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From traumatic stress to stress at work: providing psychological care for *Médecins Sans Frontières* staff

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Over the past thirty years, as the humanitarian sector has become increasingly professional, and society has recognised the importance of psychological well-being, Médecins Sans Frontières' managers have accepted that an employer is responsible for the mental health of its employees. Following on from the mental-health theme of our last issue, the authors describe how employers have adapted their approach to managing the stress faced by humanitarian workers.

In recent years, many organisations in the humanitarian sector have expanded and developed psychological care units for both expatriate and national employees. In this article, we seek to trace the origins of this concern by looking at the humanitarian medical organisation *Médecins Sans Frontières* (also known as Doctors Without Borders or MSF). Based on the testimonies of several of the organisation's psychologists, we build a chronological sequence in three stages: the first considers the management of traumatic stress in the mid-1990s; the second examines stress at work in the 2010s, and the third considers current thinking on the issues raised by the work carried out by MSF's psychology units, known internally as PSUs (Psycho-Social Units).

Stage one: the management of traumatic stress

In 1992, the International Committee of the Red Cross set up a working group led by Barthold Bierens de Haan and his team to provide psychological support for staff affected by their experiences in the field, particularly in West Africa, Somalia and the former Yugoslavia. This was followed in 1994 by the "stress programme" whose aim was to provide effective peer support.[1] Around the same time, MSF began to consider the mental health of its expatriate staff. While the myth of the hero, the taste for risk and the culture of exhaustion were prevalent at MSF,[2] the gradual professionalisation of the environment forced the organisation to change its approach. MSF's managers slowly came round to the idea that the trauma suffered by its volunteers was no longer "collateral damage" to be accepted

[1] B. Bierens de Haan, H. Van Beerendonk, N. Michel *et al.*, « Le programme de soutien psychologique des intervenants humanitaires du Comité International de la Croix-Rouge (CICR) », *Revue Française de Psychiatrie et de Psychologie Médicale*, vol. 6, n° 53, février 2002, p. 27-33, https://www.icrc.org/fr/doc/resources/documents/misc/5fzjgf.htm

[2] Nicolas Veilleux, « La mission Humanitaire. Impacts pour les équipes et dispositifs de support psychologique dans les ONGs », *in* Maryssa' El Husseini (dir.), *Soins psychologiques en terrain humanitaire : quand trauma, altérité culturelle et histoires s'entremêlent*, Collection Hospitalité(s), Éditions In press, 2022, p. 25-56, https://www.inpress.fr/wp-content/uploads/2021/10/Extrait-Soins-psychologiques-en-humanitaire-EL-HUSSEINI-.pdf

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without question but an evil that MSF must help overcome. As had been the case with the military[3] – especially since the recognition of "Post- Vietnam Syndrome" in the 1980s[4] – and the fire service,[5] regular exposure to disaster, danger and death would require psychological support that the employer must provide.

Starting in the mid-1990s, and with each section moving at its own pace,[6] the organisation reacted when its teams were exposed to events they considered traumatic. Even though most expatriates continued to carry out their missions without psychological support, in 1996 MSF- Belgium introduced expatriate-to- expatriate, peer-to-peer support on a voluntary basis for those who believed that they had suffered shock. Following the first war in Chechnya (1994-1996) and the genocide in Rwanda (1994) – where many MSF international workers saw their national colleagues die –, MSF-France introduced the *Lieu de parole* [place for speaking] system. From the late 1990s, MSF's longest-serving staff were offered free consultations with a psychologist in a logistics warehouse in Seine-Saint-Denis. This facility was then moved to MSF-France headquarters, which was on the Rue Saint-Sabin in Paris at the time. It was made available to all staff who wished to take part and offered a half-day consultation slot every week.

Until the 2010s, however, psychological support (under whatever form it took depending on the section) only addressed the most severe trauma. As one of the psychologists, who is now in charge of a PSU at MSF, said: "We used to say that you'd earned your psychological debriefing if you'd been kidnapped. It had to be hardcore though: being held up on the road was not enough."

Stage two: dealing with stress in the workplace

Although MSF gradually assumed responsibility for traumatic suffering, emotional states such as frustration, anxiety, sadness, burnout and compassion fatigue were still, at the time, a matter for the individual and therefore beyond the scope of the systems put in place by the organisation. This was not unique to the humanitarian sector. In 2006, two psychopathologists stated that, in the professional environment, particularly in France, "very few companies are inclined to implement comprehensive prevention policies".[7] Employers have long considered a psychology unit dedicated to the mental well-being of employees to be an unnecessary cost item or a "negative" sign symbolic of the stress or

[3] Carle Doutheau, François Lebigot, Christian Moraud *et al*., « Facteurs de stress et réactions psychopathologiques dans l'armée française au cours des missions de l'ONU », *Revue internationale des services de santé des forces armées*, n° 67, 1994, p. 30-34; D. Raingeard et F. Lebigot, « Action psychologique et psychiatrique en faveur des soldats de l'opération Turquoise (Zaïre, juillet-août 1994) », *Annales médico-psychologiques*, vol. 154, n° 2, 1996, p. 103-113; Neil Greenberg, S. L. Thomas, A. Iversen *et al.*, "Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment", *Journal of Mental Health*, vol. 12, no. 6, 2003, pp. 565–573; Laurent Melchior Martinez, « Les dispositifs de soutien médicaux-psychologiques dans l'armée française », *Topique*, vol. 3, n° 144, 2018, p. 59-67.
[4] Matthew J. Friedman, "Post-Vietnam syndrome: recognition and management", Psychosomatics, vol. 22, no. 11, November 1981, pp. 931–934, 941–942.
[5] Alain Flaujat et Marianne Soldin, « Soutien psychologique chez les sapeurs-pompiers français », *Annals of Burns and Fire Disasters*, vol. 16, n° 1, 2003, p. 24-27.
[6] MSF now has five operational sections: MSF-France, Belgium, Switzerland, the Netherlands and Spain.
[7] Nicolas Combalbert et Jean-Marie Lançon, « Les spécificités du débriefing psychologique en milieu professionnel », *Pratiques Psychologiques*, vol. 12, n° 3, septembre 2006, p. 261-269.

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abnormal distress suffered by their teams,[8] if not a "Pandora's box"[9] from which a torrent of responsibilities could emerge for the company.
The transformation of society, however, has forced organisations to change. Since 2008, Article L.4121- 1 of the French Labour Code requires "the employer [to take] the measures necessary to ensure the safety and protect the mental [...] health of workers". In other words, the employer has an obligation to consider not just the traumatic aspects but also the psychosocial risks associated with the work environment. Furthermore, in the humanitarian sector, the diversification of the expatriate profile since the 2010s, with more expatriates coming from specialised backgrounds with a specific career in mind,[10] has helped raise the level of attention paid to employees. Lastly, the acceptance and recognition of psychologists has evolved. As one of them at MSF-Belgium said: "[In 2009], whenever [she came] into the canteen, people would say: 'Shhhh! The shrink's here, don't say anything. She'll analyse us!' [...] It's not like that anymore, it's become the norm. We're destigmatising it."

Whilst Barthold Bierens de Haan has been suggesting since the 1990s that work-related stress (which he called "basic stress" at the time)[11] should be included in the mental healthcare of humanitarian workers, two major disasters finally acted as the catalyst for a change in MSF management's point of view regarding the nature and prerogatives of psychological support, which until then had been dedicated solely to trauma. Following the 2010 earthquake in Haiti which killed more than 280,000 people, a special "time out" system, including an appointment with a psychologist, was introduced for all MSF-France expatriates. Similarly, during the 2014-2015 Ebola outbreak in West Africa, during which about half the patients entering treatment centres died, all expatriate teams were psychologically debriefed. According to a member of an MSF- Belgium PSU: "People felt the added benefit went through the roof. That's when it all came together, the resources, etc. It was a very long emergency [...]. And it created a real change at headquarters."

This systematisation allowed other psychological themes to emerge, themes more closely linked to an individual's relationship with his/her commitment, the culture gap, life in a team, the living conditions on a mission, etc. A psychologist from these PSUs tells how several expatriates, upon returning from their recent mission to Ukraine, reported their dismay at the humanitarian competition they witnessed between organisations and how another expatriate had resigned three weeks after arriving in Ethiopia because the atmosphere between team members seemed too tense.

Psychological support is no longer confined to dealing with violent emotional shocks, therefore, but more broadly with management methods, relationships with colleagues and the meaning given to one's work. The two main avenues of psychological care – the one-off avenue of disasters of the "military" or "firefighter" type, and the continuous avenue of stress at work linked to relations with colleagues, management or to psychosocial risks of the "France Telecom" type[12] – thus gradually converge. The psychology units of MSF-Belgium and MSF-Netherlands were the first to provide support not just for

[8] Marc Loriol, « Agir contre le stress et les risques psychosociaux au travail », *Regards sur l'actualité : mensuel de la vie publique en France*, n° 363, 2010, p. 52-63.
[9] Patrick Légeron, *Le Stress au travail*, Éditions Odile Jacob, 2001.
[10] Ludovic Joxe, « Les ressorts de l'(in)satisfaction : le cas du personnel international humanitaire », thèse de doctorat en sociologie, université Paris- Descartes, 2019, https://theses.hal.science/tel-03281513
[11] B. Bierens de Haan, H. Van Beerendonk, N. Michel *et al.*, « Le programme de soutien psychologique des intervenants humanitaires… », art. cit.
[12] See, for example, the Europe 1 article of 7 July 2016 entitled *« "L'affaire" France Télécom, symbole de la souffrance au travail »* which tells the story of the "affair" until the trial: http://www.europe1.fr/societe/laffaire-france-telecom-symbole-de-la-souffrance-au-travail-2793691 and Yves Clot's work on this subject: Yves Clot, *Le travail à cœur – Pour en finir avec les risques psychosociaux*, Éditions La Découverte, 2010.

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expatriates returning from missions in war contexts and who have been exposed to death but also to expatriates simply caught up in tense work contexts, oppressive atmospheres and projects deemed frustrating. Even though MSF-France and MSF- Switzerland had fewer human resources at their disposal (MSF-Switzerland outsourced this activity to an independent psychologist, whilst MSF-France had just one psychologist), these two sections soon adopted the same vision as their two sister organisations in northern Europe. Echoing the remarks of humanitarian anthropologist Anne-Meike Fechter, a psychologist from MSF-Belgium said, "Stress is just as prevalent among workers who don't have to deal with traumatic situations"[13] and psychological suffering can exist in any context. She added: "You should see people when they come back, whatever their mission. It's not because you went to Afghanistan or Zimbabwe. That has nothing to do with it. You suffer in different ways. And you often suffer more when you come back from Zimbabwe."[14] Thus, one of the projects that recently resulted in the highest number of early end-of-mission resignations and achieved the highest indicators in terms of mental fatigue is, according to MSF-France's PSU, the project set up in the Paris region with the migrant population.

Symbolic of this transformation of the psychology unit's activities, MSF- Belgium has published a guide for project coordinators entitled "Stress prevention and management: the role of the project coordinator".[15] Just one of the guide's eleven sections deals with "critical" and/or traumatic incidents such as road accidents, hold-ups or kidnappings. The other ten deal with addressing expatriates' "physiological needs", "control needs" or "the need to belong" and more general themes relating to working in a group or to the support to be provided for employees. This guide is therefore much more focused on managing potential tension in physically and emotionally tired teams than on managing traumatic or post-traumatic stress generated by contexts of war or disaster.

Support is not just offered on return but also throughout the mission. The psychosocial service can be reached "24/7" by any member of the organisation in the field. Since 2020, MSF-France has also been developing specific support mechanisms, discussion groups and a generic email address to which all employees can write directly and confidentially. Without waiting for its staff to reveal their suffering, MSF-France, through its PSU, has also systematised proactive contact with project members deemed to be the most psychologically affected (those dealing with migrants, victims of sexual violence or burn victims) and with "emergency pool" staff (those who, over a short period of time [usually a year], are frequently exposed to a heavy workload in an emotionally demanding disaster context). Whenever possible, discussions are held in the expatriate's native language so as to "facilitate introspection".

Stage three: the current status of the psychology units

Now oriented towards comprehensive psychological care, MSF is nevertheless seeing new areas of disagreement and debate emerge. For some, psychological support is primarily a practical response to the need to retain employees and, in a way, to the pursuit of productivity. Like private sector companies, MSF needs healthy staff in order to achieve its goals. Many studies show that stress and psychological violence affect the functioning, efficiency and productivity of an organisation.[16]

[13] Anne-Meike Fechter, "The Personal and the Professional: aid workers' relationships and values in the development process", *Third World Quarterly*, vol. 33, no. 8, September 2012, pp. 1387–1404.
[14] This statement implies that Afghanistan is a source of traumatic shock while Zimbabwe is a calm country.
[15] MSF Operational Centre Brussels, "Stress prevention and management: the role of the Project Coordinator", November 2016 – 1st edition.
[16] Jeffrey P. Kahn and Alan M. Langlieb, *Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians*, Jossey-Bass, 2003; Ron Z. Goetzel, Kevin Hawkins, Ronald J. Ozminkowski *et al*., "The health and productivity cost

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According to an MSF PSU member: "Having good mental health is not an end in itself. The aim is to ensure that the teams are healthy so that the project's objectives can be achieved. Team health is a means to an end." According to this way of thinking, the psychology unit is there to serve operations. For others, being in good health is an end in itself and the psychology unit must contribute to the organisation's mission to alleviate the suffering of others, including that of its members. Where such a unit exists, it is there to avoid piling misfortune on top of misfortune, to respond to the humanitarian precept of "do no harm" and contribute to discussions on "acceptable risk". This second way of thinking gives rise to a different approach for the unit, making it more involved in operations and closer to the mental health projects of the beneficiaries. In a way, such an understanding allows the organisation to protect itself from criticism, sustain the meaning of its actions and, lastly, take part in its own autopoiesis (i.e. its self-preservation).[17]

Another area that has long been a topic of discussion among members of the organisation is whether to outsource psychological care or manage it in-house. Alongside the fear inspired by the idea that psychological care is associated with madness, and the myth of the humanitarian hero who does not need help, there was the idea that one cannot be a colleague and a therapist at the same time. Psychological support therefore had to be provided by someone from the outside. Yet there was also a prevailing idea that given a certain degree of *esprit de corps*, only someone from the humanitarian community could really understand a worker from that same sector, hence the original principle of peer-to-peer support or support provided by psychologists who had previously experienced the realities of the field. This second option, which some sections have pursued, has allowed PSUs to act as an in-house early-warning system. When, during their psychological debriefings, several individuals complained about the same type of difficulty, the PSUs reported back to the operations department or management that potential systemic problems were latent in some projects, or even at organisational level. The debate between outsourcing and in-house management has recently been settled once and for all, as MSF-Switzerland, the last section to find itself in this situation, stopped delegating its psychological care to practitioners "in town" in 2020.

Furthermore, after systematising trauma care and then recognising that stress at work was also the responsibility of the employer, MSF's psychology units are dealing with an ever-increasing number of cases. The organisation as a whole has, admittedly, taken charge of these issues, but according to all the PSUs, the operations department may have a tendency to refer issues to these units that do not fall within their remit. For example, MSF-France's PSU is seeking to refocus around what it considers to be its core business, namely the prevention of vicarious trauma (compassion fatigue) and how to treat it. The operations department may therefore take over the preventive aspects relating to organisational management methods, workload, interculturality or the advance understanding of the sector's issues and dilemmas. According to this approach, just as it would be the responsibility of the PSU to care for the victims and train the managers in psychological first aid (PFA), it would be the responsibility of management to adapt working methods with a view to reducing the psycho-social risks upstream.

Lastly, one of the main current issues of psychological support is the care of national staff. As one of MSF's psychologists said: "I'll tell you straight: 95% of the psychology units' work was on the 'expats'

burden of the 'Top 10' physical and mental health conditions affecting six large U.S. employers in 1999", *Journal of Occupational and Environmental Medicine*, vol. 45, no. 1, January 2003, pp. 5–14; Ron Z. Goetzel, Stacy R. Long, Ronald J. Ozminkowski *et al.*, "Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. employers", *Journal of Occupational and Environmental Medicine*, vol. 46, no. 4, May 2004, pp. 398–412.

[17] Niklas Luhmann, *Systèmes sociaux : esquisse d'une théorie générale*, Presses de l'Université Laval, 2011.

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who accounted for only 10% of the people in the field. So the idea is to rebalance this sort of thing." For a long time, in an organisation marked by the idea that expatriates were from the Global North and national staff from the Global South, the stereotype that local employees were used to physical and mental suffering was widespread. Given that "'nat staff'[18] were resilient, and that they knew how to cope," providing them with support seemed unnecessary. Given the "south-isation" of the organisation [19] and the in-house discussions about potential systemic racism, [20] however, this stereotype has disappeared, and psychological support has become available to all staff.

MSF-Belgium's 24/7 psychosocial service is also available to national staff, and since 2019 the organisation has opened three decentralised and intersectional psychology units in Amman (Jordan), Dakar (Senegal) and Nairobi (Kenya). These units employ psychologists who speak the local languages and are able to integrate cultural aspects into their practice. The existence of these units also makes it possible to offset the lack of skilled resources in certain neighbouring countries where the technical platform is less developed.

Yet, whilst local employees can theoretically access these psychological support services, few do. Not only do they usually rely on local resources, friends, family, or colleagues when faced with a difficult situation, they are also often unaware of the value and existence of this support. Despite the psychology units' efforts to communicate and make themselves known to teams in the field, MSF's intrinsic focus on emergency response limits this possibility. Indeed, "if, at a given moment, long-term projects account for the majority of MSF's work, they represent only a small proportion of the total number of operations, and many activities only last a few months".[21] The staff recruited to these projects, and who constitute the bulk of the organisation's workforce but are only on temporary contracts, barely have the time to familiarise themselves with the resources available to them before their contract expires.

Lastly, the distribution of tasks between the psychology units and the operations department seems to have swung back and forth in a dynamic process over the years. In any event, after being dismissed, concealed, or even deemed to be an unnecessary cost item, psychological support for MSF staff has become an essential activity from which an ever-increasing number of staff benefit, both at headquarters and wherever the organisation operates.

Translated from the French by Derek Scoins

[18] Meaning "national staff".
[19] Ludovic Joxe, « La "sudisation" du secteur de l'aide internationale. Entre opportunité d'émancipation et déplacement des rapports de domination », *Revue internationale des études du développement*, vol. 1, n° 241, 2020, p. 165-186.
[20] See for example France Info, *Un millier d'actuels et anciens salariés de Médecins Sans Frontières accusent l'ONG de « racisme institutionnel »*, 11 juillet 2020, https://www.francetvinfo.fr/societe/racisme/d-actuels-et-d-anciens-salaries-de-medecins-sans-frontieres-accusent-l-ong-de-racisme-institutionnel_4042619.html ; MSF, *Statement by the MSF UK Board of Trustees on institutional racism*, 29 June 2020, https://msf.org.uk/msf-uk-board-trustees-statement-institutional-racism
[21] Ludovic Joxe, « La pyramide de politisation – De l'impolitisation à la politisation critique chez Médecins Sans Frontières », *Les Cahiers d'Outre-Mer*, n° 286, 2022, p. 401-428.

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Biographies

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Nicolas Veilleux • A clinical psychologist, Nicolas Veilleux joined *Médecins Sans Frontières* in 2003 where he works as a psychologist, project coordinator and Human Ressources coordinator. He has been coordinating the support unit for *Médecins Sans Frontières* teams since 2011.