

**Global Connections  
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## **Specialist Care: Psychological input**

**Dr Debbie Lovell-Hawker,  
Oxford University Psychiatry Dept**

### **Summary**

Empirical research on the psychological adjustment of volunteers working overseas has been limited. In a recent study of returned missionaries and aid workers representing 62 different organisations, 46% reported that they had experienced a clinically diagnosed psychological disorder either while working overseas or shortly after returning to the United Kingdom. Depression was the primary diagnosis in 87% of these cases, and the disorder usually developed after returning to the UK, rather than during the time overseas. Clinically significant symptoms of intrusive thoughts were also common, being reported by 24% of returned volunteers who had not received personal debriefing after their return home. Only 7% of volunteers who had received personal debriefing evidenced clinically significant levels of intrusive thoughts, suggesting that debriefing can help to reduce or prevent some symptoms related to post-traumatic stress. It generally took at least 18 months for symptoms to return to baseline level after working overseas.

Psychological difficulties were more common among those who had been overseas for a longer period of time (more than 3 years), and also among those who had a tendency to invalidate their feelings (e.g. to get depressed about feeling depressed, or to believe that they were 'over-reacting' or 'should cope better'). The development of chronic fatigue syndrome appeared to be related to excessive work and stress, but not to depression.

Recommendations include educating aid workers about typical symptoms of 'culture shock' and 'reverse culture shock' (thereby normalising their experience); recommending personal debriefing; encouraging adequate rest and relaxation, and assisting in the development of stress management techniques.

### **References:**

Gamble, K., Lovell, D., Lankester, T & Keystone, J. (2001). Aid workers, expatriates and travel. In J. Zukerman & A. J. Zukerman (Eds) Principles and Practice of Travel Medicine. John Wiley & sons.

Lovell, D. M. (1999). Chronic fatigue syndrome among overseas development workers: A qualitative study. Journal of Travel Medicine, 6, 16-23.

Lovell-Hawker, D. M. (2002). Debriefing after traumatic incidents, and at the end of assignments. In K. O'Donnell (Ed.) Doing Member Care Well: Perspectives and practices from around the world. William Carey Library.

## **Biography**

Dr Debbie Lovell-Hawker is a principal clinical psychologist, working at Oxford University Department of Psychiatry. Part of her time is spent working with overseas aid and development workers. She acts as a consultant for a several aid and missionary organisations. She also travels overseas to support and train volunteers.

### **Statistics taken from OHP presentation:**

Empirical research on emotional difficulties of aid workers and mission personnel is very limited.

56% of nurses who had worked for 3 months in a Romanian orphanage reported 'depression', and 22% reported sleep problems. GHQ-30 scores had significantly increased. IES scores one month after return resembled those of clinical trauma patients (Paton & Purvis, 1995).

Mortality rate is doubled among aid workers compared with colleagues remaining at home, despite medical selection of the fittest for aid work (Schouten & Borgdorff, 1995). Stress can lead to illness, RTAs etc.

'Organisations such as voluntary disaster charities typically involved in Third World disaster settings have not recognised that their personnel inevitably suffer from catastrophic stress syndromes as a direct result of their work and no measures have been taken by the majority of these organisations to ensure the psychological health of their workers' (Busuttil, 1995)

10% of relief and development personnel had significant symptoms of PTSD and 19% had partial symptoms. N = 113 (Eriksson et al., 2001, J. Traumatic Stress)

### **Psychological adjustment among returned overseas aid workers (Lovell, 1997)**

- 1) What proportion of aid workers report experiencing psychological difficulties?
- 2) What types of problems do they report?
- 3) What are some of the risk factors?
- 4) What can be done to help reduce the problem?

### **Anonymous questionnaires completed by:**

\* 145 returned overseas aid and development workers/ missionaries

Recruited randomly  
62 organisations represented  
Had been away 1 - 324 months (mean 51 months)  
82% response rate

\* 43 people preparing to become overseas aid workers

\* 71 people who did not intend to become aid workers

**Results:**

\* 46% of the returned workers reported psychological difficulties

\* Had been given professional diagnosis / treatment

Types of psychological problems experienced

	% of those who had problems overseas or after return
<b>PROBLEMS DEVELOPED WHILE ABROAD</b>	
Depression	9.1
Chronic fatigue syndrome	7.3
"Burnout"	1.8
<b>PROBLEMS DEVELOPED AFTER RETURN</b>	
Depression	78.2
Post-traumatic stress disorder	3.6

*'Some observers have postulated that people who would seek to enter especially hazardous or upsetting situations must be acting on some neurotic motivation. Indeed, relief workers themselves have used phrases such as martyr, misfit, masochist or running away from bad relationships to categorize the motivations of others around them, perhaps not their own, for entering relief work'*

*(Smith, Agger, Danieli & Weisaeth, 1996)*

*'There is a tendency for individuals with personality problems to volunteer for the tropics'*  
*(Engel, 1980)*

**Percentage scoring above BDI cut-off of 14**

	Returned group	Preparing group
BDI < 14	118 (83.1%)	40 (95.2%)
BDI 14+	24 (16.9%)	2 ( 4.8%)

( $X^2 = 3.94$ , 1 df,  $p < 0.05$ )

**Percentage scoring above intrusion cut-off of 21 (IES)**

	Returned group	Preparing group
Int. < 21	106 (75.7%)	39 (92.9%)
Int. 21 +	34 (24.3%)	3 ( 7.1%)

( $X^2 = 5.86$ , 1 df,  $p < 0.05$ )

**Percentage of women scoring above avoidance cut-off of 17**

	Returned women	Preparing women
Avoid. < 17	66 (67.3%)	25 (89.3%)
Avoid. 17+	32 (32.7%)	3 (10.7)

( $X^2 = 5.22$ , 1 df,  $p < 0.05$ )

**Effectiveness of personal debriefing**

**Percentage scoring above the clinical cut-off levels for intrusive thoughts and avoidance:**

Not debriefed	24%
Debriefed	7%

No-one reported any negative consequences of debriefing. 40% of the debriefed group reported there had been a noticeable positive change following debriefing (e.g. fewer flashbacks; sense of relief that symptoms were 'normal'). **People studied before and after first aid work experience (n = 41)**

**Psychological problems before aid work (AW)**

	Validators	Invalidaters
Never had psyc. problems	17 (85%)	17 (81%)
History of psyc. problems	3 (15%)	4 (19%)

Fishers p (2-tail) p > .9

**Psychological problems after aid work**

	Validators (before AW)	Invalidaters (before AW)
No psyc. problem after	15 (88.2%)	10 (50%)
History of psyc. problems	2 (11.8%)	10 (50%)

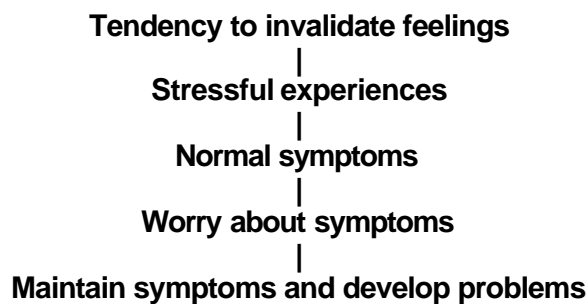
$\chi^2 = 6.13, 1 \text{ df}, p < .05$

**When to recommend professional help:**

1. Suicide risk
2. Signs of psychosis
3. Anorexia nervosa or bulimia nervosa
4. Post-traumatic stress disorder
5. Severe depression
6. Serious alcohol or substance misuse, or other damaging addictions
7. Self-destructive behaviour
8. Violence towards others/ serious anger problems
9. Physical health problems
10. Anxiety attacks or agoraphobia
11. Severe sleeping problems
12. Chronic fatigue syndrome
13. Fear of being HIV+
14. If you, or they, are concerned, it's worth recommending professional help

**With children, also recommend professional help if:**

1. Indication the child may have been abused
2. Dramatic changes in behaviour/ personality
3. Talking wishfully about being dead, or dwelling on death
4. Losing grasp of the line between fantasy and reality
5. Daily functioning severely impaired and developmental activities interrupted
6. Parents/ caregivers suffer from clinical depression
7. Self-blame
8. Distractability or other problems interferes with school performance
9. Inability to form relationships



**Chronic fatigue syndrome**

3% of 490 returned aid workers had been diagnosed with CFS

**Characteristics:**

- \* Healthy premorbidly
- \* Overwork (lack of colleagues; living 'on the job'; culture of over-activity within the organisation)
- \* Stress
- \* Physical illness
- \* Depression not a causal factor

**RECOMMENDATIONS**

- \* Listen (many people don't!)
- \* Normalise - temporary difficulties are common, and do not mean they are 'over-reacting' or 'going crazy'
- \* Recommend they receive personal debriefing (e.g. through their organisation, or InterHealth, or Elphinstone International Health Centre)

\* Recommend reading e.g.

'The art of coming home' by Craig Storti  
'Homeward Bound' by Robin Pascoe  
'Re-entry' by Peter Jordan  
'The Third Culture Kid Experience' by David Pollock and Ruth Van Reken

\* Adequate rest and relaxation are essential

\* Discuss how to establish a support network

\* Recommend stress management techniques

\* It often takes at least 18 months after returning before one feels 'back to normal'

\* If there are on-going problems consider:

§ Therapy e.g. cognitive behavioural therapy (e.g. for depression/ chronic fatigue syndrome/ PTSD)

§ Medication e.g. for sleeping problems

#### Summary of findings of Debbie Lovell's thesis: 'Psychological adjustment of returned overseas aid workers' (1997)

Within Britain, there are hundreds of organisations which between them send thousands of staff overseas each year to work on emergency aid operations, and longer term relief and development projects. 'Aid work' in this report refers to all such work, and includes the work of missionaries who are involved with relief and development work (such as teaching, medical work, etc).

Aid workers as a group encounter a variety of potentially stressful experiences, including facing widespread poverty, injustice and suffering; overwhelming responsibility and ethical dilemmas; role ambiguity; communication problems; unpredictable circumstances; cross-cultural adjustment; isolation, and risk of illness and injury. Many work very long hours. For some, the most disturbing part of their experience is returning to the home country, and many struggle with 'reverse culture shock'. There has been little research on the psychological adjustment of aid workers on their return to the home country. This study was designed as a response to questions commonly asked by people working with aid workers:

\* What proportion of aid workers experience psychological problems during or after a period of aid work, and what types of difficulties do they experience?

\* What are some of the vulnerability factors?

\* What can be done to help reduce the problem?

In this investigation, 145 returned overseas aid workers, 43 people who were preparing for their

first term as aid workers, and 71 people who did not intend to become aid workers, completed a series of questionnaires. Their responses were compared using statistical analyses. The returned group had worked with 62 different aid organisations, and had spent between 1 and 324 months overseas (mean 51 months).

Many of the returned aid workers described their time overseas as a positive, fulfilling experience, during which they had been effective in their work. 60% reported feeling predominantly negative emotions on their return home, while only 15% reported feeling glad or relieved that they were home; the remainder reported mixed feelings or no strong feelings. The most common experiences on return were feeling disorientated and confused, and feeling devastated and bereaved, having left friends overseas.

46% of the returned aid workers stated that they had experienced psychological difficulties either while they were overseas or on their return home. The vast majority of these had never had psychological problems before they became aid workers, and their difficulties appeared to be related to stressful circumstances overseas, and difficulty readjusting when they returned. Of those who developed problems, 18% reported that they had developed them while overseas, while the remainder had developed them after returning home. Depression was the problem most frequently reported, and had been severe enough in most cases to merit diagnosis from a mental health professional.

People who developed psychological problems had, on average, spent longer as aid workers than those who did not.

Compared with the group of people preparing for their first term as overseas aid workers, returned aid workers had significantly higher mean scores on measures assessing depression, intrusive thoughts and, among women, avoidance. The groups did not differ significantly on scores of anxiety, self-esteem, or anger expression. It appeared to be normal to experience some symptoms of depression and intrusive thoughts (such as having pictures about the time overseas popping suddenly into one's mind, or dreaming about it) following experience as an aid worker. People who accepted these symptoms as a normal part of the readjustment process appeared to adjust better than those who thought that they were 'overreacting'; the latter tended to develop psychological problems.

When compared with people who were not involved with aid work, people preparing to become aid workers and those who had returned appeared to be more self-accepting, and to view the world as a more meaningful and benevolent place. However, a small proportion of returned aid workers expressed views that the world was meaningless (random and unjust), and malevolent. Such views were related to the development of psychological problems.

## **Implications of the findings**

### **Selection**

Selection criteria in most aid organisations have improved during the past 25 years. No members of the group who were preparing to go overseas reported that they had ongoing psychological problems, and their questionnaires indicated that they were a psychologically healthy group. Of a group studied before and after short-term aid work, 23.5% reported that they had psychological problems (depression or an eating disorder) before they began the aid work. Most of these

respondents had worked overseas previously, and had been accepted for a further period of aid work without further psychological screening. A thorough screening process used before every aid assignment (and not just the initial assignment), might detect those who are having psychological difficulties, so that they can be offered support, rather than sent back overseas with untreated problems.

### **Preparation**

a) Stress management.

Psychological difficulties were found to be common among returned aid workers. The literature on related populations, such as the military, indicates that it may be possible to reduce some of these problems with additional preparation. Not all aid workers at present receive training in basic stress management techniques; such training would be beneficial. It might also be useful to inform preparing workers about potential difficulties they might face, so that they can consider in advance how they might deal with these. Aid workers could be trained to recognise and respond appropriately to symptoms of stress among themselves and their colleagues.

b) Normalising difficulties.

There was some evidence that invalidation of feelings (e.g. thinking that one is 'overreacting') might be a vulnerability factor for development of psychological problems. Preparation could include providing information about stress symptoms which are common following aid work, and encouraging people to accept these symptoms as a normal part of the readjustment process.

c) Length of assignments

Returned aid workers who reported that they had experienced psychological problems were found to have spent significantly longer overseas than those who did not report such problems. This result suggests that it might be worth considering shorter contracts for some aid workers, so that there would be less time for stress to accumulate, and reintegration into life in Britain might be easier. As longer term development work can be very effective, and some people find longer term work very fulfilling, contracts could be renewed after further psychological screening for individuals who wished to continue the work.

### **Education about psychological difficulties and sources of help**

46% of the returned aid workers studied reported that they had experienced psychological difficulties during or after being involved with aid work. Most of these individuals did not seek treatment, or waited many months before seeking treatment, during which time their symptoms became more severe.

Reasons for failing to seek help might have included not knowing where help was available; believing that seeking help would be seen as a sign of weakness; and feeling that they would not be understood by people who had no experience of aid work. One participant wrote:

“My organisation offered no help when I returned. I felt I really needed help from people who really understand the pressures of "re-entry" and the symptoms of burn out “

... how vital is support and debriefing in the period following return (S69).

Educating organisations and aid workers about sources of help, and that psychological difficulties are not unusual after returning from aid work, might lead to an increase in the number of individuals seeking treatment.

Health professionals (such as G.P's) could also be encouraged to look out for potential difficulties when visited by returned aid workers, who might not mention psychological difficulties unless specifically asked. Aid workers are more likely to feel "understood" by professionals who are well-informed about this topic.

Only 30% of respondents reported that they had received debriefing or professional help on their return from overseas. A number of respondents expressed annoyance at not being offered any, or adequate, debriefing. Some organisations already offer routine psychological debriefing, and further therapy when appropriate. A recent proposal has urged that all aid organisations should provide this service (Davidson, 1997). It is hoped that by informing organisations about the prevalence of psychological difficulties among returned workers, more organisations will consider this option, and offer debriefing routinely (rather than on request), so that there is no implication that those who accept debriefing are "weak". As one respondent wrote, aid workers "would like to see more counselling services offered ... as a normal part of the returning home process" (S113).

### **Recovery time**

It might also be beneficial for both aid workers and those in contact with them to be aware that return to normality following aid work can be a lengthy process. The mean length of time since respondents had returned from overseas was over 18 months, and yet they still reported having intrusive thoughts about the aid work. Some aid workers return from one assignment and are sent on another within a few weeks. This may not give them sufficient time to overcome stress symptoms, and may lead to problems with cumulative stress.

### **Treatment implications**

The results suggested that aid workers who no longer believed in a benevolent or meaningful world, or in their own worth, tended to experience psychological difficulties. It might be useful to routinely help returned aid workers find a sense of meaning in their experience and in the world, as a strategy aimed at preventing the development of psychological problems. Some forms of debriefing aim to provide this. Among those who have already developed psychological difficulties, it might be useful to offer therapy which attempts to help the client re-establish some belief in a meaningful, benevolent world, and their own self-worth.