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Barriers to accessing psychosocial support for humanitarian aid workers: a mixed methods enquiry

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Abstract

International and national humanitarian aid workers were recruited for this study through purposive sampling techniques using social media. Eight interviews and one focus group discussion were carried out (n=13), and a survey disseminated (n=62), to gather a broad range of perspectives on barriers for aid workers in seeking out and accessing psychosocial support. A thematic analysis was carried out on the interviews and focus group discussion. The hypothesis was that participants would describe a variety of personal, professional, and environmental barriers, with 'tough-guy macho culture' and/or 'martyr culture' being the strongest deterrent. Fourteen barriers, namely Accessibility, Appropriateness, Attitude, Availability, Confidentiality & trust, Duty of care, Guidance, Normalisation, Experience, Repercussions, Self-awareness, Self-reliance, Stigma, and Time, were identified. It is recommended that organisations improve provision of quality, appropriate psychosocial support for staff; that it's communicated regularly, and they train staff on identification of when others are in need of support.

Keywords: humanitarian aid workers, psychosocial support, wellbeing

Introduction

The humanitarian sector is a complex and dynamic organism that comprises several multifaceted support and relief mechanisms across a multitude of humanitarian contexts. Interventions implemented by humanitarian aid workers are carried out in extremely stressful operational contexts and difficult living environments. Year upon year, there are multiple, severe humanitarian crises, including protracted conflicts, natural disasters, and increasingly more commonly, complex emergencies, which combine both natural and man-made disasters (Hearns and Deeny, 2007). The Global Emergency Overview by ACAPS (2016), reports that in mid-2016, there were 31 humanitarian crises ongoing, 13 of which were considered severe, with a further 15 documented as areas of concern. Given the increase in need for humanitarian assistance across the globe, it is irrefutable that the number of internationally deploying and nationally recruited aid workers must have increased to meet demand. Concerns have always been raised about the ability of aid workers to remain professional and effective when they are being sent to increasingly insecure and volatile contexts, especially considering the stretched resources available to support them due to the vast numbers being deployed (McCall and Salama, 1999). In the last two decades, due to this intensification in the global humanitarian context, there has also been a proliferation of research around the stressors affecting

humanitarian aid workers and the potential impacts of those stressors on the individuals, the organisations, and the quality of the work that is done (Strohmeier and Scholte, 2015; Garbern, Ebbeling, and Bartels, 2016; Jachens, 2019).

Cumulative stress is a common experience for anyone working in chronically demanding contexts, such as the humanitarian sector (United Nations High Commissioner for Refugees, 2001). It is an accumulation of often multiple and varying stressors, which might lead the individual to feeling powerless to change the situation, and unable to relax or cope. Cumulative stress, as opposed to post-traumatic stress disorder (Batniji, Van Ommeren, and Saraceno, 2006), is desperately understudied in the humanitarian sector but by its very nature is the form of stress that can lead to incapacitation of the individual, more commonly referred to as burnout. Burnout is a fundamentally work-related condition, as opposed to a pervasive mental health disorder like post-traumatic stress, which was first defined by Freudenberger (1974) and later operationalised by Maslach and Jackson (1981) as emotional exhaustion, depersonalisation, and diminished feelings of personal accomplishment. There is a common misconception in the humanitarian field that burnout is merely physical exhaustion, understating such symptoms as emotional exhaustion, apathy, or feeling a lack of achievement. Incorrectly applying this label can work to the detriment of individuals in the humanitarian sector, as it increases the ease with which stigma can permeate the organisational culture and with which people tend to respond to the label rather than the holistic experience including the chronic stress leading to this point. Indeed, the most common stressors in the humanitarian field are workload, and relationships with managers and colleagues (Young, Pakenham, and Norwood, 2018). Relatedly, cumulative stress, can easily lead to ineffective working (Professionals in Humanitarian Assistance and Protection, 2015), presenteeism (Goetzel et al., 2004), absenteeism, or turnover (Loquercio, Hammersley, and Emmens, 2006).

There is a vast amount of academic and grey literature, including self-help documentation, guidelines, and information platforms, describing referral pathways for support and guidance for NGOs to improve access to psychosocial support (McCall and Salama, 1999; Ehrenreich, 2002; International Federation of Red Cross and Red Crescent Societies, 2009; Curling and Simmons, 2010; Mckay, 2011; Antares Foundation, 2012; Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2012; Meyer, 2013). There is clear acceptance by the humanitarian aid worker community that the accessibility of the available psychosocial support needs to be improved, and that this needs to be an organisational (Aldamman et al., 2019), even a sectoral priority in order to improve upon the dispiriting mentality (Hearns and Deeny, 2007). It is clear from the gradually accumulating evidence and critical mass, including online forum discussions, webinars, and

internal organisational reports, that this conversation is amassing a following in the humanitarian sector. For instance, there is a movement under the name 'Be Well, Serve Well' which is allowing aid workers from around the globe to speak up about the need for comprehensive, quality support to be made available and to be easily accessible to them, in order for them to do their work effectively.

Even with the abundance of psychosocial support that is available to humanitarian aid workers affected by anything from low stress to severe trauma (Quevillon et al., 2016), a lack of quality assurance mechanisms, and very little time to research and assess what is relevant and appropriate, aid workers often don't know where to look for support for their wellbeing before, during, or post-deployment. As an illustrative example, the United Nations High Commissioner for Refugees' (2014) survey of employees' mental health and wellbeing showed that nearly 50 percent of participants indicated awareness of the personal need to consult mental health services, but only 27 percent actually sought help. Despite these alarming figures, there is a chronic lack of research into reasons why this support is not regularly sought out or accessed.

Help-seeking behaviours have been studied in many different populations. Personal, professional, and environmental factors influence how and when individuals seek help (Radziwon, 2009). There are similarities between demographically disparate populations with relation to the barriers they face in initiating the help-seeking process. The self-stigma and social stigma they face when accessing help for their psychological wellbeing, the anticipated shame or embarrassment (Vogel and Wester, 2003), their experiences of previous help sought (Topkaya, 2014), their beliefs about the potential lack of confidentiality, the overwhelming nature of available support (information overload) or the lack of knowledge of what is available and the ability to recognise the need for help through self-awareness, are just a selection of the numerous barriers which are documented in the literature, common to several different populations (Gulliver, Griffiths, and Christensen, 2010).

Nevertheless, the research on help-seeking by humanitarian aid workers is scarce. There is, however, some research describing the nuanced experiences of help that has been accessed (Hearns and Deeny, 2007; Sering, 2011). Given that previous research has illustrated at least a sample of the different platforms and services available to aid workers for psychosocial support (Emmens and Porter, 2009; Zwaan, 2014), the more prominent issue seems to be related to what is stopping people accessing the vast and varying support that *is* available e.g. in-house psychosocial & psychological support, coaches, retreats, critical incident stress debriefings (CISD), institutes with staff welfare resources, etc. The fact that aid workers, given the research illustrating the detrimental psychosocial impact of their work, do not access psychosocial support in a systematic way is of concern. Therefore, the question that really needs to be asked

is what are the barriers for humanitarian aid workers in accessing available psychosocial support?

In this regard, attitudes of 'martyrdom' are easily recognisable and commonplace throughout the humanitarian sector, often in relation to the mentality that beneficiaries' problems and needs are more important than those of the aid workers' themselves (Ehrenreich and Elliott, 2004; Blanchetière, 2006; Comoretto, Crichton, and Albery, 2015). This 'Martyr' attitude encourages people to sacrifice their own wellbeing because of the critical importance of the work (Avula, McKay, and Galland, 2019). 'Macho' culture is also commonly and synonymously referred to in the humanitarian sector. This 'touch-guy macho culture', is a term about organisational culture, coined by Deal and Kennedy (1982), defined by 'a rapid feedback/reward and high risk structure, resulting in stress from high risk and potential loss/gain of reward', and identified as being commonplace in careers such as policing and medical surgery. The empathy that drives many aid workers to do the work they do, alongside the guilt that comes with being able to step out of the horrors of emergency settings into nice hotels, safe compounds, or for rest and recuperation (R&R), can often have a bearing on this 'just get on with it' 'macho/martyr' attitude that many still have. Although the term 'macho culture' is synonymous with a predominately masculine environment, it is often used colloquially in the humanitarian sector to express an organisational culture whereby traditionally masculine traits (e.g. strength, fearlessness, assertiveness, reduced help-seeking behaviour etc.) are dominant, and is organically mentioned by individuals throughout the sector, although the nuance of interpretation may differ.

Bearing this in mind, it is likely that help-seeking will be more restricted in aid worker populations due to the desire to 'put on a brave face' or not to be seen as weak in the face of adversity from which so many are suffering. If these emotions and these attitudes create barriers for aid workers in accessing support when they need it, it is likely that the most restrictive barriers will be those that are egocentric and related to personal or professional reputation. Self and social stigma are likely to be highly related to why aid workers won't access psychosocial support that's available, alongside the fear of job insecurity due to presenting oneself as incompetent or incapable (Olenick, 2011). Skeoch, Stevens and Taylor (2017) found that humanitarian trainees believed help-seeking was good practice, but mainly when referring to others not themselves. Low rates of help-seeking behaviour were reported, and self-reliance was more commonly mentioned as a coping mechanism, due to not wanting to burden others and believing their problems were not 'big enough' to warrant seeking support.

Conducting research to determine the barriers to access of support, which could improve the communication of available support, in turn improving the mental health of aid

workers and therefore their efficacy as part of the organisation they work for, is key to encouraging positive change within the sector. Based on the literature and the perceptions of wellbeing and psychosocial support from within the sector, it is hypothesised that participants will identify a multitude of personal, professional, and environmental factors as barriers to the access of psychosocial support for their wellbeing, with the sectoral 'macho/martyr' attitude being the biggest deterrent for seeking or accessing support.

Methods

Design

The exploratory nature of the research question necessitated the use of both qualitative and quantitative methods to capture the personal experiences of humanitarian aid workers, as well measuring the broader social concept of 'barriers' in the humanitarian sector via a quantitative analysis. This study had a sequential, exploratory design (Creswell and Plano Clark, 2010).

Qualitative data was collected via eight semi-structured interviews and a focus group discussion. Based on the results of the qualitative part, a quantitative survey was also disseminated broadly within the sector on social media platforms (Twitter and Facebook), on blogs and other professional information-sharing platforms (LinkedIn and MHPSS.net) and by email to a broad range of humanitarian connections. With regards to confidentiality, the information provided by all interviewees and focus group discussion participants was held anonymously, with any identifying information being edited before transcripts were analysed, and once the transcripts were written up the recordings were permanently deleted. All participants of the survey participated entirely anonymously.

Participants

The target population for the research included both international and national aid workers who were based in the field (including at the country office level). Purposive sampling was carried out for the semi-structured interviews and the focus group discussion due to the specific nature of the research question and focus group discussion participants were considered experts in the field of staff welfare (see table 1 for further details). Inclusion criteria for semi-structured interviews and for the survey was the same as the criteria used by Lopes Cardozo et al. (2012) for consistency and replicability across the evidence base around wellbeing for aid workers. Eight individuals (3 male, 5 female), all but one of whom were currently in the field as practising aid workers, with two of these individuals having dual-purpose jobs (e.g. alongside their main job they also were the psychosocial focal point for staff), and one individual being a service provider to aid workers only participated in the semi-structured interviews.

Participants for the focus group discussion were contacted via a group email after expressing interest in the research project and were provided with consent forms and information sheets as with previous participants. Finally, five individuals (3 female, 2 male) who were all considered to be experts in the field of humanitarian work and had extensive field experience but were currently not (or no longer) practising and were focusing on service provision for aid worker wellbeing participated in the focus group discussion. An appointment was made, and the group met via a collaborative Skype call. All interviews were recorded via recording software for Skype with permission from the participants.

The survey participants produced a sample population (*n*=62) assumed to be fairly representative of the target population due to the heterogeneity of responses. The survey was accessed widely, with an initial 132 individuals from 36 nationalities participating, currently on mission in over 48 contexts covering the major continents in which humanitarian emergencies are ongoing (i.e. not including Antarctica & North America). However, due to the nature of the contexts in which many of these individuals work and the likelihood that Internet connectivity was poor in many of these locations, only 62 respondents' survey results were usable (due to incomplete responses, likely due to the survey not saving, as well as a handful of participants not fulfilling the survey criteria). Of the usable responses, participants were 73 percent female, 69 percent of participants were aged between 25-34 and were represented by 20 nationalities, across 27 humanitarian contexts. Only 6 percent of respondents were national staff, however from the original cohort (of which half of responses were unusable), 12 percent of respondents were national staff from a variety of contexts. Years of experience were varied, with the highest percentage (31 percent) having 3-4 years of experience (see table 2 for further details).

Table 1. Interviews and focus group participants codes and demographic information

#	Code	Gender	International or national	Interview or FGD
1	AK	Male	International	Interview
2	PT	Male	International	Interview
3	LJ	Female	International	Interview
4	PP	Male	National	Interview
5	CA	Female	International	Interview
6	MF	Female	International	Interview
7	BD	Female	International	Interview
8	EH	Female	National	Interview
9	P1E	Female	International	Focus group discussion
10	P2B	Male	International	Focus group discussion
11	P3E	Male	International	Focus group discussion
12	P4S	Female	International	Focus group discussion
13	P5N	Female	International	Focus group discussion

Table 2. Demographic characteristics of survey respondents (n=62).

	%		%		%
Gender		**Mission context**		**Nationality**	
Female	73	Afghanistan	3	American	8
Male	27	Africa (general)	2	Australian	2
		Cameroon	2	British	18
Age		CAR	8	Canadian	3
25-34	66	Greece	2	Dutch	5
35-44	29	Iran	2	Egyptian	2
45-54	5	Iraq	19	French	29
		Jordan	2	German	2
Expatriate		Kenya	2	Irish	2
National	6	Lebanon	2	Israeli	2
International	94	Mali	2	Italian	2
		Mauritania	2	Kenyan	2
Years of experience		Mozambique	2	Not disclosed	2
<1	6	Myanmar	2	Nepali	5
1-2	10	Nepal	5	Pakistani	2
3-4	31	Niger	2	Singaporean	2
5-6	23	Senegal	3	South African	3
7-8	10	Sierra Leone	3	South Asian	2
9+	21	Singapore	2	Spanish	10
		Solomon Islands	2	Syrian	2
		South Asia	3		
		South Sudan	19		
		Sudan	2		

Syria	2
Turkey	6
Ukraine	2
Zimbabwe	2

Procedure

The University of East London Research Ethics Committee granted ethical approval, before recruitment of participants began. A preliminary forum discussion was carried out on a social media platform with humanitarian aid workers to obtain a general overview of what were considered barriers by a range of individuals of both genders and all ages, as well as individuals with a large difference in years of experience. These inputs led to the formation of a general topic guide for the interviews (see table 3). Semi-structured interviews were arranged via Skype. Each participant was contacted prior to the allocated timeslot with a consent form and information sheet about the research. Consent was taken verbally at the beginning of each interview after an initial preamble about the purpose and structure of the data collection, and their involvement. Each interview was then undertaken for approximately 60 minutes, with some trigger questions ready in case they were required. All interviews were logged via recording software for Skype with permission from the participants.

Table 3. Topic guide for the semi-structured interviews

1. What do you think the barriers to accessing psychosocial support for international aid workers are? What kind of things hinders people from seeking help for their wellbeing?
2. How do you feel about those things as barriers?
3. Whose responsibility is it to ensure the wellbeing of aid workers?
4. Do you think they differ from the barriers for national aid workers in your given context? If so, how?
5. Think about a time when you thought about seeking help, either from within the organisation or externally. Did you seek it, and if not why not – what stopped you?
6. Do you know of anyone else who has thought about seeking help but has then stopped? If so, do you know or believe you know what stopped them seeking help?
7. How does confidentiality affect the willingness to seek psychosocial support?
    - time
    - cost (either for you or the organisation)
    - availability of relevant support
    - knowledge of what's available
    - repercussions of asking for help
    - attitudes in the sector/stigma
    - trust/relationship with supervisor
    - acknowledging you need help
    - fear of loss of belief in self
    - cultural beliefs/traditional values about mental health issues
    - faith/spirituality

8. Are you aware of psychosocial support services either within or external to your organisation? If so, would you think of using them? If not, why not?
9. If you were going to seek psychosocial support either from within or external to your organisation, what kind of support do you think you would benefit from/seek out?
10. How could organisations improve their support for staff wellbeing?
11. What kind of psychosocial support do you get – personally / professionally?

After qualitative analyses were carried (see below), the survey was created with at least one item (question) being formulated from each of the sub-themes (41) within the fourteen themes. An example of a question from the theme 'Attitude' is, '*I believe that judgement around mental health and psychosocial support within my organisation would stop me seeking or accessing support for my wellbeing if I was under stress'.* There were 73 items formulated to cover all elements of the sub-themes (see table 5). The response scale was measured as 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, and 5 = Strongly Agree. The only items which were not included in the survey were those items that related to the NGO provision of support, as opposed to the individual experience, as this was not the focus of the survey. The items were then validated by member-checking with previous participants to establish if they were relevant and understandable, and the survey was then disseminated via social media platforms, as well as by email to several contacts of the research in the humanitarian sector who then forwarded the email on to their colleagues and friends.

The start of the survey contained the same information as in the information sheets provided to other participants, as well as an integrated consent form to inform them of the purpose of the study and to provide them with information about withdrawal if desired.

Analyses

Qualitative

During each of the interviews, comprehensive notes were made regarding the general themes that emerged during the discussions. These notes were referred back to during the analysis stage to provide triggers as well as a comparison to the direct experience of the researcher with the participant during the interview stages. The interviews and analyses were carried out concurrently to allow a gradual and parallel emergence of potential themes. Themes were identified as barriers in any form; from environmental or organisational, to individual or interpersonal. Themes were considered items that were regularly raised within and across transcripts. All barriers (themes) consisted of a large number of coded items, which was determined as illustrating the regularity of discussion of each barrier across the data set. The key factor for themes being identified as such was that they were deeply relevant and

interconnected with the research question and could independently be seen as deterrents to seeking psychosocial support.

After listening to the recorded interviews, a verbatim transcript was written up for each interview and was sent to each participant for him or her to review (e.g. clarify points or delete anything that they felt was identifying). All transcripts were then analysed using Atlas.ti. Once all transcripts were written up and entered into the software, thematic analysis (Braun and Clarke, 2006) was carried out on the eight interviews to identify initial codes from quotations (data extracts) in the transcripts, and gradually to identify sub-themes.

Thematic analysis allowed us to carefully record the rich, nuanced experiences of aid workers from an independent standpoint to any previous literature, whilst allowing for flexibility in interpretation of the data corpus and analysing emerging patterns in response (themes). The approach to the thematic analysis was predominately inductive or 'bottom-up', allowing the data extracts to be identified organically in relation to the research question, and then clustered into themes as opposed to theoretical thematic analysis, whereby coding would be carried out in connection to a predefined framework. The approach for coding was primarily semantic, allowing the data extracts to be explicitly describing the barriers within themselves.

After analysis was done on each transcript, the sub-themes were then grouped together into main themes. The interpretation of these themes, sub-themes and codes was documented by a process of reading and re-reading by the primary researcher followed by oversight from a second researcher to establish consistency in coding. After an initial stage of coding, the researcher consulted the literature around barriers to help-seeking in other populations to refine the themes. During the process of coding each interview, attention was paid to identification of new sub-themes and main themes within which these new codes might fit. After the individual analyses, a review of all the data set (transcripts) was carried out to ensure all data extracts were coded appropriately, comprehensively and that all codes were deemed as part of the correct sub-themes and that those sub-themes fitted into the main themes, with some adaptations to the coded items (further inclusion or exclusion of items).

After the initial stage of coding from the interviews, the themes (14) and sub-themes (41) were named as per the most appropriate terminology (i.e. descriptive of the content of the coded items), and were defined in a table with explanations, examples (coded items), and reasons for why they fit the theme. A second researcher examined the outputs from the initial analyses and the themes table, concluding that the themes and sub-themes documented based on the coded data extracts were comprehensive and pertinent to the research question, as well as internally consistent.

The table provided a basis for the formulation of questions and topics for the focus group discussion with staff welfare experts. The focus group discussion was then transcribed and analysed also using Atlas.ti, with no additional themes or sub-themes being identified.

Quantitative

Frequencies and proportions for each response option in each item of the survey were calculated using the GNU PSPP software.

Results

Qualitative analyses

Aiming to provide a rich overall description of the qualitative data corpus, most themes (barriers), data items (transcripts) and a number of the data extracts (coded items/quotations) are touched upon. The aim is to demonstrate the broad but interrelated nature of experiences within a heterogeneous group such as humanitarian aid workers, whilst trying to retain the nuanced and idiosyncratic elements of those experiences. However, it's not possible to delve into every barrier in detail, so for further information on the themes and sub-themes, see table 4.

Table 4. Themes and subthemes identified through interviews and focus group, definition, occurrences, examples, and reasons for fitting

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
1	Accessibility	Psychosocial knowledge & understanding of what support is needed (psychoeducation)	Knowledge of types of MHPS issues & appropriate support required (requires self-awareness & general MHPSS knowledge)	38	"I think there are some institutional barriers or lack of knowledge sometimes."	Comment relates to the lack of knowledge within organisations (individuals' knowledge) of MHPS issues & how to resolve them or seek help for them.
		Cost of regularly seeking psychosocial support for individual (accessibility limited)	If organisations don't have funds available or if health insurance doesn't cover the costs (real & perceived costs by individuals)	5	"Yeah I'm sure it would affect, like, how many times I went for counselling or something like that. Yeah it would probably limit me going in the first place, but it would definitely limit how often I went back, even if it was still being helpful. I would probably try to limit that."	Clear impact of cost on individual's willingness to seek regular support.
		Cost of providing psychosocial support for staff by organisations (accessibility limited)	Suggested or known costs leading to not being included in proposals (restrictions or assumed restrictions by donors)	11	"We don't usually budget for staff wellbeing, just because it's not something that we systematically do."	The fact that budgeting for staff welfare is uncommon means there is an implicit unwillingness to include it in proposals to donors, reducing likelihood of availability and therefore access of support.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
		Accessibility (physical) e.g., internet, phone, location	Practical or logistical barriers (real) hindering help-seeking or accessing help	27	"A lot of our national staff don't have email addresses. So only like a certain level of staff have access to computers and have an email within [the organisation]. And so, I think a lot of people don't have access to a lot of things."	Depiction of some physical barriers, specifically for national staff, in accessing support.
		Supervisor / employer blocking access to psychosocial support (e.g. time / funds)	Restricting access to systematic support (e.g. R&R), making it difficult to take time off, not being forthcoming with suggestions or funding opportunities for PSS	22	"I remember asking in a previous role, my manager if there was psychosocial support for people if they needed it, and the reaction I got was, "Why do you need it?". And I felt like that wasn't a very enabling reaction, it was almost like a kind of half kind of laugh, I'm not saying, maybe it just made her feel awkward as people have awkward laughs."	The role of superiors within an organisation in providing or restricting access to support is clear through the attitude during questioning, and the hesitant nature with which information was provided (or not, as the case may be).
2	Appropriateness	Quality & appropriateness of psychosocial support (& service providers)	The real & perceived relevance and quality of the support (context / audience)	48	"Probably perceptions of value. Perceptions of 'What's gonna be the actual benefit?', those types of things. With Psychosocial support it can be also hard to measure the impact of psychosocial activities, it's not like you provide an antibiotic and you're better, it	Either the real quality of support provided or in this case the perceived 'worth' of accessing support, whether it will be relevant to the individual, what's the purpose and aim, and how can you measure

Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
				helps people with a pathway to recover or whatever."	whether it's 'done what it set out to do'.
	Exclusion of people with minor psychosocial issues (pathologising problems)	Individuals declined support or unable to access appropriate support due to problems 'not being big enough' or inappropriate treatment (linked to availability or appropriate support & deprioritising self - not seeking support as downplaying own problems)	6	"So it means they only go for the people who are extremely involved in bad things."	Strong statement on the prioritisation of people with severe mental health issues, such as PTSD, rather than acknowledging the preventative measures of supporting those with seemingly minor issues.
	Different coping mechanisms & different PSS needs (due to different cultural / traditional beliefs around seeking support for mental health issues)	Closely linked to traditional & cultural beliefs, national & international aid workers can have different views about MHPSS as well as different coping mechanisms requiring different support (& different stressors e.g. home duties - national staff)	68	"They also have a different way of relaxing."	Simply depicted by the fact that national and international (and both these groups) have different coping mechanisms and different cultural and individual needs that should be acknowledged by providing PSS that doesn't have blanket coverage as it

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
						won't be relevant to everyone.
3	Attitude	Judgement around psychosocial issues & seeking support	Closely linked to macho attitude, but around actual judgement of MHPS issues & seeking support	59	"This, I think goes back to how organisations perceive psychosocial support and also the level of support that people have. Are we talking about, psychosocial counselling or medical mental health care? And then, this is where that grey area comes about, or are we talking about a one off critical incident stress debriefing?"	Perceptions of MHPSS in itself, rather than the macho attitude, more related to the negative connotations of MHPSS specifically. This statement exemplifies the thoughts about organisations judging MHPSS, which is linked to the sectoral attitude.

Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
	Self-care seen critically	Linked to judgement, but more specifically about criticism of taking care of one's self (e.g. finishing work on time)	12	"The sector attracts people who are naturally empathic, and have a lot of compassion, so it's almost like you feel guilty taking time out for yourself and taking care of your own wellbeing and I think the focus needs to be in any induction process, or even before you get to that stage, just really encouraging individual aid workers that it's okay to love yourself and these are some of the things that you can do when you go, before you go, and when you're in the field, to take care of yourself."	Self-care and self-love or self-appreciation being considered negatively by aid workers due the nature of the work and the type of focus they should or do have (on others / empathic).
	Seeming weak or unfit to work (& feeling the need to be more tough)	Closely linked to judgement: a real perception by peers, subordinates or superiors that the individual is unfit to work or a fear of this by the individuals	54	"People are scared of thinking when they show that they are vulnerable that they are not competent."	The connection between stigma (discrimination because of MHPS issues), self-perceptions & external judgements on ability to do the job (competency).
	Organisational / sectoral culture (suppressing emotions / avoidance as coping)	Linked to organisational /sectoral attitude (macho) but more related to the culture of suppressing emotions as a way of coping	38	"There's also a culture, I guess that's another part, the culture of erm, emergency peers, the culture of coming together and drinking and, having parties here, but erm, so people talk but not enough."	The culture around repressing (unconsciously) or suppressing (consciously) psychosocial issues & avoiding them through activities such as drinking.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
		Organisational / sectorial attitude (superhero / macho)	Attitude of aid workers, about aid workers, and the high expectations of 'toughness'	67	"Shame, but also the culture. You know, it is 'shape up or ship out'. The whole culture is, 'if you can't manage, resign'"	Succinctly describing the macho culture around having to be tough to be an aid worker.
4	Availability	Knowledge of what's available & how to seek it	Closely linked to actual availability of support (perceptions of what's available is a real barrier to seeking)	57	"I think that really depends on how long the person's been in the system and how much they look for information on this issue."	An example of perceptions of who knows more about how to seek support, and their knowledge of the organisation.
		Availability of sources of help	The actual availability of psychosocial support & communication of that support	22	"I think first of all, the barriers, to me, the opportunities are not there. The service providers are not there."	Clear statement about the lack of availability in some contexts.
		Prioritisation of psychosocial support by organisations (planning / budgets)	PSS not prioritised in proposals, with donors, in budgets, therefore not available (no finances, resources, or personnel)	28	"So generally, I would say there is no investment in psychosocial support on the part of humanitarian agencies."	Linked to Duty of Care but in relation to the knock-on of lack of availability due to not investing in PSS or prioritising it during planning processes.
		Lack of normal social support networks - reduced help-seeking (normal sources unavailable)	Not able to engage with normal psychosocial support mechanisms or not willing to (due to lack of understanding)	13	"Exactly. So I think that's what stopped me. It's probably what's stopping me now, as well. I don't like being reminded of a lot of stuff though you know. People are asking me now, "What's wrong?" and "What happened?" and it's really hard, especially with your	Not having your normal social support networks nearby, but also them not understanding your situation which limits you utilising them as you normally would as a first response to stress - illustrated here.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
					family, and they really don't get it."	
5	Confidentiality & trust	Confidentiality & trust relationships	Closely linked to feeling heard by the organisation - trust relationship & actual confidentiality kept (as well as perceptions of confidentiality) by HR / Security / Service Providers (impartiality of service provider)	43	"People come out with issues and I think some of them are worried that it might go to HR and then HR could take some actions to inadvertently help the person but could also create challenges, particularly if people don't want things documented in their personnel file."	Fear or reality of HR or other internal focal points not keeping information confidential, and the possibility of a knock-on effect on their career opportunities or relationships in the organisation.
		Feeling heard by the organisation	Not feeling like an asset but an individual and being willing to voice issues (requires trust)	22	"I think it's not only me or someone else who is keeping quiet. I think a number of people, both nationals and internationals who need support, but I think they have no, they don't know, they have no one to turn to."	Not feeling like they are heard when they try and speak up, or not feeling the people are there to listen to them in the first place.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
6	Duty of care	Preparedness (individuals & organisations) & information during orientations	Employer providing quality preparation (information & training) & individual taking steps for self-care (time / attitude issue)	13	"It's quite hard to know at what point you have your barrier, and it's quite difficult to manage that as well because sometimes you don't know who's going to affect you and who isn't."	The clear need for the organisation to provide support and training in the early days because individuals only know so much about what they may face and the resources they may need.
		Optional, ad hoc, reactive PSS (not systematic or well-known)	Linked to employer duty of care to provide & communicate quality psychosocial support for staff. Ad hoc, responsive activities are often poorly communicated (about what they are, who they're for, and when) and therefore underused	31	"I do think, one possibility for making it kind of a more acceptable part of humanitarian work would be to make it not optional."	The desire for PSS to be an integral part of humanitarian work, rather than a response action is clear.

Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
	Supervisor / employer blocking access to psychosocial support (e.g. time / funds)	Restricting access to systematic support (e.g. R&R), making it difficult to take time off, not being forthcoming with suggestions or funding opportunities for PSS	22	"I wasn't really happy about that. I was being made to jump through hoops. I realised after it was approved it was jumping through hoops and my line manager wouldn't have denied my leave but I felt it was really insensitive at the time of having just admitted that I'm not doing okay, then there was like a huge task with a one day deadline for producing this document to prove that I can go on leave. It was just pretty insensitive."	The Duty of Care of the employer and Supervisors in positions of authority to provide quality PSS, rather than restricting access to external or internal PSS resources or even personal coping mechanisms. Distinct hindrance in the ability to access support, due to the perceptions of impact on career and working relationships.
	Prioritisation of psychosocial support by organisations (planning / budgets)	PSS not prioritised in proposals, with donors, in budgets, therefore not available (no finances, resources, or personnel)	28	"For me generally I think the whole organisation doesn't have that support structure. Whether for nationals or internationals, across the board it's all the same. It's like mainly, if they realise there's a problem, it's not that the organisation takes responsibility to provide the service, but it's rather like a buddy group, you know people, like friends."	Duty of Care of organisation to prioritise PSS for their staff, from proposals to implementation, rather than solely relying on individual and peer support (informal).

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
		Employer duty of care to inform, communicate, & provide support	"Paying lip service to psychosocial support" or "tick-boxing" but quality & regularity of information-sharing, communication of what's available and direction to or direct provision of support lacking	132	"I think communication from internal departments needs to be clear that some services are available, for example the agency I work in now, there is a clinical psychologist on call for all staff. Do the staff know that she's there... Mmm... yes and no, do they use the support process, probably not because it's difficult to call them, they're in a different country and lots of other factors."	Employer's role in informing people, regularly, about the support that is available, as well as making sure that support is available and is of good quality (appropriate), so it's not just about 'saying they've done it'.
7	Guidance	Reduced rational decision-making when under stress (needing support but unable to seek it)	Requiring direction or guidance from others due to decreased ability to manage self under high stress	6	"I think there's like, blinders when you're in that position, to rational thought. I mean, for example, I saw self-tests for stress, self-tests for burnout, and I went through them and all of those things are common sense and I should be able to identify them anyways as symptoms of burnout and symptoms of stress."	Clear depiction of how people don't know how to care for themselves in the best way when they are highly stressed. Normal coping mechanisms may not be enough, but they are too burnt out or exhausted to realised exactly what is needed, so require guidance.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
		Quality direction / guidance e.g., senior management / supervisor & having skills to help	Role of supervisor in directing staff to support when symptoms of high stress recognised	59	"I think in my case it had to be really bad, but I also, I think looking back, I was waiting it out expecting that someone should have noticed or should have said something, and so a lot of the waiting was also kind of, just expecting that sooner or later someone would, and then eventually when they didn't and things still were really bad I decided I should bring it up."	Requiring support from a person in a position of authority to provide guidance to the relevant PSS.
		Senior management / supervisor as role model for coping mechanisms	Often negative role models through things like e.g. drinking heavily, negative attitude towards being weak/taking time for self-care (R&R etc), ignoring MHPS issues	22	"...there are some organisations where it is kind of cool to say that you do not go on R&R because you're too busy, and I find that always very concerning, especially when senior management are doing that, because they kind of set the pace or set the norm, and then other people feel guilty that they are so weak to go on R&R."	The explicit and implicit role of Supervisors for staff members in providing guidance and showing them how to care for themselves. Clear how they present themselves affects the way junior staff act or cope.
8	Normalisation / avoidance / comparison / deprioritising	Normalisation & 'wait & see' coping	Personality trait where individual considers their issues to be not 'bad enough yet' which leads to reduced help-seeking	18	"It would have to be really, really serious before I signalled something was wrong."	Illustration of how people wait until it's too bad to cope with anymore, rather than seeking support as a preventative measure.

Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
self / downplaying own issues	Compartmentalisation, detachment & avoidance as a coping mechanism	Personality trait (linked but different to 'wait & see' coping) which leads to reduced help-seeking	28	"I mean you see so many distressing things, people are in a lot of really terrible situations, and if you emotionally connect with all of them, I find it overwhelming. Some people are able to do that; I am not."	Linked to the culture of suppressing issues, but more about specific individual experiences of detaching for emotional reasons - such as this statement about finding it overwhelming and avoiding it.
	Comparison with others (beneficiaries / national staff) as 'benchmark'	Comparisons with people 'worse off' leading to a to reduction in acknowledging impact of own MHPS issues, and reduced help-seeking	16	"They think, ‘what right do I have to take a day off when all around me, people are being attacked’ and all the rest of it."	Direct comparisons to either beneficiaries or national staff as a benchmark for your own suffering.
	Guilt about taking time to focus on selves	Linked to comparison to others & deprioritising own needs due to guilt	26	"When there is this inequity in the service provision, even the things that are being done are tainted by that feeling of, ‘why do I get this and the people around me don’t?’."	The guilt connected to focusing on themselves, linked directly to comparing with others.
	Downplaying or belittling own issues	Linked to comparison to others, deprioritising own needs & 'wait & see' coping where people belittle their own issues (sometimes in comparison with others')	12	"When they have issues with security they say “Yeah yeah we have difficulties with security, but our [national colleagues] are just living as vulnerable as everybody else but they don’t have the money so who am I to complain?”"	Deprioritising own issues due to the comparably worse issues impacting on national staff or beneficiaries. Downplaying own suffering as it's 'not as bad'.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
9	Past experience	Past experiences of seeking or obtaining psychosocial support	Negative experiences in asking for help (& not getting it) or receiving help & it being inappropriate (or too emotionally exhausting)	9	"The people I know who have engaged in therapy or some sort of counselling remotely have often found it to be, not in a bad way, but really disruptive initially because it caused them to engage with their emotions in a way that can be surprising and have unexpected results, so exactly as you said to open that can of worms and then leave could potentially be difficult to manage."	Either negative experiences of internal or external PSS, or negative impressino of accessing that support due to emotional impact during working time, as this statement represents.
10	Repercussions	Impact on working relationships (fear of)	Jeopardising professionality of relationships and perceptions of ability to cope by peers, subordinates & supervisors	16	"We think, our relationship should be professional, but we cannot be like this, we cannot easily, because it is our personal issue. So, we think like this, line manager can think, 'I am not able to maintain these tasks, or I am not responsible for many other things' maybe."	The fear of the impact on the working relationship (often superior & junior staff), perceptions of competency and respect.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
		Impact on career (fear of)	Often there are perceptions of (or actual) repercussions on future or current career progression including direct (or perceived) impact on employer's ability or willingness to clear staff for high pressure environments, field visits etc	34	"People might be reluctant to come forward, because it could be recorded in their professional file and it may affect their future prospects, particularly if the case is related to a breach of security or breaking the curfew, where you know, they've accidently stayed out for ten minutes past curfew, then something bad happens, then there's that particular aspect of it."	The direct impact or fear of the impact on the current career progression or opportunities (e.g. field/security clearance), or future career prospects due to documentation.
11	Self-awareness	Self-awareness & appraisal of need for support	Perceived need for support (after ability to recognise need / signs of stress) can be a real barrier to seeking - first step in help-seeking process	66	"I think also it's quite hard to know when you're suffering or when you need help."	Clearly demonstrated how self-awareness impacts on ability to seek help.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
12	Self-reliance	Fear of worsening problem/emotional exhaustion of seeking support	Linked to self-reliance and wanting to manage self & own problems (repercussions of seeking help on self)	11	"I think a lot of people for various reasons don't actually want to seek the help, and I think part of that is due to the fact that this work can be really emotionally exhausting, and for some people, myself included, it's easier not to engage in any sort of profound way with your feelings or stress level, because that makes it harder – for me – but I've also met other people who feel this way, to go about your day-to-day work because it's just too exhausting. "	Clearly described as a fear of seeking help during a deployment because it's 'easier not to engage'.
		Preference for self-reliance	Not wanting to resort to external support	25	"I normally manage, or if I have issues I raise it among my peers and we discuss it and it's done. Sometimes, I speak to my brother, and the good thing I do is I don't hide any problem, if I have problem I don't hide I just say to people, "See I am having a problem" and immediately people are just, "Ah, just you have to do this do this", and that's that. Yeah."	Often, individuals prefer to be self-reliant than depend on others for support or ask for help, as described.

	Themes	Sub-themes	Definition	Occurrences	Examples	Reason for example fitting sub-theme
13	Stigma	Self- or social- stigma	Feeling discriminated against due to seeking support (linked to seeming weak/attitude) or stigmatising self	21	"Maybe I have some internal feelings about it but I don't think among my peers or in the workplace I've seen stigma related to seeking help. That said, I haven't really seen or known of anyone seeking help. So, and maybe people are but they're keeping it a secret because of that."	The view that stigma doesn't occur, but also a realisation that people don't talk about seeking help and the implication that this might be due to fear of stigma.
		Feeling isolated (like the only one feeling that way)	Comparing to others & seeing self as weaker, therefore not seeking support (stigmatising self & own issues)	8	"They think they are the only one who's not sleeping in the night. They think they're the only one who is having heart palpitations. They think they're the only one who has difficulties with bad dreams."	Feeling alone in suffering, and not knowing that others are going through it, so not discussing it, and not seeking help for it (or seeking help and feeling alone during the process).
14	Time	No time to think about self or self-care or to research & seek external support (overwhelming environment)	Due to nature of the work, realistically very little time to provide self-care or think about own needs (e.g. no time to rest) or to research, seek, & regular access PSS	45	"I think the workload and the time and the judgement are institutional, and there's not much you or the organisation can do to change that."	The institutional nature of the sector is described, and how this links to time scarcity (or the impression of time scarcity due to pressure).

MHPSS: Mental Health and Psychosocial Support

Fourteen barriers to accessing psychosocial support for aid workers emerged. The themes identified were a variety of personal, professional, and environmental barriers that hindered aid workers from seeking out or accessing support for their wellbeing, with the most prominent barrier, as hypothesised, being the 'macho/martyr' attitude within the sector, followed by the Duty of Care of the employer.

The 'macho/martyr' attitude, often also referred to as a 'superhero' or 'martyr' attitude, was the strongest barrier for aid workers, arising 230 times during the qualitative analysis. Participant AK stated very succinctly:

> *You know, it is 'shape up or ship out'. The whole culture is, 'if you can't manage: resign'.*

And for BD, it appeared that the 'macho/martyr' attitude is one that filters down from senior management or supervisors, that it's not just a peer culture but also a hierarchical one:

> *Because it's tough to get in they feel like the people below them have got to be tough as they had to be tough to get there. You know, it perpetuates.*

From the focus group discussion, P5N equally reflects this sentiment:

> *If I reflect on my own journey, one of the things that I've seen not only from myself but also from others around me, it fits in within the superhero culture. There is a massive peer pressure culture that we have.*

This pervasive, negative attitude that is intrinsic within the humanitarian sector is directly connected to the employer's Duty of Care to prioritise the wellbeing of their staff. This barrier was the second most prevalent, with 226 items coded under this theme. The two come hand in hand, especially given the filtering down of negative attitudes from superiors to subordinates. According to EH, a female, national aid worker:

> *Organisations really have some responsibility, because they need to ensure the staff's wellbeing, because otherwise staff will not be able to provide their best output, or it may really have an impact on the activities of the organisation.*

This comment clearly demonstrates that Duty of Care is seen as a priority for ensuring the wellbeing of staff, and that employers who don't take this responsibility seriously are

reducing the likelihood of their staff seeking support. It is also the responsibility of supervisors and senior management, as part of the organisational Duty of Care, to guide their staff, to be able to identify when there is a problem and when they need support, and signpost them in the right direction, as explained by BD:

> *I have a slight bugbear that I think people get promoted into managerial positions because they're good at their job and they have experience, but it doesn't necessarily make them a good manager*

It is, however, obsolete, for managers to direct aid workers towards support if the support available is not appropriate, relevant, or of value to the individual, as raised by PT:

> *Probably perceptions of value. Perceptions of 'What's gonna be the actual benefit?', those types of things. With Psychosocial support, it can be also hard to measure the impact of psychosocial activities.*

This is relevant as it illustrates how 'tick-boxing' when it comes to psychosocial support and wellbeing will only go so far, as if the substance isn't there or if a service is provided superficially, aid workers will not benefit or will not seek support in future, as summarised by MF:

> *Now a lot of organisations at least pay lip service to the importance of psychosocial support and not being burnt out and paying attention to your own wellbeing, but they also create structures in which we're all working 20 hours a day and are incredibly stressed out and doing multiple jobs at one time.*

Connected to the appropriateness of support is the actual availability. There are levels of availability: if individuals don't know what's available, that is one thing, but if there are physically no services available that is a deep-rooted issue for the sector. Very simply stated by participant PP, a male, national aid worker:

> *I think first of all, the barriers, to me, the opportunities are not there. The service providers are not there. Generally humanitarian agencies don't invest in psychosocial support work; they don't have specialists who are hired to do the job.*

Another national aid worker, EH, this time female and from a different location, mimicked this response:

> *I think there was nothing available because that time it was really difficult time for me. I had to maintain many roles at the same time, but no one could help. There was no assistance, no support.*

The fact two national aid workers explicitly state that the lack of services available to them mean they aren't able to seek out psychosocial support is a concerning trend which is already acknowledged on a larger scale in the humanitarian sector (McFarlane, 2004). The accessibility of support that *is* available was also considered a relevant barrier. This includes physical access, as well as cost, lack of knowledge, and the blocking (or making difficult of accessing) support by supervisors.

The remaining barriers, normalisation ('wait and see' coping, until it's 'bad enough' to require help), self-awareness, desire self-reliance, fear of repercussions (on relationships or job security), and the perception of past experiences of seeking or accessing support are all personal barriers or personality traits that appear to be universal and commonplace within the aid worker population. Other barriers, which were a combination of personal, professional, and environmental, were perceived (or real) issues with confidentiality and trust relationships, self and social stigma (real or perceived), and insufficient time. All of these barriers described, and quotes expressed, effectively highlight the situation for aid workers in terms of the personal, professional, and environmental barriers that hinder them from seeking or accessing psychosocial support for their wellbeing. As hypothesised, the most prevalent factor was the 'macho/martyr' attitude, raised by all participants across the qualitative part of the study.

One noteworthy finding was that, even being aware of having distress, people still were in need of guidance and support. Participant LJ eloquently describes this:

> *I was self-aware to know that I wasn't okay, but I didn't know exactly how I wasn't okay, and I didn't have any sort of clue about what would make it better, or what I needed to do personally to make it better, or what I needed help doing to make it better.*

This unequivocally demonstrates the need for supervisors and senior management to better understand the needs of their staff, and to not assume that individuals can assess their own needs and respond effectively when they are experiencing stress or burnout.

Quantitative analysis

Percentages of each Likert answer option for each item can be seen in table 5. Most respondents said they had good knowledge of the type of psychosocial issues an aid worker might face while on deployment, with 47% saying they knew what support was available to them, and 56% saying they knew how to seek it out and access the available support. These results are interesting as they contradict the information provided in the qualitative portion of the study. They also are inconsistent with the seeming realities in the sector, which show that individuals often don't know what support is available to them.

In relation to the sectoral attitude or culture (e.g. 'macho/martyr'), 82% of respondents said they felt there was a culture of suppressing emotional issues, however only 32% said they personally felt they suppressed emotions, and 84% said they felt there was a culture of avoidance, with only 26% saying they personally engaged in avoidant activities.

This incongruence between how individuals see themselves and how they view the rest of the aid worker population is a great insight into needs and ways to engage individuals in psychosocial support activities. 56% of respondents said they think that aid workers are not very self-aware when it comes to recognising when they're under stress, however, only 19% of respondents said they personally felt they were *not* self-aware. This, again, is a noteworthy disparity, as it suggests that aid workers have a cognitive bias called 'illusory superiority' when it comes to their enhanced (and possibly erroneous) view of themselves and their ability to cope, as opposed to their view of the rest of the aid worker population (Hoorens, 1995).

Of all 62 respondents, 68 percent said they believe there is a 'macho/martyr' attitude in the humanitarian sector. However, only 21 percent said they believe they personally held this attitude. Worryingly, 58 percent of people surveyed said they felt the need to be tougher in the humanitarian sector than they actually felt, which seems to be intimately connected to the 'macho/martyr' attitude. 73 percent of participants believed that their organisation had a Duty of Care to provide them with psychosocial support and 74 percent said employers have a responsibility to communicate what support is available regularly to their staff.

Table 5. Percentage frequency distribution of respondents' level of agreement with the items of the survey.

Theme	Order*	Text of the item	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Potential issues with accessing psychosocial support	1	I understand the concept of psychosocial wellbeing	1,6	1,6	3,2	46,8	46,8
	2	I have good knowledge of psychosocial issues an aid worker might face when on deployment/in the field	0,0	3,2	6,5	41,9	48,4
	3	I have good knowledge of a range of resources or services that might be useful for psychosocial wellbeing	1,6	14,5	27,4	37,1	19,4
	4*	I believe that psychosocial support can cost a lot of money to access on a regular basis	4,8	21,0	29,0	37,1	8,1
	5*	The cost of accessing psychosocial support is something that would hinder me from accessing it in the first place	6,5	48,4	19,4	21,0	4,8
	6*	The cost of accessing psychosocial support is something that would hinder me from accessing psychosocial support on a regular or long-term basis	4,8	30,6	19,4	40,3	4,8
	7*	Physical barriers such as the language used by service providers, the services themselves, internet access, a private space to talk, and quality of network (phone) connection would likely be a problem in accessing psychosocial support for me	1,6	25,8	6,5	43,5	22,6
	8*	Physical barriers (as above) are likely to impact on national aid workers more than international aid workers	1,6	12,9	21,0	30,6	33,9
	9*	Supervisors or employers restricting, or making it difficult for me to access psychosocial support, would prevent me from seeking support (either in that instance or in future)	12,9	35,5	14,5	27,4	9,7
The relevance of types of psychosocial support	10*	My perceptions of the quality of psychosocial support available would deter me from accessing that support	8,1	16,1	16,1	53,2	6,5
	11*	My perceptions of the appropriateness or relevance of the psychosocial support to me, in my situation, would deter me from accessing that support	8,1	22,6	16,1	46,8	6,5
	12*	I believe that organisations I have worked with prioritise people with 'serious' mental health issues, such as people suffering from post-traumatic stress, rather than focusing on all people suffering from stress	1,6	24,2	21,0	33,9	19,4

	13*	Organisations prioritising 'serious' mental health issues over the day-to-day stress that builds up, makes me less willing to speak up about difficulties I'm having and asking for help	4,8	24,2	27,4	33,9	9,7
	14*	Organisations prioritising 'serious' mental health issues over the day-to-day stress that builds up, makes it difficult for me to access psychosocial support without being feeling I have to be 'diagnosed' with something	4,8	19,4	29,0	33,9	12,9
	15*	I believe that national and international aid workers have different psychosocial needs, due to different stressors, and also have different coping mechanisms to handle those stressors	1,6	14,5	12,9	51,6	19,4
	16*	I believe that national and international aid workers have different coping mechanisms to handle different stressors they may face	0,0	9,7	11,3	61,3	17,7
	17*	The difference in needs and coping mechanisms for national and international aid workers makes it difficult for organisations to provide psychosocial support that is relevant to everyone	14,5	38,7	19,4	17,7	9,7
Humanitarian sector attitude	18*	I believe there is judgement around mental health and psychosocial support within my organisation or organisations I have worked for in the past	9,7	29,0	12,9	29,0	19,4
	19*	I believe that judgement around mental health and psychosocial support within my organisation would stop me seeking or accessing support for my wellbeing if I was under stress	6,5	51,6	11,3	24,2	6,5
	20*	I think taking time to look after yourself (e.g. finishing work at 6pm, taking evenings and weekends off, doing activities that you enjoy outside of work etc.) is not appropriate/possible given the work I do	25,8	17,7	8,1	40,3	8,1
	21	I think I can be critical of aid workers who take time to look after themselves in the middle of a deployment (e.g. by taking time off, finishing work at 6pm, socialising etc.)	43,5	33,9	8,1	12,9	1,6
	22*	I am fearful of seeming weak to my peers if I ask for support for my wellbeing	19,4	38,7	9,7	27,4	4,8
	23*	I am fearful of seeming weak to my superiors/supervisor if I ask for support for my wellbeing	12,9	40,3	4,8	33,9	8,1
	24*	I constantly feel the need to 'be more tough' in this sector	6,5	29,0	6,5	48,4	9,7

	25*	I think there's a culture of suppressing psychosocial/emotional issues (i.e. consciously hiding or burying issues and not facing them) in the humanitarian sector, rather than dealing with them	0,0	9,7	8,1	51,6	30,6
	26*	I think there's a culture of avoidance (i.e. doing activities that distract people from their psychosocial/emotional issues) in the humanitarian sector (e.g. drinking heavily)	1,6	4,8	9,7	40,3	43,5
	27*	I think I am the kind of person who suppresses my psychosocial/emotional issues when I'm on deployment	8,1	38,7	4,8	40,3	8,1
	28*	I think there is a 'macho' (also often called a 'superhero' or 'martyr') attitude in the humanitarian sector, where aid workers feel they should toughen up and not show emotions	0,0	11,3	14,5	56,5	17,7
	29*	I think I have a 'macho' attitude when I work in the humanitarian sector	12,9	46,8	17,7	21,0	1,6
Availability issues	30	I know what psychosocial support is available to me from within my organisation/externally, outside of my organisation (e.g. online/back home)	3,3	13,1	1,6	50,8	31,1
	31	I know how to seek different types of psychosocial support if and when I need them	1,7	21,7	15,0	43,3	18,3
	32	There are options available for me to access if I need psychosocial support from within my organisation	0,0	18,6	10,2	52,5	18,6
	33	There are options available for me to access if I need psychosocial support from outside my organisation (e.g. from the Internet/recommendations from friends)	2,0	13,7	9,8	51,0	23,5
	34*	My normal social support networks are not available to me when I'm on deployment	6,8	39,0	11,9	33,9	8,5
	35*	My normal social support networks do not understand what I'm going through when I'm on deployment (or after I return home)	1,8	23,2	10,7	32,1	32,1
	36*	Not being able to easily access or discuss my psychosocial/emotional issues with my normal social support networks stops me from discussing my problems or seeking further support	3,4	37,3	11,9	32,2	15,3
The confidentiality of support	37*	Perceived lack of confidentiality (e.g. believing that information could be passed onto others without my consent) is something that stops me asking for psychosocial support within my organisation	11,3	27,4	14,5	33,9	12,9
	38*	Work relationships that lack trust (e.g. between Supervisor and Supervisee & between Staff & HR), would stop me from seeking psychosocial support	6,5	17,7	9,7	51,6	14,5

	39*	I feel that I am not really heard in my organisation if I speak up about my psychosocial/emotional issues	6,5	40,3	22,6	19,4	11,3
	40*	Feeling like an 'asset' to the organisation, rather than an individual person, stops me from speaking out about psychosocial/emotional issues or asking for support	6,5	35,5	17,7	25,8	14,5
Employer's duty of care to support aid workers	41*	I feel like I haven't prepared myself well enough for the field (e.g. by preparing my self-care resources or tools, by learning about stress and trauma, by ensuring I have a social support network to talk to)	17,7	45,2	14,5	22,6	0,0
	42*	Optional psychosocial support means I am less likely to seek out or access help, compared to mandatory support (that I could cancel if I really didn't want it)	8,1	17,7	17,7	43,5	12,9
	43	I believe NGOs have a Duty of Care towards their employees to ensure they have good wellbeing and that psychosocial support is available to them	0,0	1,6	0,0	24,2	74,2
	44	I believe an employer has a Duty of Care towards its staff, and should not just 'pay lip service' or 'tick boxes' when it comes to their wellbeing	0,0	1,6	1,6	32,3	64,5
	45	I believe an employer should regularly communicate to all staff the availability of relevant, quality, and accessible psychosocial support	0,0	0,0	0,0	33,9	66,1
Guidance from others	46*	When I am really stressed or burnt out, I don't know what kind of support I need	3,2	38,7	14,5	37,1	6,5
	47*	When I am really stressed or burnt out, I don't know how to find the support I need	3,2	41,9	17,7	35,5	1,6
	48	When I am really stressed or burnt out, I want to know that my Supervisor or someone else in my organisation is looking out for me and can guide me to the relevant psychosocial support I might need	0,0	8,1	4,8	62,9	24,2
	49	I think it's important that my Supervisor has some knowledge about psychosocial issues and is able to guide me to relevant support if I need it	1,6	4,8	1,6	56,5	35,5
	50	Senior Management are important role models for psychosocial wellbeing, especially to their Supervisees or to junior staff	0,0	1,6	12,9	37,1	48,4
	51	If Senior Management display negative coping mechanisms (e.g. heavy drinking, not going on R&R), then I am less likely to ask them for help	0,0	8,1	12,9	37,1	41,9
	52*	If Senior Management display negative coping mechanisms (e.g. heavy drinking, not going on R&R), then I am likely to do the same	17,7	40,3	12,9	22,6	6,5
Personal barriers to	53*	I tend to 'wait & see' with my issues, rather than speak up early on or ask for help when I start noticing I am stressed	3,2	27,4	12,9	43,5	12,9

seeking support	54*	I wait until my issues are 'really bad' before I seek or access psychosocial support	8,1	22,6	17,7	37,1	14,5
	55*	I think I am the kind of person who avoids my psychosocial/emotional issues when I'm on deployment (e.g. engages in behaviours like heavy drinking to escape thinking about them)	22,6	38,7	12,9	24,2	1,6
	56*	I think I am the kind of person who detaches from psychosocial/emotional issues when I'm on deployment (e.g. when I feel an emotion I separate myself from it)	9,7	30,6	17,7	33,9	8,1
	57*	I think I am the kind of person who compartmentalises my experiences when I'm on deployment (e.g. I focus on work, and don't focus on my emotional responses)	6,5	30,6	16,1	35,5	11,3
	58*	I sometimes compare myself with others (i.e. beneficiaries or national staff) who are often 'worse off', which leads to me feeling like my issues are not bad enough to seek help	12.9	19.4	16.1	38.7	12.9
	59*	When I compare my issues to people who are 'worse off' than me, I feel guilty about taking time to look after myself (e.g. R&R/weekends off) or asking for help	12.9	37.1	19.4	19.4	11.3
	60*	I often downplay my own psychosocial issues, thinking they're not such a big deal, putting myself down or belittling myself for complaining when there are people suffering more than me	9.7	21.0	17.7	40.3	11.3
Previous experience with psychosocial support	61*	If I have a negative experience with asking for help (and not getting it) or receiving help that is not relevant to me, not appropriate for the context, or not of good quality, I am unlikely to seek help again in the future	6.5	22.6	24.2	35.5	11.3
	62*	If my past experiences of seeking help for my psychosocial wellbeing have been too emotionally exhausting while on deployment, I am unlikely to seek help again in the future	4.8	30.6	27.4	25.8	11.3
Impact on career or relationships	63*	I am worried that if I seek support for my psychosocial wellbeing because of stress, that I will jeopardise my professional relationships and will be perceived as incompetent or unable to cope by my subordinates, peers, or superiors	9.7	27.4	19.4	29.0	14.5
	64*	I am worried that if I seek support for my psychosocial wellbeing because of stress, that it will impact upon my current career progression (e.g. security clearance, future responsibility delegation), or my future career prospects (e.g. recruitment)	8.1	29.0	16.1	27.4	19.4
Limits to self-awareness	65	I believe that humanitarian aid workers are not very self-aware and are not always able to recognise when they're under stress and when they need support	1.6	12.9	9.7	58.1	17.7

	66*	I believe I am not particularly good at being self-aware about my wellbeing so am not always able to recognise when I'm under stress and when I need support	12.9	54.8	6.5	24.2	1.6
The desire to be self-reliant	67*	I would be concerned about seeking psychosocial support while on deployment in case it worsened my emotional state	12.9	24.2	12.9	43.5	6.5
	68*	I always prefer to be self-reliant when it comes to my own wellbeing, and would avoid seeking help initially because I want to be able to take care of myself	4.8	27.4	14.5	45.2	8.1
Stigma as a barrier	69*	I think that I would feel self-stigma for seeking psychosocial support for my wellbeing (e.g. I would feel ashamed and like I was not able to do the job)	19.4	48.4	1.6	29.0	1.6
	70*	I think that there would be social stigma from seeking psychosocial support for my wellbeing (e.g. subordinates, peers, or superiors discriminating against me or changing the way they act/work with me)	6.5	38.7	16.1	30.6	8.1
	71*	I often feel like I'm the only one experiencing psychosocial issues, and this makes it harder for me to access psychosocial support	16.1	48.4	16.1	17.7	1.6
Time as a barrier	72	Due to nature of the work, there is realistically very little time for self-care or to think about my own psychosocial wellbeing	3.2	14.5	12.9	51.6	17.7
	73*	Due to the nature of the work, there is realistically very little time for me to research what support is available, to seek it out, and to access it regularly	0.0	17.7	11.3	62.9	8.1

*Items whose score is considered inversely proportional to seeking help attitudes have been marked with an asterisk. **For each item, the two highest frequencies have been shaded for easy reference.

Discussion

Our results clearly show that there are real and perceived repercussions for aid workers who seek out or access psychosocial support, including the impact on their professional (peer and supervisor) relationships, as well as the impact on their career progression. It is also clear that time is a barrier, both the perception that there is not enough time for self-care or support, or for committing to access the support on a regular basis. Finally, the personality traits that are common within the sector that reduce aid worker's willingness to engage with psychosocial support services, include 'wait and see' coping styles (avoiding accessing support until it is 'bad enough'), poor self-awareness (which was acknowledged as a sector-wide issue, with 56% of respondents thinking that aid workers are not very self-aware or able to recognise when they're too stressed), and a desire for self-reliance rather relying on support from someone else.

The barriers are all interlinked and form a cycle of obstacles that aid workers must break through on a regular basis to ensure they are able to access support. A lack of self-awareness and a desire for self-reliance are barriers in the first instance, and might require attitude change and access to information, alongside the stigma and sectoral attitude, which might require sector-wide psychoeducation. The employing organisation has a responsibility to ensure that aid workers can better prepare themselves, monitor themselves, and speak out when they need support, and that that support is available, accessible, well communicated, and appropriate. All of these factors fall under the responsibility of the employer, and it is this that is defined by the term, Duty of Care (Jachens, 2019), with which everyone is familiar but with which not everyone agrees is adhered to by NGOs. The hypothesis was that the 'macho/martyr' attitude in the sector would be the biggest hindrance for individuals in the sector, and from the qualitative analysis, this is supported.

Given the myriad nationalities, cultural backgrounds, and aid workers from different mission contexts that participated in this research study, it could be of interest to distinguish between the various populations to understand the needs and resources of each population. Carrying out organisation-specific, consultancy-type research would be a way of doing this without losing richness of information. It is also important to note that the aid worker population is not a homogeneous one. There are many people who are living outside of their normal, social context, and therefore help-seeking may be inhibited or carried out differently than if they were at home, surrounded by their normal social support networks. It could be an interesting area of research, to look into whether aid workers employ more coping resources because they don't have access to their normal networks, or the opposite (Wind, 2013).

Forty-two percent of respondents in the survey, as well as individuals from the interviews, said that optional or ad hoc psychosocial support mechanisms meant they were less

likely to seek out psychosocial support, as opposed to if standardised, systematic, and/or mandatory services were available (opt-out rather than opt-in). With this in mind, it could be beneficial for NGOs to consider having cost-shared psychosocial support personnel carrying out mandatory 'check-ins', where NGOs commit resources to having shared focal points with other NGOs in-country, which covers the confidentiality aspect by reducing the likelihood that individuals will see the person as 'inside' the organisation.

The clear inconsistency between individual aid worker's responses and the descriptive statistics from the survey in relation to their views of the aid worker population as a whole is pertinent. The low sample size could be a contributing factor this disparity. It is worth investigating, in particular, the views around the 'macho/martyr' attitude. 68% of respondents believed that a 'macho/martyr' attitude exists, whereas only 21% believed they held this attitude. Understanding the disparity between the beliefs of individuals that the sector as a whole holds a 'macho/martyr' attitude, but individuals themselves often believe they personally do not, should be investigated further.

Given the significance of reflexivity in qualitative research (Dodgson, 2019), it was highly prominent for the researcher that themes emerging from the conversation as it was happening and those that occurred during analysis outside of the direct experience might have differed, so having both sets of information to cross-reference for verification was valuable. This awareness of the presence of the relationship between researcher and participant, as well as the impact of the researcher's views, allowed for a distancing during the analysis where themes seen as 'emerging' from the transcripts were reconsidered several times to ensure their relevance to the analysis.

However, caution should be taken when inferring the nuanced experiences of individuals of participants in the qualitative part of the study to aid workers across the sector. In the same respect, the quantitative analysis is representative, in the fact that it includes a variety of nationalities and mission locations, years of experience, gender, and international and national aid workers. However, there are limited numbers of national aid workers who participated from only a few countries, and we cannot generalise to 'national aid workers' from this sample in any respect. Also, of the 132 respondents who initially participated, only 62 could be used due to incomplete survey responses or not fulfilling criteria. The generalisability of this research is therefore something that should be taken under consideration. There is also a risk that the data is subject to social desirability response bias, for instance if respondents were not willing to be completely truthful about their experiences or were overstating issues in order to be able to advocate for change rather than speaking honestly about their perceptions. This was anticipated and accounted for through the confidentiality and anonymity of all responses. The

fact there were no respondents of the original 132 who participated that were in the '65+' age category could be relevant. It could be a methodological limitation that the survey was online, shared by social media, and by email, but that made it less accessible to older generations of aid workers. However, it could be an insight into the attitudes of older aid workers, that there is less willingness to engage in conversations around wellbeing. This might be an area of interest for future research.

Conclusion

The current study was carried out primarily to highlight the limited prioritisation by humanitarian organisations of the wellbeing of aid workers, in order to encourage positive change in the availability and access, as well as help-seeking behaviour for psychosocial support in the sector. However, it should be recognised that some organisations are beginning to acknowledge the importance of providing quality, appropriate support and to understand the stressors and psychosocial needs of their staff (United Nations High Commissioner for Refugees, 2014). In order for the humanitarian sector to be effective, for the interventions that we are accountable for to be of the utmost quality, our aid workers need to be well. This is essential and indisputable.

However, availability of support still needs to be increased and accessibility of this support needs to not be impeded by barriers that can be reduced or eradicated relatively easily by employers. Attitudes and stigma that surround seeking or accessing support are overshadowing people's inclination or willingness to do so. Support provision is not always relevant or appropriate to the individuals or the context, and supervisors and employers are not always fulfilling their Duty of Care, to ensure that aid workers have the information or direction to access this support. Confidentiality issues (perceived and real) and lacking trust relationships are hindering aid workers from going to HR or supervisors for support, as well as previous negative experiences of seeking or accessing support (which again comes back to the provision of appropriate support). Balancing workloads, providing time and space to recover from work, increase positive feedback, offering increased opportunities for career development, and enhancing interpersonal skills of managers are all approaches at a managerial level that can reduce the likelihood of burnout (Jachens, Houdmont and Thomas, 2018, 2019). All of these considerations can be related to enhancing the rewarding and purposeful nature of humanitarian work. Relatedly, the humanitarian sector is in need of a central platform, an ombudsman, union, or institute of sorts, that can act as a supportive mechanism for aid workers in ensuring they have access to psychosocial support, as well as have the capacity to hold

organisations accountable. A structure similar to CIPD, to the military sector, or any other unionised body could be considered.

Before and during a deployment, it is a priority that HR staff are trained in psychoeducation and have a system for regular communications about what psychosocial support services or resources are available. HR exit interviews should involve a psychosocial component, and referral mechanisms should be made available. In 2019, CHS Alliance developed a thirteenth edition of The Debriefing Toolkit for aid workers, based on the principal that around 50% of aid workers develop some sort of psychological difficulty during or after their mission, but that with quality debriefing (operational, psychological, critical incident), the negative psychological impact of the work on the aid worker can be reduced. Therefore, debriefing after deployment is recommended.

It is also recommended that staff are provided with some level of psychosocial support training, in order that they can provide basic psychological first aid (PFA) to their peers, and that they can identify people in need of support, as well as learning who to refer the individual to, and that this training is also provided to HR staff providing the operational debriefing at the end of the mission. For NGOs to provide basic psychosocial support or PFA training to the most-used providers would be a good way of indirectly supporting national staff. It is also encouraged that national staff have specific days allocated as 'family days', where they can take time (e.g. a long weekend) to go and visit family, especially if they do not live near to them while they are in the field etc.

The priority is for NGOs to include psychosocial support, in whatever form it may be, from recreational space or gym memberships; to trainings for staff, supervisors, or external service providers; to specific psychosocial focal points, in their proposal budgets. Without this first step, the largest barrier of all – funding – none of these other activities can occur. Humanitarian agencies have a responsibility to their staff, even before they are recruited for a project, to ensure that there are systems in place to support them. If NGOs can start to implement this, the change will be gradual, but the impact could be remarkable.

Without the bravery and commitment of these individuals, who regularly give more than they have and draw upon the extremely limited resources available to them to do so, there would be no humanitarian sector. It is with this in mind, that this research has been carried out, to speak out on behalf of the population of aid workers who participated in this study from humanitarian crises around the world, encouraging strategists, policy, and decision-makers to ensure that aid worker wellbeing is prioritised, and further research is performed in this respect.

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