How can organizations better discern the specific difficulties faced by their staff? How might we fine tune staff care programs so that prevention and intervention both hit the bull’s-eye for diverse needs and mindsets? How might staff care programs for a subsection of staff induce benefits in multiple levels of our organizations and the communities with whom we work?

An organization that can confidently answer these questions will experience self-assurance in place of doubt when it comes to staff care. And doubt exists in the minds of many when staff care is mentioned. Leadership and boards of directors are unsure about how to allocate resources. Some staff have high expectations, but doubt their expectations will be met. Some staff grumble about being taken away from program implementation. The communities with whom we work are entitled to wonder if staff care enhances program delivery or merely puts focus on the sacrifices that humanitarian workers make.

Applying what has been learned from the fields of behavioral medicine, public mental health and global health can greatly influence our staff care outcomes. Staff care programs should have the following components:

- **Right-sized prevention**—to provide education/resiliency factors before difficulties arise and to prevent the worsening of existing difficulties;
- **Accurate assessments**—to determine the nature and extent of difficulties; and
- **Smart interventions**—to mitigate and heal difficulties that do occur.

These components may be elementary, but the challenge is how to implement them in ways that resolve the doubts and questions mentioned above. Three principles can facilitate implementation, by inspiring confidence and promoting effective, far-reaching staff care: (1) differentiation in assessment; (2) diversity of interventions; and (3) diffusion of learning.

**Differentiation in assessment**

Figure 1 illustrates the first principle: differentiation. Like differential diagnosis in medicine, the first step is generating a list of possible difficulties from which staff may suffer given the assessment. The next step is a systematic comparison of findings that support the presence and extent of different difficulties. Differentiation is a logical tour through possibilities; and ideally, other assessors are able to agree with the logic because other competing difficulties are either “ruled in” or “ruled out” by evidence.

Staff care assessment is not medical diagnosis. Nor is pathologizing mostly well people going to make staff care providers very popular. However, the failure to take important possibilities into account means that a difficulty may be overlooked and the opportunity to be “ruled in” missed. If difficulties are determined incorrectly or partially, the selection of staff care interventions is likely to be flawed or incomplete.

Differentiation, therefore, begins by understanding and appreciating all the different possibilities that can cause staff and operations to suffer. This does not mean every possibility must be checked in every assessment. One narrows down possibilities given the data: staff profiles (e.g., past experience), different exposures sustained (e.g., severe trauma in the community they are working with) and work context (e.g., management/leadership/mentorship, in-country conditions). The difficulties (X, Y...) may then range...
Benefits can be realized by both staff and leadership.
from individuals feeling burned out, to individuals sustaining traumatic stress injury (from a critical event or vicariously), to leadership dysfunction, poor team dynamics, communication breakdowns and many other possibilities.

The importance of competent differentiation is illustrated in the contradictory “next steps” when determining whether someone has burnout or traumatic stress injury. For burnout, giving time for R&R (i.e., rest, relaxation, recreation, recuperation) tends to be an effective intervention. Individuals do well with self-directed activities when they take a break from circumstances that engender burnout. However, giving R&R to someone with traumatic stress injuries can lead to recurrence or worsening of symptoms because individuals with trauma frequently suffer an inability to relax and may indeed be triggered by many of the otherwise enjoyable R&R activities. The nervous system of a traumatized person requires more targeted interventions.

Quite often, staff members suffer from more than one difficulty. There are so-called co-morbid (meaning “suffered together”) difficulties, a most common combination being that poor team dynamics and burnout that occur simultaneously and can perpetuate each other. Being alert for such co-morbid difficulties will excel in applying the second principle: diversity of interventions.

**Diversity of Interventions**

Given any difficulty or set of difficulties, an appropriate set of prevention activities and interventions needs to be selected for staff care to actually be experienced as “care.” Diversity refers to taking into account the various realities in which staff care interventions will be employed. Three prongs of diversity must be considered in the intervention selection process: culture, cognitive style and capacity (see Figure 2).

The cultural background of staff members—be that nation of origin, religious traditions, or other measures of “culture”—configures the suitability of any particular intervention. Individuals with a connection to specific cultural traditions may benefit greatly from familiar traditions (e.g., rituals) that are re-tooled to soothe specific stresses or heal specific experiences of trauma.

The organization’s culture should also be considered when selecting and presenting interventions. Stigma can be significantly attenuated if interventions are explained (along with the assessment’s findings and conclusions) in a way that reflects a deep understanding of organizational culture. When staff care difficulties and interventions create a shared vocabulary that works with an organization’s culture, stigma begins to come out of the closet and get aired out. A shared vocabulary helps individuals collectively acknowledge that staff stress and staff difficulties are the group’s responsibility and that anyone can be vulnerable at times.

The second intervention prong within diversity is cognitive style.

Taking culture into account means that inter-group variety has been considered. However, there is also significant diversity within every cultural group. Because learning styles and sensibilities are varied, the way interventions are presented should satisfy the cognitive styles of diverse staff. For example, some learn best with an evidence-based, scientific approach; others respond to a warm, personable approach. While blended approaches may successfully satisfy a diverse group, the attempt to satisfy all cognitive styles with one experience may also alienate individuals at the extremes. However it is achieved, matching cognitive style is important since a good fit can add to the durability of any intervention over time. Individuals will stick to interventions they agree with.

Interventions that match cognitive styles also engage people more deeply with the cause of staff care. One-size-fits-all interventions run the risk of missing significant individual needs while providing a good fit to only a fraction of individuals. The following one-size-fits-all interventions can miss individual needs:

- “Let’s all debrief what you are going through.”
- “For anybody who wishes to use our employee assistance program, here is the number. We think it is only smart to maintain your wellness while doing this work.”
- “Yoga is proven to help you relax. We’ll have weekly classes at 9am.”
- “Here are breathing techniques to calm your mind when you feel stress.”

In an ideal world there would be a custom designed intervention for each individual. Staff would make informed decisions among empirically tested interventions. Some individuals gravitate towards mind-body therapies; others use techniques from their religious traditions. Others see a psychotherapist. Some seek self-care techniques in order to be totally self-reliant in their healing process, while others prefer to heal in relationships and groups.

But the ideal isn’t practical. Nor is the other extreme, in which everyone must use the same one-size-fits-all intervention. The middle way is a menu of options that fit diverse cognitive styles. Information and training is provided on this menu of options so staff members can make an educated choice. A well-chosen menu of options provides variety and allows individuals to gravitate towards interventions that will be durable in challenging circumstances.

A note on matching both culture and cognitive style: When interventions agree with a person’s culture and sensibilities, shame decreases. The shame-reduction stems from individuals feeling aligned with how difficulties are being conceptualized and handled. Non-alignment leaves people feeling blamed or misunderstood.

The third prong of intervention diversity is capacity—the resources continued on page 30
an organization can employ for staff care. Funding, travel arrangements, training space and materials are obvious examples. The biggest variation in capacity lies in the range, approach and quality of human resources brought to bear on staff difficulties. Diversity entails building capacity in, having access to, and selecting the optimal mixture of human resource professionals, trainers, counselors, clinicians, healers and spiritual practitioners to implement the interventions. A credible and skillful team member can greatly affect the “buy-in” to interventions because he/she will be responsible for acting upon the differentiated assessment, implementing the intervention, and giving opportunity for positive learning within staff members.

Diffusion of learning

Staff care is a form of learning that includes awareness, skills, organizational responsibility and person-to-person accountability. Diffusion of this learning flows from any and all of the stages of assessment, prevention/intervention selection, and prevention/intervention implementation (see Figure 3). It is not just staff care participants who are following how these issues are addressed: so are other staff members and people outside the organization as well. Multiple levels of our organizations and the communities with whom we work are affected by the success or failure of staff care. Consequently, the application or non-application of differentiation and diversity at these stages will determine whether the diffusion of learning is positive or negative.

Staff care difficulties and our program outcomes are interconnected. Negative experiences in applying staff care can hurt the overall cause of human thriving and community wellness. A bad program or inaccurate assessment can be costly, leading to:

- trainees having a bad taste in their mouth, feeling that energy has been wasted and continuing to work with compromised bandwidth;
- senior leadership viewing staff care as a soft discipline with nothing tangible to offer; and
- communities with whom we work finding staff to be shut down, unskilled, jaded or outright destructive.

Positive experiences in applying staff care, in contrast, will diffuse in constructive ways. Differentiated and diverse staff care can interest others in one’s peer group in having their own staff care learning. Peers not directly involved in a staff care experience may experience indirect benefits because of the increased resilience of their participating colleagues. International staff influence national staff and vice versa. In-country staff influence headquarters and vice versa. This indirect benefit is akin to what preventive medicine calls “herd immunity”—a proportion of people vaccinated for a communicable disease confer protection to unvaccinated people because the contagion is less able to propagate itself in a smaller pool of susceptible individuals.

Positive staff care also benefits the communities with whom we work. Staff that understands its own vulnerability to difficulties such as stress, trauma, grief, loss, fear, conflicted communication and overall dysfunction will be better equipped to design programs that are nuanced for communities affected by these same difficulties. Staff can implement programs with a greater sensitivity to the deficits that individuals suffer when affected by a difficulty such as trauma (e.g., memorization, calculations, planning for the future, interpersonal relationships, forgiveness can all be inordinately challenging). More importantly, such staff have the psychosocial bandwidth as people to partner with communities in a more attentive and effective way. All of these benefits are in keeping with a global health model that acknowledges the interconnectedness of health and broader outcomes.

Finally, positive staff care diffuses to senior leadership. This provides two concrete benefits. First, the buy-in of senior leadership is critical to securing the funding, organizational will and acceptance necessary to sustain staff care programs in the organization. Second, it may help senior leadership to differentiate their own psychosocial wellness needs, accept their own vulnerability and incorporate diverse interventions for themselves. Boards of directors and executives frequently experience isolation because they are “holding it together” for the entire organization or they have nowhere to turn. If these levels of an organization are touched positively, further transformation in our field will ensue.