

Engaging in Humanity Care Stress, Trauma, and Humanitarian Work

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Palestinian Refugees in Yarmouk, Syria (2014) UN Photo, UNRWA

"I used to think that I was kind of hardened to suffering and misery...You learn to deal with it and hold it at bay while you are working. It's when you're alone that it creeps up on you." Arès (2002, pp. 117)

In this article we focus on the wellbeing and effectiveness (WE) of staff in the humanitarian sector. More specifically, in Part One we highlight stress and trauma for humanitarian workers and in Part Two we share perspectives and resources to support humanitarian workers. We draw from our work as Christians in mental health and member care and in the context of our broad, multi-sectoral involvements for "engaging in [humanity care](#)." Keep in mind the personal and organizational benefits when everyone involved in the humanitarian sector stay resilient and healthy. This includes administrators, managers, leaders, volunteers, international and local/national staff, family members, teams, organizations, and the helpers themselves. This article is by no means comprehensive, so take a look at the resources at the end of the article for additional information (we especially recommend [Helping the Helpers: 50 Resources for Humanitarian Workers](#) and the many resources developed by the [Headington Institute](#)).

Numbers at a Glance

- 200+ million people needing humanitarian assistance ([ALNAP](#))
- 25% of people in need from 3 countries: Yemen, Syria, Turkey ([ALNAP](#))
- 70+ million people forcibly displaced with 25M+ international refugees ([UNHCR](#))
- \$40 billion needed in funding annually, \$25+ billion received, short \$15 billion ([ALNAP](#))
- 570,000 humanitarian aid workers—over 90% are national staff ([ALNAP](#))
- 14 million Red Cross and Red Crescent volunteers worldwide ([IFRC](#))

Despite its ubiquitous presence, whether in crisis zones such as Syria, Yemen or the Congo, or day-to-day existence in both the developing and industrialized worlds, stress and trauma take their toll on people's lives. It is the same in the humanitarian sector. As mental health professionals working for dozens of years in the mission and humanitarian sectors, we have observed our own vulnerability—and that of others—to the debilitating impacts of stress and trauma. One resource we regularly use and recommend is the [CHOPS Inventory](#), a self-assessment tool which explores ten areas of stress in terms of struggles, successes and strategies (latest version, Tone *et al.*, 2020).

Stress, of course, is an entirely normal daily experience. It can motivate us to develop new strengths and skills. We are reminded, for instance, of the relevance of the Peace Corps refrain: "This is the toughest job you will ever love."

For humanitarians, 'common stressors' arise from a wide array of conditions such as hazardous living environments, relationship or communication issues, family problems back home, lack of privacy, frequent transitions, work travel, and re-entry. Other typical stress factors are lack of leisure activities, boredom, uncertainty about work contracts, or having to deal with personal health problems. Humanitarian operations and organizations, large or small, all encounter such stressors.



Humanitarian Workers in Yemen, International Committee of the Red Cross

PART ONE: TYPES OF STRESS

1. Cumulative Stress—Dealing with Ongoing Daily Realities

"What pushes me to act as a humanitarian?...It's possible [for people] to go two days without eating. But if you have water, you can survive." "Of course we feel homesick, we are away from our families. But this is the humanitarian world and we have to accept how it is." "Why would anyone kill a child?" "All these little girls [sexually abused] that came to us. And I have my own girl... [But helping] is the greatest joy that I can have." [Voices from the Field](#), United Nations (August, 2014)

One of the most debilitating, prevalent, and often unrecognized types of stress in humanitarian work is 'cumulative stress'. It results from the prolonged exposure to work and non-work stressors, and is

intensified when one feels unable to help (Carter, 1999). This type of stress is a core contributor to the following mental health issues commonly experienced by both international and national/local staff, at a much higher rate than in the general population: depression, generalized anxiety, substance dependence and abuse, and burnout. (e.g., Strohmeier, Scholte, and Ager, 2018).

In disasters and armed conflict, the impacts of stress can escalate quickly, exhausting one's normal coping mechanisms. The physical symptoms can be overtiredness, diarrhea, constipation and headaches. Some emotional results are anxiety, frustration, guilt, depression, and creeping cynicism. Cognitive impacts can affect one's job performance: forgetfulness or poor concentration. The results in personal relationships may be feeling isolated, resentful or intolerant of others. One common but serious result of incapacitating, cumulative stress is 'burnout', evidenced by severe emotional distress and behavioral dysfunction.

Unhealthy behavioral changes include increased intake of alcohol, caffeine, drugs, tobacco and addictions, as we have frequently observed. Some aid workers, for example, may drink coffee throughout the day and follow this with an extended "happy hour" into the night. This is typically "socially-acceptable" yet it is a warning of unacknowledged and mismanaged cumulative stress.

Stress can look different in everyone, and it is helpful to identify what circumstances in life can contribute to stress. How each individual responds to stress depends on his/her background, values, experiences and current level of perceived support. A large majority of those who work in humanitarian settings are able to eventually cope after violent traumatic events. At times it is the sense of betrayal from those that are meant to support and protect that leads to symptoms of ongoing emotional and mental distress.

One of the authors, working with victims of terrorist attacks, heard that after the shock had worn off, clients struggled with lingering feelings of resentment, hopelessness, apathy and anger. Oftentimes, these were caused not by the brutal attack but by the failure of their organizations and superiors to provide adequate support and follow-through.

2. Traumatic Stress: Managing Responses to Conflicts and Calamities

"I had been a reporter for nearly a dozen years when I met Sarajevo. Nothing could prepare me, really, for its deadly game of chance....no one ever spoke much about the personal armor needed to weather a war...the emotional risks writing about war...There was no time or place to tell the private battles waged to capture the trauma on paper." Spolar (2002, pp. 301-302)

'Traumatic stress' is caused by events that are shocking and emotionally overwhelming: the constant snipers targeting civilians in Sarajevo during the Bosnian war, the deliberate shelling of crowded market places in Somalia by rival combatants, managing nuclear catastrophe in Fukushima, or dealing with trapped earthquake victims in Haiti or Mexico. These stressors can and often do lead to more serious psychological difficulties. Some of these emerge relatively promptly; but delayed expression can also appear years later.

For some, their responses to major stressors can be mild and manageable, as was the case of a team that two of the authors helped debrief who were held captive for weeks by a terrorist group. For others the impact can be extremely strong, even disabling. In one incident, a major international humanitarian organization in West Africa had to pull out an entire team because of severe psychological stress and secondary trauma brought about by dealing non-stop with brutally savaged victims of violence, including women who had been repeatedly raped.

Single Incident Trauma or Critical Incident Trauma

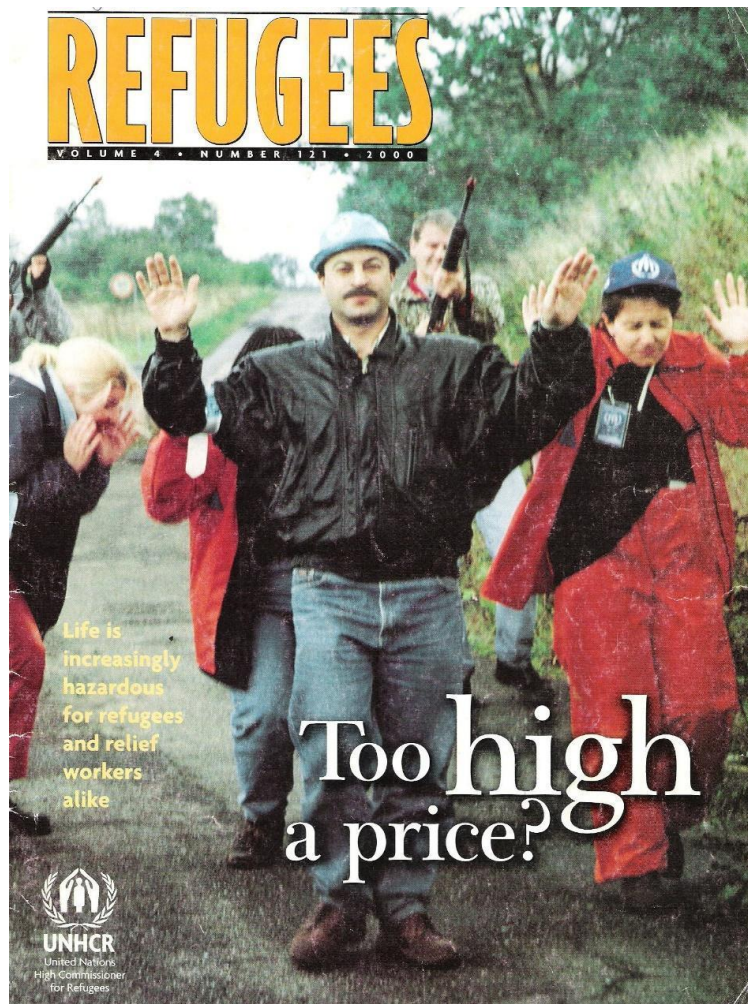
People can often have strong reactions following a single traumatic event. These reactions are usually temporary. Some of the common reactions during the first hours after an event may be:

- Shock, disbelief, feeling of being overwhelmed
- Strong emotional reaction or detachment
- Confusion, difficulty in making decisions
- Physical reactions: nausea, dizziness, intense fatigue, sleeping difficulties, muscle tremors.

Additional reactions during the first days and weeks may be:

- Persistent, intrusive recollections (flashbacks) of the incident, nightmares
- Tendency to avoid certain aspects of the incident (places, thoughts, emotions, activities)
- Hyper-alertness accompanied by a startle reflex, quick temper and sleeping problems.

All these stress reactions, however worrying they may be, are normal consequences of a critical incident and a high stress level. Even the most robust, experienced humanitarian personnel can experience them. No one is immune to stress, no matter how resilient. However, if symptoms are particularly intense (acute) and persistent, or if suicidal thoughts and feelings are present, it is important to seek out professional help so that the symptoms don't worsen or develop into Post Traumatic Stress Disorder (PTSD).



Post-Traumatic Stress Disorders

"When it happens to you there is no time for thinking, no time for praying. My brain went automatic, rewinding quickly the life I just left behind...Then a process of dehumanization started that day...317 days of captivity...23 hours and 45 minutes of darkness every day..." Cochetel (2014)

Post-Traumatic Stress Disorder (PTSD) can occur after exposure to extreme stressors (including ongoing or intermittent exposure) where there is the threat to oneself or others of death, serious injury or violence. It is accompanied by intense fear and feelings of helplessness, with distressing recollections, dreams or flashbacks along with hyper-vigilance and avoidance of anything that reminds one of the stressor. These symptoms usually occur within one month of experiencing the traumatic event, although 'delayed expression' of symptoms can also occur. PTSD is most often associated with at least one other major mental health conditions such as depression, anxiety, panic disorder, and alcohol or substance abuse.

Post-Traumatic Stress Disorder in the [*International Classification of Diseases-11*](#) (ICD-11, 2018), "is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following:

- 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations;
- 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and
- 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning."

Uncomplicated PTSD is sometimes used to describe PTSD that involves the above three symptom criteria. **Co-morbid PTSD** is a term used when PTSD is associated with at least one other major mental health conditions such as depression, anxiety, panic disorder, and alcohol or substance abuse.

Vicarious or Secondary Trauma

Humanitarian workers can predict to a certain degree that their role has inherent risks. However, the cumulative exposure to stories of unbearable pain and tragedy can have a profound impact on coping mechanisms. Vicarious trauma is caused by exposure to often large numbers of traumatized and vulnerable populations. Even when humanitarian personnel have had no direct exposure to traumatic events, there is a risk of vicarious trauma. Hearing detailed, and at times harrowing, stories can sometimes cause severe distress and disturbance that can impact daily functioning.

The humanitarian worker's sense of overwhelming helplessness can be compounded by **moral injury** when working with victims of war, torture, abuse and rape (for more information on moral injury see [this presentation](#) by Sonya Norman, US National Center for PTSD). Vicarious trauma is often linked with compassion fatigue and burnout. The latter is related to an accumulation of chronic, unresolved stress over time, from overwork, too high expectations/disappointments, exposure to problems, poor self-care and social support, etc. leading to incapacitating emotional distress and behavioral dysfunction.

Complex Post-Traumatic Stress Disorder, according to ICD-11, "is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, complex PTSD is characterized by:

- 1) severe and pervasive problems in affect regulation;
- 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor; and
- 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.”

Dissociation for Coping

In the face of extreme emotional pain, a survival mechanism—*dissociation*—can be activated that shuts down the capacity to feel to varying degrees. Typical dissociative behaviors include emotional numbing, lack of awareness of or inability to connect with feelings/ emotions and/or sensations. As trauma symptoms become more widely understood, the role dissociation plays can sometimes be undetected. The function of dissociative behaviors is to allow a person to escape, avoid or even get rid of unpleasant personal experiences. These are often situations that would make an individual feel fear, anxiety, pain, disgust, shame and guilt, among others. Signs of dissociation include:

- Spacing out, day-dreaming
- Glazed look, staring
- Mind going blank
- Mind wandering
- Sense of world not being real
- Watching self from outside
- Detachment from self or identity
- Out of body experience
- Disconnected from surroundings
- Amnesia
- Inability to feel some part or parts of your body.

If a humanitarian worker is attending to vulnerable populations in a dissociated state, the possibility to cause further harm to self and others can be high. And yet, it is rare to find organizations that provide routine checks for symptoms of dissociation for staff working in vulnerable settings. A tool that is easily used to assess for dissociation is the [Dissociative Experiences Scale](#) (Carlson and Putnam, 1993).

One of the best interventions when working with dissociation is to provide assistance in staying in the present moment. Having the person who is experiencing dissociation smell something with a strong odor, such as coffee or mint; asking them to sing; or name a list of objects/colors they can see around them, all contribute to supporting the dissociated person in coming back to the here and now. Further resources are found also in providing safety and soothing. Encouraging the person to take off their shoes and feel their feet on the ground while placing a hand on their heart and abdomen is another very effective tool.

PART TWO: PERSPECTIVES AND RESOURCES FOR SUPPORT

1. Resilience and Spirituality

“There will come a time, if you pursue this career for long, when a profound lack of understanding will threaten to sweep away your actions, beliefs, achievements, and even reason for being. Knowing this challenge will come, and ensuring that there are close friends who can hear your questions without harming you, is . . . essential.” Fawcett (2003, cited in McKay, 2010, page 11)



Image source unknown

Resilience, the ability to engage with and grow through life's challenges and adversities, is necessary to maintain one's health and effectiveness while working in crisis situations. Eriksson et al. researched stress, trauma, and burnout for World Vision field staff from over 30 countries. Their findings emphasize the need for resilience:

“Staff need to have ‘healthy personal resilience’ in order to survive and in order to continue contributing to the critical work of their organizations... for each of the mental health risk adjustment measures (depression, post-traumatic stress disorder, and burnout) 30-50% of staff scored in the moderate to high-risk range. This is a significant number of people who are working and ‘surviving’ while experiencing considerable emotional distress. These staff may not be incapacitated by these symptoms presently, but we cannot deny the effects that depression, burnout, and PTSD can have on relationships, work, and personal health. An NGO’s commitment to people includes the welfare of beneficiaries around the world, but it also includes the well-being of staff who commit their lives to serving and saving others.”
(p.95)

Fortunately, resilience can be developed. It is based on and supported by five key areas: personal character strengths; personal core beliefs/values including a sense of purpose/meaning and faith/God; ongoing social support from family, friends, and colleagues; coping skills for self-care and work-life balance; and staff care/personnel programs. The mental health and resilience of personnel in humanitarian operations significantly impacts the effectiveness and success of their interventions, especially if their terms of reference include the protection of civilians. If humanitarian personnel themselves, as helpers, are chronically stressed and traumatized (often without being fully aware of their condition), their productivity and relationships will begin to decline, ‘burnout’ can develop, and, in some scenarios, abusive behaviors towards others can occur. People who are sent to do good can thus become people who do harm.

It is vital for *all* those in humanitarian work to be trained to develop and/or to maintain good social, coping, and helping skills before being deployed. Further, humanitarian personnel must learn to recognize early signs of stress and trauma, assess the severity of their own or their colleagues’ symptoms, and be given a clear guide in how to proceed when follow-up is needed.

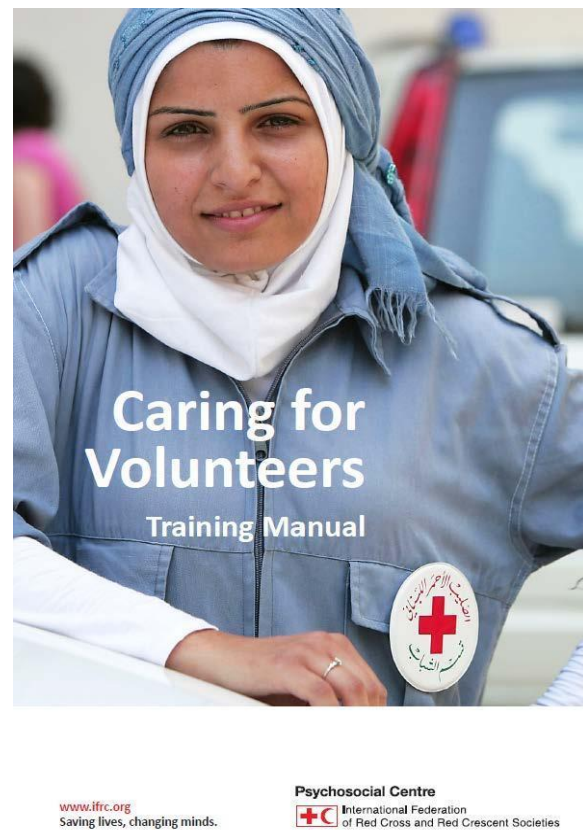
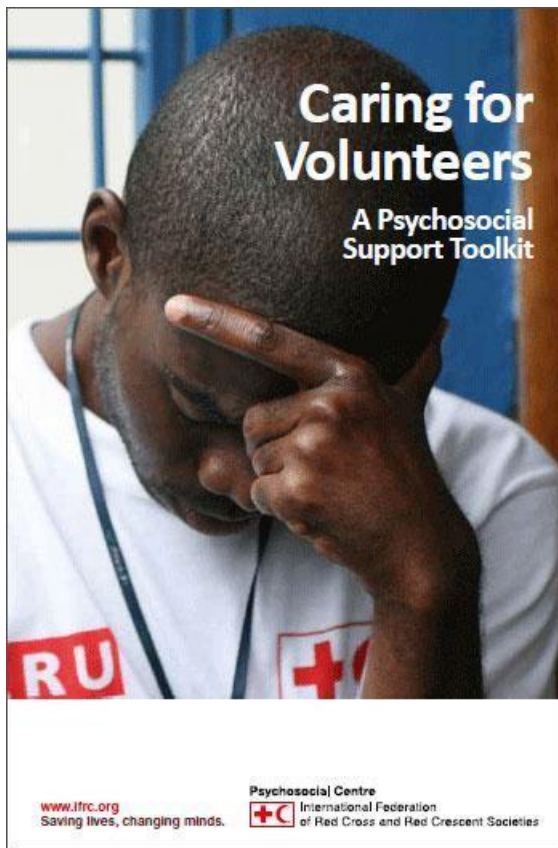
For people in humanitarian work, core beliefs and values (human worth and dignity, sense of duty) along with a strong personal faith and spirituality (transcendent purpose, meaning, hope) can be foundational to motivation (“calling”) and resilience. Less discussed, but deeply impactful, are the thoughts and feelings which challenge one’s spirituality or core beliefs about God, humans, and life. Humanitarian workers witness and wrestle with some of life’s extremes—violence, death, misery, injustice—which can lead to disillusionment and shattered ideals.

Notice two factors in Fawcett’s quote at the opening of Part Two, which are essential to a positive outcome when facing such anguish : 1) “knowing the challenge will come”—realizing it is inevitable, even normative, can help one begin to process the difficult emotions and 2) “close friends who can hear your questions without harming you”. Investing in enduring friendships is one of the best ways to cope with the spiritual challenges of humanitarian work. One thing is certain, humanitarian work will change you on the inside and how you experience your faith and spirituality. “Humanitarian work is a profession that carries with it huge potential for spiritual disruption on the one hand and spiritual growth on the other.” (McKay, 2010, page 7).

2. Care and Support of National Staff in Humanitarian Work

“A full local staff support program will need to consider the practical conditions of life—food, housing, job security, education, health, insurance, and so on. Psychological support may be required. Counseling services, based on local cultural practices, will almost certainly be needed. Spirituality, the need for a person to meet with God, must be central with understanding/respect being shown towards previous religious experiences.” Fawcett (2002, page 285)

As the nature of international humanitarian work continues to change in the direction of more involvement and leadership by local partners, it is imperative that organizations work with national staff to co-create and develop culturally sensitive support programs. This means that those who will both implement and benefit from such programs need to design them from the outset. Most likely this requires a planned process to identify and define what is “stress”—or idioms of stress—and “psychological trauma” in the local culture, how it impacts local staff at a personal and organizational level, how it is typically addressed, what local resources are the available, and agreement regarding the individual and organizational responsibility for the resulting plan. This is followed by an ongoing phase that involves the plan’s implementation and evaluation. World Vision has developed an assessment process that meets these criteria which Fawcett describes as an inexpensive, “technology-free...based on verbal conversations,...portable and applicable in a wide range of environments, ... with small or large numbers, for urban or rural programs.” Fawcett (2002, page 283)



The International Federation of the Red Cross/Red Crescent Societies (IFRC), has developed a tool kit and a training manual entitled, *Caring for Volunteers*, to fulfill their commitment to ongoing staff psychosocial support. Included in the *Tool Kit* (2012) are chapters addressing, resilience and risk; self-care; peer support; “Psychosocial Support Before, During, and After” crises; Psychological First Aid; monitoring and evaluation of support. The *Training Manual* (2015) contains relevant resources to conduct a two or three-day workshop addressing the above topics and includes worksheets and activities adaptable for many contexts. These are available on-line in four languages from IFRC [Psychosocial Support Resource Centre](http://www.ifrc.org/psychosocial-support-resource-centre).

3. Barriers to Seeking Help: Internal Factors

“In the midst of emergencies, there is a sense that our personal wellbeing and mental health are not worth looking after, and we become ashamed of expressing our needs. A woman serving with refugees told me, “If you claim that you are too stressed, the organisation will maybe relocate you to a boring job, then it goes on your record...It’s a taboo subject, you are seen as unstable, insecure...So it’s best only to seek help when your contract comes to an end.” A Syrian humanitarian officer added, “People either don’t acknowledge that they have a problem or don’t want to ask for help; sometimes we don’t even realize we are not well, since the pressure is constant.”” (Pigni, 2016, p. 42).

The barriers to receiving adequate mental and emotional care are not only external. Most humans will do anything, including suffering pain, in order to avoid diminished self-esteem and shame. This presents a significant problem when someone is experiencing burnout, compassion fatigue, vicarious trauma or PTSD. The need to avoid being ashamed of oneself and feeling shamed by others keeps many from accessing the support they need to find relief and healing. Others may feel afraid of repercussions from either a perpetrator or a supervisor if they make known the abuse or violence they have endured.

Those who are attracted to the field of humanitarian work are frequently adept at providing for the needs of others. When their own needs arise, it can be quite alluring to diminish or deny that they need time off for rest and recuperation. Instead, they push themselves past their own limitations, which leads to a cascade effect ending in resentment, cynicism, irritability, frequent illnesses and an 'us-them' mentality.

Furthermore, the widely held stigma that seeing a mental health professional means that one is 'crazy', keeps many people from seeking help. Additionally, those suffering from stress and trauma symptoms may not trust that the mental health professional will maintain confidentiality. One of the authors was contracted as an external mental health professional for volunteers in a large organization who were suffering from symptoms on a continuum from anxiety to trauma. She was consistently asked by each volunteer who came for therapy, if what they revealed in session would be shared with the organization.

Many who experience stress, burnout or trauma symptoms may not be aware that there are tools that will effectively relieve the distress. Through the use of EMDR and stabilization techniques such as these taught by [Capacitar International](#), one of the authors has witnessed numerous clients' deep sense of relief, soothing and safety after having suffered from nightmares, irritability, a constant sense of confusion or hypervigilance for months or sometimes years. Sadly, some organizations only respond when staff has reached a crisis level and can no longer perform their duties, leading to costly interventions such as evacuations and hospitalizations.

4. Organizational Culture and Management Practices

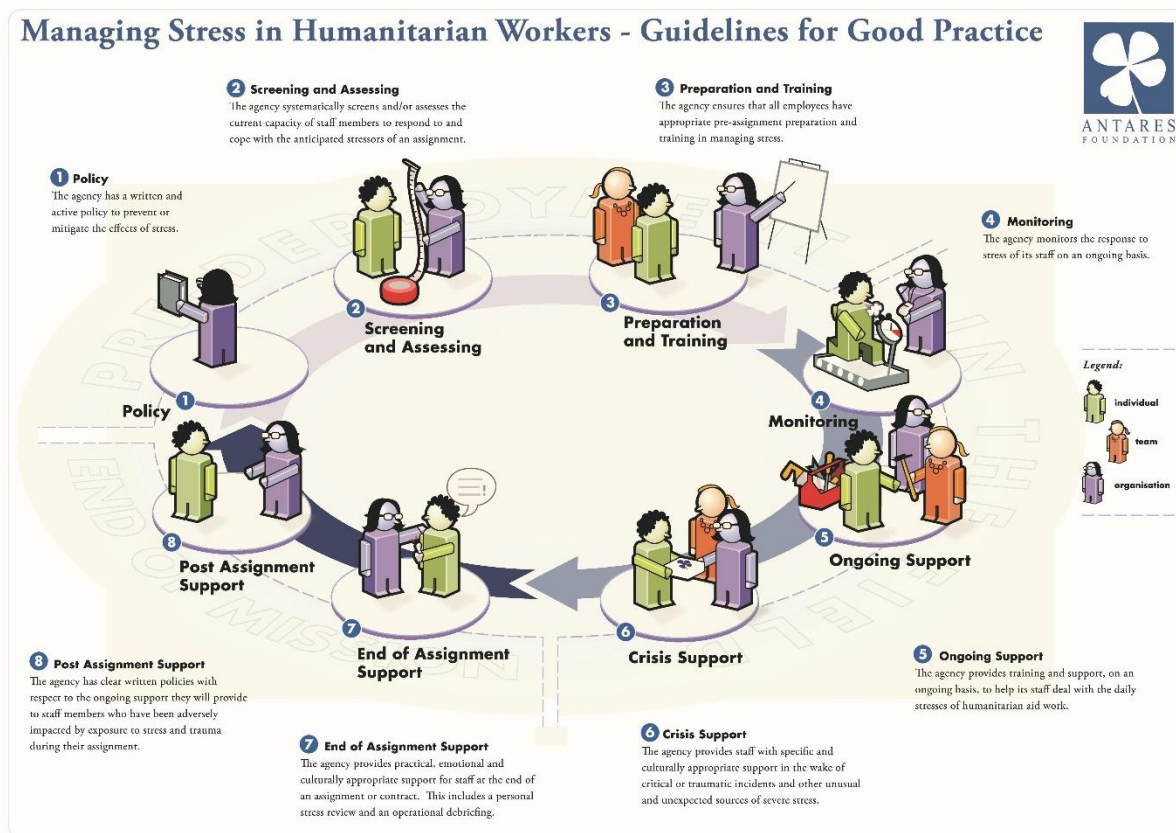
"[T]he most stressful events in humanitarian work have to do with the organizational culture, management style and operational objectives of an NGO or agency rather than external security risks or poor environmental factors. Aid workers, basically, have a pretty shrewd idea what they are getting into when they enter this career, and dirty clothes, gunshots at night and lack of electricity do not surprise them. Intra-and inter-agency politics, inconsistent management styles, lack of team work and unclear or conflicting organizational objectives, however, combine to create a background of chronic stress and pressure that over time wears people down and can lead to burnout and even physical collapse... Our findings suggest that strong relationships afford the best protection in traumatic and stressful environments." Fawcett (2003, page 6)

If poor management, lack of peer support and isolation are among the chief causes of stress for humanitarian workers, then building organizational capacity, trust, and increasing loyalty to those who are often putting their lives on the line would be some of the most critical strategies to increase both institutional and personal wellbeing.

The Antares Foundation has created a consensually-derived, core set of Guidelines to help organizations manage stress in humanitarian workers (eight principles; see the diagram below). The eight principles are:

1. Creating a clear policy of how to prevent and address stress
2. Regular screening and assessing, before, during and after placement
3. Adequate preparation and training
4. Ongoing monitoring
5. Ongoing support
6. Crisis support and management
7. Practical, emotional and culturally appropriate support at the end of assignment
8. Clear policies on post-assignment support

Although this information is widely available and understood, there is still a need for more organizations to provide sustainable financial and human resources to implement these practices focusing on prevention rather than costly crisis intervention.



Managing Stress in Humanitarian Workers (five languages), [Antares Foundation](#)

SUMMARY: STRESS AND SUPPORT FOR HUMANITARIAN WORKERS

Recognizing Strengths, Vulnerabilities, and Resources

“Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.” [Core Humanitarian Standard](#), Principle 8

1. Share the responsibility. Managing stress and trauma are not just personal responsibilities. Humanitarian organizations must also accept some major responsibilities, not the least of which are recognizing and treating stress and trauma, ensuring healthy organizational practices, and integrating stress management and resilience-building capacities across the organization and throughout all phases of humanitarian involvement.

2. Model health. In some humanitarian settings, the worst stressors have to do with the culture of the organization and management style rather than security risks or lifestyle demands. Hence field leaders and managers can support their teams through more effective leadership styles, management practices, and their own behavior.

3. Defuse stigma. Humanitarian workers can be reluctant to seek help. Both during deployments or even long afterwards, there may be a realistic fear that they will be seen as weak and inadequate for redeployment or promotion. Consequently they can often disconnect from their feelings and help perpetuate the “be-tough culture” that permeates the humanitarian sector.

4. Cultivate resilience in five areas: character strengths such as perseverance and integrity; coping skills for stress management, self-care, work-life balance, and interpersonal relationships; mutual support for colleagues, friends and family; staff support and wellbeing resources in one's organization; and a transcendent sense of purpose, meaning, and hope.

5. Stay aware, get help, and grow. Humanitarians are not unbreakable and it is important to remind them: "Don't overestimate your immunity; but don't underestimate your resilience. Stay in touch with the stressors in your life and their cumulative and possible delayed impacts. If you get stuck from stress or trauma, get help. Find safe places, safe people, and ways to help you grow through the challenges of humanitarian life—and beyond."

There are effective treatments for trauma, including the two therapies that the WHO has approved as evidence-based: EMDR (eye movement desensitization and reprocessing) and TF-CBT, (trauma-focused cognitive behavioral therapy). Although the availability of these therapies has grown substantially in recent decades, not all humanitarian workers, and especially national/local staff have access to mental health workers who speak their languages or understand cultural practices that have historically helped mitigate the impact of trauma.

Tools for Helping Ourselves and Others

- [Alternatives to violence program](#) (website)
- [Anxiety BC. Self-help strategies for PTSD](#)
- [Breathing Exercises](#), Dr. Andrew Weil
- [DisasterReady](#), Cornerstone on Demand Foundation. (free online courses for humanitarian action)
- [EMDR International Association](#): Creating global healing, health and hope.
- [Harvard Trauma Questionnaire](#) (self-measure for trauma events and emotional symptoms)
- Hidden Hurt. (2015). [Self-care following trauma](#). Hidden Hurt: Domestic Abuse Information
- Johnstone, M. (2012). [I Had a Black Dog](#) (short video about depression and recovery)
- [Kessler Psychological Distress Scale](#) (self-measure of anxiety and depression)
- Moodjuice. [Post-traumatic stress: Moodjuice self-help guide](#)
- [Non Violent Communication](#) (website)
- O'Donnell, K. (2010). [Team building and resiliency](#) (short course and tools)
- [ProQOL 5](#) (self-measure for the negative/positive affects of helping others who experience suffering and trauma, available in 26 languages)
- [PTSD Association of Canada](#). (2016). Various resources for growth and recovery
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- Schwiebert, P and DeKlyen, C. [Tear Soup: Recipe for Healing after Loss](#) (2005). (book and DVD, available in English and Spanish)
- UNITAR. [Understanding and Transforming Stress](#). *Wellbeing for Peace Series* (free online course)
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Final Thoughts

"...humanitarian work is, after all, a celebration of life, not homage to death and despair." Fawcett (2003, page 1)

It has been an honor and inspiration to work in the humanitarian sector, meeting and supporting such a variety of dedicated and compassionate people. In the most difficult contexts they bear witness, sow seeds of hope, and give dignity to those who struggle, while they themselves may be facing similar adversity and challenges just like the people they are helping. We are also mindful of our own limitations and vulnerabilities—our breakable humanity—in the face of unspeakable tragedy and injustice and the ongoing, cumulative grind of "engaging in humanity care." Nonetheless, we consider ourselves blessed to follow and serve Jesus in this way as mental health professionals (John 12:26)!



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Notes

1. This article includes materials and perspectives from these primary sources:

--O'Donnell, K. (October 2017). [Unbreakable? Recognizing humanitarian stress and trauma](#). *Global Geneva*, Issue 3, 56-57 (hard copy and online pp. 60-61).

--O'Donnell, K, and Pidcoke, H. (2017). [Module One: Introduction to stress, resilience, and self-care](#). In Farrell, D., with Blenkinsop, C., Carriere, R., Croci, C., O'Donnell, K., and Pidcoke, H. *Confronting Stress and Trauma: A Resource Kit for Personnel Dealing with Violent Conflicts and Natural Disasters*; University of Worcester in association with UNITAR, Geneva.

--International Federation of Red Cross and Red Crescent Societies (2009). [Managing Stress on the Field](#), 4th ed.

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