



USAID
FROM THE AMERICAN PEOPLE

ASSESSMENT ANNEX

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

September 2015

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

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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¹ The assessment team received no response or data for these queries.

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The official U.S. Army program that assists and advocates for severely wounded, ill, or injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status. For more information, see:

[http://myarmybenefits.us.army.mil/Home/Benefit_Library/Federal_Benefits_Page/Army_Wounded_Warrior_Program_\(AW2\).html](http://myarmybenefits.us.army.mil/Home/Benefit_Library/Federal_Benefits_Page/Army_Wounded_Warrior_Program_(AW2).html)

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ANNEX 2. GLOSSARY

1. **Acute Stress:** Exposure to stressful conditions or circumstances that are unusually intense, with sudden onset and lasting for a period of brief duration, resulting in an intense state of arousal in which an individual experiences demands that exceed the inner and outer resources available for dealing with them.

Related concept: Critical Incident Stress.

2. **Adaptive Behavior:** Any personal or social behavior that allows an individual to adjust to a new, negative, or uncomfortable situation that is triggering stress or resulting in generalized stress-related anxiety. In general, a behavior is considered adaptive when it is successful in reducing or otherwise allowing integration of the stress or subduing anxiety, and has no otherwise negative consequences for the biopsychosocial health of the individual.

Related concepts: Coping Behaviors and Maladaptive Behavior.

3. **Allostatic Load:** Allostatic Load is the cumulative degradation of systems of the body that occurs over time when an individual is exposed to repeated acute stress events or lower-grade but chronic stress. Allostatic Load is the physiological consequence of protracted heightened neural or neuroendocrine excitation or arousal that is triggered by the stress response. This construct is used to explain how frequent activation of the body's stress response can create damage to the body. Allostatic Load is generally measured through an index of indicators on several organs and tissues, but especially on the cardiovascular system.

Related concepts: Cumulative Stress and Stress Injury.

4. **Anxiety:** A mental state characterized by worry, nervousness, uneasiness, apprehension, or fear, and often accompanied by physical sensations or symptoms such as changes in breathing, elevated heart rate, or muscle tension. Anxiety commonly manifests around anticipation of imminent negative events, or in situations with uncertain outcomes, but can also become “free floating” in that it is unconnected to anticipating a specific negative event. Sources of anxiety may be real, imagined, internal, or external; these may be an objective and identifiable situation, or a more vague and generalized fear of the unknown.

In some individuals, anxiety can become severe enough (for example, triggering panic attacks) or remain present long enough, and when coupled with disruption of normal functioning, it meets diagnostic criteria as a psychiatric disorder.

5. **Arousal:** (See: Excitation).

- 6. Biopsychosocial:** A term that captures the multi-modal aspect of the locus of stress, and also captures the spectrum of stress reactions. This concept describes a complex and interactive model of health that recognizes that linkage between the nervous system and the rest of the body are both influenced by and can impact cognitive and affective (emotional) neural processing systems, behavioral styles, and interpersonal relationships. A biopsychosocial approach to stress recognizes that sources of stress reactions can emerge from or can reside in each of these inter-dependent spheres; stress effects can and often do manifest to varying degrees in all of these spheres, with great individual variation; and stress can be treated or effectively reduced through various interventions targeted at or in each area.
- 7. Burnout:** A state of extreme physical, emotional, and mental exhaustion that occurs in helping professionals who perform under high levels of exposure to work-related stress, and often results in them choosing to leave their profession. Burnout is a well-researched and well-documented phenomenon among helping professionals such as nurses, emergency medical technicians, and fire-fighters, and increasingly is recognized as a condition particularly affecting international aid workers. Burnout is characterized by cynicism, a decrease in motivation and performance, and emotional disconnection from the people they are helping; sufferers often feel emotionally exhausted and have negative feelings towards those they are working with and for. Burnout also produces mental, emotional and physical fatigue related to the excessive number of hours that a person is required to work; depersonalization, or emotional detachment from the people they are working with and the work tasks they must perform; and lack of a sense of personal accomplishment, expressed by feelings of inadequacy and poor self-esteem.
- 8. Chronic stress:** Exposure to stressful conditions or circumstances that is extended for long duration, and results in a continuous or longstanding state of heightened arousal in which an individual experiences demands that exceed the inner and outer resources available for dealing with them. Chronically stressful environments may lead to habituation (a situation in which exposure to stress comes to be perceived as 'normal'), various stress-related health conditions, or Burnout.
- 9. Compassion Fatigue:** The emotional after-effects or strain of exposure to working with those suffering from the consequences of traumatic events. Compassion Fatigue can occur due to isolated exposure or can be cumulative, building up over time. Compassion Fatigue differs from Burnout, but can co-exist, and shares many of the emotional characteristics of Burnout, and may be a significant emotional precursor to someone reaching the stage of being burned out. Compassion Fatigue can lead to cynicism, a decrease in motivation and performance, emotional disconnection with neutral or negative feelings towards the people being helped, and feeling

emotionally exhausted. Compassion Fatigue also produces mental and physical fatigue; depersonalization; and feelings of inadequacy and poor self-esteem.

Related concepts: Burnout, Vicarious Trauma, and Secondary Trauma.

- 10. Coping Behavior (or Coping Mechanism):** Any personal or social behavior, or other tool or resource, that allows an individual to adjust to a new, negative, or uncomfortable situation that is triggering stress or resulting in generalized stress-related anxiety. Coping Behaviors allow individuals to accommodate, regulate or reduce the severity of their stress reactions, so that they can continue to operate normally or maintain emotional stability. Coping Behaviors can be conscious or sub-conscious, and can be adaptive or maladaptive.
- 11. Crisis Counseling:** Crisis Counseling is provided to people experiencing acute stress reactions, either following a critical incident or as a result of a severe psychological reaction triggered by chronic stress or other circumstances. There are multiple modes of this, which can be done in one-on-one sessions, group sessions, or remotely via telecommunications. Crisis Counseling is not the same thing as long term psychiatric care. Typically, Crisis Counseling is of limited duration and immediately or nearly immediately follows the crisis.
- 12. 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.
- 13. Critical Priority Country (CPC):** Hard to fill, one tour, unaccompanied posts. As of September 2015, the current CPCs are Afghanistan, Iraq, Pakistan, and South Sudan.
- 14. Culture:**¹The sum total of behavior patterns, attitudes, customs, values and beliefs that distinguishes one group of people from another. Culture is socially transmitted from one generation to the next, and it is learned and reinforced through language, ritual, institutions, material objects, and art. Culture constitutes the shared basis of social action and establishes the boundary markers for social identity formation, parameters for necessary or appropriate individual behavior, and what is socially acceptable or taboo. Culture is significant to the study of stress- and trauma- as well as stress management and stress or trauma care because it heavily conditions a person's perception of what is stressful or traumatic, what are appropriate or inappropriate reactions to stress, and what forms of care may or may not be suitable to assist someone in addressing stress reactions in themselves or others.

¹ <http://dictionary.reference.com/browse/culture>. This definition has been modified somewhat to make it applicable to the specific purposes of this study.

15. Culture (Organizational):²The sum total of the values and behaviors that contribute to the unique social and psychological environment of an organization. Organizational Culture includes an organization's expectations, experiences, philosophy, and values, and is expressed in its self-image, inner workings, interactions with the outside world, and future expectations. It is based on a set of shared attitudes, beliefs, customs, and written and unwritten rules that have been developed over time and are considered valid by consensus. Organizational Culture is shown in:

1. The ways the organization conducts its business, and treats its employees, customers, and the wider community;
2. The extent to which freedom is allowed or supported in decision making, taking risks, developing new ideas, and personal expression;
3. How power and information flow through its hierarchy;
4. How decisions are made and resources allocated; and,
5. How committed employees are towards the organization itself and its shared objectives.

Culture affects the organization's productivity and performance, provides informal or formal guidelines on customer care and service, establishes and validates the organization's mission and modes of operation, creates standards of product quality, defines parameters around attendance and punctuality, determines interpersonal and team dynamics, conditions how power is used to manage and direct personnel and other resources, and reveals and defends concern (or lack thereof) for the welfare of personnel. Organizational culture is unique for each organization and is often very resistant to change.

16. Cumulative Stress: A concept that recognizes stress can build up over time and thus accumulates within an individual, especially when people have no opportunity post-exposure to de-stress and restore themselves to a pre-exposure baseline. Previous exposure to stress or traumatic events can increase the level of cumulative stress a person is carrying (and a related concept, Allostatic Load, describes the wear and tear on the biological system that occurs through stress exposure), thus reducing an individual's ability to be resilient in the face of new stress exposure.

Related concepts: Allostatic Load and Stress Threshold.

17. Distress: Stress on an individual that outstrips internal coping mechanisms and external supports, and thus produces negative biopsychosocial effects. Distress is a term coined by the

² <http://www.businessdictionary.com/definition/organizational-culture.html>. This definition has been modified somewhat to make it applicable to the specific purposes of this study.

pioneering endocrinologist Hans Selye and illustrates how stress, in some cases, produces negative effects on an individual.

- 18. Duty of Care:** A legal and/or moral obligation to conform to a certain standard of conduct that reasonably ensures protection of personnel against foreseeable risk of harm.
- 19. Eustress:** Stress that challenges an individual, is coped with successfully, and subsequently is easier to cope with. Eustress is a term coined by the pioneering endocrinologist Hans Selye, and illustrates how stress, in some cases, is perceived to be positive by the individual and in fact sometimes produces growth or other positive effects for the individual.
- 20. Excitation:** The state of arousal that occurs in an individual when the biological circuits of the brain are activated and trigger the wider autonomic nervous system, wired into the various and non-specific systems of the body (such as the circulatory system), in order to prepare the individual for responding to threats or adaptation challenges. Excitation can be tracked through various measures including levels of various hormones, such as adrenaline or cortisol, or through other “biomarkers” such as elevated blood pressure, altered breathing patterns, and increased muscle tension. Excitation alters the normal function of the entire biopsychosocial framework of an individual, affecting homeostasis and altering normal processes for biological regulation, impairing cognition, dysregulating emotional experience, disrupting normal behavior, and impairing social function.
- 21. “Fight, Flight or Freeze”:** The various reactions to perceived threat that an individual can manifest that are considered to be evolutionary responses to ensure the survival of the individual, and that characterize the biopsychosocial behavioral reactions to stress that occur at the individual level. Most of the stress reactions that occur in individuals are in some way linked to priming the body and/or the individual psychology to respond appropriately to actual or perceived threats.
- 22. Hazard (stress related):**³In terms of workplace health and safety, a hazard is any potential source of damage, harm or adverse health effects to an individual that may occur as a result of conditions at work. A hazard is any work condition that can cause harm or adverse health effects to individuals.

In risk assessment, risk is determined by multiplying the severity of the harm that a given hazard can produce by the likelihood that that hazard will occur. When resources to mitigate risk are constrained, these limited resources are devoted to managing those hazards that are, relatively, both most severe and most likely.

³ http://www.ccohs.ca/oshanswers/hsprograms/hazard_risk.html. Slightly rewritten for the purposes of this study.

23. Hardiness:⁴A personality style or tendency, fairly stable over time, that is composed of the following interrelated components:

1. Commitment (vs. alienation), referring to the ability to feel deeply involved in activities of life;
2. Control (vs. powerlessness), the belief one can control or influence events of one's experience; and,
3. Challenge (vs. threat), the sense of anticipation of change as an exciting challenge to further development.

Related concept: Resilience.

24. High Threat Environment (HTE): A country, city, area, sub-region or region in which USAID is hindered from accomplishing its mission due to security risks, such as:

1. Specific targeting of U.S. interests or personnel
2. A favorable operating environment for terrorists, organized criminal or armed militant groups
3. Intelligence indicating that a threat is imminent, or
4. Other significant risk as identified by the Office of Security (USAID/SEC), the Regional Security Officer (RSO), or other appropriate U.S. Government official in consultation with the RSO.⁵

25. Maladaptive Behavior: Similar to Adaptive Behavior, Maladaptive Behavior serves the purpose of allowing an individual to adjust to a new, negative, or uncomfortable situation that is triggering stress or to successfully manage generalized stress-related anxiety. Unlike Adaptive Behavior, Maladaptive Behavior produces results that are dysfunctional, unproductive or counter-productive, and in the long-term may produce more severe problems than the situation it was originally meant to assist adaptation to, and can have severe negative biopsychosocial health consequences. Some diagnostic criteria for stress related disorders may have originally served as Maladaptive Behaviors for the individual.

26. Meaning Injury: (See: Moral Injury).

27. Moral Injury:⁶Moral Injury occurs when a person is confronted by “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and

⁴ Adler, Amy B., and Carol A. Dolan. “Military Hardiness as a Buffer of Psychological Health on Return from Deployment.” *Military Medicine*, Volume 171, no. 2: February 2006. Pp 93-98.

⁵ This definition is taken, slightly modified, from: USAID. “GLOSSARY of ADS TERMS.” 04/30/2014 Partial Revision. Available at: <https://www.usaid.gov/sites/default/files/documents/1868/glossary.pdf>

⁶ This definition was constructed, and rearticulated specifically for the purposes of this research, from the discussion found here: <http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v23n1.pdf>

expectations.” Many development practitioners enter the field due to strongly held values and personal convictions related to justice, ethical behavior, and service to humanity. But serving in high-operational stress postings may lead to situations in which values-driven officers are confronted with ethical and moral challenges that are difficult to reconcile with these values. In some situations, such values conflicts are navigated successfully because of effective leadership, or the purposefulness and coherence that arise in cohesive units during and after challenges. However, in some operational contexts, some experiences can transgress these deeply held personal beliefs that undergird a USAID officer’s motivation for performing the work. Transgressions can arise from individual acts of commission or omission, the behavior of others (especially leaders who possess the power to make or prohibit certain operational decisions), or by bearing witness to intense human suffering without being able to respond in a way that is seen to be congruent with personal convictions. Perceived betrayal on either a personal or an organizational level can also act as a trigger. This serious inner conflict, precipitated by an experience that is at odds with core ethical and moral beliefs, is often accompanied by an overwhelming experience of shame, guilt, and self-handicapping behaviors, all of which make moral injury distinct from other, long-established post-deployment mental health problems such as PTSD.

Related concept: Meaning Injury.

- 28. MOSS:** Minimum Operating Security Standards. A set of objective, clearly defined minimum standards for operational safety and security in high-risk and high-threat operating environments, originally developed by the UN but taken up by the larger international development community as a response to the increased levels of programming occurring in unstable, violent, or militarized development contexts.
- 29. NIOSH:** The National Institute for Occupational Safety and Health. NIOSH is an organizational component of the Centers for Disease Control and Prevention (CDC) and is charged with ensuring safety and health for all people in the workplace through research and prevention.
- 30. Non-Permissive Environment (NPE):** NPE definition from an USAID Agency Notice of March 30: "USAID defines an NPE country as having significant barriers to operating effectively and safely due to one or more of the following factors: armed conflict to which the U.S. is a party or not a party; limited physical access due to distance, disaster, geography or non-presence; restricted political space due to repression of political activity and expression; and uncontrolled criminality including corruption." As of September 2015, the eighteen (18) NPE countries are: Afghanistan, Democratic Republic of the Congo (DRC), Egypt, Honduras, Iraq,

Jordan, Kenya, Lebanon, Mali, Mexico, Niger, Nigeria, Pakistan, South Sudan, Sudan, Uganda, Ukraine, Yemen.

- 31. Non-Stigmatizing:** To stigmatize is to characterize a behavior or characteristic of a person as disgraceful, or condemn a behavior or characteristic as shameful. Stigma is a process by which a group shows social disapproval. Non-stigmatizing is therefore behavior, communication, and social interactions that do not brand behavior or characteristics as disgraceful or shameful, and in fact may establish certain behaviors or characteristics as normal, expected, socially approved, or even virtuous.
- 32. Occupational Stress:** Biopsychosocial adaptation challenges encountered by employees on the job. In general, Occupational Stress is understood to occur due to a mismatch between job demands or conditions and worker knowledge or capabilities, that challenges a worker's ability to cope. Occupational Stress can stem from multiple conditions of work, including heavy or unremitting workload, high-pressure deadlines, perceived unsupportive supervision or disengaged or abusive management, difficult decisions or inappropriate levels of responsibility, perceived lack of control over work processes or conditions, lack of necessary knowledge, skills, or experience, factionalism or clique-ism among worker groups, conflict, harassment or bullying in the workplace, unpleasant or disagreeable working environments, job dangers, competition over resources among workers, fear of potential unemployment, and others. The causes of Occupational Stress have been thoroughly studied, especially a highly developed subset among health care workers and emergency responders, and all of these are well-documented in an extensive body of academic literature. The somewhat unique causes of stress that occur among international aid workers are also fairly well-documented, although the study of this particular population is relatively recent and still emerging.
- 33. Organizational Politics:** Any behaviors that relate to influencing organizational actions, policies, resource distribution, or getting and keeping power within an intra- 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 that takes the form of seeking control over decisions, activities, policies, or resources.
- 34. Post-Traumatic Stress (PTS):** An adaptive biopsychosocial response to experiencing an acutely stressful or traumatic event.
- 35. Primary Intervention:** In the three-tiered model of occupational stress intervention, Primary Interventions are those that seek to address the root causes of stress by adjusting organizational structures, systems, and processes that directly contribute to stress in the workforce to make them less stressful. This may involve establishing or revising policies, adjusting workloads,

adjusting roles and responsibilities, improving organizational communication or employee consultation, etc.

36. PTSD (Post-Traumatic Stress Disorder)⁷: A recognized mental health condition triggered by exposure to an acutely terrifying event. The diagnostic criteria for PTSD identify the trigger as exposure to actual or threatened death, serious injury, or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

- Directly experiences the traumatic event;
- Witnesses the traumatic event in person;
- Learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or,
- Experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

Regardless of its trigger, exposure causes clinically significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning. The behavioral symptoms that accompany PTSD occur in four distinct diagnostic clusters. These are:

- Re-experiencing: spontaneous memories, recurrent dreams or flashbacks of the negative event, or other intense or prolonged psychological distress.
- Avoidance: avoiding distressing memories, thoughts, or feelings, or external reminders of the event.
- Negative cognitions and mood: these may encompass myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in normal activities, to an inability to remember key aspects of the event.
- Arousal: marked by aggressive, reckless or self-destructive behavior, sleep disturbances, and hypervigilance or related problems.

Interestingly, the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, was recently updated (to the 5th edition, DSM-V: 2015) and now

⁷ American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-V)." (5th ed.). Washington, DC: 2015.

includes a specific chapter on Trauma and Stressor related disorders, and addresses PTSD as such, rather than as an anxiety disorder.⁸

Related concepts: Traumatic Stress Syndrome (TSS), Sub-threshold Trauma

- 37. Psychometrics:** The measurement of mental traits, abilities, and processes. A branch of psychology concerned with the design and use of psychological tests through the application of statistical and mathematical methods to psychological testing.
- 38. Psychosocial:** Involving both psychological and social aspects; relating social conditions and social functioning to mental health, both as cause and as consequence (or symptom). The dynamic and interacting nature of the social environment with psychological functions.
- 39. Psychological First Aid (PFA):** Built on the concept of human resilience, Psychological First Aid is an evidence-based approach that aims to immediately reduce distress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or a personal crisis.
- 40. Psychological Evacuation:** A process whereby someone is removed from a field location due to acute psychological distress, an emotional breakdown, or some other severe psychological episode.
- 41. Psychopathology:** Psychiatric illness. The conditions, processes, or symptoms of a mental disorder.
- 42. Resilience:** The process of adapting well in the face of adversity, tragedy, threats, trauma or other significant sources of stress. One definition from the medical literature describes resilience in the following way:

Resilience is the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost; resilient individuals "bounce back" after challenges while also growing stronger.⁹

The RAND Corporation identified nearly one hundred distinct definitions for resiliency when studying the U.S. military's operationalization of this construct.¹⁰ While acknowledging that consensus is difficult, the report selected the following definition as the most useful:

Resilience is the capacity to adapt successfully in the presence of risk and adversity.¹¹

⁸ American Psychiatric Association. "Posttraumatic Stress Disorder." Factsheet. 2013. Available at: <http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf>

⁹ Epstein, Ronald M., and Michael S. Krasner. "Physician resilience: what it means, why it matters, and how to promote it." *Academic Medicine*. vol 88, no. 3. 2013. pp. 301-303.

¹⁰ 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. http://www.rand.org/pubs/research_reports/RR420.

Resilience is heavily influenced by: personal disposition and available coping resources, previous life experience or stress exposure, the presence or absence of physical health and fitness, and supportive social connections.

Related concepts: Hardiness and Stress Threshold.

43. Risk (stress-related): Risk is derived from the combination of the severity of impact and the likelihood for harm- as relates to stress, likelihood increases along with the intensity and duration of exposure. Risks are categorized in levels that go from Very Low to Very High, allowing for their relative prioritization.

44. Secondary Intervention: In the three-tiered model of occupational stress intervention, Secondary Interventions are those that seek to address the root causes of stress by improving individual capabilities, such as wellness behaviors and coping abilities, which directly contribute to stress and resilience in the workforce. Secondary Interventions may take the form of resilience or stress management training, offering on-site coping resources such as exercise facilities or massage therapy benefits, or providing staff with stress assessment tools. It may also take the form of other training, such as interpersonal or leadership skills development.

45. Secondary Trauma (or, Secondary Traumatic Stress):¹² Secondary Trauma refers to the presence of Traumatic Stress or PTSD-like symptoms caused by indirect exposure to a traumatic experience. Secondary Traumatic Stress is the emotional duress that results when an individual directly witnesses or hears about the firsthand trauma experiences of another. Individuals affected by Secondary Traumatic Stress may find themselves re-experiencing their own personal trauma, or may notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience: changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; disruption in their perceptions of safety, trust, and independence; hypervigilance; hopelessness; inability to embrace complexity; inability to listen and avoidance of clients; anger and cynicism; sleeplessness; fear; chronic exhaustion; physical ailments; minimizing; and guilt. Several other terms, including Compassion Fatigue and Vicarious Trauma, capture elements of this definition but are not fully interchangeable with it.

Related concept: Compassion Fatigue and Vicarious Trauma.

¹¹ Jenson, Jeffrey M., and Mark W. Fraser. "A Risk and Resilience Framework for Child, Youth, and Family Policy," in *Social Policy for Children and Families: A Risk and Resilience Perspective*, J.M. Jensen and M.W. Fraser, Editors. 2005, Sage Publications: Thousand Oaks, CA.

¹² National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. "Secondary traumatic stress: A fact sheet for child-serving professionals." Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. 2011.

46. Self-care: Any behavior or practice put in place by an individual that is consciously designed to reduce the causes of stress, or bolster the individual's resilience in the face of stress, to enhance their ability to cope or to adapt.

Related concepts: Stress Management and Resilience.

47. Social Contagion: The spread of emotion or behavior from one person to another. One person serves as the stimulus for the feelings or actions of another. This is related to the recognition that stress reactions can be triggered simply by interacting with other people who are experiencing stress.

48. Subcortical: Structures and processes of the brain closely related to the limbic system and so-called "reptilian brain." These structures are mostly located below the brain's cortex, which is the outer layer and the layer where most conscious control lies.

Related concepts: see next Annex for expanded brain terms.

49. Sub-threshold Trauma: a single symptom or constellation of symptoms that do not meet the diagnostic criteria for ASD or PTSD, but nevertheless do limit a person's ability to function normally. Examples include: Difficulty regulating emotional states, Physiologic instability, Feeling "off," Chaotic interactions with family and other social relationships, Job related dysfunctions or incompetence.

Related concepts: Traumatic Stress Syndrome (TSS), Post-traumatic Stress Disorder

50. 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.

51. Stress: The pattern of specific and nonspecific biopsychosocial responses of an individual to stimulus events that disturb its equilibrium, create challenges that require adaptation, and tax or exceed its ability to cope. Stress is a response or a reaction to a stimulus.

52. Stressor: Any real or perceived, inner or outer, biopsychosocial stimulus that triggers the stress response. The "source" or "trigger" of an individual's stress reaction. Synonym: Adaptation Challenge.

53. Stress Affected: A description of anyone who has been exposed to stressors and thus has had their stress response activated. In general, people who are stress-affected manifest a spectrum of common reactions that can be viewed as symptoms of heightened excitation within the biopsychosocial system for responding to threats, and these biopsychosocial reactions include well-documented and consistent physiological, emotional, psychological, and social reactions. However, everyone reacts to stress differently, with some individuals being hardier and more

resilient than others, and manifestations of different configurations of these biopsychosocial reactions can vary extensively between individuals and also can vary widely within an individual over time.

54. Stress Assessment: Conducting objective, evidence-based research to identify causes and effects of stress. In workplace settings, this process could entail any of a number of approaches, with greater or lesser degrees of scientific rigor, designed to assist managers and staff in identifying, understanding, addressing, and ultimately resolving the causes and effects of stress that affect the work force.

55. Stress Awareness: The non-stigmatizing and objective 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.

56. Stress Effects: The consequences of exposure to and attempts to adapt to stress. Acute effects commonly include elevated heart rate, sweating, headache, neck/shoulder/back discomfort, and jittery digestive sensations. Chronic effects include immune system suppression, cardiac disease acceleration, neck/shoulder/back pain syndromes, decreased fertility and libido, menstrual dysfunction, digestive disorders, disordered eating, sleep disturbance, respiratory disorders, various skin conditions, increased irritability, decreased patience, impaired cognition, and heightened hostility toward others.

Related concepts: Allostatic Load, Resilience, and Stress Affected.

57. Stress Injury: Any persistent biopsychosocial difficulty resulting from exposure to high levels of chronic stress or acute traumatic stress. These may include a broad range of symptoms, such as impairment in normal functioning or recognized and diagnosed psycho-social conditions such as anxiety, depression, and PTSD. Additionally, there is mounting evidence that severe stress exposure, both in acute and chronic forms, alters the structure of the brain and impairs normal neurological processes and functions in a manner that is consistent with a concept of neuro-physiological damage to the nervous system. Furthermore, stress affects all systems of the body and activates degenerative processes, such as the non-specific inflammation response, that are known to trigger, or exacerbate pre-existing, purely physical health conditions, many of which are potentially debilitating and/or life-threatening.

Related concept: Allostatic Load.

58. Stress Inoculation:¹³ Stress Inoculation is a process by which a person's resistance to stress is enhanced by exposure to a stimulus strong enough to arouse defenses and trigger coping processes without being so powerful that it overwhelms the individual, thus providing individuals experience with minor stressors that foster psychological preparedness and promote resilience. Exposing an individual to a milder form of stress can bolster coping mechanisms, and increase individual or group confidence and sense of mastery in using a coping repertoire, enhancing a sense of preparedness.

59. Stress Management: Any intentional technique or practice used by an individual to help the individual to lessen the causes of stress or better cope with the biopsychosocial effects of stress. In an institutional setting, any system, process, resource or set of resources, or practices designed to either lessen the sources of stress affecting personnel or to assist personnel in being better able to cope with unavoidable stress effects. In general, Stress Management is any practice that aims to prevent or reduce the causes of stress.

Related concept: Coping Mechanisms and Stress Mitigation.

60. 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 immediately.

Related concepts: Stress Management and Stress Prevention.

61. Stress Monitoring: Conducting objective, evidence-based research to track stress exposure and/or the effects of stress, either among populations or among individuals. The purposes of stress monitoring are to:

1. Identify patterns of stress in Operational Units so that pro-active responses can be implemented before stress exposure begins to result in severe stress effects or toxic exposure;
2. Ensure that individuals who have been exposed to high levels of stress, especially those currently suffering from stress effects, are identified, in order to make support resources available to them;
3. Prevent exposed and/or affected individuals from re-entering a high-stress operational environment before they have had the opportunity to effectively recover from previous exposure;

¹³ Extracted, with editing for clarity, from Meichenbaum, Donald. "Stress Inoculation Training: a Preventative and Treatment Approach." A web-published version of a Chapter to appear in Lehrer, Paul M., Robert L. Woolfolk and Wesley E. Sime, "Principles and Practice of Stress Management (3rd Edition)." Guilford Press: 2007.

In workplace settings, this process could entail any of a number of approaches, with greater or lesser degrees of scientific rigor and using any of a number of off-the-shelf stress measurement instruments. Stress monitoring is designed to assist managers and staff in identifying, understanding, addressing, and ultimately resolving the effects of stress exposure that affects the work force.

- 62. Stress Prevention:** Any behavior or practice, either at individual or institutional levels, designed to reduce, mitigate, or manage stress. This could include training and skills-building to improve resilience or develop coping among managers and staff; stress management resources provided to assist staff to be better able to respond to stress; or any organizational development processes designed to identify and reduce the causes of stress in the workplace.

Related Concepts: Stress Management and Stress Mitigation.

- 63. Stress Reactions:** (See Stress Effects).

Related concept: Stress Affected.

- 64. 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 Responsiveness has two key components: Stress Mitigation and Staff Care.

- 65. Stress Threshold:** This concept relates to the recognition that stress is cumulative and at a certain point, if unable to engage in recovery from stress exposure, a person may receive a toxic level of exposure which triggers a stress reaction that may take the form of manifesting the symptoms of various stress-related conditions. Stress Threshold varies widely by individual and is heavily influenced by various factors, including personal disposition and available coping resources, previous life experience or stress exposure, the presence or absence of physical health and fitness, and supportive social connections.

Related concepts: Resilience and Cumulative Stress.

- 66. Tertiary Intervention:** In the three-tiered model of occupational stress intervention, Tertiary Interventions are those that seek to address consequences of stress by providing access to appropriate staff care resources after stress injuries or negative health effects have occurred. Providing access to psychosocial counseling and extended medical leave are examples of Tertiary Interventions.

- 67. Trauma:** The definition of Trauma used in the DSM-5 is heavily informed by the cause of the trauma. According to this definition Trauma is an occurrence wherein an individual experiences a threat to their own life or physical safety, or witnesses such a threat to other people, and feels

acute or otherwise extreme terror, fear, or helplessness. (See PTSD for an expanded description of this definition.) However, this definition does not fully capture another very important dimension to the concept. A strict definition of trauma is: an injury (as a wound) to living tissue caused by an extrinsic agent.¹⁴ A second definition is: a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury.¹⁵ So, from the authors' perspective, the most useful definition is: a psychological or emotional injury received as a result of exposure to an acutely terrifying or otherwise overwhelming experience that results in disruption to the individual's normal ability to maintain stable emotional, psychological, or social/behavioral functioning.

Related concept: Traumatic Stress.

68. Traumatic Brain Injury (TBI): Traumatic brain injury (TBI) is a non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to temporary or permanent impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.¹⁶ However, there is mounting evidence that exposure to severe stress, either acute or chronic, results in morphological changes in the anatomical structures of the brain and creates changes in the ability of the brain to neurochemically self-regulate, and this could be argued to also be a form of injury to the brain that does not require the delivery of external mechanical force.

Related concepts: Allostatic Load and Stress Injury.

69. Traumatic Stress: The pattern of specific and nonspecific biopsychosocial responses that occur in an individual to acute or protracted stimulus events that disrupt normal emotional, psychological, or behavioral functioning. Traumatic Stress can resolve naturally over time, or may require an extended recovery period, possibly accompanied by therapeutic assistance.

70. Traumatic Stress Syndrome (TSS): A term used to describe the set of symptoms associated with exposure to traumatic stress that may not fully meet the diagnostic criteria to warrant a diagnosis of PTSD, such as prolonged grief or adjustment disorders, but may nonetheless be symptoms or conditions associated with exposure to traumatic stress. There have also been some attempts to establish awareness of stress related conditions that do not include the diagnostic term "disorder", viewed by some, especially those in the military, as being inappropriately stigmatizing.

Related concepts: Posttraumatic Stress Disorder, Sub-threshold Trauma.

¹⁴ <http://www.merriam-webster.com/dictionary/trauma>

¹⁵ *Idem.*

¹⁶ <http://emedicine.medscape.com/article/326510-overview>

71. Vicarious Trauma:¹⁷ Vicarious Trauma refers to changes in the inner experience of an individual resulting from empathic engagement with a traumatized person or, in the case of international aid workers, with traumatized beneficiaries or colleagues. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic experience. The primary symptoms of Vicarious Trauma are disturbances in the individual's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

Related concept: Secondary Trauma.

¹⁷ National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. "Secondary traumatic stress: A fact sheet for child-serving professionals." Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. 2011. Available at:

http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf

Definition is slightly modified by the authors to reflect the specific international aid focus of this document.

ANNEX 3: KEY NEUROBIOLOGY TERMS

KEY FEATURES OF STRESS BIOLOGY

Because much of the stress reaction that occurs in the individual is biologically based, here we provide a brief overview of the major anatomical structures and biological systems that are activated by or involved in the stress response.

KEY BRAIN REGIONS:

Amygdala: associated with fear and alarm, it plays a central role in fear conditioning and triggering raw, visceral emotions unfiltered by conscious interpretation, and the “fight or flight” response.

Prefrontal Cortex: often referred to as the brain’s “executive center”, it facilitates planning and rational decision-making; it helps to regulate emotions and acts to keep the Amygdala (the “fear and alarm center”) in check.

Hippocampus: plays a critical role in learning, forming new memories, and regulating the stress response; more so than many other brain structures, it is vulnerable to the effects of chronic stress.

Anterior Cingulate Cortex: plays an important role in the ability to focus attention, monitor and detect errors and conflicts, assess the importance of emotional and motivational information, and regulate emotions; it is connected both to the Prefrontal Cortex and the Amygdala.

Anterior Insula: located in the fold of the Cerebral Cortex that marks the boundary between the Frontal and Temporal Lobes; it is involved in many functions related to emotions, and aids in the sense of self-awareness.

Nucleus Accumbens: sometimes referred to as the “pleasure center”, plays a central role in the brain’s reward circuit; in association with the Ventral Tegmental Area, it mediates the experience of reward and punishment, and is associated with the pleasurable effects of food, sex, and drug abuse.

Subcortical: Structures and processes of the brain closely related to the limbic system and so-called “reptilian brain.” These structures are mostly located below the brain’s cortex, which is the outer layer and the layer where most conscious control lies.

Limbic System: the inner portion of the brain, located beneath the cortex. It is not really a system per se, but is a region made up of the Amygdala, the Hippocampus, the Hypothalamus, and numerous other

structures involved in emotion, behavior, motivation, learning, memory, attention, and sensory processing. Other autonomic functions, many of which regulate the visceral feedback loops between conscious thought, body sensations and physiological processes, also originate or are regulated through the structures in this brain region.

Autonomic Nervous System: The ANS is composed of two parts, the Sympathetic Nervous System, which mobilizes the body under conditions of stress; and the Parasympathetic Nervous System, which conserves resources and maintains functioning under normal, non-stressful conditions.

KEY NEUROTRANSMITTERS AND HORMONES THAT TRIGGER AND/OR CONDITION THE SYSTEMIC STRESS RESPONSE WITHIN THE HUMAN BODY:

The Hypothalamic-Pituitary-Adrenal Axis: a major part of the neuro-endocrine system that regulates many body processes, including digestion, the immune system, mood and emotions, sexuality, and energy storage and expenditure, and responds to stress with a complex set of stress reactions involving the Hypothalamus, the Pituitary Gland, and the Adrenal Glands. These glands secrete various hormones and neurotransmitters that activate the stress response and condition the overall biologically grounded stress reaction of the individual.

Cortisol: a stress hormone released through activation of the HPA axis. It produces energy by converting food into fat and glucose. Temporarily bolsters the immune system.

Epinephrine (also known as Adrenaline): released by the Adrenal glands under conditions of stress. Accelerates the heart rate, alters blood vessel diameters, and dilates air passages as part of the “Fight or Flight” response of the Sympathetic Nervous Systems.

Norepinephrine (also known as Noradrenaline): facilitates alerting and alarm reactions in the brain and is critical for responding to danger, as well as for remembering emotional and fearful events.

Serotonin: involved in the regulation of mood as well as sleep, appetite and other physiological homeostatic functions.

Dopamine: associated with pleasurable feelings and plays a key role in the reward systems of the brain. An important factor in cravings, pleasure seeking, and addictive behaviors.

Neuropeptide Y: associated with decreasing anxiety and hastening return to baseline after the nervous system reacts to stress.

Oxytocin: sometimes called the “love hormone” or the “cuddle hormone” is associated with maternal caregiving behaviors, pair bonding, social communication, trust, social support, and anxiety reduction.

Brain Derived Neurotrophic Factor: acts to support the nervous system through repair of existing neurons and growth of new ones.

ANNEX 4: SOW

DESCRIPTION/STATEMENT OF WORK: ASSESSMENT OF USAID STAFF CARE ISSUES

I. OBJECTIVE

To assess the availability, utility, appropriateness, and quality of support to USAID staff posted to high stress, Non-Permissive Environments (NPEs) and Critical Priority Countries (CPCs) and to recommend improvements to staff care services, especially for staff who are currently or have previously been assigned to NPEs, CPCs, or high-stress environment posts.

In general, USAID seeks to understand, to the extent possible, the nature and magnitude of professional and personal problems faced by Agency staff* as a result of deployments to high stress, NPE, and CPC posts.

II. BACKGROUND

USAID personnel who are serving or have served in NPEs or CPCs currently obtain support through various channels.

A. USAID funded-program 'Staff Care':

- USAID's Staff Care Program supports a vibrant, healthy, and diverse Agency workforce by providing assistance in addressing a range of day-to-day life and resiliency issues, healthy lifestyles, fitness, improved lactation facilities, increased counseling services, etc.
- Staff Care promotes work-life balance by encouraging employees to maintain a balance between work and family.
- Staff Care supports a range of programs and initiatives, such as the federally mandated child care subsidy program as well as other child and elder care initiatives.
- Staff Care recognizes the importance of communication on employee issues and the need for improved internal communications.
- Staff Care recognizes that intense assignments in Non-Permissive Environments, Critical Priority Countries, and other high stress posts are rarely "over" after departure from the site and that assistance with emotional adjustment is needed.
- The Staff Care program is overseen by USAID and implemented by independent contractors, separate from and subordinate to guidance from the Department of State Medical Unit and their relevant activities. Staff Care does not provide medical services, but instead provides support to USAID staff in navigating a range of work place issues. As a separate contractor, Staff Care provides an additional level of confidentiality, because consultations with Staff Care professionals are protected information of the contractor and not entered into USG systems.

* "Staff" includes all Agency personnel, regardless of which mechanism they are working under (i.e., USDH – FS and CS - FSN, FSL, USPSC, PASA, etc.)

- All categories of USAID’s workforce are covered, regardless of hiring mechanism, and especially including those USAID staff who have previously served or currently serve in high stress, CPC, or NPE posts.

B. ICASS-funded Mental Health Services through the Department of State:

The Deployment Stress Management Program (DSMP) is located within the Office of Medical Services in the Office of Mental Health Services and was developed to assist State Department and USAID personnel en route to or returning from High Threat Posts.

DSMP provides services throughout the deployment cycle, from pre-deployment through reintegration. Services include prevention, intervention, assessment, treatment, counseling, education, and referrals associated with deployment-related psychological health issues — before, during, and after deployment. DSMP provides services to help build psychological resilience, reduce stress associated with deployments, and overcome the stigma associated with seeking mental health care when the need arises.

C. USAID-funded participation in the Foreign Service Institute’s (FSI) pre-deployment programs:

The Foreign Affairs Counter Threat course is mandatory training for all U.S. government direct-hire personnel, Foreign Service (FS), Civil Service (CS), Personal Service Contractors (PSC), permanently assigned to and serving under Chief of Mission authority at designated high threat, high risk posts. The course provides participants with the knowledge and skills to better prepare them for living and working in critical and high threat environments overseas. It instructs participants in the practical skills necessary to recognize, avoid, and respond to potential terrorist threat situations.

III. SCOPE OF WORK

A. Based on USAID’s engagement in high stress, NPEs or CPCs where the stresses imposed on staff are both significant and, often, cumulative, USAID seeks contractor support to form and lead an assessment team composed of outside members and USAID staff (see team composition in section IV) to:

1. Collect baseline and historical data on USAID personnel who have served or currently serve in high stress posts (e.g. frequency, number, and 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 e.g. Department of Defense (DoD), Department of State (DoS), Peace Corp (PC), and 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 staff care 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 contractor-formed outside 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.

IV. Assessment Team Composition

For this assessment, USAID seeks contractor support in forming a two-tiered team:

1. A senior advisory group (SAG) comprised of senior leaders (former or current) from USAID, DOD, Department of State, White House, PC and DHS to support an operational assessment team. For example, the SAG could include former Ambassadors, high-ranking military at the flag level, surgeon generals, General Council and mental health professionals, e.g. PhD Clinical Psychologist, licensed clinical social worker, M.D. psychiatrist. This SAG will serve as a reference/sounding board for the contractor-formed assessment team, providing liaison and linkages to other key constituents and service entities. They will provide insight on staff care policies, care and support, focused on staff serving in high stress posts.

2. An operational assessment team comprised of a mental health professional (specialized in high stress/post-traumatic stress, resilience). In addition the team will include senior USAID personnel, an evaluation specialist versed in qualitative and quantitative evaluation methodologies, two experienced interviewers, as well as an administrative support person. The operational assessment Team will review documents available on all current staff care programs, develop and/or refine interview and survey instruments, conduct interviews/surveys,

*The training assessment must be conducted in coordination with the Non-Permissive Environment working group's effort, currently underway.

compile data, evaluate and analyze survey and interview data, policies, and current staff care programs available to USAID personnel. USAID will require the team to travel to select high stress, NPE and CPC countries to conduct interviews and focus group discussions with Embassy/USAID personnel at post.

V. Time Frame

Approximately 6 months; from on/about Oct 1, 2014 through March. 31, 2015 While this may be an ambitious time frame, USAID would like to collect and analyze data and provide a list of recommendations for senior leadership by the end of CY14

VI. Deliverables

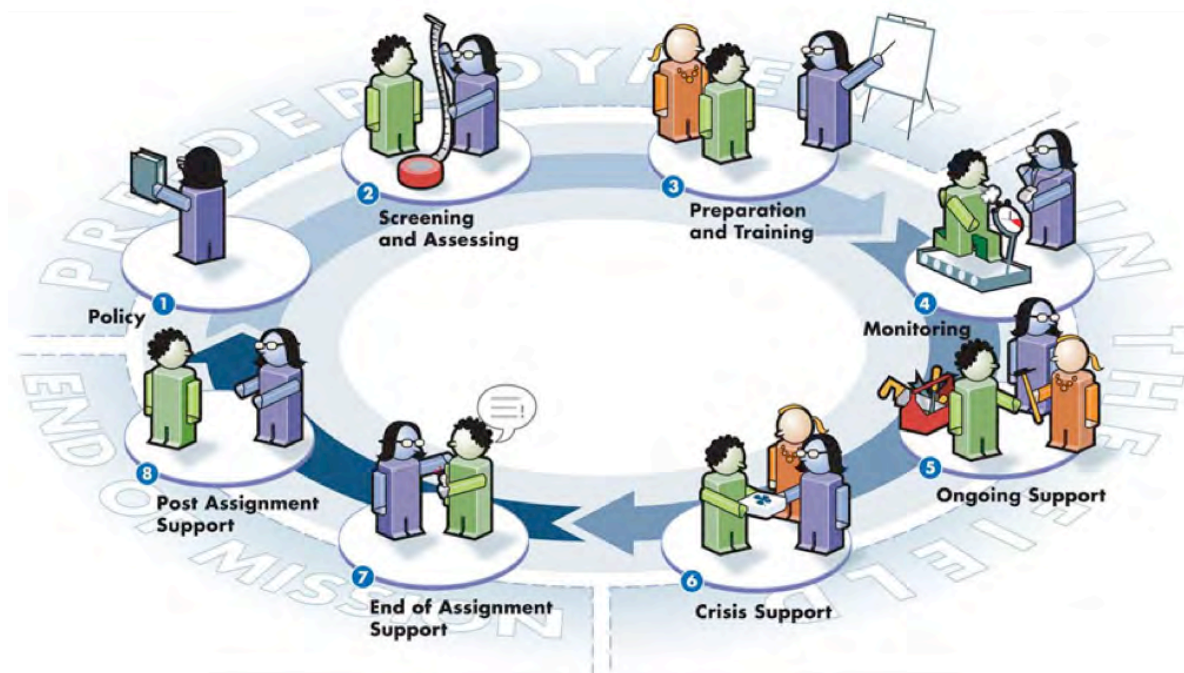
Once the review is completed the assessment team will prepare a comprehensive afteraction report detailing their findings and recommendations within thirty (30) days after the completion of the review.

At the end of the evaluation the team will 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.

ANNEX 5. ANTARES MODEL OF MANAGING STRESS IN HUMANITARIAN ORGANIZATIONS

The Antares Model¹⁸ should be considered a minimum standard, or the minimum level of stress responsive organizational practices that all international organizations should comply with when fielding people into international relief or development contexts. Developed in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), the model of stress management for international organizations described in the guidelines document is evidence-informed and based upon a rigorous analysis of the triggers of stress and appropriate mechanisms to mitigate or eliminate these.



The Antares Model explicitly recognizes the unavoidable stressors inherent in fielding people into international settings to perform the difficult, demanding, often frustrating and sometimes traumatic work of international relief and development. It is primarily structured around a hypothetical assignment cycle that is generic to most personnel being deployed into the field, and has key actions to address stressors occurring at all stages of that cycle, as well as to address critical incidents that may occur during the assignment. These actions include:

¹⁸ Antares Foundation. “Managing Stress in Humanitarian Workers- Guidelines for Practice,” 3rd edition. March, 2012. The graphic can be found on page 4.

- **Principle 1: Policy:** The agency has a written and active policy to prevent or mitigate the effects of stress.
- **Principle 2: Screening and Assessing:** The agency systematically screens and/or assesses the capacity of staff to respond to and cope with the anticipated stresses of a position or contract.
- **Principle 3: Preparation and Training:** The agency ensures that all staff have appropriate pre-assignment preparation, and training in managing stress.
- **Principle 4: Monitoring:** The agency ensures that staff response to stress is monitored on an ongoing basis.
- **Principle 5: Ongoing Support:** The agency provides training and support on an ongoing basis to help its staff deal with their daily stresses.
- **Principle 6: Crisis Support and Management:** The agency provides staff with specific and culturally appropriate support in the wake of critical or traumatic incidents and other unusual and unexpected sources of severe stress.
- **Principle 7: End of Assignment Support:** The agency provides practical, emotional and culturally appropriate support for staff at the end of an assignment or contract.
- **Principle 8: Post Assignment Support:** The agency has clear written policies with respect to the ongoing support it will offer to staff who have been adversely impacted by exposure to stress and trauma during their assignment.

Under each principle there are several associated indicators that establish useful compliance metrics. A rapid overview of the Model's indicators and standards are as follows:

INSTITUTIONAL CONTEXT:

- Stress management and staff care policy in place and adequate resources allocated
- Training for managers in stress aware and stress sensitive management paradigms and practices
- Production of resource materials: training content, field handbooks, interactive self-assessment and self-care resources

PRE-DEPLOYMENT: Robust Induction Processes

Keynote: Making sure deployees fully and accurately understand the demands and the stressors, are fully prepared for and fully accept these going in, is critical.

- Selection and recruitment: assessment not just for technical competence but for psycho-social suitability (recognition of need is frequent, but no clear example of how to do this...)
- Safety and security awareness training (Basic practice)
- Stress awareness and stress management training (a few examples)
- Accurate preparation: what to expect, living conditions and working environment (with site visit as an ideal- barring that, discussion with recent returnee or with staff on the ground)

ON DEPLOYMENT:

Keynote: Most Implementers lack a pro-active and integrated approach and focus almost exclusively on crisis response services, with responsibilities for “stress management” often

grafted onto security units and operating primarily as critical incident counseling interventions and staff psychological evacuation

- On-call critical incident response and crisis counseling
- Routine non-critical incident counseling access
- Team based debrief processes; peer counseling
- *Strong, client-centered admin support re: housing and various other administrative processes*
- Ongoing stress assessment and monitoring
- *Stress and self-care awareness raising programs*
- *Healthy food options*
- Exercise facilities and programs (*including on-site massage therapy, yoga, etc.*)
- R&R and leave
- CLO functions: FLO support and at-post recreation opportunities
- *Psych-evac-medical services- often this is about the team and NOT needs of the individual*

POST-DEPLOYMENT:

Keynote: services and care is not only needed at the immediate end of a tour, but may be necessary for months or years afterwards, with structured check-ins

- Stress and psychosocial out-brief (*not only immediately after deployment ends...effects manifest later, often at next post*); peer debriefing
- Decompression period
- Ongoing support for stress treatment post deployment

ANNEX 6. MODEL PRACTICES WITHIN USAID

OFFICE OF FOREIGN DISASTER ASSISTANCE (OFDA)

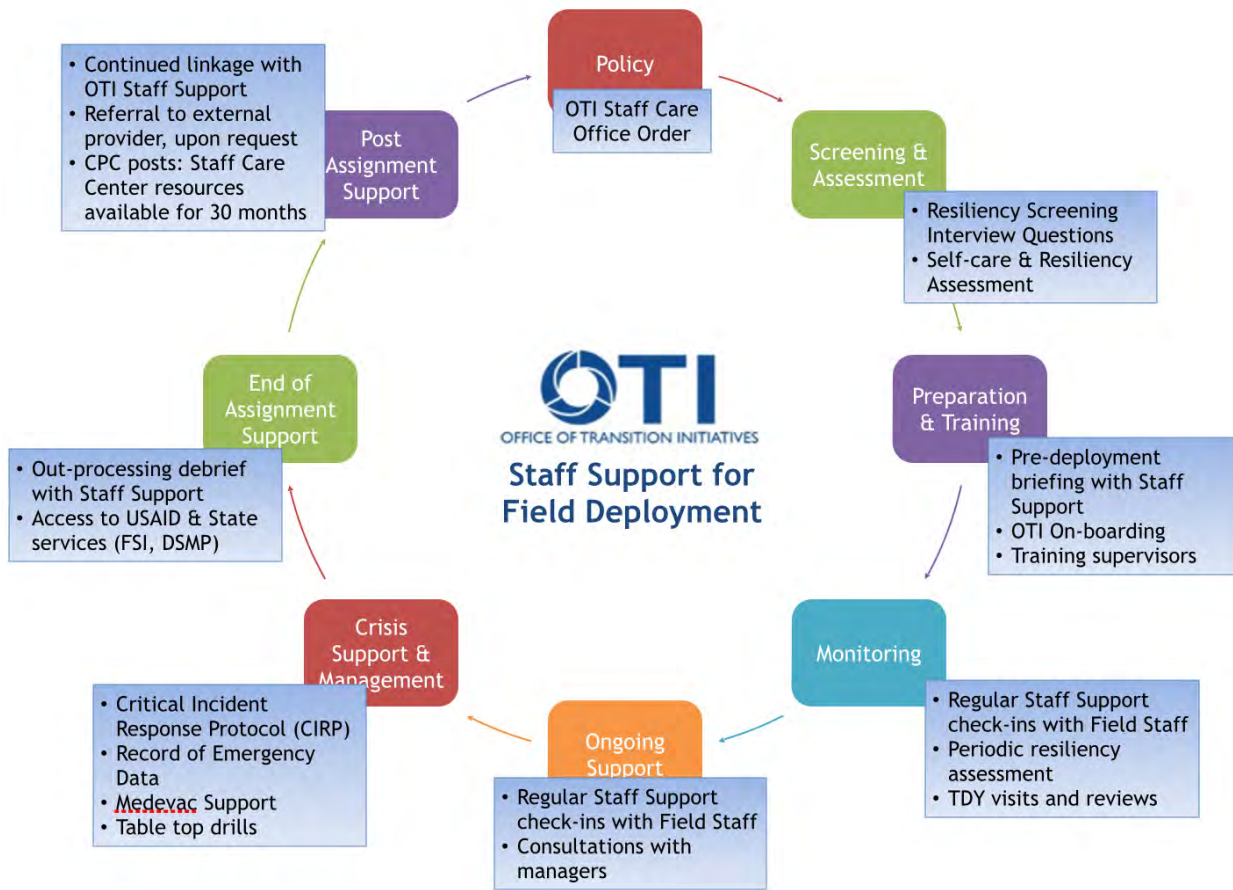
The Office of Foreign Disaster Assistance (OFDA) has recognized the need for additional support for their staff over the years. During times of particular strain (e.g. Haiti earthquake response), OFDA has procured SMEs to provide stress mitigation workshops. During interviews, the assessment team heard from senior leadership in OFDA that additional attention is being brought to both preparation and mitigation of stress in staff. This includes a recent decision to pilot a series of half-day workshops. The first iteration of this monthly workshop was held in July 2015 and open to staff of all levels, providing them with training on the signs of stress, self-care and resilience skills and practices, education on when to seek additional help through the Staff Care Center or other professional support, and a forum for discussing positive/negative experiences. Additionally, during OFDA's pre-departure security briefing course, Staff Care Center makes a presentation about available services.

OFFICE OF TRANSITION INITIATIVES (OTI)¹⁹

A model that USAID should consider up-scaling is that currently being implemented by the Office of Transition Initiatives (OTI). OTI has developed a robust series of policies and procedures based on best practices to support an office of personnel who consistently work in or on CPC and NPE countries. OTI's current approach to staff care is full cycle, mirroring the Antares model, and providing stress aware and stress responsive support through:

- A full-time in-house social worker dedicated to staff care.
- A formal and established staff care Policy codified through the OTI Staff Care Office Order. This includes specific requirements for supervisors to check-in with staff regarding their well being and self-care practices, in addition to modeling stress mitigating work-life balance behaviors.
- Resiliency-oriented interview questions for screening all new hire candidates.
- A self-care and resilience assessment worksheet available for staff to self-assess their current wellbeing. Self-care tips and techniques for stress management provided through regular awareness raising emails.
- Required pre-deployment training for all field staff prior to assignment covering mental well-being and staff care resources.
- Regularly scheduled check-ins with field staff and managers.
- A critical incident response protocol partnering with OTI, Office of Security, and Staff Care to support staff following an incident.
- A "Staff Care Month" program to raise awareness, with activities and information provided during the entire month of May.
- Feedback mechanisms including an annual survey for staff to provide feedback.
- Inclusion of staff care concerns in regular management and programmatic assessments.
- Information and resources provided to staff post-assignment, including tips on reintegration.

¹⁹ This information was provided via a key informant interview and correspondence with the USAID/OTI Staff Support Coordinator.



This full cycle support is provided to all staff members. The decision to include a full-time social worker focused on staff care provides a safe and easily accessible resource in the office to provide OTI-relevant information for the unique challenges staff may be facing, as well as an opportunity for senior management to maintain awareness on the current psychosocial wellbeing of a given team or the entire office.

USAID UGANDA'S MISSION OF LEADERS PROGRAM²⁰

USAID Uganda has created a *Mission of Leaders* program to promote leadership skills and team-based management among all staff members, at all levels and across all functional areas within the Mission. According to materials provided to the assessment team by USAID/Uganda senior leadership, “The ability to lead, make connections, build relationships, influence, learn what works, know how to make a difference, manage development processes and change, administer resources, plan... all of these are required of our staff, our teams and our Mission.” This approach recognizes that “to be successful in achieving USAID’s development objectives in Uganda, we must make sure that we are all equipped to execute this work effectively.”

This appears to be a promising example of implementing an organizational development approach that addresses stress mitigation. This strategic approach to leadership development “recognizes the intersections among:

- **The Individual:** the experiences, skills and commitment each of us bring to our work, and the ongoing investment required in personal effectiveness.

²⁰ This write-up is verbatim as provided to the research team by USAID/Uganda Mission leadership.

- **The Team:** whether that's an individual's 'home' office, a cross-sector project management team, or a short-term cross-functional task team.
- **The Mission:** that we have an organizational culture all our own, a fusion of Agency-wide culture with that of the history and people of Uganda, our backgrounds and experience.”

The *Mission of Leaders* program includes mutually-reinforcing components that continue to evolve and adapt to the emerging needs of USAID Uganda's staff and development agenda:

Leadership Charter: This (text box below) explicitly articulates the leadership behaviors most critical to achieving USAID's objectives in Uganda. Collaboratively developed through task teams and internal consultations, the charter is a tool for staff at all levels to understand expectations and to know what good leadership 'looks like' for the Mission, establishing role clarity and objectives, as well as more precise indicators under each objective, and this Charter has been used to establish performance management metrics. A pilot '360'-type monitoring tool has provided a measure of individual and Mission-wide performance against the charter and the leadership behaviors it establishes.

Organizational Diagnostics: Periodic 'temperature checks' are conducted, whereby USAID Uganda staff contribute to and receive analysis of staff engagement, as well as organizational issues and opportunities. Conducted with the help of an external consultant team, these diagnostics have informed a variety of organizational development activities, including talent management, internal communications, realignment of management structures and teambuilding.

Insights Discovery ^{TM:21} Based upon the work of Carl Jung, this tool captures and reveals personality differences and styles of behavior. It describes the unique traits of each individual, generating a profile, as well as highlighting preferred communications styles and potential blind spots. Each staff member completes an online profile and then participates in a one-on-one and/or group workshop to receive the profile and accompanying briefing. The Mission organizes periodic all-hands workshops to leverage the self-awareness generated, to develop interpersonal skills and strengthen teams.

Leadership Training: USAID Uganda also offers a tailored week-long leadership development course, modeled after the Agency's Emerging Leaders Program. Designed to bolster skills and foster a leadership mindset, the training brings together nearly 30 representatives from across the Mission and seeks to support individual leadership approaches as well as serve as a launch pad for the participating cohort to enable change and continuous.

Executive Coaching: A tailored approach to leadership development through an Executive Coaching program provides coaching services to Mission leaders in supervisory positions. A combination of in-person and remote coaching sessions, with areas of focus defined by the individual staff member further informed by the periodic organizational diagnostics and the Mission Leadership Charter.

Staff Transition Management: Staff transition support strategies include explicit processes for onboarding, knowledge transfer, and exit. USAID Uganda manages staff transitions through resources to support knowledge transfer (such as access to video exit interviews with outgoing staff), and transition teams that empower FSN staff while providing tailored support to offices undergoing a leadership change. The program also includes an orientation to the unique elements of USAID Uganda, including the *Mission of Leaders* initiative.

²¹ Insights Discovery is a proprietary personality assessment tool used for organizational development purposes. More information on this approach to organizational development can be obtained here: <https://www.insights.com/>

USAID/Uganda Mission Leadership Charter

We, the leaders of USAID/Uganda WILL...

Maintain a common vision for our goals, objectives

This person...

- *Demonstrates ownership in defining, seeking, sharing and updating our goals and objectives.*
- *Proactively communicates in order to reconcile competing priorities.*
- *Regularly assesses progress toward achievement of objectives and targets.*
- *Identifies, communicates and prioritizes tasks that align with our Mission goals and objectives, while de-prioritizing, clarifying and/or proposing to minimize that which does not.*

Be field focused

This person...

- *Empowers self and colleagues to manage workflows (including sharing information with 'backups') in order to prioritize site visits and other forms of stakeholder engagement.*
- *Gives others opportunities and support to represent USAID at external events and meetings.*
- *Actively pursues follow-up actions, information sharing and 'closing loops' connected to site visits and external engagements.*

Take informed risks, adapt to, and manage change

This person...

- *Asks "How can we do this better or differently?"*
- *Approaches change with an open attitude.*
- *Actively seeks and rewards creative solutions.*
- *Fosters an environment where we learn from our failures.*

Seek evidence and apply lessons learned so we leave things better than we find them

This person...

- *Documents and shares relevant lessons learned.*
- *Actively seeks expertise and evidence to inform decisions and avoid 'reinventing the wheel'.*
- *Challenges if evidence is not apparent (ask "how do we know?") and creates a safe environment for others to do the same.*
- *Recognizes when there is a need for change, seeks solutions and takes actions that do something about it.*

Support and encourage work-life balance

This person...

- *Shows consideration for maintaining personal time for self and others.*
- *Encourages and demonstrates reasonable flexibility in working hours.*
- *Supports colleagues in appropriate use of leave.*
- *Cultivates strong work relationships through enabling and participating in team social events.*

Give credit where it is due

This person...

- *Acknowledges special efforts regularly, formally and informally in various venues.*
- *Celebrates accomplishments, successes and achievements.*
- *Gives credit via peer-to-peer feedback, 'bottom up' as well as 'top down'.*

Ensure effective and transparent communication and feedback

This person...

- *Offers and solicits clear, timely, concise examples that provide constructive feedback, via informal and formal means.*
- *Is open to constructive feedback.*
- *Shares information on a regular basis about new developments in the organization.*
- *Practices active listening, as commonly understood across the organization.*

Promote a working environment of mutual respect, trust and integrity

This person...

- *Demonstrates high ethical standards, ensuring appropriate use of USG funds and positions for self, partners and staff.*
- *Respects colleagues' time, including planning, consulting and incorporating adequate time for organizational processes.*
- *Ensures that various points of view are heard.*
- *Proactively supports a decision even when my/our personal point of view is not adopted.*

Build relationships to achieve development objectives

This person...

- *Understands the motivations of co-workers, and then positions themselves as a leader to motivate and support them.*
- *Demonstrates an appreciation of collaboration as key to development.*
- *Looks for opportunities to work with other sections/offices within the Mission.*

ANNEX 7. RESILIENCE SPECIFIC MODULES AND COURSES AT FSI

Course No	School	Course Title	Module Title
PC530	SPAS	Basic Consular Course (ConGen)	Resilience and Consular Work
PC106	SPAS	Regional LE Staff Workshop	Resilience for Consular Professionals
PC107	SPAS	Consular Agents' Workshop	Resilience for Consular Professionals
PC108	SPAS	Consular Leadership Development Course	Resilience for Consular Professionals/Crisis Management and Nurturing Resilience
PC558	SPAS	Overseas Citizens Services Issues for Mid-Level Consular Officers	Resilience for Consular Professionals
PN106	SPAS	Foreign Service Specialist Orientation	Resilience Overview
PN106	SPAS	Foreign Service Specialist Orientation	Enhancing Resilience
PG101	SPAS	Foreign Service Officer Orientation (A100)	Resilience Overview
PG101	SPAS	Foreign Service Officer Orientation (A100)	Enhancing Resilience
PN127	SPAS	Civil Service Orientation	Resilience Resources - 2 short sessions
FT610	SPAS	Iraq Familiarization	Thriving in a High Stress Environment
RS415	SPAS	Afghanistan Familiarization	Thriving in a High Stress Environment
RS417	SPAS	Pakistan Familiarization	Thriving in a High Stress Environment
OT611	SPAS	Foreign Affairs Counter Threat (FACT 2.0)	Practical Exercise - Refugee Camp

RS251	SPAS	Diplomacy at High Threat Posts	Fostering Resilience in a High Threat Environment
	SPAS	Diplomacy at High Threat Posts	Leading for Resilience
MQ500	TC	Encouraging Resilience in the Foreign Service Child	n/a
MQ502	TC	Resilience Strategies for Success Overseas	n/a
PD26A01	DL/TC	Developing Character for Perseverance and Resilience	n/a
PD26A02	DL/TC	Achieving Goals through Perseverance and Resilience	n/a
PT102	LMS	Deputy Chiefs of Mission/Principal Officers Seminar	Resilience and the Foreign Service
PT120	LMS	Ambassadorial Seminar	Resilience
	LMS	USAID Mission Director	Resilience
	TC	Ambassadorial Spouse/Partner Seminar Resilience Session	Resilience
	TC	DCM Spouse Partner Resilience Sessions	The Human Side of Crisis Management,
	TC	DCM Spouse Partner Resilience Sessions	Medical and Mental Health (MED) with DCMs and POs
	TC	Security Overseas Seminar	Coping in a Crisis
	TC	Customized personal and community resilience training for domestic offices and groups	
	TC	Customized personal and community resilience training for overseas posts	

ANNEX 8. KEY PRACTICES WITHIN UNITED NATIONS AGENCIES AND U.S. DEPARTMENT OF DEFENSE

UNITED NATIONS HIGH COMMISSION FOR REFUGEES (UNHCR)

UNHCR is located in Geneva and seven other regional locations that put them closer to their field operations. They have offices in 130 countries in about 300 locations. Their staff numbers are approximately 13000, including local staff. Approximately 2,500 are international staff and among those about 40% are in a non-family location, usually “security affected”.

UNHCR’s Staff Welfare Section was developed in 1994 to help people cope with organizational adaptation and stress. As UNHCR increased its operations to intervene with genocide, the Staff Welfare Section shifted to psychological services linked to critical incidence and the vicarious exposure to violence. The senior counselor has observed “We are not underutilized, [still] very little abuse of the resource” because “people tend to call us when they **really** need us.” [Of note, UNHCR’s EAP – a separate service – has a usage of 1.5%.]

Initially, humanitarian workers experienced stigma in regards to psychological services due to the norm of being “tough and rough”. A concerted campaign for awareness raising and coupled with positive experiences with the counselors led to broad acceptance and utilization at UNHCR.

It has developed its policies based on standards and learning from IASC-MHPSS, SPHERE, the Antares Guidelines and People in Aid. In the view of one of the most senior counselors working at the office: “We cannot separate trauma from organizational stressors.” It has been found that supportive working environment is critically important to reducing the impact of traumatic stress and critical incidents.

UNHCR has an active network of peer support, which they are finding very useful in places like Yemen. It has also strengthened psychological first aid (PFA) training more generally.

To both screen and prepare staff going to severe contexts, UNHCR has developed an offering called “Psychological Preparation for Hardship Assignments” that was initially done sporadically, but is now done systematically. It is a one on one conversation to which a person is invited to think about what this particular assignment means for you in this particular moment in life. How does your family fit in? What concerns might you have? Is this assignment right for you? If not, curtail. If so, let us prepare.

UNHCR has a SOP for critical incident roles of administration, HR, security, management, medical, psychological, peer support and career management professionals. UNHCR also provides support for vicarious trauma because of the “Way the humanitarian agenda can take over one’s belief about the

world, including personal priorities.” While keeping personal needs in view, we help people check-in existentially around vicarious trauma: “Why am I doing this? What is good in this for me? What hurts?”

UNITED NATIONS OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS (OCHA)

OCHA has a staff of approximately 2000, with approximately 300 in Geneva, 200 in NYC and 1500 in over twenty field duty stations. Our interview subject, Dr. Jorge Sierralta, explained that before he took the post, “No one was doing MHPSS (mental health and psychosocial support) at OCHA.” Dr. Sierralta set out to do an assessment that would do the following: (a) set a baseline for trauma, anxiety, depression and alcohol misuse; (b) determine which duty stations needed the most attention. He engaged a local university in Geneva to design the psychometric study instrument and perform statistical analyses; he remarked that the university partner was a significant factor in quality and performance. Senior leadership at OCHA promoted the assessment, which also contributed to success.

Only field staff data have been analyzed thus far. The most heavily reported adaptation challenge is workload. Among the findings is that, among those who drink alcohol socially, nearly 50% misuse it. It was remarked that alcohol is used as a “mood stabilizer.” And the highest scores in depression, anxiety, and trauma can be found in duty stations in the Middle East and Northern Africa region, which did not surprise Dr. Sierralta, as this OCHA region includes Syria, Yemen and Iraq.

Staff preparation for hardship posts is currently ad hoc and voluntary. Dr. Sierralta estimates that 25% wish to speak to a counselor pre-deployment to obtain coping ideas. He estimates that seven out of ten wish to speak to a counselor post-deployment in order to make meaning of their experience, vent frustration, and consolidate positive experiences. This is termed an “End of Assignment Discussion” and deliberately not called a “debrief.” Crisis counseling is offered for 3-4 sessions, and if further assistance is required then a referral is made. As a counselor, Dr. Sierralta noted that problematic psychological consequences of hardship posts include: depersonalization, traumatic stress, anxiety and depression. Staff come to sessions disoriented, saying, “I don’t feel right.” Furthermore, the divorce rate is “high,” especially for Europeans who have been to more than three hardship posts.

Managers are expected to support staff as a “moral obligation,” as there is no current job objective for them to do staff care. Poor managers make the mistake of thinking that high salaries provided for hardship posts is how OCHA is “taking care” of staff.

OCHA counselors are critical, according to Dr. Sierralta; however, they are not a substitute for multi-dimensional staff care, including the support provided by good managers. He explained counselors are like “paracetamol” [similar to Tylenol] -- temporary relief that fades. Additionally, counselors who are situated in HR are sometimes perceived as a defensive move by organizations trying to check boxes and avoid lawsuits.

Plans at OCHA include a second counselor joining Dr. Sierralta. Also, OCHA seeks to implement a peer support program in the coming year. Finally, in 2015 the UN is poised to approve an updated policy on stress management.

DEPARTMENT OF DEFENSE (DoD)

The Department of Defense (DoD) has made significant progress in addressing and preventing stress of their personnel. The assessment team, in a series of interviews and email exchanges with military officers, verified current and previous DoD initiatives to address occupational, deployment and operational stress – as well as the interventions designed to mitigate that stress. Interviewees suggested that major changes in DoD took place from a “Bottom up, Top down” two-pronged approach in which grassroots operational changes were implemented coupled with leadership modeling changes through relatable language and concrete behavior. Former Vice Chief of Staff for the Army, General Peter Chiarelli, in a 2010 report Army Health Promotion, Risk Reduction, Suicide Prevention elevated awareness and acceptance both in the Army and through DoD around the issue of Post-Traumatic Stress Disorder (PTSD). To reduce stigma, General Chiarelli integrated “post-traumatic stress” as common nomenclature by including the term in speeches for both internal and external audiences. Such modeling shifted cultural and social norms in the organization, further opening space for acknowledgement and safe discussion of stress-related injuries. In addition to senior leaders such as General Chiarelli raising awareness on stress-related concerns, political pressure increased following mediagenic coverage of staff dismissals and public concerns raised regarding the Department of Veterans Affairs missteps in addressing stress effects of former military personnel.

In the military branches, there are three layers of defense against mental health suffering:

- 1) Leaders are first line of defense. Officers are evaluated on compliance with Department of Defense and Service Standards. As leaders they are responsible for and are evaluated on ensuring the personnel that fall under them have the proper resources, training and tools to be successful.
- 2) Family Services, Medical, and Chaplain Services are the next line
- 3) Mental Health Professionals are the third line of Defense

While each branch of service is different, overall, DoD has diverse and far-reaching support mechanisms to prevent and intervene with stress-related injuries. Support is multi-layered and flows throughout the organization for the following core activities:

- Strengthen – building/maintaining resilience through training, unit cohesion, and effective leadership
- Mitigate -- reduce/eliminate unseen or unnecessary stress
- Identify – locate/characterize stress problems
- Intervene -- support and treat individuals through camaraderie, leadership, chaplaincy, counseling and therapy

These core activities have created an organization that addresses nearly all deployment cycle issues with knowledge, skills, and tools to manage stress; a team-oriented culture that encourages management and peers to monitor the wellbeing of colleagues; family support and services providing support pre, during, and post-deployment for family members of DOD personnel; and the chaplain role outside of the chain of command to provide a safe space for regular discussion and check-ins with staff.

USAID may benefit from several lessons from the DoD experience. The assessment team identified that **leadership vacuums in matters of stress, unsupportive management, a stoic culture, training gaps**

and inconsistent access and quality of resources contribute to stress experienced by USAID personnel. While DoD itself still has room to improve, USAID may find it beneficial to learn from three reinforcing elements of DoD's experience:

1. Accelerating how leadership models and discusses the importance of addressing stress and fostering staff resilience. This includes a culture in which individuals who are promoted are understood to "take excellent care of the force."
2. Integrating stress education and tools in required trainings for all levels of personnel. For example, the Navy has created a comprehensive Combat and Operational Stress Control approach that includes policies, procedures, in-classroom training, guidebooks for staff and managers, and tools that create a common language and framework for understanding and discussing stress throughout the organization.
3. Fostering a "team culture" through training, assignments, and core values guiding the organization. Simulations and practice occur when personnel complete "war gaming" scenarios during which the five core objectives (name 5 objectives here) are applied so that both peers and unit leaders are vigilant for resiliency and vulnerability.

During interviews the assessment team heard time and again about the important role that managers played in creating and maintaining a culture that is supportive of staff care. Extensive training requirements for both management and non-managerial staff ensure that all levels of staff are provided with knowledge, skills, and tools to enable personnel to both monitor and address stress as a result of the work on their job. This creates a common language and toolset that is reinforced at all levels of the organization and all phases of deployment. Chaplains regularly provide commanders with a "pulse" of the force as an early warning system for morale and/or the wellbeing of staff. One interviewee described a best practice as when there are concerns about deteriorating morale, all-hands meetings are called for staff to provide honest feedback to leadership, ask questions, and get honest answers.

To ensure personnel are well biopsychosocially individuals are required to receive a medical clearance prior to going to an assignment overseas. During the clearance, the individual may be asked to complete therapy prior to being given a full medical clearance to return to the field. This comprehensive understanding of wellness increases the likelihood that personnel are both physically and psychosocially well prior to deployment. Further details of policies, training, and services provided by many DoD organizations can be found in this matrix.

While there are some similarities between USAID and DoD, it should be acknowledged that, as one interviewee pointed out, the military was built with 18-year olds in mind, and sought intentionally to "grow an individual up" through an organization and into a career. USAID personnel tend to be older individuals who have personalities that have formed through experience with other institutions. Furthermore, unlike DoD, USAID does not currently deploy previously-formed teams to the field, except for unique responses like OTI, OFDA, and civilian surges in the past.

POLICIES IN 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*. Others include *Counseling for Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Families*; *Defense Suicide Prevention Program*; and *Common Military Training Requirements* (to include suicide prevention, substance abuse, sexual assault prevention and response). DoD health protection strategy is to deploy healthy, fit, and medically-ready forces; minimize illnesses and injuries during deployments; and evaluate and treat physical and psychological problems.

DoD-wide

Mental Health Evaluations of Members of the Military Services (DoDI 6490.04)

4 March 2013

Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation (DoDI 6490.12)

26 February 2013

Executive Order, Improving Access to Mental Health Services for Veterans, Service Members and Military Families

31 August 2012

Continuity of Behavioral Health Care for Transferring and Transitioning Service Members (DoD 649.10)

26 March 2012

Maintenance of Psychological Health in Military Operations (DoDI 6490.05)

22 November 2011

Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members (DoDI 6490.08)

17 August 2011

Assistant Secretary of Defense (Health Affairs) Memorandum, Guidance for Mental Health Provider Training for the Treatment of Post-Traumatic Stress Disorder and Acute Stress Disorder

13 December 2010

Army

Policy Guidance for the Assessment and Treatment of Post-Traumatic Stress Disorder
(OTSG/MEDCOM Policy 12-035)

10 April 2012

Combat and Operational Stress Control Field Manual (FM 6-22.5)

18 March 2009

Army Wounded Warrior Program (AW2)

The official U.S. Army program that assists and advocates for severely wounded, ill, or injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status.

Air Force

Combat and Operational Stress Control (AFI 44-153)

(COSC thus added to Disaster Mental Health Response doctrine of 8/29/2011)

Compliance with this Publication is Mandatory

http://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-153/afi44-153.pdf

29 May 2014

Mental Health (AFI 44-172)

14 March 2011

Traumatic Stress Response (AFI 44-153)

29 August 2011

Navy/Marines

Combat and Operational Stress Control (Marine Corps Order 5351.1)

22 Feb 2013

<http://www.marines.mil/Portals/59/Publications/MCO%205351.1.pdf>

Combat and Operational Stress Control (MCRP 6-11C and NTTP 1-15M)

(COSC here supercedes 6/23/2000 Combat Stress doctrine of MCRP 6-11C and NTTP 1-15M)

20 Dec 2010

<http://www.med.navy.mil/sites/nmcsc/nccosc/coscConference/Documents/COSC%20MCRP%20NTTP%20Doctrine.pdf>

Mental Health Evaluations of Members of the Armed Forces

15 January 1999

Navy Leader's Guide for Managing Sailors in Distress, Command-Directed Evaluations

http://www.med.navy.mil/sites/nmcphc/documents/lguide/command_evaluations.aspx

Veterans Administration Policy

Programs for Veterans With Post-Traumatic Stress Disorder

12 March 2010

VHA HANDBOOK 1160.03

Military OneSource Web site. The Military OneSource Web site is able to coordinate counseling services for Soldiers and Families who need assistance with deployment-related issues at the Web site (<http://www.militaryonesource.com>).

ANNEX 9: QUERIES SENT TO STAFF CARE CENTER²²

Overall Tempo and Resources	
	In what respects has the Center been under-resourced for the demand?
	If the Center were better resourced, to what extent would you employ more staff? And to what extent would you employ staff with higher qualifications? How would you broaden the spread of services delivered, both geographically and in terms of services offered?
	How quickly are emails requesting assistance answered? What is the email management system in place to ensure follow-up?
	Has there ever been a surge or glut of requests for assistance/referrals such that emails or voicemails went unanswered?
	What cases of structural or institutional barriers have occurred such that the Center staff could not travel for services at missions? For example, has difficulty in getting security clearances either seriously delayed your response...or eliminated your ability to go TDY?
	Are there any additional specialized services you would offer if the resources were available? What would these be and why?
Counseling	
	Our understanding from interviews is that counseling allowances are "per incident/per year". What exactly constitutes an incident?
	What are the specific allowances (or cut-offs) in session number?
	Can someone get another set of sessions for the same incident next year, or does a new incident need to occur?
	Are there examples of individuals who had two distinct incidents in a single year and thus were entitled to two sets of allowances? If so, could you provide the example in broad strokes without any PII?
	How and why was this cut-off determined? Is it related to resource constraints?
	When allowance is being exhausted, and the client could use more counseling, what is your SOP on transitioning the person to further sources of counseling?
	How do you assess individual providers' performance?
	How do you assess the progress or lack of progress with any particular client?
	How do you assess your Center's aggregate progress from a quality standpoint?
	How do you do quality control or improvement for counselors?
	What is the nature of clinical supervision for counselors?

²² The assessment team received no response or data for these queries.

	How do counselors in remote sessions establish rapport with overseas USAID staff who may have doubts about whether a counselor based in DC can relate?
	To what extent, and in which circumstances, without violating confidentiality, do counselors coordinate care with colleagues outside the Staff Care Center?
	What is the SOP for beginning a counseling process?
	What distinguishes a service that is designated EAP versus ERP?
	When a client warrants counseling to help with decreasing stress, what are some examples of the interventions used by the Center? That is, how is this achieved?
	How do you identify, select and/or vet external service providers? How do you quality assure?
	How do you identify, select and/or vet local service providers? How do you quality assure?
	What are 'voluntary check-ins'? What are voluntary pre-deployment and post-deployment consultations and how are these structured?
	Counseling limits are per incident/per year. So one person could have more than 6 or 8 sessions, I think, if another incident occurs. What exactly constitutes an incident? Please define incident.
	Can someone get another 8 sessions next year, or does another "incident" need to occur?
	How and why was this 6 or 8 per incident/per year cut-off determined? Is it related to resource constraints?
24/7 Support	
	Is there a two tiered, or multi-tiered, staffing model to give access to services during regular DC business hours versus after-hours?
	If so, how are the staff after hours different than the ones during regular DC business hours?
Training	
	Exactly which standalone staff care trainings have been offered, and how many times, since inception of the Center?
	Exactly which training modules have been developed, and which have been implemented? Our data shows that FY 2013 aspired to the development of the following modules: <i>Stress and Resilience: The Basics for Staff;</i> <i>Stress and Resilience: The Basics for Managers;</i> <i>Teams and Resilience;</i> <i>Conflict and Resilience;</i> <i>Stress and Resilience in High Threat Environments for Staff; and</i> <i>Stress and Resilience in High Threat Environments for Managers.</i>
	What are the objectives of all these trainings, or modules?
	How many trainings or modules are in the pilot stage?
	What is the duration of each training?

	Would you match your training materials and processes with an adult learning theory? Demonstrate how, if at all, there is a best practice rationale to teaching the way you do.
	Would you match the training content and objectives with best practice content in our field?
	To report on quality, we need outcomes data from the trainings. Please provide training participant raw evaluation forms and your analysis of them.
	How many trainings have graduated from the pilot phase and are now "good to go" for repeating with little need for revision?
	How many individuals have participated in any particular training or module?
	Have you provided the training or module to a specific office or cohort? If so, which?
	Have there been requests for training that you have not been able to gratify immediately (but you eventually got around to them)?
	Have there been requests that are still outstanding?
	Have there been requests that you have deemed inapplicable, infeasible, misguided, or inappropriate such that you do not intend to fulfill the request? If so, what were the disqualifying criteria?
	Can we get a complete list of training offerings. All those currently developed and/or regularly provided?
	Please provide any training evaluation reports or stats you possess.
Coaching	
	For which specific purposes is coaching offered?
	What types of requests for coaching are denied approval by the discretion of the Center staff or COR?
	How are leadership coaches selected? Quality assured?
	Which leadership competencies (from OPM, or USAID criteria) do your service target specifically?
Organizational Resilience Services	
	Please describe the timeline for development of these services as part of the Staff Care portfolio. And for which challenges were these developed?
	Please describe in detail the process for one illustrative intervention. Are these always done at the Mission in question?
	Please describe a Change management intervention process and timeline in detail.
	What methods -- other than surveys, interviews and focus groups -- does Staff Care use to identify strengths and improvement opportunities. (This statement was made in the info previously provided...)

	When Staff Care meets with leadership and planning teams, what exactly is a planning team?
	When psycho-social surveys are conducted to identify issues in Missions, is there ever follow-on to make comparisons over time against the initial survey baseline?
	Are we able to track the results of any of the other interventions described over time? Are mission stress environments being tracked for improvement?
	What exactly do Staff Care Champions do? What are the activities expected of them? How are Staff Care champions identified and selected? How is their capacity developed? How are they supported in that role? How are they empowered in that role? Do they have any formal authority?
	So no pre-TDY assessment occurs before responding to a CI? Does any assessment occur, perhaps after the team is on the ground? What does this assessment entail?
	Is there ever a follow-up after the intervention to compare against the findings of a pre-TDY assessment? In other words, are stress levels tracked over time?
	Is there ever evaluation conducted of TDY interventions? If so, what is the structured process for learning and continuous improvement?
Services and Utilization: Tracking, Assessment, and Performance Evaluation	
	To the extent that we can report specifically on utilization numbers, please provide any and all documents, survey data, reports, or statistics Staff Care possesses that address any element of the above.
	If time restricts the collection of exhaustive data, the study is impoverished without raw numbers of utilization put against specific services. Percentage increase year over year are not enough. The study is particularly interested in utilization of services for high stress situations related to working in NPE/CPCs such as counseling, resiliency coaching and targeted training.
Group Facilitation	
	We have had a handful of subjects express desire for group therapy.
	What is the duration (session time and total number) of groups that you have facilitated?
	Have any of the groups been targeted for relieving traumatic stress?
	Have any of the groups been targeted to coping in high threat environments?