Psychological Tools for Humanitarian Aid Workers in Post-Catastrophe Programmes: Raising the Bar for Sustainable Recovery

EARL JAMES GOODYEAR, PhD

Abstract

Recent global events, specifically the invasion of the Ukraine by Russia and other acts of terrorism, have driven this desk review to identify critical tools for the establishment of frameworks to institute and establish mental health and psychosocial support at the humanitarian organizational level. What now is required is that agencies accept the fact that present day humanitarian operations have become inherently more dangerous. Thus, the possibility of developing a psychological or physical problem because of the nature of humanitarian aid activities has increased along with the rise in levels of disease, injury, kidnapping, and assault. As a result, expressions of traumatic stress have become the norm rather than an exception.

Whether the event that significantly alters the lives and livelihoods of an individual, family, a community, or a country, be it human-induced (violence, an economic downturn or loss of personal rights) or natural events (climatic disasters like floods, cyclones, droughts, earthquakes etc.), knowledge of the elements to address the myriad of psychological nuances that accompany human dysfunctional episodes is critical. Humanitarian aid workers must be equipped with an understanding of the mechanisms to redress the consequences of human suffering while engaging in their sustainable recovery programs. And, ensuring that mechanisms are in place for front-line and support staff, both national and international, to support physical and mental health priorities.

The central focus of this document is to better prepare individuals and institutions engaged in humanitarian activities to engage in greater forethought to the adverse psychological and long-term impact accompanying humanitarian aid workers on the front line of a crisis event.

Keywords: *Humanitarian and Trauma Therapy, Posttraumatic Stress Disorder*

1. Introduction

There are approximately 450,000 professional aid workers throughout the world at any one time, many of whom move from one humanitarian emergency to another. These cycles are a form of self-medication; many aid workers find it comfortable and reassuring to be with others who share similar experiences. They have a familiar refrain, "You get addicted to this work, (because it is) hard to settle back into normal life".

A large part of being human is to recognize that we all have both good days and bad days. We should know that depression is a widespread mental illness that affects an estimated 5 percent of adults worldwide - rooted in everything from societal stressors to chemical imbalances to genetically inherited traits. On a sliding scale of nature versus nurture, depression will manifest itself from a variety of sources. No matter the cause, it is essential to finds ways to cope with and combat depression. And for those suffering from stress-related issues, it is critical to know that they need not face their issues solely by themselves. This is where words of assurance can remind us of others that struggled and experienced similar pain and found a better future.

Khalil Gilbran, the author of The Prophet said, "Sadness is but a wall between two gardens". Gilbran is posing that we should be glad for every experience, even if it seems full of pain, because life has a pattern and a purpose. And what seems to us now as "good" or "bad" will be appreciated without judgement as good for our souls.

The tragic loss of life that occurred in the United States on September 11, 2001 was one outcome of horrendous events that became etched into the memories of countless millions of people around the world. While most Americans were resilient in the face of this tragedy, some experienced depression, grief, and post-traumatic stress disorder. Thus, the events of that day were both a challenge and a call to action for all those responsible for the organization and provision of mental health services. The feelings of loss of our security and well-being - arguably the most crucial abstract ingredients for leading a happy, healthy life – dramatically affected the citizens of the United States. Looking to the future, an understanding of behavioral health consequences delivered by subsequent disasters may help in lessening the shock and impact expected.

2. Crisis Situations - Setting for Humanitarian Trauma

Humanitarian aid workers are an overlooked population within the structure of post-traumatic stress disorder (PTSD) research and assistance. This negligence is an industry-wide failure to address aid workers' psychological health issues. The suspected numbers of death by suicide, diagnosed PTSD, depression, anxiety disorders, hazardous alcohol and drug consumption, emotional exhaustion, and other stress-related problems are impossible to quantify but are considered endemic.

Tools for establishing organizational frameworks for mental health and psychosocial support are readily available. However, the capacity to implement this assistance requires the creation and practice of an open and non-judgmental culture, based on the realistic acceptance that aid work has become inherently dangerous. The possibility of developing a psychological problem because of aid work has increased along with the rise in levels of disease, injury, kidnapping, and assault. As a result, expressions of traumatic stress have become the norm rather than an exception. This commentary outlines the

essential steps and components necessary to meet these requirements.[2]

Consider your role in assigning a team of aid workers to respond to a rural community on an isolated isle in the Philippines struck by a catastrophic cyclone. Or, responding to the needs of a civilian population caught in a devastating, ongoing conflict of war between a super-power and a smaller nation struggling to retain its democratic authority for self-government and alignment with Western nations. Or, addressing the survivors and victims of an attack at a religious place of worship by another conflicting sect. Not only must a leader of a response to humanitarian crises have a presubscribed response plan in hand for addressing the affected population, but also grasp the emotional capacity and fortitude to handle the short-term and long-term effect of humanitarian trauma.

A significant problem in responding to the psychological needs of aid workers is quantifying the problem[3]. Many humanitarian relief and development agencies working in third-world nations often rely on the services of experienced staff serving in other global assignments to gear up for post-crisis episodes. While usually adept at performing response-related logistical tasks, they may be ill informed on the cultural and socio-economic aspects of the affected population. Leading a team composed of new personalities can add to the escalation of tension affecting the entire relief and recovery intervention.

Post-disaster assessments have shown that it is possible to measure safety and security incidents and statistics in undertaking a post-mortem of a relief intervention. Regretfully, assessments, usually short-term in nature, do not gather indicators of diagnosed PTSD, suicide, emotional exhaustion, depression, anxiety disorders, hazardous alcohol and drug consumption, and other stress-related problems. In many instances, aid staff are reticent to seek help because of the potential negative impact on their career and carrying a stigma of weakness in meeting the objectives during a crisis episode. As such, organizations engaging in crisis management, in addition to their development programmes, must adopt specific systems to support national and international staff mental health needs.

The following components are considered essential to creating a trusted framework for organizational psychosocial programs from the staff members' perspective:

- Affirm that the psychological well-being of every staff member is a primary concern;
- Include staff members from all corporate hierarchy levels in designing a support system, which builds a culture of staff well-being;
- Define clear lines of authority and procedures for providing psychological assistance;
- Determine and publish who are eligible to receive mental health support, such as permanent staff, volunteers, consultants, national staff, and part-time employees;
- Design and implement administrative procedures to safe guard confidentiality;
- Incorporate meaningful practices created to reduce and mitigate the causes of stress;

2. Macpherson RIS, Burkle FM Jr. Humanitarian aid workers: the forgotten first responders. Prehosp Disaster Med. 2021;36(1):111–114.
3. Research Suggests Mental Health Crisis Among Aid Workers. The Guardian. http:// www.theguardian.com/global-development-professionals-network/2015/nov/23/ guardian-research-suggests-mental-health-crisis-among-aid-workers.

- Institute or revitalize a grievance redress mechanism; and
- Identify vulnerable groups based on the complexity of their operating environment and the number of deployments.

While some humanitarian organizations recognize and address staff mental health problems, there remain significant barriers to implementing general mental health support services. Presently, assistance is mostly insufficient, stigma in organizations is still significant, and donor funding for staff wellness is inadequate, especially for national staff.

3. What is Psychological First Aid?

According to Sphere (2011)[4] and IASC (2007)[5], psychological first aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes:

- Providing practical care and support, which does not intrude;
- Assessing needs and concerns;
- Helping people to address basic needs (for example, food and water, information);
- Listening to people, but not pressuring them to talk;
- Comforting people and helping them to feel calm; and
- Helping people connect to information, services and social supports; protecting people from further harm.

WHO (2010)[6] and Sphere (2011) describe psychological debriefing as promoting ventilation by asking a person to briefly but systematically recount their perceptions, thoughts, and emotional reactions during a recent stressful event. This intervention is not always recommended. This is distinct from routine operational debriefing of aid workers used by some organizations at the end of a mission or work task.

Psychological First Aid: Guide for Field Workers

PFA is an alternative to "psychological debriefing" which has been found to be ineffective. In contrast, PFA involves factors that seem to be most helpful to people's long-term recovery (according to various studies and the consensus of many crisis helpers). These include:

- Having access to social, physical, and emotional support;
- Feeling able to help themselves, as individuals and communities; and
- Feeling safe, connected to others, calm and hopeful.

Although people may need access to help and support for a long time after an event, PFA is aimed at helping people who have been very recently affected by a crisis event. You can provide PFA when you first have contact with very distressed people. This is usually during or immediately after an event. However, it may sometimes be days or weeks after, depending on how long the event lasted and how severe it was.

People who need more immediate advanced support include:

- People with serious, life-threatening injuries who need emergency medical care;

4. The Sphere Project Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response, Third Edition, 2011. Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.
5. Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.
6. WHO 2010, The World Health Report. 2010.

- People who are so upset that they cannot care for themselves or their children;
- People who may hurt themselves; and
- People who may hurt others.

4. Where is Psychological First Aid Provided?

You can offer PFA wherever it is safe enough for you to do so. This is often in community settings, such as at the scene of an accident, or places where distressed people are served, such as health centers, shelters or camps, schools and distribution sites for food or other types of help. Ideally, try to provide PFA where you can have some privacy to talk with the person. For people who have been exposed to certain types of crisis events, such as sexual violence, privacy is essential for confidentiality and to respect the person's dignity.

PFA is part of a broader response to large humanitarian emergencies (IASC, 2007). When hundreds or thousands of people are affected, different types of emergency response measures take place, such as search-and-rescue operations, emergency health care, shelter, food distribution, and family tracing and child protection activities. Often it is challenging for aid workers and volunteers to know exactly what services are available where. This is true during mass disasters and in places which do not already have a functioning infrastructure for health and other services.

Be aware of what services and supports are available so you can share information with people you are helping and tell them how to access practical help. It is not necessary to have a "psychosocial" background to offer PFA. If you are engaged in a crisis, convential wisdom suggests working in concert with an organization or community group. If you act on your own, you may put yourself at risk, it may have a negative effect on coordination efforts, and you are unlikely to be able to link affected people with the resources and support they need.

5. When Terrible Things Happen - What You May Experience[7]

5.1. Immediate Reactions:

There are a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster. These include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt, and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Psychological	Fatigue, headache, muscle tension, stomachache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

7. Yasinski, Emma. "Why Psychedelic Drugs May Become a Key Treatment for PTSD and Depression". Smithsonian Magazine:smithsonianmag.com: 05-03-2022

5.2 Common Negative Reactions That May Continue Include:

- Intrusive reactions;
- Distressing thoughts or images of the event while awake or dreaming;
- Upsetting emotional or physical reactions to reminders of the experience; and
- Feeling like the experience is happening all over again ("flashback").

5.3 Avoidance and Withdrawal Reactions:

- Avoid talking, thinking, and having feelings about the traumatic event;
- Avoid reminders of the event (places and people connected to what happened);
- Restricted emotions; feeling numb;
- Feelings of detachment and estrangement from others; social withdrawal; and
- Loss of interest in usually pleasurable activities.

5.4 Physical Arousal Reactions:

- Constantly being "on the lookout" for danger, startling easily, or being jumpy;
- Irritability or outbursts of anger, feeling "on edge"; and
- Difficulty falling or staying asleep, problems concentrating or paying attention.

5.5 Reactions to Trauma and Loss Reminders:

- Reactions to places, people, sights, sounds, smells, and feelings that are reminders of the disaster;
- Reminders can bring on distressing mental images, thoughts, and emotional/physical reactions; and
- Common examples include sudden loud noises, sirens, locations where the disaster occurred, seeing people with disabilities, funerals, anniversaries of the disaster, and television/radio news about the disaster.

5.6 Positive Changes in Priorities, Worldview, and Expectations:

- Enhanced appreciation that family and friends are precious and important;
- Meeting the challenge of addressing difficulties (by taking positive action steps, changing the focus of thoughts, using humor, acceptance);
- Shifting expectations about what to expect from day to day and about what is considered a "good day";
- Shifting priorities to focus more on quality time with family or friends; and
- Increased commitment to self, family, friends, and spiritual/religious faith.

6. Responsibility for Staff Wellbeing

Nearly a decade ago, the Security Management Initiative (SMI; Switzerland) produced a document entitled, "Can you get sued? Legal liability of international humanitarian aid organizations towards their staff." It reviewed the existing laws in four European countries and America demonstrating that nongovernmental organizations (NGOs) are accountable for the same legal standards as any other group. The paper highlighted that NGOs' responsibilities for staff well-being are a legal and mandatory requirement. Around the same time, a series of lawsuits against aid agencies commenced on behalf of aid workers or the families of aid workers who were kidnaped, assaulted, injured, died, or suffered other violations of their person while working as humanitarians.

In 2015, a Norwegian court found the Norwegian Refugee Council (Oslo, Norway) liable for compensation and to have acted

with gross negligence in the case of Steven Dennis following his kidnapping in Kenya. Because it was the first case of its kind to reach a court ruling, it is considered a watershed moment in which organizations finally recognized they were responsible for staff well-being, including issues of psychological stress and illness suffered while providing humanitarian service.

However, operational stresses associated with delivering humanitarian aid can be dramatic and the resulting problems involving staff mental health are seldom clear cut. Their work's physical consequences can be dangerous, but the constant ethical and moral quandaries that confront them are often cumulative. No matter how hard humanitarian workers try to handle it, constant exposure to death, starvation, and mayhem affect their belief in justice and human rights. Every personal and professional value they hold is under assault.

A significant problem in responding to the psychological needs of aid workers is quantifying the problem. While safety and security incidents and statistics can be measured, definitive data regarding deaths by suicide, diagnosed PTSD, depression, anxiety disorders, hazardous alcohol and drug consumption, emotional exhaustion, and other stress-related problems are difficult to gather. Aid workers still fear seeking help because of the stigma associated with mental illness or substance abuse and the potential negative impact on their career. Also, defining and implementing specific systems to support national and international staff mental health needs remain under-developed and lack attention and resources.

7. Creating a Framework for Mental Health and Psychosocial Support

To establish an industry standard, the Antares Foundations and the Centers for Disease Control and Prevention (CDC; Atlanta, Georgia USA) formed a partnership with NGOs to develop a consensus approach to mitigate stress in aid workers: "The resulting Guidelines for Good Practice: Managing Stress in Humanitarian Workers was published in 2004 and revised in 2012." The guidelines were developed to:

- Ensure the planning for psychological assistance includes the means to aid national staff;
- Provide all staff with a pre-deployment brief, including an overview of the physical and health dangers they may experience;
- Confirm ways to deliver on-site mental health assistance to staff experiencing stress in the field or appropriate and accessible tele-mental health services;
- Ensure aid workers receive a post-deployment brief, which includes a detailed discussion of the mental health support available and how to obtain it; and
- Ensure line managers have additional assistance, as appropriate, to manage stressful and complex situations.

For several years Antares has been collaborating with the Centers for Disease Control and Prevention (CDC) to coordinate a series of studies addressing issues of stress amongst humanitarian workers. This has involved several researchers from institutions based in Europe, north America and the rest of the world. The major focus of the group has been a longitudinal study of expatriate humanitarian workers, combined with 4 national staff surveys in Uganda, Sri Lanka, Kosovo, and Jordan.

Humanitarian workers are at significant risk for mental health problems, both in the field and after returning home. The good news is that there are steps that they and their employers can take to mitigate this risk.

The team surveyed 212 international humanitarian workers across 19 NGOs. Prior to deployment, 3.8% reported symptoms of anxiety and 10.4%, symptoms of depression, broadly in line with prevalence of these disorders in the general population. Post-deployment, these rates jumped to 11.8% and 19.5%, respectively. Three to six months later, while there was some improvement in rates of anxiety—they fell to 7.8%—rates of depression were even higher at 20.1%.

Rather than experiencing dangerous or threatening situations, it was continual exposure to a challenging work environment that increased risk for depression. Weak social support and a history of mental illness also raised risks. On the plus side, aid workers who felt highly motivated and autonomous reported less burnout and higher levels of life satisfaction, respectively.

The paper outlines several recommendations for NGOs:

- Screen candidates for a history of mental illness, alert them to the risks associated with humanitarian work, and provide psychological support during and after deployment;
- Provide a supportive work environment, manageable workload, and recognition; and
- Encourage and facilitate social support and peer networks.

The wellbeing of humanitarian workers can be overshadowed by the needs of the populations they serve. "It has been challenging to get mental health care for workers onto the agendas of agencies employing them—and even onto the radar of workers themselves," says Alastair Ager, one of the research team. "Depression, anxiety and burnout are too often taken as an appropriate response to the experience of widespread global injustice. We want them to know that the work they are doing is valuable and necessary and the situations difficult, but this doesn't mean they need to suffer[8]." The study, he suggests, provides "the first robust research evidence to establish the case that good staff care can make a real difference."[9]

8. Implementation Difficulties

Humanitarian aid workers are an overlooked population within the structure of post-traumatic stress disorder (PTSD) research and assistance. This negligence is an industry-wide failure to address aid workers' psychological health issues. The suspected numbers of death by suicide, diagnosed PTSD, depression, anxiety disorders, hazardous alcohol and drug consumption, emotional exhaustion, and other stress-related problems are impossible to quantify but are considered endemic.

However, even when adequate structures are in place to assist staff, many aid workers are reluctant to seek help from their organization, often due to stereotypes and biases that result from a diagnosis of psychological illness. Additionally, an aid worker may face a vicious cycle. The intensity, stress, and exposure to violence

8. Cardozo, B.L., Crawford, C.G., Eriksson, C., Zhu, J., Sabin, M., Ager, A., Foy, D., Snider, L., Scholte, W., Kaiser, R., Olff, M., Rijnen, B. & Simon, W. "Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study" Public Library of Science One, September 2012, 7(9).
9. Eriksson, C. B., Lopes Cardozo, B., Foy, D., Sabin, M., Ager, A., Snider, L., Scholte, W.F., Kaiser, R., Olff, M., Rijnen, B., Gotway Crawford, C., Zhu, J. & Simon, W. "Pre-deployment Mental Health and Trauma Exposure of Expatriate Humanitarian Aid Workers Risk and Resilience Factors ". Traumatology, 19(1), 41-48.

may manifest as survivor's guilt or survivor's syndrome. Often, there is an assumption that those who survive the trauma and intensity a complex humanitarian response considers themselves lucky or fortunate. However, they feel guilty for leaving their colleagues and the people they were assisting behind, analogous to how a wounded Marine feels about abandoning their unit during a conflict. The aid worker returns to a world of relative safety, with adequate food and shelter, but cannot forget the devastations of war, natural disaster, or famine.

Even within a robust organizational culture of support and resilience, aid workers may fear to acknowledge that the pressures associated with their work have caused an illness or coping difficulty. They fear the loss of their work. Beyond financial considerations, aid work tends to be a "calling." A mental illness may rob them of the opportunities that define their life and engagement in a profession they love. Thus, it is incumbent that line management is trained to recognize acute and chronic stress symptoms and have the confidence and support to intervene when necessary.

9. The Dilemma of National Staff

Discussions regarding the psychological issues of aid workers include references to national staff. However, they are often generalized because of cultural and legal differences, and the employment of national staff is decentralized within the structure of the host nation. This is problematic because humanitarian organizations currently employ far more national staff than expatriates and are thus at higher risk of violence. According to The Aid Worker Security Database (Humanitarian Outcomes; London, United Kingdom):

National aid workers continue to endure most of the violence in terms of absolute numbers. The most recent data show that while attack rates have risen for nationals and internationals, the rate increase has been steeper for national staff than for their international counterparts. Furthermore, although national and international staff now have the same overall attack rates, the fatality rates for nationals are higher than for internationals—and the gap has widened considerably in recent years.

Although the initiatives to hire more national aid workers is commendable, it is not morally or ethically responsible for employing increasing numbers of local staff and not providing the same health and well-being benefits as enjoyed by expatriate counterparts. The Duty of Care Paper reports that approximately 50% of international aid organizations "have systems that are not unified, not coherently implemented or not functioning properly, or have no existing unified system when it comes to national staff [mental] and physical health insurance."

According to Collins Dictionary, duty of care is "the legal obligation to safeguard others from harm while they are in your care, using your services, or exposed to your activities." The concept is related to other legal terms such as "ordinary care" or "reasonable care," which essentially mean "what is expected of most people in most cases."

10. Psychedelic Drugs: A Key Treatment for PTSD and Depression

Patients diagnosed with PTSD today, more than 70 years after initial observations, are most likely to be given a cocktail prescription combination of therapy and anti-depressant drugs. The results are mixed with some patients seeing a significant difference in their quality of life while in others will continue without relief from

nightmares, flashbacks, severe guilt, and anxiety. [10]According to the U.S. Department of Veterans Affairs, about 6 percent of Americans will be diagnosed with PTSD at some point in their lives, whether they served in the military or not. While PTSD is often associated with traumas from war, it can also refer to symptoms after other traumatic experiences such as being involved in a serious accident, witnessing a death or injury or being the victim of traumatic assault.

Now, certain psychedelic drugs like LSD and psilocybin (an active ingredient in magic mushrooms) that have been banned in the United States are under controlled studies to determine if their limited usage combined with therapy may help patients with PTSD or other mental illnesses. Results have been promising enough for the U.S. Food and Drug Administration (FDA) to designate both treatments as breakthrough therapies - a priority status given to promising drugs designed for an unmet need.

Many patients prescribed anti-depressants experience a range of side effects from upset stomach to insomnia. One of the reasons that psychedelic therapies are so appealing is that they're thought to work with only a few doses - limiting the risk of side effects. Currently, over 200 clinical trials are registered on clinicaltrials.gov to test the effects of psilocybin on conditions like PTSD. Before this medication is available for wider usage, the FDA must recognize the safety and efficacy of this form of treatment.

11. What Lies Ahead ...

The answers to proper psychological support and care for humanitarians require solutions forthcoming from humanitarian staff members and their institutions. At its core is the creation and practice of an open and non-judgmental culture, based on the realistic acceptance that aid work has become inherently dangerous. The possibility of a mental health problem associated with this work is as real as the increasing possibility of disease, injury, kidnapping, and assault. As a result, forms of traumatic stress have become the norm, not an exception.

Let us remember one of the most devastating cyclones to form in the Indian Ocean made landfall across Bangladesh 30 years ago. The Bangladesh Cyclone of 1991 was classified as a super cyclone that packed deadly winds, powerful storm surge and massive flooding.

The storm developed over the southern region of the Bay of Bengal as a region of thunderstorms that had recently banded together. Thanks to warm, moist air and lack of wind shear, this system quickly organized into a Tropical Cyclone by April 24, 1991. From here, the storm increased in strength, becoming classified as a Severe Cyclonic Storm (equivalent to a Tropical Storm in the U.S., with winds up to 73 mph) by the India Meteorological Department on April 25.

The storm went into overdrive as wind shear decreased further, strengthening to a Super Cyclonic Storm (equivalent to a Category 5 Hurricane on the Saffir-Simpson Hurricane Wind Scale) with sustained winds of 150 mph by April 29. As the storm traverse the warm waters, a subtropical ridge sunk southward, steering the storm northeastward.

This powerful cyclone impacted the city of Chittagong, Bangladesh, just after midnight on April 29, making it even harder to detect tornadoes and flying debris associated with

10. Yasinski, Emma. "Why Psychedelic Drugs May Become a Key Treatment for PTSD and Depression". Smithsonian Magazine:smithsonianmag.com: 05-03-2022

the storm. The hilly nature of the city helped to weaken this behemoth of a storm, but damaging scars were left in the storm's midst before it dissipated on April 30.

Damages stemmed from massive storm surge that struck during high tide. At its peak, the surge piled up to 20 feet high on top of 18 feet of higher-than-normal tide waters. The storm surge coupled with winds more than 140 mph led to the deaths of 138,000 people with damages upwards of $1.7 billion U.S. in 1991 (equivalent to more than $3 billion in 2021). In Chittagong, livestock was decimated and up to 90% of homes were destroyed. This cyclone was so devastating that it is known as the fifth deadliest storm cyclone on record. In the aftermath, the U.S. and many other countries provided disaster relief in the wake of this detrimental storm.[11]

The author, working in Bangladesh for a humanitarian agency at the time of this major catastrophe, was greatly affected by the extent of loss of lives and livelihoods in a matter of hours. This event, replayed to hundreds of disaster preparedness trainees in countries around the vulnerable world, served as a vivid reminder of both man's vulnerability to nature as well as our ability to recover and rebuild from among the ashes.

Another case in point is actions to follow the Russian invasion and the war in Ukraine. If the destruction of so much of Ukraine's infrastructure is put into a "disaster" framework, then the natural disaster response and disaster recovery offer a plethora of lessons. And this invasion—with its increasingly indiscriminate targeting of physical, natural, and human infrastructure—has created a real disaster. It is a man-made disaster relating to conflict, not a natural one relating to weather or earthquakes, but some of the lessons hold. History will record this conflict and shall attest to those responsible for crimes against humanity.

A global challenge ahead is creating mechanisms for the several million or more refugees so they can return home. Conflict-related forced displacement tends to be longer term than natural disaster-related displacement, which is often short-term in nature. Ukraine will face its own challenges, including the wholesale destruction of homes, schools, medical facilities, and places of work.

Caring for those suffering from the physical and mental trauma caused by the Russian invasion are not only the Ukrainian people themselves but also humanitarian aid staff. Post-traumatic stress is a terrible outcome of war, and the challenge of making the population feel safe and secure, and the caregivers able to cope with firsthand witness of horrific war crimes is a daunting, but not insurmountable task.

Perseverance is a word I have used during my career in international development and disaster risk management. Considering that falling to obstacles as not a viable option has given me a mindset that challenges can be seen as opportunities, part of a new learning curve. Once you begin to judge both obstacles and opportunities as chances to expand your portfolio of coping skills, you have mastered perseverance.

As Winston Churchill said,

Success is not final, failure is not fatal:

It is the courage to continue that counts.

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(Earl James Goodyear, Ph.D. resides in the United States and his career spans forty years in the design, management, and evaluation of economic, social development and disaster risk management programmes for international humanitarian organizations, the United Nations and nations in Asia, Africa, and the Caribbean. Email: redseadiver2000@yahoo.com).