarily pre-deployment to CPCs or upon specialized request.	UNHCR, UNICEF, ICRC DoD wide. -Part of the Orientation process when reporting to a command -- Naval Center for Combat and Operational Stress Control teaches sailors and Marines how to deal with every day and combat-related stress starting at the beginning of their military careers. --Annual mandatory training.
	Training for managers in stress aware/responsive practices	Staff Care provides some training content, and arranges "executive coaching".	DOD -- training occurs at all levels of leadership and supervision (i.e. In Navy: Commanding Officers, Command Master Chiefs, Department Heads, Division Officers, and Chiefs).
	Performance management objectives, metrics and systems for ensuring stress responsive management and staff supervision practices	USAID has no such systems in place.	HSE has a suite of highly developed materials to support production of performance management tools. DoD does not specific metrics or performance objectives related to stress responsive management. The understanding is that each leader should take care of their troops and if that does not happen, informally they know that they will not be promoted.
	Ongoing stress assessment at institutional and OU levels	Staff Care currently performs "organizational resilience" assessment, but does not track stress levels over time.	
	Production of resources (training curricula and materials, knowledge and awareness handbooks, self-assessments tools)	USAID/DoS has some resources/materials, but these are disjointed and do not present a coherent set of consistent content. Stress aware Powerpoint in USAID/ Kosovo prepared by State/MED. Staff Care training resources.	DOD, UNHCR, International Organization for Migration ICRC, UNICEF (handbooks) Antares and Headington Institute have publications
	Selection and recruitment psycho-social assessment • Antares • InterHealth	USAID currently has no such tool; using "incentives" to fill difficult-to-staff slots; seems "willingness to go" is the primary selection criteria.	CDC currently developing tool DoD has pre-deployment preparation in which personnel completes Deployment and Mental Health Assessments reviewed by health care provider; and if necessary will be referred to mental health provider for further support.

Pre-Deployment	Pre-departure briefing and psycho-social preparation • Antares • InterHealth	Standard for CPCs but some briefings were not up to date or representative of stresses to be encountered USAID Staff Care develops individualized "resilience plans" upon request.	UNHCR. OCHA has opt-in briefing. Many implementers include this to varying degrees. DoD -- personnel right before they deploy are provided Force Health Protection Briefs that outline health threats, how to protect themselves against those threats along with what health capabilities are available to them during deployment.
	Pre-departure briefing and psycho-social preparation for family		DoD views families as an integrated element of support for warfighters and provides extensive support. Knowing your family is taken care of when you are deployed is part of military care.
	Safety and security awareness training • InterHealth	via FACT training and some supplemental information via USAID Staff Care.	Most every organization provides briefings, but only DoD and CDC found to make the connection between maintaining safety/security and stress effects.
	Training Simulations of High-Threat or High-Pressure Scenarios	Muscatatuck Urban Training Center (Camp Atterbury), DoSFACT course, SNOE – previously used for USAID CRC.	CDC. DoD – In addition to operational training, units do war games before going out to the field together and are observed. Some receive simulation lab exercises.
	Operational stress awareness and operational resilience training	Pre-deployment stress and resilience in high threat environments workshop (limited to OAPA)	CDC DOD – all branches have Combat and Operational Stress Control doctrine with training exercises
	On-call Critical Incident response and crisis counseling	via USAID Staff Care. Currently there is no established "tripwire" to initiate a response, so it is dependent upon request for support from the field.	World Bank, UNHCR, OCHA, UNOPS. Most implementers have some component of this; some implementers have robust mechanisms.
During Deployment	Routine non-critical incident counseling access	via State/MED for CPCs, worldwide through USAID Staff Care.	DoD has mental health, medical and chaplain services attached to units making access readily available.
	Team based debrief processes, peer counseling	Cases of unofficial (no protocol) team debriefs, no peer counseling.	A few implementers have developed advanced models. DoD -Unit Cohesion is paramount. -Training together prior to deploying together is a core and invaluable principle. -- Example: Navy "Take Care of Your Shipmates"
	Client-centered admin support, including EFM-supportive policies and practices	There are many structural and systemic gaps in how USAID supports personnel and families when being deployed to CPCs and other high-operational stress postings.	A few implementers have developed an advanced model of this to work from as an example. DOD views families as an integrated element of support for warfighters and provides extensive support.

During Deployment	Ongoing stress assessment and monitoring of staff's risk	Staff Care does this through "voluntary check-ins", but it is not systematic, routinized "psychosocial maintenance" that applies to all USAID personnel.	UNHCR Health Risk Appraisal. A few implementers have developed an advanced model of this to work from as an example. DoD-- Deployment Health Assessments (DHA) are three mandated instruments: (1) Predeployment complete no earlier than 60 days prior to deployment. (2) Re-deployment (complete not earlier than 30 days before expected re-deployment date); (3) Post -deployment must be conducted 90-180 days after returning from deployment.
	Stress and self-care awareness raising programs	Introductory through FACT and USAID Staff Care website. State/MED provides on post-by-post basis.	CDC. Peace Corps. DoD includes these in Health and Wellness programs; Conduct annual suicide prevention that includes stress management.
	Biological stress mitigation: Support for nutrition, ergonomic workspaces, environmental comfort, and sleep hygiene	Found at some CPCs to varying degrees	DoD provides guidance through Health and Wellness program. Also individuals can have one on one session with a nutritionist. Leadership enforces time for rest, exercise and nutrition.
	Exercise facilities and programs that connect physical fitness with mental fitness	Facilities provided by USAID at post and in Washington. Literature makes physical-mental connection. Not aware of programs.	DoD provides physical fitness regimens.
	Supportive R&R and leave policies and practices	Limited to CPC augmented leave requirements. Staff are expected to remain in office long hours, and often are required to put in time on weekends and over vacations.	A few implementers have developed an advanced model of this.
	CLO/FLO functions	Provided through DoS	DOD's OneSource website coordinates counseling services for Soldiers and Families who need assistance with deployment-related issues. Also, Military Family Life Counselors (MFLC) and Fleet and Family Services have been made available. At post, Morale, Welfare, Recreation (MWR) Programs available. Someone from each unit "stays behind" on base to serve as the rep. for care. This commanding officer in the Army would give updates to the family and call and check on the family from time to time.
	Psych-evacuation with extensive, long-term psychosocial support services provided as may be required	USAID provides counselling through Staff Care, but it is of limited duration and is only available in Washington. Staff Care can provide extended support and can arrange external local referrals, but this does not currently seem to be an intentional and systematic approach to supporting psych-evacuees.	A few implementers have developed an advanced model of this. Inquiring about Peace Corps model. DoD -- person to be evaluated by health team on ground and MEDEVAC coordinated if required for care. Rather than MEDEVAC, medical provider may order monitoring and rest for that person to recharge.
	On-site Staff Care resource person available at all posts	Available at CPCs through State/MED, and through RMOPs at unrepresented posts.	

During Deployment	Stress and psychosocial out-brief	Mandatory end-of tour outbrief and in later stages of post-deployment only at request of staff. Many staff report "ticking the box."	A few implementers have developed an advanced model of this yet often limited to an immediate end-of-tour approach. DoD has Deployment Health screening and follow up
Post-Deployment	Reintegration/Homecoming assistance and support	Staff Care offers a voluntary Personalized Transition Plan.	DOD
	Peer debriefing	USAID has no system in place to develop and support systematic peer debriefing mechanisms.	A few implementers have developed this. Guidelines exist.
	Decompression, rest and stress recovery period	USAID staff feels pressure to go to onward assignments before accumulated leave has been spent. Even on leave, staff are hyper-connected and not truly off-duty.	International Organization for Migration's Rest and Recuperation Travel Scheme for hardship posts (Dec 2014 policy) DoD has strict decompression protocols depending on the operations.
	Ongoing and long-term support for stress treatment post-deployment, when necessary	USAID Staff Care provides initial services and referrals upon request from staff, but limits the number of sessions-although under certain circumstances can extend coverage up to 36 months.	DOD's OneSource website is able to coordinate counseling services for Soldiers and Families who need assistance with deployment-related issues.
	Systematically tracking stress exposure trends by comparing baseline assessments to all assignments in longitudinal fashion.	None.	DoD -- Army's GAT 2.0 (Global Assessment Tool).

Table 10.2. Gap Analysis on Best Practices vis-à-vis Workforce Stress (Annex 8 provides more details regarding practices at specific agencies)

GAPS IN STAFFCARE CENTER SERVICES AND OPERATIONS

USAID personnel feedback data on StaffCare during this assessment is decidedly mixed.

"I have no interest in StaffCare or the social worker; when I went to see them [they did not respond to my needs in what I felt was an appropriate way]. (Note: The statement in brackets was made in a personally identifiable way; in order to protect anonymity the statement is paraphrased by the authors in a generic way). I have heard, however, that StaffCare was helpful about referrals to other service providers, so if I need help with that I might use them again. I've heard other negative feedback about them, though, that means that I will never use them for my own mental health services should that become necessary."

- From email communication with a USAID FSO

"[After an evacuation], StaffCare focused on self-care, which was very inappropriate. FSNs had witnessed atrocities, had had atrocities committed to their families and friends. StaffCare responded well to those FSO staff evacuated back to DC...but did not respond at all to FSNs who stayed behind. This was a complete and total failure on the part of HCTM."

- From USAID Key Informant Interview

“Hello? Mental health care? Why isn't that on any of your lists? You need to provide real mental health care which is completely separate from State/security clearance. By the way - whatever StaffCare is doing is in no way perceived by the field as filling this requirement.”

- From the USAID CPC Incentives Survey

“StaffCare came out after the Kabul bombing, but they should have come out 100 more times. It was at onward posts where people freaked out...”

- From USAID Focus Group Interview

“StaffCare is highly responsive when asked, but there is a disconnect that exists between staff at Post and StaffCare in Washington.”

- From USAID Key Informant Interview

“StaffCare gave a presentation- sounds great, very useful - if [posted] in Washington. I like the idea. But much of what they provide doesn't work for me...”

- From USAID Key Informant Interview

There was both negative and positive feedback about StaffCare services from both interviews and surveys. This ambiguity leads to the conclusion that StaffCare services are, at the very least, problematically inconsistent: sometimes helping, but too frequently leaving a number of people who feel unhappy and expressing the perception that their needs were not met. If nothing else, this lack of consistent positive feedback is a problem when it is directed at the unit responsible for providing sensitive, supportive assistance to stress affected personnel. A reasonable caveat to these perceptions is that they come from stress affected USAID personnel. USAID personnel who are fearful and aversive due to the stigma of needing or seeking care might have distorted perceptions or stress-induced emotional over-reactions. USAID perceptions matter, of course, and tell us how people think and feel about StaffCare- but these data points alone do not allow an objective, technical critique of StaffCare services.

Internal M&E (monitoring and evaluation) at StaffCare is a recent development. Reportedly StaffCare does “check-ins” to assess services provided, but these do not appear to be tracked or followed up systematically, and as an M&E instrument this informal approach likely suffers from numerous threats to validity that could render the information obtained highly unreliable. In terms of the information the assessment team was able to obtain about StaffCare, it appears that this information suffers from a practice of aggregating different indicators together in a way that obscures basic performance metrics (as one example, counting individual counseling sessions provided to staff posted abroad as “engagements” with a Mission).

There is little evidence of systematic assessment of results at StaffCare that could be used for basic accountability oversight, or more importantly, to inform program learning and ensure continuous improvement through systematic reflection on performance. This lack of carefully collected performance

information makes it difficult for external observers to understand levels of service delivery and access, and to assess the quality of StaffCare services and resources. It also makes it nearly impossible for StaffCare personnel to identify for themselves any negative patterns affecting quality or content of services and to reflect on this information for program learning and continuous improvement.

The literature on occupational stress management,¹⁸² as well as the literature related to occupational stress in the field of international development,¹⁸³ explicitly identifies the need for systematic monitoring and evaluation of all interventions designed to address stress among employees. This weakness should be addressed, with StaffCare developing and rigorously applying careful, systematic M&E to all activities.

Many people in the field do not trust Washington-based assets, and currently StaffCare is seen by many to be Washington-based. This decreases the likelihood that people in the field will feel comfortable accessing StaffCare services. Additionally, time differences and awkwardness associated with phone-based counseling also prevent many from accessing StaffCare services based out of Washington.

StaffCare has rather recently developed an expeditionary awareness and an extended, far-ranging approach that is still evolving; this end-of-the-tether operational approach needs to be developed further still. Clarifying the specific roles and responsibilities of HQ and the StaffCare Center in relation to supporting and supervising a permanent and/or a roving field presence will be required. An operational division of labor and responsibility similar to the GS/FS is likely required, with an operational model similar to the OTI Staff Support approach, relying on a centralized resource manager who coordinates activities and resources and maintains ongoing contact with personnel and senior managers, with elements of the roving-RMO/P model blended-in to ensure routine, regular coverage at post, with face-to-face services being offered. Likely there is a need to locate LCSWs or other service professionals in regional platforms to provide for rolling coverage of small, relatively low-stress Missions that nonetheless are likely to be receiving people from CPCs who are recovering from acute stress exposures and are thus in need of relatively intensive support. StaffCare will also most likely need to post people full time into Missions that are either large and high-volume, or especially intense in terms of being high-profile and high-political scrutiny, and thus are also high in terms of operational stress.

¹⁸² See, for example, NIOSH. "Stress at Work. Publication no. 99-101." National Institute for Occupational Safety and Health. (Undated). p. 19; and, Kendall, Elizabeth, and Patricia Murphy, Veronica O'Neill, and Samantha Bursnall. "Occupational Stress: Causes and Management Models." Centre for Human Services, Griffith University: August, 2000. p. 105; and, Mental Health Commission of Canada. "Psychological Health and Safety: An Action Guide for Employers." January, 2012. pp. 36-40.

¹⁸³ See, for example, People in Aid. "The People in Aid Code of Good Practice in the Management and Support of Aid Personnel- Principles and Indicators." 2006; and, Welton-Mitchell, Courtney E. "Mental Health and Psychosocial Support for Staff." UNHCR: July, 2013. p. 77; and, Porter, Benjamin, and Ben Emmons. "Approaches to Staff Care in International NGOs." InterHealth/People in Aid: September, 2009. pp. 47-49.

ROUTINIZED PSYCHOSOCIAL HEALTH MAINTENANCE SUPPORT

An approach to ongoing, routinized systematic psychosocial service delivery is required that constitutes “psychosocial health maintenance” that, ideally, applies to all personnel.¹⁸⁴

“The agency should be more proactive with service provision and not wait for the employee to contact them, because sometimes you don't know what's out there or aren't able to ask for help that you might need. So much of the services offered seem to be Washington based... what about support in the field? We are a Foreign Service agency, aren't we?”

“Counseling and vigilance [is required]. This pressure cooker visibly makes people act in unusual and inappropriate ways: shouting in meetings, talking out loud to themselves, walking in circles, and so on. These individuals think they do not need help, and refuse it - and then extend for multiple years.”

- Quotes extracted from the USAID CPC Incentives Survey

“Some type of mandatory mental health program. I found multiple-year folks in Kabul to be in need of it but not taking advantage of counselors at Post.”

“More staff care targeting mental and emotional health. Especially for two years tours and it really should be face to face, not a phone call to the staff care office or a “screening” when you leave a CPC.”

- Quotes extracted from the USAID CPC Incentives Survey

This routine support should not be entirely dependent upon staff arranging services for themselves “on request” and/or “with supervisory approval” as per the current model. When psychosocial services are entirely demand driven and “upon request” there is a danger they will be utilized only as emergency responses to crises; many people may not necessarily self-diagnose and pro-actively recognize the need for preventative or pre-crisis assistance. Advanced psychosocial issues are always harder to address- not to mention more damaging to individual, familial and organizational health- when they have escalated into a crisis situation. Prevention through health management is a far more prudent approach.

This psychosocial maintenance approach also entails tracking of stress exposure and psychosocial health at an individual level.¹⁸⁵ According to StaffCare, State/MED already has an individual assessment template used for case management of individuals, and this could likely be adopted unchanged, or, if appropriate, could be easily modified for use by USAID. There are also a variety of psychosocial assessment instruments that are standard, off-the-shelf instruments and these are widely available.¹⁸⁶ Although there are very good reasons to not make psychosocial counseling fully mandatory, neither is it prudent, given the high levels of stress exposure and biopsychosocial distress reported, to make engagement with

¹⁸⁴ This requirement re-occurs consistently throughout the literature, but the most cogent description of the need and the approach is found in the Antares Foundation document, “Managing Stress in Humanitarian Aid Workers- Guidelines for Good Practice.” 3rd edition. Antares Foundation. March, 2012. See specifically Principle 2, Screening and Assessment, pp. 16-18; and Principle 4, Monitoring, pp. 22-23.

¹⁸⁵ Ibid.

¹⁸⁶ For a partial list of these, see Self-Assessment Mechanisms in section 4.B.1.

psychosocial health systems entirely voluntary. USAID must establish and navigate a middle ground that ensures all personnel are regularly assessed for emerging psychosocial health conditions. This allows USAID to prevent stress exposure that may worsen a pre-existing condition, and also allows for a discreet, confidential opportunity to identify issues, seek treatment if appropriate, or develop personalized self-care and/or stress management plans. USAID personnel must be regularly contacted and supportively engaged to ensure they are aware of the warning signs, and that they have absolute clarity about what services are available and how to access these in a safe and confidential way. If necessary, they can then address any challenges pro-actively before these escalate to personally unmanageable levels of distress or active crises.

Given the nature of the work, USAID personnel will inevitably be exposed to highly stressful and potentially traumatic experiences throughout the course of their careers in the Foreign Service- it is unavoidable. For this reason, they must have routinized, reliable, and consistent worldwide access to high-quality, non-stigmatized counseling services whenever these become necessary. USAID personnel can and should be equipped with knowledge, self-care practices and resilience skills that will mitigate these effects- but they should not be left to deal with the sometimes severe consequences of work-related stress exposures on their own. USAID has a clear duty to provide resources and support, and USAID personnel have a clear and perfectly reasonable expectation that they will receive this. With the right sensitive, respectful, evidence-based approach, USAID can develop and support a capable, healthy, resilient workforce that is fit for service anywhere they are required to go.

CULTURE OF STOICISM AND STIGMA WITH NEEDING OR USING PSYCHOSOCIAL SUPPORT

Strikingly, of those that reported they had accessed StaffCare Center support in the survey, 34.6% reportedly concealed their use of support from others. Only 18.1% said that their manager made getting support easy. Many respondents shared their reasoning for concealing their use of support: “Embarrassment and bullying,” “stigma, lack of empathy,” “People judge and use the fact of needing support as a character flaw,” “We are not a supportive environment,” “It could adversely impact my career,” “It didn’t seem like something anyone else would understand.” 13.1% of people mentioned that they concealed their use of support during deployment, explaining that “USAID culture expects stoicism, and punishes problems coping in informal, indirect ways,” and that seeking support was a “sign of weakness.” One respondent elaborated: “There is professional stigma on using support. It is not possible to access USAID or State support without doing so publicly, as the place and method of reserving times is public. And we know that our security clearances rely on not having used mental health services.”

Compared to during deployment, fewer respondents identified concealing their use of post-deployment psychosocial assistance (9.8%), but more reported feeling as if they were “on their own” for obtaining assistance post-deployment (32.1%). And again, many reported stigma-related barriers to obtaining help within USAID.

"I have heard other employees explain that only marital difficulties or death of a close family member are "acceptable reasons" for accessing mental health service; other issues will pose difficulties in maintaining a security clearance. This is a wide perception..."

- From a personal email communication with USAID FSO

This perception that merely accessing mental health services can endanger security clearances persists even though it has been regularly rebutted as inconsistent with USAID/SEC's adjudication policy. In our interviews, the perception that USAID looks negatively upon mental health services was asserted to be completely false by multiple senior managers interviewed, as well as an interviewee from inside USAID/SEC. Additionally, the Agency has developed and delivered multiple informational messages designed to educate personnel that the threat to a security clearance for accessing psychosocial care for stress-related issues is a myth.¹⁸⁷ For this reason, it is essential that all routinized psychosocial maintenance coverage provided by StaffCare be experienced by staff as, in the words of one key informant interviewee, "safe, respectful, and non-threatening." Another interviewee said that people need "safe and discreet access" to services. By making it part of a regular, routine approach to psychosocial health maintenance, stigma can be lessened by making everyone go through a regular screening and maintenance process, and thereby no-one who is accessing these services stands out.

This perception that needing or seeking support is not acceptable within the organizational culture of USAID, and will result in negative outcomes in relation to one's security clearance, is a significant barrier to ensuring a healthy workforce that USAID must overcome.

ROLLING STRESS ASSESSMENT AT OU LEVEL

Regular and routine Operational Unit assessment is also required, tracked over time. A standard method and instrument should be developed, and this assessment instrument should include specific metrics looking at stress responsive leadership and supervision. StaffCare Champions need to have a formal role in this ongoing OU assessment and tracking process.

Currently, StaffCare has no formal strategy in place. This leads to a lack of a strategic approach to engagement with Missions and personnel posted abroad, and ad-hoc, employee-driven delivery of services to staff serving in peripheral high-stress environments. In order to roll out the enhanced suite of services that are recommended in this assessment, StaffCare requires a strategy to address the complexity and the change management needed as the Agency transitions to a more stress responsive culture and set of integrated stress management practices. This strategy must at a minimum contain a set of specific objectives and the steps and stages necessary to achieve these objectives, along with clear assignment of roles and responsibilities, timelines for key deliverables and achievements, and a clear set of metrics for managing processes and ensuring achievement. The strategy should include an engagement workstream that addresses coordination with HCTM (developed in collaboration with HCTM), engagement with senior leadership at USAID Missions, and with the entire USAID workforce; a recruitment workstream to ensure the StaffCare Center and the expeditionary unit are fully staffed with

¹⁸⁷ This stigma was mentioned multiple times in Key Informant and Group Interviews, and also appeared in the open-ended answers provided in the USAID Incentives Survey, as well as the USAID staff stress survey delivered by this assessment team.

fully capable professionals; and critically important, a strategic communication workstream that will ensure USAID personnel at all levels are fully aware of coming changes and the suite of services and resources StaffCare offers currently or will offer in future.

EAP APPROACH VS. AN “EXPEDITIONARY MODEL”

The classic response to managing stress in a workforce is to design and implement an Employee Assistance Program (EAP). More enlightened employers who have a stronger emphasis on maintaining the social contract with employees, or who explicitly value employee wellness as a business ethic, often seek to address the organizational causative factors of stress as well, and by doing so seek to reduce or eliminate the stressors associated with specific business practices or work processes within the organization. Regardless of whether or not an employer takes this integrated, multi-tiered approach, as discussed above, EAPs tend to focus on some mixture of secondary and tertiary interventions¹⁸⁸ and are typically provided through a centralized Operational Unit often housed in a Human Resources office. The various resources and benefits that employees are entitled to are communicated, and it is generally up to the employee, with the support of Human Resources, to know about and access the applicable features of the program. This model presents several conspicuous weaknesses when it comes to ensuring the biopsychosocial health of the USAID population.

All of these issues are discussed elsewhere in this document in greater detail. However, to ensure the point is also made here for readers, these points are summarized as follows:

1. With a globally dispersed workforce, a centralized EAP does not adequately address employee access needs. With stress care personnel located in Washington, and providing information, resources, and assistance that is substantially Washington-centric and Washington-based, many USAID personnel in need of assistance do not receive the support they require.
2. With a purely voluntary model of staff support, many personnel who do not recognize their need for support do not elect to receive assistance. As a result, many USAID personnel who might benefit from focused stress support remain untreated, and this further intensifies the stress environment affecting everyone else due to social contagion of stress.
3. The unique stressors associated with international development work are so consistent and predictable, and so unusual from the perspective of a “normal” approach to design and implementation of an EAP, that a somewhat radical and alternative approach is required to meet the needs of peripherally deployed personnel.

USAID requires a multi-pronged and multi-tiered approach to manage and mitigate stress among its workforce. This multi-faceted approach includes delivery of strong pre-deployment preparation that readies people for the stress of working abroad and working in high-operational stress environments. This preparation involves training in stress awareness and stress management that is robust and equips people to recognize the signs of stress in themselves and others and, to the degree appropriate, to possess a broad array of potential self-care tools and practices that allow them to actively manage and mitigate their own stress. Preparation also entails providing accurate, current briefings to prepare them for the inevitable stressors they will face. Finally, there needs to be an assessment process to identify people struggling with a heavy stress load. First, to prevent people struggling with stress-related difficulties from being exposed to levels of additional stress that may trigger severe reactions or stress-related injuries; and second, to channel people who need it into structured support assistance that can help to reduce the stress load they carry.

¹⁸⁸ Blaug, Ricardo, Amy Kenyon, and Rohit Lekhi. “Stress at Work.” The Work Foundation. February 2007. p.79.

Furthermore, as many USAID interviewees and survey respondents noted, most, if not all, USAID posts are stressful -- even Washington. Given that many people at any given time will be rotating out of acute stress environments into chronic high-stress environments, it should be assumed that the entire workforce requires easy access to staff care services all the time. This requires a permanent support framework posted abroad. For particularly large or particularly demanding high-stress posts, this may require a full-time staff care counselor on-site; for other Missions that do not have quite so high a need, a rotating presence similar to the RMO/P model will likely meet the requirement. In combination with the other policy and business process changes contained in the recommendations of this report, this expeditionary model will ensure that all USAID staff, regardless of their location, have regular access to high-quality staff care support services wherever and whenever these are required.

13. CONCLUSIONS

The following interlocking concepts have been used throughout this document to identify gaps and will now inform conclusions and recommendations.

1. **Stress Awareness:** The non-stigmatizing understanding by staff and managers that stress is biopsychosocial and has specific consequences that affect health, work performance and interpersonal behavior. Furthermore, the knowledge that stress can be managed and moderated with positive self-care and benevolent stress-supportive management systems, and is exacerbated by unskillful management practices and dissonant organizational systems.

2. **Stress Responsiveness:** Based on an objective understanding of stress (Stress Awareness), an organization's adoption of practices that

mitigate stress and care for staff; in other words, practices that eliminate avoidable adaptation challenges (stressors), minimize exposure to unavoidable adaptation challenges, mitigate current stress effects, care for distressed personnel, and reduce strain on the organization as a whole.

3. **Stress Mitigation:** Interventions that either prevent or reduce the prevalence/severity of adaptation challenges. For example, management might mitigate stress by providing clarification on the relative urgency of tasks so that staff is not frantic with the perception that everything is important and must be completed immediately.
4. **Staff Care:** Interventions that provide relief, support or treatment for personnel that have been negatively affected by adaptation challenges. For example, an organization with occupational exposures to trauma might provide a counseling center providing trauma-informed services.



Figure 13.1. Stress Awareness Driving Stress Responsiveness



Figure 13.2. Stress Responsiveness with its Two Components Stress Mitigation and Staff Care

Simply put, policies based on Stress Awareness are realistic, higher-yield and have a better “do no harm” profile that can substantially lower risk. Stress Aware policies lead to better guidance on Stress Responsiveness and the institutional practices such policies establish, which in turn produce better outcomes for staff and consequently for the organization as a whole.

With the above concepts in mind, this report's conclusions are:

KNOWLEDGE AND BEST PRACTICES OUTSIDE USAID

1. **Stress is biopsychosocial.** Stress causative factors reside not just in the environment, but in the biological, psychological, and social milieu of individual persons. Stress also produces disruptions and alterations in each of these elements, and an integrated approach of stress responsiveness must operate within and address each of these dimensions as well.
2. Members of the workforce who carry a heavy stress burden due to high levels of chronic stress exposure, as a result of the **cumulative nature of stress** and allostatic load, have a **diminished ability to be resilient** when exposed to the potentially traumatic stress of a critical incident. Therefore, the likelihood that a critical incident will result in traumatic stress — or a stress-related psychological injury — is markedly increased (Nash, 2010).
3. There are **extensive standards and associated best practices for managing occupational stress** in general, and specifically for managing occupational stress in international relief and development organizations.

SYSTEMS WITHIN USAID

1. **USAID as a whole is not adequately in alignment with these standards and best practices** for managing the stress of its workforce. There are numerous gaps that require USAID attention if it is to successfully mitigate stress' negative consequences.
2. USAID currently does not possess **data systems or technology to track chronic or acute stress** among personnel, Missions/OUTs, and the Agency as a whole. Additionally, there is a lack of analytic capacity to determine where preventive measures may be taken or extra support may be necessary.
3. **USAID lacks a set of coherent, overarching, and multi-tiered policies** for stress management across USAID.
4. **USAID lacks a “permanent organizational development” approach to stress management.** This includes processes that focus on leadership development, coaching and mentoring of inexperienced officers, developing skills in team-based management, and developing specific USAID tradecraft. USAID also lacks systems of accountability and performance management related to stress responsive management and supervision.
5. This situation has **long-term implications** for the performance/effectiveness of USAID personnel, physical and psychological health, total workforce management, and the achievement of USAID's mission.
6. There are special opportunities to reduce risk at CPCs/HTEs/NPEs and positively affect the cadre of personnel operating in these high stress environments. **USAID warrants targeted policies and practices to address stress exposure throughout the entire CPC/HTE/NPE deployment cycle.**

PERSONNEL EXPERIENCES WITHIN USAID

1. Given the **consistency of response across Missions and DC**, as well as across management levels and employment categories, it is concluded that **USAID's stress levels are indicative of systemic, Agency-wide challenges that require a coherent, systemic, Agency-wide response**. Providing additional training and stress management tools to USAID personnel, or making incremental adjustments to improve the fielding process, is unlikely to significantly alter the stress conditions affecting USAID personnel.
2. **The USAID workforce is currently exposed to severe levels of stress and is at risk for developing numerous stress-related health conditions and/or disorders**. Every adaptation challenge and stress effect reported by USAID personnel is mirrored in an extensive body of literature with similar findings across similar institutions. While USAID has unique configurations of adaptation challenges and stress effects, the problems appear to be widespread throughout the U.S. government, the development sector and international relief organizations.
3. **Major sources of stress as reported by USAID personnel are related to institutional management practices**. These institutional stressors are:
 - Leadership deficits, including lack of defending USAID institutional interests in interagency forums, lack of defending USAID personnel interests (prioritization of tasks and reasonable workload), lack of personnel management skills, and lack of team-based management skills.
 - Inadequate HR management and personnel support practices.
 - Poor and unsupportive assignment/fielding practices.
 - Excessive workload: overlong days, overlong weeks, and inadequate time to recover.
4. These **institutional stressors are exacerbated with the threat exposure**, operational tempo and political pressure of CPCs/NPEs/HTEs and result in unhealthy stress loads.
5. With the current model of staff support being purely voluntary, **lack of awareness of the need for support, an agency culture of stoicism, and significant stigma to seeking support**, many personnel do not elect to receive assistance. As a result, many USAID personnel who would benefit from focused stress support **remain untreated**, which further intensifies the stress environment affecting the workforce as a whole, due to **social contagion of stress**.
6. The mindset and engagement of USAID personnel is profoundly affected by **family concerns**. Relationship strain is a substantial drain on workforce morale.
7. Through **provision of services through the Staff Care Center**, USAID is responding to people dealing with stress reactions. Of those who have used it, the data shows 74% have found it useful; at the same time, the data shows close to half (45%) of USAID personnel respondents found **service was not available** to them and did not utilize the services. There are numerous gaps, which limit the overall effectiveness of the Staff Care intervention:
 - **Lack of expeditionary approach** for a consistently perceptible field presence.
 - **Lack of routine psychosocial health maintenance approach**, including periodic individual level stress assessment and tracking.
 - **Unfavorable restrictions** (low caps to session quantity) to providing on-going and long-term support to people with stress reactions and other conditions traceable to occupational or traumatic stress exposure.
 - **Lack of systematic M&E** for quality assurance and organizational learning.

I 4. DETAILED RECOMMENDATIONS

Many sources of input informed these recommendations. Published research, normative best practices, and the experiences of USAID and other organizations were all input to the recommendations contained here. USAID leadership and staff offered input and analysis at every step of the assessment, and special care was taken throughout the study to ensure that all advice and every suggestion that emerged from USAID personnel during data collection was considered. These recommendations also benefitted from the generous input of the Senior Advisory Group for this project, which included members of the US State Department, US Department of Defense (DOD), US Department of Homeland Security (DHS), National Institute of Occupational Safety and Health (CDC/NIOSH), US Public Health Service, and former USAID leaders.

An important factor in recommendations having organizational impact is often the integration of participatory reflection and feedback; in a sense, conducting parallel “utilization research.” By reality-testing and refining initial findings and conclusions, validating emerging hypotheses with the client organization, and establishing early-on what type of recommendations would be most suitable and effective in context, the likely applicability of these recommendations to the unique institutional culture and operational environment of the client is assured. This has, throughout the research process, been the intent of the assessment team — to provide a set of recommendations that are well-suited to the USAID institutional frame. These recommendations have therefore benefitted from regular and continuous engagement with USAID personnel, including integrating USAID personnel as field researchers; consultation with a USAID working group assembled to provide review and analysis for this project; input from USAID Mission Directors; and input from several senior USAID leaders who remained committed and engaged throughout the study. All of these USAID personnel shared ideas, vetted suggestions of the assessment team, and contributed to the shape of the recommendations that follow. Furthermore, during the course of Key Informant Interviews and Group Interviews, as well as in open-ended comments provided through the *Staff Care Needs and Stress Exposure Survey* delivered as part of this assessment, and open-ended comments contained in a previous USAID survey looking at CPC incentives, USAID personnel provided numerous recommendations that heavily informed and align with the recommendations contained in this report. The assessment team thus believes that each of the recommendations below reflect and respond to the suggestions, sensibilities, and requirements of USAID. The assessment team understands that, as the recommendations in this report are broad in scope, USAID will likely need to refine these recommendations further as they operationalize them for implementation. For example, data on the operations of the StaffCare Center were limited at the time of report writing, and as more extensive data are obtained, USAID may wish to further refine some of these recommendations.

The framework for these recommendations is loosely inspired by the Antares Guidelines for Good Practice, found in the document “Managing Stress in Humanitarian Workers – Guidelines for Good Practice,” (3rd edition: March, 2012). This foundational document has been referenced throughout this report. The framework for these recommendations closely follows the three phases of the Antares framework: pre-deployment, in the field, and end of mission. However, not all USAID staff are, strictly speaking, “deployed” — some never leave the country they were hired in (whether this is the US or

another nation). For staff who do not receive explicit deployment to a specific Mission or project, it is recommended that those practices in the standard Antares model triggered by deployments (e.g., a stress check-in with your supervisor) be periodically conducted for all staff, such as on a quarterly or an annual basis.

In addition, this study uncovered a number of areas that represent broader USAID institutional concerns beyond the specific Antares cycle. The framework has therefore been expanded to include larger institutional factors that are critical for Stress Responsiveness, represented visually through an Institutional Support “Umbrella.”



Figure 14.1. Recommendations Organized as Institutional Umbrella and Assignment Cycle

I. INSTITUTIONAL SUPPORT

This table summarizes the Institutional Support recommendations. Details follow.

Area	Findings/Conclusions	Recommendations	Responsible
A. Leadership	a. No explicit stress-specific policies at USAID b. Lack of authority, resources and accountability for stress responsiveness at USAID c. Gaps in leadership behaviors that affect USAID personnel	a. Develop an ADS and sub-policies focused on Stress Mitigation and Staff Care b. Provide all-agency direction and oversight to the implementation of stress responsive policy, leadership and interventions c. Deploy leadership training throughout the organization	a. HCTM/PPSM, HCTM/SCC b. AID/A, HCTM/SCC c. HCTM/CPD
B. Budgets & Planning	a. No dedicated budget resources available throughout the agency and Operational Units b. Lack of institutional coherence in various stress mitigation investments c. Lack of systematic M & E of stress-related programs	a. Plan and allocate budget for stress mitigation and staff care programs b. Coordinate with Operational Units that have made their own investments in stress mitigation c. Monitor and evaluate stress mitigation programs, making updates as needed	a. AID/A b. HCTM/SCC c. HCTM/PPSM
C. Operations & Organization	a. Lack of business processes and work practices that are stress aware b. Gaps in personnel management skills in supervisors and gaps in tradecraft skill in inexperienced staff	a. Expand organizational development, and b. Expand professional development functions at USAID to coherently support stress mitigation.	a. AID/A b. HCTM/CPD
D. Environment	a. Inadequate family engagement to support the family system, including the USAID staff member b. FSNs and TCNs substantially left out of service delivery and lack culturally adapted resources c. Interagency factors negatively impact the morale and welfare of USAID personnel d. Gaps in information sharing and institutional learning between USAID and similar agencies	a. Family engagement (briefing, services, skills) to prepare for deployments, to provide ongoing support, to reach out for crisis support and post-assignment support b. Culturally adapted stress mitigation and staff care for FSNs and TCNs c. As per QDDR, engage interagency partners whose decisions impact the operational stress of USAID personnel d. Maintain flow of ideas and best practices among care consortiums within DOD, VA, and United Nations counseling units	a. FSI Transition Ctr, HCTM/OHCI, HCTM/SCC b. HCTM/OHCI, HCTM/SCC c. AID/A d. AID/A, HCTM/SCC

Table 14.1. Institutional Support Recommendations

A. LEADERSHIP

It is critical that USAID Senior Leadership support, validate, and implement an organizational culture change initiative focused on Stress Awareness and Stress Responsiveness.¹⁸⁹ This will require considerable support capacities that do not currently exist within USAID.

a. Develop an ADS and sub-policies focused on Stress Mitigation and Staff Care

The Policy is to include vision, purpose, and outcomes; clear and specific assignment of operational roles and responsibilities; and a detailed description of mechanisms, processes, and procedures, both for management response to routine sources of chronic stress and to unforeseen stressful circumstances that affect both national and international staff (such as forced evacuations, critical incidents, and international residents in more intense chronic stress situations).¹⁹⁰

A process of creating a working group and getting broad participatory feedback from the organization is required to further validate the ADS sections and establish the depth to which ADS requirements should go. The working group will have to decide to what extent topics require uniformity and standardization across USAID versus allowing individual units to develop and apply flexible, OU-appropriate standards and practices. The Policy should include the following components:

- i. Assignment and bidding process
- ii. Adherence to Antares Guidelines
- iii. Standard Operating Procedure for comprehensive Critical Incident Response, including definitions of what constitutes a CI and meets the requirement of mandatory critical incident reporting and roles and responsibilities for the StaffCare Center
- iv. Standard Operating Procedure for comprehensive Crisis Response, including specific management authorities and roles and responsibilities for the StaffCare Center
- v. Standards for work week and working hours, including Leave, Vacation, and R&R
- vi. Workforce Planning; Right-sizing the Staff to Budget ratio
 1. Surge Capability and Agility to address unforeseen foreign policy priorities, and heavy portfolio/high political scrutiny Missions
 2. Non Direct Hire mechanisms to supplement FSOs
 - a. PSCs
 - b. FSLs
- vii. Follow on assignments and bidding process
- viii. Procedures and mandatory requirements related to data collection for pre-deployment assessment for deployment suitability and for cataloguing/recording personal stress exposure and cumulative stress effect of assignments
- ix. Family support
- x. Treatment access for stressed and or traumatized people
- xi. Codify expectations in job descriptions for stress mitigation and fostering resiliency
 - I. Roles and responsibilities for StaffCare Center

¹⁸⁹ Antares (Annex 5) Guideline I.e. See Antares Foundation. “Managing Stress in Humanitarian Aid Workers-Guidelines for Good Practice.” 3rd edition. March, 2012.

¹⁹⁰ Antares (Annex 5) Guideline I.c.

2. Roles and responsibilities for HCTM
3. Roles and responsibilities for Supervisors
4. Roles and responsibilities for Mission Directors
5. Roles and responsibilities for EXO
6. Roles and responsibilities for StaffCare Champions
7. Performance management systems and supervisor performance appraisal

In addition to an overarching ADS Stress Management Policy, there are specific policies and practices needed for HCTM, the StaffCare Center, and other Operational Units. These policies should include:

- a. HCTM
 - i. Workforce fielding processes that systematically address recommendations 1-8 (Eight principles of the Antares Cycle)
 - ii. Revision of bidding and assignment process to be Stress Responsive
 - iii. Development of performance management system for Supervisors, including objectives and indicators and 360°-style feedback mechanism on management performance
 - iv. Strategic communication plan with USAID personnel and provision of user-friendly sources of information such as deployment process requirement checklists, web resource “one stop shop” for forms and requirements, and customer service oriented help desk
- b. HCTM/SCC or HCTM/CPD
 - i. Coaching and Mentoring Parameters
 - ii. Mechanism for accessing and approving
 - iii. Quality criteria
 - iv. Vetted Provider referral list
 - v. Budget authorities
 - vi. Stress Aware/Stress Responsive Considerations
- c. HCTM/CPD Training requirements include:
 - i. Stress Awareness -- Physiology and Effects on Performance and Operations
 - ii. Requirements of Tradecraft
 - iii. Personnel management
 - iv. Team-based management
 - v. Leadership skills
- d. Operational Units (Missions and Offices)
 - i. Staffing appropriate to portfolio
 - ii. Workload and limits to workday/ work week policies
 - iii. Leave and time off policies
 - iv. Supervisor accountabilities
 - v. Establish the role responsibilities of the StaffCare Champions and designate the person
 - vi. Organizational Diagnostics requirements
 - vii. Team Based management practices
 - viii. Tradecraft and Leadership Development (coordinated with USAID’s Nodes of Learning – WLC, FEI, FSI, mentoring)
 - ix. Staff Transition Management and EXO Customer Service
 - x. Critical Incident reporting and staff support “tripwire” requirements

b. Provide all-agency direction and oversight to the implementation of stress responsive policy, leadership, and interventions (SRPLI).

An effort of this size requires dedicated expert resources to advise and support the Office of the Administrator and other parts of the Agency on two aspects of stress responsiveness -- stress mitigation and staff care. The objectives of SRPLI are:

- **Policy:** Provide advice and guidance on policies for stress mitigation and staff care, including drafting these into the ADS
- **Leadership:** Be a resource for leadership at USAID and provide thought leadership on evidence-based best practices in stress mitigation and staff care
- **Interventions:** Provide the expertise and capacity to maintain, update, and implement stress mitigation and staff care activities across the Agency and for specific Operating Units

It is appropriate that USAID have two levels of interventions, one global and the other specific to an Operational Unit or group of Operational Units, in order to establish and support a set of minimum standards throughout USAID, while flexibly accommodating the dozens of OUs with separate purposes and operational requirements. There are interventions that will work best and most effectively with global participation, such as the data and analytics dashboard. Other interventions will be prompted by local circumstances particular for certain OUs. For example, a mission that is operating in a high-threat environment, with difficult travel restrictions, may need to supplement the basic ADS standards for critical incidents with additional tools and procedures to ensure appropriate responses.

We strongly recommend SRPLI provide support to USAID in both kinds of interventions:

I. Support for Agency-wide Interventions

- a. **Policy:** Develop policies that establish minimum standards. This includes not only ADS components addressing stress mitigation and staff care, but also supplemental, ongoing and adaptive policies and procedures developed through applied research and organizational learning. Using data, SRPLI can advise leadership on whether policies are producing intended results or not and which need to be revised or updated.
- b. **Expert Consulting:** Provide biopsychosocially grounded consulting to Agency leadership, including USAID/A, senior Mission managers, and HCTM. Through conversations and professional meetings, SRPLI experts will maintain an information exchange with counterparts in the relevant fields of research, keeping up to date with and sharing research and the development of new best practices, as well as allowing USAID to be a thought leader helping to create sectoral standards for staff care and resiliency in the field.
- c. **Analytics:** Create and operate a data gathering and analytics function for USAID. This will enable creating dashboards for summarizing and interpreting data so leadership can be aware of, and even anticipate, potential stress and trauma problems in their workforce and be empowered to take proactive and reactive mitigation measures. SRPLI will support identifying and procuring IT solutions needed to support the stress mitigation programs.
- d. **Online Resource Repository:** SRPLI would collect tools, templates, and best practices for the Agency from both internal and external sources. These would be archived in an online repository that is globally accessible, with indexing to make navigation of the resources easier for Agency staff. This would allow easy access and aggregation of both external resources and tools developed within USAID, avoiding duplicate efforts.

- e. **Monitoring and Evaluation:** SRPLI would monitor and evaluate the success of all stress mitigation and staff care interventions. This would enable SRPLI to perform quality assurance of all interventions and activities, as well as make recommendations to the Agency on budget and planning, what works, what does not work, and how all should be changed over time, if required.
- f. **Change Management:** Mainstreaming stress mitigation and staff care within the Agency will require ongoing support for change processes, especially in the early phases of implementation. Designing internal and external communications strategies and otherwise assisting USAID leadership in the complex process of consultation execution (e.g. developing communications videos or memos, holding facilitated consultation or outreach events, etc.) will be an essential part of SRPLI's mandate.

2. Support for interventions for specific USAID units

- a. **Global Coordination Hub:** Different USAID units have already developed creative local solutions to stress and staff care challenges. These provide a rich resource to the rest of the agency. SRPLI would track and maintain contact with various efforts that meet/exceed minimum standards of the Agency and archive these in the Online Resource Repository. SRPLI will also consult with local teams who wish to go beyond the Agency minimum standards, ensuring that these are consistent, as appropriate, with established terminology, concepts, and practices for the Agency. SRPLI can put USAID units with similar needs or experience in touch with each other so best practices and innovation spread across the Agency via peer learning.
- b. **Flexible Capacity:** If individual USAID units need support beyond the minimum standards services provided to the entire Agency, they should be empowered to develop a custom solution through the technical assistance of SRPLI. SRPLI should be flexible enough to add short-term capacity to design and/or facilitate interventions for USAID units (e.g., procuring the services of additional subject matter experts as surge capacity, if and when required). SRPLI can also provide referrals to other, pre-vetted vendors (e.g., for IT solutions, specialized facilitation services, etc.). This would enable SRPLI to provide quality assurance over consulting services offered to USAID.
- c. **Policy Exceptions:** SRPLI should provide USAID leadership with advice when there are requests for exceptions to the ADS. Where possible, SRPLI will attempt to problem-solve creatively with USAID units to ensure minimum standards are met while also allowing for appropriate flexibility.

In addition to supporting interventions within the Agency, USAID will task SRPLI to provide support to or interface with external parties, especially interagency partners. Since so many staff care service issues overlap with State, SRPLI will enable a collaborative approach to that relationship, for example through convening interagency working meetings, participating jointly in developing strategies, or coordinating joint services delivery. In addition, USAID may occasionally convene external advisory groups of the kind that supported this study. High level meetings such as this are very intensive in terms of the content and facilitation expertise needed, and SRPLI will support planning and executing events such as these on demand.

c. Deploy leadership training throughout the organization

Research studies consistently find that leadership skills for those in supervisory roles are critical for mitigating stress. In surveys and interviews, USAID personnel confirmed that they believe in the critical importance of leadership skills. Leadership skills create a vehicle for establishing Stress Aware and

Stress Responsive personnel management practices and ensuring staff are managing stress in necessary, appropriate and healthful ways. In managers, leadership skills create positive, supportive management behavior that avoids negative magnification of other stressors. Supportive, skilled leaders create strong teams, enhance stress-mitigating social support, and help others better adapt and cope when stressors are unavoidable. There are many possible best practices for USAID to study and draw from, where appropriate, including the USG (including but not limited to DOD), the UN, other donors/implementers, and private sector practices. Leadership behaviors will help ensure the success of the specific initiatives recommended in this report.

B. BUDGET AND PLANNING

a. Plan and allocate budget for stress mitigation and staff care programs

Throughout the planning process, leadership must ensure appropriate budget and planning for stress mitigation programs to include direct interventions, such as maintaining SRPLI, appropriate StaffCare Center staffing levels, appropriate interventions at Operational Unit levels, developing and maintaining assessment tools, etc. The planning process also must include indirect investments, such as ensuring funding and right-size work-planning at OU level that ensures adequate levels of staff where required.

b. Coordinate with Operational Units that have made their own investments in stress mitigation

USAID is a large agency made up of diverse Operational Units. Individual units may have particular programs they have initiated for stress mitigation (e.g. OTI, OFDA, OAPA, USAID/Uganda). There are applicable lessons-learned and best practices that could be scaled to the Agency level. While there does not need to be structured and mandatory integration of every Operational Unit program into the Agency-wide program, coordination to make sure content and language is consistent and applicable standards are met is necessary. Ensuring the appropriate information sharing and coordination linkages are established and maintained is important. For example, there should be clarity about the role of the StaffCare Center in responding to critical incidents. Coordination will reduce duplication of efforts and improve economies of scale; i.e., rather than different units in USAID building stress assessment tools or procuring service providers simultaneously but separately, diverse OUs could pool resources reducing administrative costs and improving pricing from vendors.

c. Monitor and evaluate stress mitigation programs, making updates as needed

Stress mitigation is an important investment for USAID. USAID should routinely and consistently monitor and evaluate all stress mitigation interventions. Evidence-based analyses and discussions with leadership will undoubtedly lead to the need for adjustments in the program. Therefore, monitoring and evaluation information should be regularly reviewed by leadership, and the appropriate changes made in both planning and budgeting processes.¹⁹¹ In addition, there is a need to provide decision support to Agency leadership when new policies are introduced that have a potential to impact staff stress and to provide recommendations to leadership to mitigate stress exposure.¹⁹²

¹⁹¹ Antares (Annex 5) Guideline 1g(i).

¹⁹² Antares (Annex 5) Guideline 1g(ii), 2b.

C. OPERATIONS AND ORGANIZATION

a. Expand organizational development and professional development functions at USAID to coherently support stress mitigation and staff care.

One senior USAID Mission leader advanced the idea of a “Permanent ‘Organizational Development’ approach” to stress management. This viewpoint aligns perfectly with findings from USAID interviews, surveys, and the wider literature on occupational stress management. Both organizational development and professional development will provide valuable support to mitigating stress and better taking care of staff. The centrality of coaching and mentoring programs to organizational development will also support achievement of the USAID mission beyond simple stress management.

A robust system to guide and support change management would also reduce stress throughout the change process. Mission directors noted that, while reducing stress is everyone’s preference, they are concerned about new processes causing new burdens upon them. Structuring and clarifying the initial stresses of organizational change, and providing specialized technical assistance at organizational and OU levels, will reduce stress on staff going through it. In addition, effective change management processes will allow the organization to change and adapt to volatile, uncertain, complex and ambiguous (VUCA)¹⁹³ circumstances, ensuring change is better fit-to-mission, which will also reduce stress.

A number of specific issues should be addressed through establishing and supporting professional norms and practices, such as defending time away from job tasks for healthy lifestyle behaviors, ensuring job descriptions that are properly scoped, and addressing the harm done by difficult managers and disrespectful behaviors.

D. ENVIRONMENT

a. Family engagement (briefing, services, skills) to prepare for deployments, to provide ongoing support, to reach out for crisis support and post-assignment support

Families have frequently felt “left out” and uninvolved in the support process. They both need support and are a source of support. USAID has the opportunity to engage families through Stress Aware and Responsive briefings, services, and skills. It must be remembered that many staff will have non-related significant others or other non-traditional family members who are just as important to them as spouses, children, and traditional family members are for others. These significant others can be engaged on the request of the staff member. The entire deployment, assignment, or job cycle is relevant to family.¹⁹⁴ FSI has several new offerings for family, and these should be taken into account as USAID

¹⁹³ VUCA: This acronym emerged in the 1990s to describe the capability to engage situations marked by change and challenges. For leaders in the military and beyond, the doctrine underscores the importance of strategic decision-making, readiness planning, risk management, and situational problem-solving. For more information on the concept, see: https://en.wikipedia.org/wiki/Volatility,_uncertainty,_complexity_and_ambiguity.

¹⁹⁴ Weinick, Robin M., Ellen Burke Beckjord, Carrie M. Farmer, Laurie T. Martin, Emily M. Gillen, Joie Acosta, Michael P. Fisher, Jeffrey Garnett, Gabriella C. Gonzalez, Todd C. Helmus, Lisa H. Jaycox, Kerry Reynolds, Nicholas Salcedo and Deborah M. Scharf. Programs Addressing Psychological Health and Traumatic Brain Injury Among U.S. Military Service members and Their Families. Santa Monica, CA: RAND Corporation, 2011. http://www.rand.org/pubs/technical_reports/TR950. See also Meredith, Lisa S., Cathy D. Sherbourne, and Sarah J. Gaiot. *Promoting Psychological Resilience in the US Military*. RAND Corporation, 2011.

reaches out to families and also accepts help from families as a noted protective factor for the psychological health of their staff.

b. Culturally adapted stress mitigation and staff care for FSNs and TCNs

Mission leaders, managers and staff in general have enormous respect for the work and dedication of FSNs and TCNs. USAID should provide minimum standards for FSN and TCN stress mitigation and staff care. Further study may be necessary to optimize this for a highly culturally diverse set of individuals. Resources and templates are numerous in this area and, with the right investments, much can be done with profound positive effects.

c. As per the QDDR, engage interagency partners whose decisions impact the operational stress of USAID personnel

At post, DOS Security management via RSOs, staff complements, housing and office assignments, and leave policies all provide opportunities for Stress Awareness and Stress Responsiveness. For example, PEPFAR operations are strongly impacted by the conduct of CDC staff. USAID must decide how to proceed with these relationships in order to improve its operational capacity as well as reduce some of the most significant sources of occupational stress. In DC, the State Department's Management Bureau, specifically it's FSI Transition Center and Office of Medical Services, are allies in the cause of maintaining USAID human capital and talent. Again, there are opportunities for coordinating resources depending on the strength of the relationship cultivated between USAID and these units.

d. Maintain flow of ideas and best practices among care consortiums within DOD, VA, and United Nations counseling units

Through conversations and collegial meetings, SRPLI experts will maintain an information exchange with their counterparts in the field, keeping up to date with research and the development of new best practices as well as enabling USAID to be a thought leader that helps create standards.

II. ASSIGNMENT CYCLE

As mentioned above, not all USAID staff go through the cycle of assignments, nor do they necessarily change locations. For staff who do not actually go through assignment cycles, the cyclic processes (e.g. check-ins with supervisors about stress) should nonetheless be instituted on a recurring, periodic basis.

Area	Findings/Conclusions	Recommendations	Responsible
Training	a. Inadequate and inconsistent training to prepare personnel to operate effectively in the midst of stress b. Managers/supervisors recognize deficit in skills to optimally address diverse stress situations	a. Staff trained to be Stress Aware and Stress Responsive b. Up-skill managers/supervisors to be optimally Stress Aware and Stress Responsive	a. HCTM/CPD b. HCTM/CPD
Assessing	a. Assignment processes pre- and post-NPE do not consider an individual's vulnerabilities (including prior exposures) or the predictable exposures at post	a. Assess the appropriateness of assignments using stress awareness	a. HCTM/SCC, State MED
Briefing	a. Inaccurate and outdated information on assignment conditions and inadequate information on existing adaptation challenges	a. Brief staff on the specific stress risks they can expect to face on their assignment	a. Regional Bureaus, HCTM/FSC
Monitoring	a. Inadequate and inconsistent use of self-monitoring b. No aggregate data to track stress at Operational Unit level c. No agency-wide, systematic, and routine stress monitoring of Operational Units d. No evidence-based tracking of workforce stress health risks	a. Provide mobile, interactive self-monitoring tools for personnel b. Anonymously aggregate self-monitoring data to track stress at Operational Unit level c. Conduct systematic, routine stress monitoring of Operational Units d. Conduct Health Risk Appraisal of the workforce periodically	a. HCTM/SCC b. HCTM/SCC c. State MED, HCTM/SCC, Missions d. State MED, HCTM/SCC

Support Services	a. Gaps in scope of and access to StaffCare Center services b. Inconsistent quality and variable customer service orientation c. Lack of designated resource person at every Operational Unit of concern d. Personnel experience StaffCare Center as DC-centric e. Difficulty locating suitable external care providers	a. Expand StaffCare Center's focus and staffing numbers b. Alter StaffCare Center operations to shore up quality and customer service c. Strengthen and mainstream StaffCare Champions d. Identify and reduce gaps to support and care e. Identify pre-vetted roster of external care providers and provide USAID-tailored services	a. HCTM/SCC b. HCTM/SCC c. HCTM/SCC d. HCTM/SCC e. HCTM/SCC
Crisis Response	a. Lack of awareness on which incidents warrant crisis response b. Lack of standard operating protocol on how to psychosocially respond when crises occur c. Non-response in episodes of extreme stress and lack of culturally appropriate service delivery	a. Establish policy providing thresholds for mandatory critical incident response and/or to enable crisis response b. Develop standard operating protocol for psychosocial crisis response c. Increase StaffCare's network of qualified specialists for crisis support and develop surge roster of pre-selected, vetted, and operationally prepared service providers	a. AID/A, Crisis Response Team to be formed at HCTM b. HCTM/SCC c. HCTM/SCC
Transition Considerations	a. Inadequate consideration of stress during start of assignment in- processing b. Inadequate consideration of stress during end of assignment out- processing	a. Add stress component to onboarding and assignment in-processing b. Add stress awareness to operational debriefings and assignment out-processing	a. FSI Transition Center, HCTM/SCC, HCTM/FSC b. HCTM/SCC HCTM/FSC
Post-Exposure Follow Up	a. Individuals are frequently overlooked by agency outreach efforts b. Access to services is insufficient and overly time-restricted	a. Follow through with post-assignment contact and support b. Increase quantity and duration of service provision	a. HCTM/SCC b. HCTM/SCC

Table 14.2. Assignment Cycle Recommendations

II.1 TRAINING

a. Staff trained to be Stress Aware and Stress Responsive

Design and select curricula and training materials that explicitly, and in suitable detail, discuss the causes and effects of stress and useful mitigation measures for both individuals and teams. Well-established scientific principles and neurobiologically-valid techniques not only protect against harm (it should be noted here that some well-intended and intuitive debriefing methods have been found to actively exacerbate trauma), they also improve utilization among educated and discerning trainees. Training should include:

1. USAID Stress Management Policy
2. Biopsychosocial causes and effects of stress
3. Dealing with critical incidents through Do No Harm methodologies such as Psychological First Aid
4. How to work successfully and manage biopsychosocial health under stressful conditions

Training will need to be customized to some degree to take into account operational differences between USAID Operational Units.¹⁹⁵ In addition to formal training, staff can be empowered by other kinds of communications and resources, such as videos of advocates and influencers. Other informational support products, such as handbooks, agency notices, and social media content, can be held in the online resource archive mentioned earlier. Networking or social media tools that connect staff to each other for peer support are also highly recommended. Further study is required to determine which specific interventions will be most effective in USAID's unique institutional environment.

As with all stress mitigation interventions, the effectiveness of the training and other preparatory aids should be routinely monitored and systematically evaluated, and updated as needed.

b. Up-skill managers/supervisors to be optimally Stress Aware and Stress Responsive

USAID should provide Stress Responsive management training (including critical incident and crisis response) for managers.¹⁹⁶ This training would include how to manage teams under stressful conditions. Supervisors must receive clear guidance and become competent on the latitude and limits of broaching the subject of stress effects, as well as providing stress mitigation and care ideas. Behavior change methods, such as conversation starters and simulation-based practice, should be part of any training provided. The training will create shared language and practices, which reduces stigma in talking about stress and increases the likelihood that staff will take care of themselves and access resources made available to them. It is important that a large number of managers receive this training, as it will provide a benefit akin to what preventive medicine calls a “herd immunity” effect, where even those who have not had the training will benefit from the culture change caused by the large majority who have had the training. In addition, trained managers will accelerate the extent to which best practices are diffused through the organization.¹⁹⁷

¹⁹⁵ Antares (Annex 5) Guideline 3a.

¹⁹⁶ Antares (Annex 5) Guideline 3c, 6b.

¹⁹⁷ Shah, Siddharth A. “Three Principles of Effective Staff Care: Differentiation, Diversity and Diffusion.” *Monday Developments: The Latest Issues and Trends in International Development and Humanitarian Assistance*. Volume 28, Issue 12, December 2010. InterAction. pp. 8-10 and 30.

II.2 ASSESSING

a. Assess the appropriateness of assignments using stress awareness

For specific projects and/or Operational Units, USAID should develop a stress risk profile that is routinely and regularly updated to remain current, used to inform recommended screening criteria for recruitment, and to make recommendations to reduce stress.¹⁹⁸ Individuals should be held responsible for disclosing relevant information during the screening process and the Agency must ensure that the data collected are secure and confidential.¹⁹⁹ The approach used is one in which self-selection based upon stress awareness is the primary mechanism used for determining assignment suitability. Assignment counselors must be provided with appropriate training needed to support this process sufficiently.

II.3 BRIEFING

a. Brief staff on the specific stress risks they can expect to face on their assignment

USAID should provide a candid and up-to-date briefing to staff about the stressors they will face on an assignment and any recommendations to mitigate staff vulnerability. The process should allow staff to defer an assignment without penalty, after the briefing, if they feel it is not the right time for the assignment given their current situation or previous stress exposure. The briefing should take into account vulnerabilities based on gender, sexual orientation, race/ethnicity, nationality, or other predisposing personal factors.²⁰⁰ In order to rapidly build a briefing template and process, USAID should draw upon existing assignment risk templates from organizations whose staff face similar risks and vulnerabilities, such as UNHCR, OCHA, and the World Bank. Deferments should not be considered permanent as individual staff resiliency can shift over time, as may the kinds of stressors that are prevalent on assignments.

II.4 MONITORING

All the tools, instruments, and processes in this section should be evidence-based. USAID must ensure that personal data collected is kept securely and respects medical privacy principles.

a. Provide mobile, interactive self-monitoring tools for personnel

USAID should make stress self-monitoring tools available to all staff.²⁰¹ There are multiple examples of these, including several that have been developed for and deployed within OAPA. Given that USAID staff frequently travel and have access to mobile devices, a secure, mobile-device hosted application is ideal. Such an application would help staff understand their stress levels and track these over time, and guide them to taking appropriate interventions. The application should be pilot tested and refined to ensure that the tool strikes the right balance between being comprehensive and user-friendly.

¹⁹⁸ Antares (Annex 5) Guideline 1f.

¹⁹⁹ Antares (Annex 5) Guideline 2c.

²⁰⁰ Antares (Annex 5) Guideline 1h, 3b.

²⁰¹ Antares (Annex 5) Guideline 4a.

b. Anonymously aggregate self-monitoring data to track stress at Operational Unit level

The multiple analytics we have recommended, especially the stress self-monitoring tool, will provide a rich stream of data that should be mined to track stress by Operational Unit. These data can be aggregated to remove individually identifiable information while providing insight into OU stress levels as a whole. Aggregating this data will allow USAID to track consequences of critical incident exposure(s), as well as sub-critical incidents. USAID should analyze data for both those directly affected and those indirectly affected.²⁰² For example, if a large number of sleep problems were reported, USAID could increase the sleep tips available through the application, as well as inform managers of the need to analyze stress conditions and perhaps determine an appropriate response. The analytics would provide alerts, flagging where problems are likely to occur and where preventive measures may be undertaken before serious consequences occur.

c. Conduct systematic, routine stress monitoring and collate feedback from Operational Units

In addition to instruments that allow individuals to self-monitor and allow management to track Operational Units with potentially traumatic exposures, USAID would greatly benefit from routinely tracking the workforce at a group level, or “temperature taking.” In addition to the anonymous aggregation of self-reported data, an instrument is needed that includes employees who do not use the stress self-monitoring application but would respond to the occasional survey or participate in other research methods. A well-designed assessment instrument that likely includes some sort of a survey tool augmented with qualitative processes as applicable would enable USAID to track stress trends. These data would point to the most applicable group interventions, such as identifying where additional team building, leadership development, and/or other interventions are needed. The results of these temperature taking exercises would provoke necessary dialogue in teams. In addition, USAID functional offices (e.g. HCTM or Bureaus) could monitor these results and proactively offer help where needed. There are a number of existing and applicable models currently being implemented within parts of USAID, and others that are externally available, that could be integrated to build a collective stress monitoring tool.²⁰³ Leveraging the data from the tools for self-assessment and personnel assessment would provide USAID a technological solution to easily analyze large data sets to develop highly targeted interventions.

Mitigation of stress should therefore be a part of Agency performance management mechanisms. This includes not only high level surveys like the FEVs but also the routine implementation of other instruments, such as 360° feedback on managers/supervisors and Mission or OU “temperature taking” assessments. SRPLI will be a place where employees are able to anonymously raise stress concerns (including harmful behaviors, fears, perceived risks of trauma, crises and critical incidents),²⁰⁴ which will be reported to senior leadership in an anonymized, aggregate form. This will encourage accountability to stress management in the Agency.²⁰⁵ USAID should create a hotline where management behavioral issues that are severely contributing to stress synergies at a given post can be anonymously reported, as well as urgent high-risk behavior can be made known to leadership and assessed, as may be appropriate. This hotline would require a specified responsible party to receive calls, as well as specific protocols for responding to these and escalating such a report into actions by managers.

²⁰² Antares (Annex 5) Guideline 4c.

²⁰³ Antares (Annex 5) Guideline 4e.

²⁰⁴ Antares (Annex 5) Guideline 6a.

²⁰⁵ Antares (Annex 5) Guideline 1i.

d. Conduct Health Risk Appraisal of the workforce periodically

USAID should take a stress baseline with periodic reassessments to gauge the effectiveness of its stress mitigation and staff care strategy. This could be a part of a larger Health Risk Appraisal (HRA), or more targeted to Mental Health. We recommend having an academic third party do the assessment (a route similar to the one pursued by UNHCR). The HRA would allow tracking of the success of investments in resiliency and identify areas for improvement, thus providing decision support for future investment. The analytics would also help identify specific populations who warrant special, tailored attention.

II.5. SUPPORT SERVICES

StaffCare is the current mechanism constituted to provide services and support to USAID personnel. As a very young OU, it is suffering from the growing pains that are inevitable as it matures into the configuration that will allow it to perform as originally intended. To meet the needs objectively identified in this assessment, and better align itself with established standards, significant change is required. A fully capable and stress responsive StaffCare program must further differentiate the needs of the Foreign Service from the needs of Washington-based staff, and will respond to these by maintaining a “pre-positioned” workforce with worldwide availability, already cleared and prepared to be deployed, that is capable of responding to crises anywhere they might occur on an immediate basis. StaffCare must take a pro-active, systematic, and routine approach to ensuring the psychosocial health of the USAID workforce, and must either establish a permanent presence- or at the very least regularly rotate through- high-stress environments. StaffCare must engage with and support other functional units that are responsible for managing transitions, and through supportive collaboration work to ensure that at each of the pressure points in the job cycle USAID operations are Stress Aware and Stress Responsive.

StaffCare must have an explicit and intentional culture of customer service, sharpened through a coherent vision and shared understanding of mission that is focused on ensuring that even USAID officers posted abroad (and their families) feel they are supported by a safe, supportive, accessible wellness scaffolding that understands and responds to their unique needs. StaffCare must engage in strategic and consistent outreach, ensuring that services and resources, as well as the mechanisms for accessing these, are known by and available to all. Where necessary, these services and resources must be provided in flexible, sensitive, and adaptive ways to meet the unique requirements of personnel posted abroad. Finally, StaffCare must emphasize accountability and adaptive learning, systematically applying structured M&E to assure quality, facilitate learning, and ensure continuous improvement.

a. Expand StaffCare Center’s focus and staffing numbers

Below are the expanded capacities for the current DC-based center:

I. Counseling Capacity

- a. Increase the number of counseling sessions from current cap and extend the period of availability. This includes communicating very clearly which caps are applied per issue, versus per calendar year.
- b. Provide adequate variety of stress and trauma processing modalities so that a wider diversity of biopsychosocial styles and symptom presentations are addressed in more compelling, inviting and cost-effective ways

- c. Develop manager/leader specific support offerings as needed.²⁰⁶
- 2. Connect individuals and Operational Units with resources (consultants, therapists, web-based tools) that meet specific needs.
- 3. Track staff care
 - a. Integrated with monitoring functions described elsewhere in recommendations
 - b. Use data and consultation to drive development of support activities and tighten effectiveness of services
- 4. Increase telemedicine capacities for more “touch” with field staff while new expeditionary capacity is being ramped up (see “e” below)
- 5. Increase the availability of evidence-based and widely-validated Integrative/Alternative Care methods targeting stress relief and prevention

b. Alter StaffCare Center operations to shore up quality and improve customer service

The StaffCare Center currently provides many valuable services. USAID should seek to further increase the positive impact of the SCC. SCC should:

- I. Create a Strategic Operational Plan
 - a. A customer service orientation should be enhanced and made more consistent across US and international services
 - i. Conduct a StaffCare mission and vision development process
 - ii. Design and implement Monitoring and Evaluation system
 - a. Correlate with Workforce Health Indicators
 - i. Establish Baseline Measures
 - ii. Mental Health Risk Appraisal
 - 1. Severity + Likelihood
 - 2. Exposures
 - iii. Capacity development of StaffCare personnel
 - 1. Training and Professional Development
 - 2. Establish and maintain Expeditionary node of StaffCare (see “e” below for more details)
- 2. Develop and implement a Strategic Communication Plan

c. Strengthen and mainstream StaffCare Champions

USAID should further institutionalize and expand the use of StaffCare Champions, building upon practices that are already in place.

- I. Further develop functions and capabilities of StaffCare Champions
 - a. Increase number of StaffCare Champions and locate in every Operational Unit, as appropriate
 - b. Establish and formalize expanded roles and responsibilities for StaffCare Champions
 - i. Develop focused peer support capabilities among designated “StaffCare Champions” through training and ongoing professional development.
 - ii. Integrate Psychological First Aid (PFA) and other specialized skills training for ongoing support and critical incident response.
 - iii. Minimum Recommendation: Champions serve as StaffCare “Navigators” who understands available StaffCare resources and can advise colleagues. Establishes

²⁰⁶Antares (Annex 5) Guideline 5b.

- a formal POC between StaffCare and OUs. Holds the Critical Incident response tripwire.
- iv. Optimal Recommendation: Champions serves as a Staff Welfare “Officer” role, which includes navigator duties but also supplements stress mitigation resources already available (e.g. the CLO at post, or other USAID HCTM staff in DC)
- c. Recognize service as a StaffCare Navigator or Staff Welfare Officer in annual evaluations, promotion decisions, etc.²⁰⁷

d. Identify and reduce gaps to support and care

Continual M&E should seek to identify gaps (or barriers) to support and care. Two specific gaps that currently exist are that staff care resources are concentrated in Washington DC, and State Department support is not experienced as a coherent package. We recommend that:

- I. USAID should create an Expeditionary Mandate for StaffCare Center for full-time or periodic engagement, as appropriate, with Missions abroad, to provide a routinized, proactive field presence. This can be achieved via an increase in the number of counselors available to deploy from DC to USAID missions abroad, as well as locating counselors overseas regionally and/or at high risk Missions.
2. USAID should further coordinate with State Department to ensure optimal USAID utilization of State resources that are intended to contribute to stress mitigation and staff care. For example:
 - a. Social Workers and RMO/P
 - b. DSMP, ECS, ADAP
 - c. FLOs
 - d. CLOs
 - e. FSI Programs
 - i. Transition Center Outbriefs
 - ii. Classes that cover resilience of staff and families (roster in Annex 7)

e. Identify pre-vetted roster of external care providers and provide USAID-tailored services

There are USAID employees whose needs exceed the services that can be reasonably provided by the StaffCare Center. However, finding external care providers of sufficient quality is a challenge for the individual staff person. In addition, USAID staff are more likely to utilize and respond positively to services that are tailored to their needs.

- I. Engage USAID insurance providers to reduce barriers and optimize utilization. For example:
 - a. Persuade insurance providers to invest in USAID-specific outreach (e.g. website of Deployment Health issues and a 1-800 number) and/or create sub-sites specific to those working in high threat environments
 - b. Provide suitability criteria and narrow down their roster of in-network therapists who can provide USAID-optimized services
 - c. Identify specialized care “centers of excellence” for the following mental health concerns, to provide USAID-tailored services:

²⁰⁷ Antares (Annex 5) Guideline 6c.

- i. Substance abuse
 - ii. Eating disorders
 - iii. Suicide risk
 - iv. Intractable conditions
 - v. Stress related disorders
- II. Identify a pre-vetted roster of non-StaffCare Center, out-of-network therapists who can provide USAID-optimized services
 - a. Map therapists in DC metro area and beyond; Update this roster periodically and maintain records of fees to reduce “shock” factor
 - b. Identify exceptional telemedicine providers
 - c. Explore venues for low-cost or no-cost therapy that serve military veterans and may have extra capacity for federal government civilians and foreign service officers

II.6 CRITICAL INCIDENT AND CRISIS RESPONSE

a. Establish formal policy providing thresholds for mandatory critical incident response and/or to enable crisis response

This policy should be part of the overall ADS policy mentioned in section A.a. It would lead to uniform understanding on what constitutes a critical incident, and what constitutes a sub-critical incident, as well as what situations constitute a crisis that is suitable for response. For example, evacuations with no violent incidents would qualify as sub-critical but may nonetheless represent a crisis. As another example, an individual who is close to someone operating outside the wire during violent conflict may warrant closer attention than the Mission staff in general.

b. Develop standard operating protocol for psychosocial crisis response

Specific procedures for reporting a CI or a crisis situation to appropriate point of contact in StaffCare must be included, as well as details of roles and responsibilities for key personnel in the chain of response. In terms of a psychosocial crisis response, specific management authorities must be delineated. Once the trigger has been tripped, a standard operating protocol specifies the behaviors required of supervisors, managers, leaders, HCTM, SCC and, if abroad, the DC staff response (which likely includes desk officers StaffCare personnel).

c. Increase Staff Care’s network of qualified specialists for crisis support and develop surge roster of pre-selected, vetted, and operationally prepared service providers

USAID should increase the number of experts available for critical incident and/or crisis support. However, further data about the StaffCare Center’s operations is needed to provide more specific recommendations. Based on staff interviews, it seems that there is an appetite for more support during critical incidents and sub-critical incidents, as well as increased access to face-to-face counseling services while in the field, and numerous managers expressed the need for appropriate tools to respond to crisis

situations.²⁰⁸ Critical incidents likely require deployment of a very specialized team of experts, and this team should be pre-vetted, selected, and should possess willingness and all necessary clearances to deploy at a moment's notice anywhere in the world, including into high-threat environments such as Afghanistan or remote locations such as South Sudan. The StaffCare Center should also, as appropriate, cultivate a network of counselors in country who could be accessed on demand during a crisis, and who have been vetted, or "field-tested", by staff in country based on the feedback from interviews. That list could include noting the cultural and/or professional specialization backgrounds of counselors, for example, so that appropriate, culturally sensitive matches could be made for FSNs in any country affected by critical incidents.²⁰⁹

II.7 TRANSITION CONSIDERATIONS

a. Add stress component to onboarding and assignment in-processing

The beginning of an assignment is a key period during which ambiguity and information overload may exacerbate stress. Additionally, the operational knowledge of the outgoing staff may be lost. USAID should leverage current onboarding best practices and scale these when possible. For example, USAID/Uganda works out a personalized transition plan, does deliberate knowledge transfer to incoming staff, empowers FSNs to provide knowledge and program continuity to offices undergoing leadership change, and offers special counseling for staff losing their jobs or who are stressed for known reasons. These practices should be replicated at other OUs that have similar circumstances to USAID/Uganda.

b. Add stress awareness to operational debriefings and assignment out-processing

Frequently, stress mitigation and staff care is concentrated at the front end (training), and is a crisis response in the case of an emergency (critical incident services). However, this minimalist approach is often inadequate to ensure personnel have the support they require. The transitions that are inherent in the end of assignments are profound for most people. Some are excited and happy to be completing an assignment; others are matter of fact; while still others dread what is to come. Additionally, handoff procedures can be rushed or incomplete. End of Assignment support will include preparing staff for productive, healthy transitions, including recognition of "reintegration" or reverse culture shock. An operational debriefing with one's supervisor or team is an opportunity to smooth the transition, and stress issues (both resolved and unresolved) must be adequately covered in any debrief.²¹⁰

II.8 POST ASSIGNMENT FOLLOW UP

a. Follow through with post-assignment contact and support

Many individuals are not ready to have a productive conversation or debrief about their psychological state immediately after an assignment ends. There can be enormous frenetic activity in the days of

²⁰⁸ Pfefferbaum, R. L., Pfefferbaum, B., Van Horn, R. L., Klomp, R. W., Norris, F. H., & Reissman, D. B. The communities advancing resilience toolkit (CART): An intervention to build community resilience to disasters. *Journal of Public Health Management and Practice*, 19(3), 2013. pp. 250-258.

²⁰⁹ Antares (Annex 5) Guideline 6d.

²¹⁰ Antares (Annex 5) Guideline 7b.

returning to the U.S., or starting one's new position, or ending USAID employment. The dust often needs to settle for an individual to know the impact of a previous assignment. Therefore post-assignment conversations and debriefs are important to execute not only immediately to ensure effective handover, but again in a range of 1-2 months after an assignment has ended. If the assignment was high-stress and staff have not participated in the post-assignment debrief process, staff should be located and follow-up should occur.

Finally, staff must receive appropriate follow-up assessment and resources depending on whether they are separated from USAID, reassigned or resting. Additional training or "flagging" should be provided to new managers to teach them to recognize this potential delayed reaction to stress factors, so they are aware of and prepared to address effects and potential risk behaviors.

b. Increase quantity and duration of services provision

Many of the psychosocial effects of stress do not manifest immediately at the end of an assignment, but may emerge months or even years later. For this reason, routine tracking of who has been assigned to high-stress postings and routine psychosocial health maintenance processes must be used to periodically check-in and assess the state of a person's onward adjustment. In order to meet the needs of staff experiencing delayed reactions, the quantity and period of availability of counseling sessions should be increased to meet the need.

15. FINAL WORD

This report was designed to serve as decision support for USAID, as it became apparent through the assessment project that USAID's current circumstances of workplace and traumatic stress are unsustainable. Some personnel are adapting reasonably well to USAID's mix of challenges. However, some have experienced breakdowns because they do not have the resources and support they need to adapt to these challenges. Others are on the verge of breakdown. It is not possible to predict how many more individuals will succumb to these compounded stressors or how many teams will experience serious breakdowns, but a substantial proportion of the workforce is exposed to all the factors that lead to poor outcomes.

There are four organizational risks of concern: health risks, security risks, reputation risks, and threats to mission achievement.

I. Health Risks – Scientific studies (Sections 6 and 7) convincingly show that stress injuries trigger a range of costly physical health conditions, including pain syndromes, sleep disturbances, immune system breakdowns, and heart disease. In its current state, USAID employment exacerbates serious psychosocial health conditions, notably anxiety, depression, shattered relationships, and PTSD. With regards to mental health emergencies and their worst outcomes, it is when these stigmatized conditions do not get attention and people suffer in silence that suicide risk thrives.

II. Security Risks – As noted in military mental health, moment-to-moment situational awareness is compromised in people who are severely stressed.²¹¹ Anxiety, depression, shattered relationships, and PTSD all contribute to unintentional but sometimes grave mistakes in judgment. Furthermore, as security professionals increasingly warn, the more disgruntled staff are in an organization, the more risk for sabotage behavior exists.

III. Reputation Risks – There is a substantial cohort of USAID who are disheartened at how they have been treated by the Agency. The theme of “I feel alone” is prevalent, and staff cannot rely on their supervisors to take health-promoting steps. Morale is suffering among current staff, and it will be increasingly difficult to recruit new talent due to a reputation for insufficient staff support.

IV. Threats to Mission Achievement – Stress affects performance in all organizations. Neuroscience reveals specific effects of degraded cognitive performance. Tasks that would take minutes may take hours. People need more sick days. People unintentionally make errors. Perceptions of friend and foe get distorted. Discipline problems increase. All of these stress effects pose risks to USAID achieving its mission.

Simultaneously, there is good news. The USAID workforce is hungry for leadership on matters of stress. Their interest and enthusiasm will fuel the way forward for a more stress responsive culture. Furthermore, all of the problems outlined in this report are manageable. There are applicable lessons learned and clear templates from other workforces facing similar challenges. USAID does not need to guess or improvise on devising and implementing the management and leadership steps necessary to combat stress and its effects to USAID staff.

²¹¹ Army, U. S. *Health Promotion, Risk Reduction, Suicide Prevention Report*. Washington, DC: Army's Suicide Prevention Task Force. 2010.

The changes proposed herein are complex and far reaching; they will entail significant dedication of resources and adjustments to institutional practices. The evidence-based analysis in this report provides the objective rationale with which the Agency can defend its implementation of the above recommendations for the future health of its workforce and the maximal success of its mission.

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