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Trauma, Depression, and Burnout in the Human Rights Field: Identifying Barriers and Pathways to Resilient Advocacy

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INTRODUCTION

Human rights advocates often confront trauma and stress in their work. They are exposed to testimony about heinous abuses; work in insecure locations; visit physical sites of abuse; review forensic, photographic, and video evidence; directly witness abuses; experience threats; and can also suffer detention, be attacked, or be tortured themselves. Such exposure risks adversely impacting the wellbeing and mental health of advocates.[1] While the human rights field is diverse and work varies widely, most—if not all—advocates are likely directly or indirectly exposed to potentially traumatic events or material in the course of their work. The degree and type of exposure to human rights violations and insecurity can vary considerably among advocates: they work on human rights issues ranging from genocide to the right to water, in the midst of extreme poverty or armed conflict, as well as in countries experiencing relative peace and economic advantage. Some human rights advocates live and work in the same community, documenting abuses close to home. Others take up positions in national, regional, or international organizations, traveling to the scene of violations for defined periods. Many advocates have a wide variety of experiences over the course of a lifetime. One constant is that human rights advocates are likely to work in environments with abusive, violent, threatening, or otherwise distressing materials that can pose risks to advocates' mental health and wellbeing. Yet many human rights advocates have little education in or support for the potential mental health impacts of their work, there is very little research in this area in either the human rights or psychology fields, and there is limited evidence-based guidance for promoting resilience and sustainable advocacy practices.

This Article is part of an effort to close these gaps and to document the mental health of human rights advocates, who, in the pursuit of the rights of others, may neglect their own wellbeing. The Article is also part of an effort to understand the causes and dynamics of both positive and adverse wellbeing among advocates, with a view

1. We use the terms "wellbeing" and "mental health" in very broad senses, in order to encompass a broad range of emotional, psychological, and spiritual aspects, not only a "medical" model of mental health.

to improving how advocates are prepared for and conduct their work. It is crucial to identify specific factors that might place human rights advocates at risk for negative mental health impacts, as well as those factors that may help them develop resilience and ensure sustainable work practices, at both the individual and the institutional levels.

In an international survey we implemented with human rights advocates, we found concerning rates of adverse mental health issues among participants. Alarming proportions of those responding to our survey met criteria for post-traumatic stress disorder (PTSD) (19.4%), sub-threshold PTSD (18.8%), depression (14.7%), and burnout (19%). We found that large majorities of survey participants had accessed little to no counseling (83%), received little to no education in the potential emotional impacts of human rights work (62%), and reported little to no mental health support from their employers or schools (75%). We found that advocates in the survey had significant exposure to trauma. For example, 34.4% of survey respondents directly witnessed trauma toward others, and 89.3% were indirectly exposed to trauma through work with clients, survivors, and witnesses. In addition, up to 21% were directly exposed to trauma because they themselves were victims of violence, detention, or threats. We found that exposure to human rights-related trauma was associated with greater severity of PTSD and depression. We also found that various individual cognitive styles (how people think about themselves and the world) were associated with PTSD and/or depression, including perfectionism (high standards combined with overly self-critical evaluations), impaired self-efficacy (negative views about one's ability to exercise control and to cope with adversity), coping inflexibility (an inability to engage in different coping styles), and negative appraisals about the advocate's work and the human rights field. Despite significant trauma exposure among those in the sample, we also found that a large proportion of survey participants showed resilience, a positive outlook, and adaptation to trauma: 43% of all survey respondents reported little to no symptoms of PTSD.

This study is part of a multi-year interdisciplinary collaboration among academics and practitioners in the fields of human rights and psychology. This collaboration began as a series of in-depth discussions and joint training exercises among the authors with law students engaged in human rights law clinics taught by two of the co-authors.[2] Through this work, it became clear that the dearth

2. Co-authors Knuckey and Satterthwaite teach human rights law clinics. Their clinics partner with communities and civil society organizations to advance

of empirical information about the impacts of human rights work on advocates and of training materials tailored for advocates was a serious barrier to improving preparation for human rights work and the mitigation of secondary trauma and promotion of resilience. As a step toward addressing this, we set out to design a cross-sectional, internet-based survey to gather preliminary data about the occupational and cognitive variables that might be associated with both adverse and positive mental health. Parts of the study used scientific/medical mental health concepts and research tools, e.g., concepts such as PTSD and measuring instruments that have been developed and tested primarily in Western cultures and high-income countries. We used these concepts and tools because they allow us to place our findings into conversation with broad-ranging empirical work in the field of mental health and psychology, which is useful for establishing the state of these issues in the human rights field, and for exploring potential solutions developed by psychologists, and because they can provide insights into individual and organizational dynamics. The methods and measures employed are one framework for understanding wellbeing issues, and others—including those that take different approaches to the way in which communities conceptualize mental health issues and distress—are also critical and will be studied further in future work.

This survey was an initial attempt to investigate mental health outcomes and predictors in this population and has a number of limitations. We do not draw prevalence conclusions about mental health across the human rights field because survey participants volunteered to participate and, although participants were diverse, the survey was not designed to yield a representative sample. In addition, because the mental health findings are based on self-reported symptoms, rather than clinical interviews, our findings may overestimate the severity of adverse mental health conditions. Finally, the survey allows us to measure correlations or associations between mental health and various factors, but cannot be used to support conclusions about causation. Although we cannot determine the directionality of these findings, they shed light on a number of occupational and individual processes that are associated with mental health outcomes among human rights advocates.

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human rights through fact-finding, advocacy, and skill-sharing. Law students in the clinics learn how to be effective advocates by directly engaging in human rights work under the supervision of professors and lawyers. The clinics also seek to research and improve human rights practice.

The study concludes with strong recommendations for a future research and action agenda. These include: dedicated research on human rights organizations' responses to mental health concerns around the world; further studies on the prevalence and nature of mental health impacts and resilience among advocates; longitudinal research with human rights organizations and movements; studies of low-cost, non-stigmatizing interventions aimed at preventing ill-effects and advancing resilience; and the building of a community of practice devoted to collectively filling gaps and advancing opportunities for wellbeing and resilience among advocates.

I. EXISTING RESEARCH AND TRAINING MATERIALS ON MENTAL HEALTH AND HUMAN RIGHTS

There has been surprisingly little research specifically on mental health in the human rights field and minimal attention across the field as to how organizations should support advocates. In very recent years, some important research has been conducted, and more advocates have begun to more seriously discuss mental health and wellbeing. This section summarizes existing research and some organizational efforts. It also outlines findings from research on related professions and relevant insights from psychology research on risk factors and strategies for resilience.

A. Research on Human Rights Advocates

Noting that "[f]ew formal mental health surveys . . . have been carried out among personnel doing human rights work," one important 2002 study by Holtz and others of human rights advocates working in Kosovo sought to assess the exposure of human rights advocates there to traumatic events—such as the murder of a coworker, being taken hostage, verbal threats to life, imprisonment, and handling dead bodies—and mental health among advocates.[3] The study found elevated levels of anxiety in 17.1% of respondents, depression in 8.6%, and PTSD symptoms in 7.1%.[4] Prolonged periods (over six months) of human rights work were associated with clinical levels of adverse mental health impacts[5] and the researchers concluded that "very

3. Timothy H. Holtz et al., *Mental Health Status of Human Rights Workers, Kosovo, June 2000*, 15 J. TRAUMATIC STRESS 389, 390, 393 (2002). The study did not appear to include potentially traumatic *vicarious* experiences, such as interviewing victims of human rights violations or viewing video of abuses.

4. *Id.* at 393.

5. *Id.* at 393–94.

severely traumatic exposures (such as an armed attack) and the [hostile] reaction of a beneficiary population to human rights work may play a key role in mental health."[6]

In 2012, the *Iniciativa Mesoaméricana de Mujeres Defensoras de Derechos Humanos* (Meso-American Initiative of Women Human Rights Defenders) carried out an important study on self-care among women human rights defenders in Guatemala, El Salvador, Honduras, and Mexico.[7] The study found that 88% of participants live with stress at least some of the time, with 28% experiencing stress all the time.[8] Those who reported experiencing stress also experienced troubling symptoms, including: muscle pain/tension (83%), headaches (55%), and loss of concentration (50%).[9] A striking 78% of the participants reported not having sufficient time, and 41% reported not having sufficient money, to develop self-care practices.[10] At the organizational level, 86% of participants reported that their organizations had been the targets of harassment or attacks, including threats, harassing phone calls, and physical attacks.[11]

A 2015 study by Eyewitness Media Hub examined exposure specifically to traumatic media content, such as videos of bombings recorded by an eyewitness on a smartphone.[12] In an online survey of 209 journalists and human rights and humanitarian workers, participants reported very high levels of exposure to traumatic online content: 83% viewed traumatic media several times a month or more, with 54% viewing such content at least several times per week.[13] Forty percent of participants reported that this exposure had high or very high "personal adverse effects," and 20% reported high or very high

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6. *Id.* at 394.

7. INICIATIVA MESOAMÉRICANA DE DEFENSORAS DE DERECHOS HUMANOS, TRAVERSÍAS PARA PENSAR Y ACTUAR: EXPERIENCIAS DE AUTOCUIDADO DE DEFENSORAS DE DERECHOS HUMANOS EN MESOAMÉRICA 19, 114 (2014) [hereinafter TRAVERSÍAS PARA PENSAR Y ACTUAR]. For more on the work of the Meso-American Initiative, and how they promote wellbeing among advocates, see generally Ana María Hernández Cárdenas & Nallely Guadalupe Tello Méndez, *Self-Care as a Political Strategy*, 14.26 SUR INT'L J. HUM. RTS. 171–80 (Dec. 2017) (discussing the Mesoamerican Initiative of Women Human Rights Defenders and Consortium for Parliamentary Dialogue and Equity Oaxaca).

8. TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7, at 98.

9. *Id.* at 99.

10. *Id.* at 107.

11. *Id.* at 113.

12. SAM DUBBERLEY ET AL., MAKING SECONDARY TRAUMA A PRIMARY ISSUE: A STUDY OF EYEWITNESS MEDIA AND VICARIOUS TRAUMA ON THE DIGITAL FRONTLINE 4 (2015).

13. *Id.* at 17–18.

"professional adverse effects."[14] The study focused on trauma exposure, training, and support for mental health, and did not seek to determine what other factors, such as cognitive styles, could influence mental health.

Some qualitative research has been conducted into the potential dynamics behind burnout among human rights advocates, highlighting factors such as a "martyr" culture and lack of attention to self-care. A pioneering resource for advocates is *What's the Point of Revolution If We Can't Dance?*, written by Barry and Djordjevic in 2008. This book, based on qualitative research among human rights advocates and feminist activists, examines advocates' perceptions that they are expected to sacrifice their own time and wellbeing, and to prioritize the needs of the movement and the human rights cause above themselves.[15] A 2015 article by Chen and Gorski presents the results of interviews with twenty-two U.S.-based social justice and human rights advocates about their experience of burnout.[16] This study examined a snowball sample of individuals who identified social justice or human rights advocacy as "their primary life's work," had experienced burnout, and identified self-care strategies as important to their activism.[17] While the study did not set out to examine the prevalence or causes of burnout, it presented several factors that participants themselves viewed as triggering their burnout, including infighting within activist communities, deep sensitivities to injustice, and a lack of attention to self-care in activist communities.[18] Another qualitative study by Rodgers, based on interviews with Amnesty International researchers, noted similar institutional or cultural factors at work, finding that researchers were expected to be "selfless," denied "their own needs in light of the gravity of human rights abuse," and felt "morally obliged to work to the point of physical and emotional exhaustion."[19]

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14. *Id.* at 32–33.

15. JANE BARRY & JELENA DJORDJEVIC, WHAT'S THE POINT OF REVOLUTION IF WE CAN'T DANCE? (Rick Jones ed., 2008).

16. Cher Weixia Chen & Paul C. Gorski, *Burnout in Social Justice and Human Rights Activists: Symptoms, Causes and Implications*, 7 J. HUM. RTS. PRAC. 366, 367 (2015).

17. *Id.* at 371; Paul C. Gorski & Cher Chen, *"Frayed All Over:" The Causes and Consequences of Activist Burnout Among Social Justice Education Activists*, 51 EDUC. STUD. 385, 392, 397 (2015) (arguing that a "culture of martyrdom" among fourteen education advocates contributed to burnout).

18. Chen & Gorski, *supra* note 16, at 377.

19. Kathleen Rodgers, *'Anger is Why We're All Here': Mobilizing and Managing Emotions in a Professional Activist Organization*, 9 SOC. MOVEMENT

Nah led a multi-year study into the security and protection practices among human rights defenders in Colombia, Mexico, Egypt, Kenya, and Indonesia.[20] She reported in 2017 that 86% of those in the study were "somewhat" or "very" concerned about their wellbeing.[21] Advocates "spoke about the challenges of living with pervasive fear and anxiety; of their inability to sleep; of their feelings of powerlessness in the face of oppression; of feeling 'numb' or emotionless; of being in constant 'fight mode'; and of their fatigue, despair, isolation, and stigmatization."[22]

Nah found that despite these concerns, wellbeing was not commonly discussed in the human rights field. Like the research on U.S.-based advocates and Amnesty researchers, her study noted that advocates "tend to prioritise the necessity and importance of their work before thinking about their personal well-being," found thinking about their own wellbeing to be "self-indulgent," and adhered to "strong social and cultural norms about self-sacrifice, heroism, and martyrdom."[23]

There has been little other academic research examining mental health in the human rights field. Almost no research has quantitatively examined the various kinds of contributing or mitigating factors relevant to human rights advocates' mental health. Some critical gaps in existing literature have included: how often human rights advocates are exposed to what types of potentially traumatic experiences in their work; whether human rights advocates exhibit elevated rates of mental health distress; what kinds of work exposure is associated with adverse mental health impacts such as PTSD and depression; what kinds of cognitive styles may be common among advocates and how such styles can influence mental health; the extent to which human rights advocates have access to care and training about mental health issues; what organizations are doing to support advocates; and what kinds of interventions or reforms would improve the human rights field. While various recommendations have been directed at addressing trauma impact, we are aware of no

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STUD. 273, 287 (2010). Others have argued that idealization of victims may contribute to traumatic stress among human rights advocates. *See* David P. Eisenman, Sharone Bergner & Ilene Cohen, *An Ideal Victim: Idealizing Trauma Victims Causes Traumatic Stress in Human Rights Workers*, 1 HUM. RTS. REV. 106, 111 (2000) (arguing that idealization of trauma victims removes the worker's ability to engage in self-reflection and self-care).

20. ALICE NAH, HUMAN RIGHTS DEFENDER HUB, WELLBEING, RISK, AND HUMAN RIGHTS PRACTICE 1 (2017).

21. *Id.*

22. *Id.* at 2.

23. *Id.* at 1–2.

research in psychology that specifically seeks to understand how to promote resilient human rights advocates.[24]

The lack of research is astonishing, given the large size of the human rights field and the enormous number of advocates in countries around the world, the field's global reach, its increasingly professionalized nature, its growing political influence and important role in advancing social justice, and the reality that much human rights work involves direct and indirect exposure to often serious violence and harm of many forms.

B. The Human Rights Field's Approach to Mental Health and Wellbeing

In addition to the lack of research on human rights in the field of psychology, and with the notable exception of some feminist advocacy groups, many organizations in the human rights movement have paid scant attention to the mental health of advocates. Advocates frequently remark on the "tough" or "cowboy" attitude that seems expected, note the stigma associated with discussing mental health in the field, and are told by colleagues that they should simply remain "detached" from the suffering they witness.[25] Advocates who are based in communities where conflict and severe repression is ongoing often find it difficult, if not impossible, to take a break from their efforts to protect their communities.[26] Many employers lack comprehensive organizational responses and funders have not often built in support for wellbeing initiatives as part of their general grant-making. Apart

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24. Dubberley et al. present numerous recommendations specifically aimed at helping reduce trauma and promoting resilience when handling eyewitness media. DUBBERLEY ET AL., *supra* note 12, at 62–66.

25. *See, e.g.*, Yara Sallam, *"No One Warned Me": The Trade-Off Between Self-Care and Effective Activism*, OPENDEMOCRACY (June 20, 2017), https://www.opendemocracy.net/openglobalrights/yara-sallam/no-one-warned-me-trade-off-between-self-care-and-effective-activism [https://perma.cc/TPG9-XHGM] (tracing a career in human rights through various organizations with no institutional support for trauma exposure).

26. *See, e.g.*, Nazik Awad, *We Cannot Afford to be Traumatized: The Reality for Grassroots Advocates*, OPENDEMOCRACY (Apr. 10, 2017), https://www.opendemocracy.net/openglobalrights/nzik-awad/we-cannot-afford-to-be-traumatized-reality-for-grassroots-advocates [https://perma.cc/264T-M5PL] (explaining the difficulty of "establish[ing] professional boundaries" to maintain "mental and emotional wellbeing").

from feminist activists,[27] movements and organizations have only rarely embraced wellbeing as a core goal of their organizing.

In very recent years, more organizations in the human rights field have begun to improve their attention to mental health, and advocates are increasingly discussing the issue.[28] Yet many advocates feel their organizations fail to devote adequate resources to the mental health and wellbeing needs of their employees and volunteers.[29] Nah's 2017 study found that "few human rights NGOs embed wellbeing practices into their work."[30] The *Iniciativa Mesoamericana de Mujeres Defensoras de Derechos Humanos* found that only 14% of the women human rights defenders who took part in their 2012 study reported that their organizations had taken sufficient steps to address wellbeing.[31] It is difficult to ascertain from publicly available materials specifically what most NGOs around the world *are* doing, and we are aware of no study seeking to collect NGO strategies and assess

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27. *See* BARRY & DJORDJEVIC, *supra* note 15 (describing the ways feminist activists have made wellbeing and sustainability a goal of their work); TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7 (presenting resources and training materials for women human rights defenders in Guatemala, El Salvador, Honduras and Mexico to develop self-care practices); Cárdenas & Méndez, *supra* note 7 (discussing wellbeing practices employed since 2010).

28. *See, e.g.*, *Resilience as Resistance: Mental Health and Well-Being in Human Rights,* OPENDEMOCRACY (Fred Abrahams et al. eds.), https://www.opendemocracy.net/openglobalrights/mental-health-and-well-being-in-human-rights [https://perma.cc/G92F-LU65] (last visited Feb. 19, 2018) (a special blog series designed to foster discussion in the human rights field); *Self-Care and Collective Wellbeing Webinar*, AWID WOMEN'S RTS. (Nov. 3, 2016), https://www.awid.org/news-and-analysis/webinar-summary-self-care-and-collective-wellbeing [https://perma.cc/57PK-XTP5] (documenting a discussion hosted by the Black Feminisms Forum and the Advisory Group on Wellbeing on self-care in "struggl[ing] for rights and justice"); Keramet Reiter & Alex Koenig, *Reiter and Koenig on Challenges and Strategies for Researching Trauma*, SOC. SCI. MATTERS, http://www.palgrave.com/gb/social-science-matters/reiter-and-koenig-on-researching-trauma [https://perma.cc/YXN8-Y645] (last visited Feb. 27, 2018) (discussing techniques to mitigate the emotional challenges that come with studying trauma); Carlos Patiño Pereda, *Resilience in Times of Repression*, SUR INT'L J. HUM. RTS. (Dec. 2017) (discussing strategies employed by activists in Venezuela).

29. *See, e.g.*, TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7, at 108 (noting that 72% of women surveyed consider that the self-care practices adopted at their organizations are not enough). The study by *Iniciativa Mesoamericana de Mujeres Defensoras de Derechos Humanos* presented the results of a survey of Mesoamerican human rights defenders' access to mental health resources at their institutions and suggested changes based on those results. *Id.* at 95–114.

30. NAH, *supra* note 20, at 3.

31. TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7, at 108–09.

organizational responses globally.[32] Our review of the websites and publications of large international human rights NGOs showed little dedicated space for mental health, few public guidelines or protocols, and few detailed collections of resources for employees.

The guidelines that are available are often brief or simplistic. The U.N. Office of the High Commissioner for Human Rights (OHCHR) has recently improved its guidelines, expanding them from just three to forty pages, but still offering largely basic advice such as "limit . . . exposure to traumatic situations and material" and "consider speaking to a professional."[33] Other organizations offer similarly limited guidelines or checklists for employee care, or small stipends for wellness activities.[34] Some organizations offer counseling sessions, but these can be limited in number. Some groups provide resources aimed at enhancing wellbeing through programs of transformative leadership or mindfulness[35] and some have recently created intensive retreat

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32. At the time of writing, we had begun a research project to examine NGO practices around the world, through surveys and interviews with organizations.

33. OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, TRAINING MANUAL ON HUMAN RIGHTS MONITORING, CHAPTER 12: TRAUMA AND SELF-CARE 32, 34 (2014) [hereinafter OHCHR, TRAUMA AND SELF-CARE]. A 2001 version of the guidelines offered a mere three pages on trauma and self-care. *See* OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, TRAINING MANUAL ON HUMAN RIGHTS MONITORING 465–67 (2001). In contrast, the 2014 version includes a forty-page chapter on the subject. *See* OHCHR, TRAUMA AND SELF-CARE, *supra*, at 4–39.

34. *See Benefits*, AMNESTY INT'L, https://www.amnesty.org/en/careers/benefits/ [https://perma.cc/9W9K-ARJT] (last visited Feb. 27, 2018) (stating that they provide employees a pension scheme, life insurance, and other benefits); *see also* UNITED NATIONS INTER-AGENCY STANDING COMM., IASC GUIDELINES ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS 14–15, 22–32 (2007) [hereinafter U.N. IASC GUIDELINES] (gathering and systematizing the experiences of diverse humanitarian actors, as well as a minimum response matrix); CTR. FOR VICTIMS OF TORTURE, HEALING THE HURT: A GUIDE FOR DEVELOPING SERVICES FOR TORTURE SURVIVORS 36–37 (2005) (presenting general advice for professionals working with torture survivors, including a "do" and "don't do" checklist); U.N., UNITED NATIONS STRESS MANAGEMENT BOOKLET 13, 16, 33 (1995), http://humanitarianlibrary.org/resource/united-nations-stress-management-booklet-0 [https://perma.cc/KYP4-57WC] (advising individual stress reduction techniques like breathing and communication, and a ten-question self-evaluation test).

35. *See* SRILATHA BATLIWALA & MICHEL FRIEDMAN, ACHIEVING TRANSFORMATIVE FEMINIST LEADERSHIP: A TOOLKIT FOR ORGANISATIONS AND MOVEMENTS 14–15 (2014), http://www.creaworld.org/sites/default/files/Final%20Feminist%20Leadership%20Manual%2014-4-14_0.pdf [https://perma.cc/52JK-CM3Q] (using a transformative feminist leadership toolkit to encourage mindfulness and develop safe spaces).

spaces for reflection and healing.[36] Others have recently integrated wellbeing into security guides through a framework of "holistic security."[37] Mental health and wellbeing consulting has also risen in recent years, with companies and non-profit organizations offering training, advice, and program development for humanitarian and human rights organizations, but it is unclear how widespread the use of such services is among NGOs.[38] Although the increasing number of internal and public guides related to mental health and resilience suggests a positive trend in the human rights field, we are aware of no studies presenting evidence of their success in implementation.[39]

C. Insights from Research on Related Fields: Risk Factors and Strategies for Resilience

Although there is little research specifically on or within the human rights field, other research in psychology has studied the mental health of professions in which individuals may share some similar work-related experiences, such as working in insecure

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36. *See* Cárdenas & Méndez, *supra* note 7 (discussing the creation in August 2016 of "*Casa La Serena*," available to women human rights advocates from Honduras, Guatemala, El Salvador, Nicaragua, and Mexico).

37. *See* TACTICAL TECH. COLLECTIVE, HOLISTIC SECURITY TRAINER'S MANUAL (2016), https://holistic-security.tacticaltech.org/ckeditor_assets/attachments/60/holisticsecurity_trainersmanual.pdf [https://perma.cc/Q8W9-VS4W] (integrating attention to stress, trauma, and burnout throughout manual); *see also* JANE BARRY & VAHIDA NAINAR, WOMEN HUMAN RIGHTS DEFENDERS' SECURITY STRATEGIES, INSISTE, RESISTE, PERSISTE, EXISTE 87 (Rick Jones ed., 2008), https://urgentactionfund.org/wp-content/uploads/downloads/2012/06/Insiste-Resiste-Persiste-Existe-WHRDs-Security-Strategies.pdf [https://perma.cc/2UMW-88DW] (laying out a framework for women to approach security, including economic, political, environmental, health, and physical security).

38. *See, e.g.*, HEADINGTON INST., http://www.headington-institute.org [https://perma.cc/M8B2-QFRW] (last visited Feb. 10, 2018) (providing online training in trauma, stress management, and resiliency); ANTARES FOUND., https://www.antaresfoundation.org [https://perma.cc/5ZD3-9KEK] (last visited Feb. 10, 2018) (providing individual and team trainings on stress management in humanitarian work); CAPACITAR INT'L, http://www.capacitar.org [https://perma.cc/PYK2-Z7B6] (last visited Feb. 10, 2018) (offering various programs for trauma healing and wellbeing).

39. In another context, one 2014 study of the U.N. Inter-Agency Standing Committee's mental health guidelines raises cause for concern, finding that "only 32% of respondents agreed or strongly agreed that the Guidelines are incorporated into their agency's human resources documentation and practices." *See* U.N. INTER-AGENCY STANDING COMM., REVIEW OF THE IMPLEMENTATION OF THE IASC GUIDELINES ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS 52 (2014).

environments and witnessing or hearing about abuse. This includes studies on humanitarian workers,[40] police officers,[41] rescue workers,[42] war correspondents,[43] psychologists and counselors working with trauma victims,[44] criminal lawyers,[45] and combat veterans,[46] who have been frequently studied. This research offers relevant insights for the human rights field concerning heightened levels of risk, institutional responses, and the individual and community-level dynamics leading to distress.

Studies have found alarming rates of PTSD among humanitarian workers. A 2012 study of peer-reviewed research on humanitarian workers, for example, found that they "face chronic occupational exposure to trauma, which appears to result in subsequent elevated rates of PTSD."[47] A 2006 study of post-tsunami humanitarian aid workers in Asia found that the prevalence of PTSD was "similar to that of disaster victims."[48] Similarly high prevalences of depression, anxiety, and PTSD were found across a variety of studies

40. Ellen Connorton et al., *Humanitarian Relief Workers and Trauma-Related Mental Illness*, 34 EPIDEMIOLOGIC REV. 145 (2011).

41. Charles R. Marmar et al., *Predictors of Posttraumatic Stress in Police and Other First Responders*, 1071 ANNALS N.Y. ACAD. SCI. 1 (2006) [hereinafter Marmar, *Predictors of Posttraumatic Stress*].

42. William Berger et al., *Rescuers at Risk: A Systematic Review and Meta-Regression Analysis of the Worldwide Current Prevalence and Correlates of PTSD in Rescue Workers*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1001 (2012).

43. Anthony Feinstein et al., *A Hazardous Profession: War, Journalists, and Psychopathology*, 159 AM. J. PSYCHIATRY 1570 (2002).

44. COMPASSION FATIGUE: COPING WITH SECONDARY TRAUMATIC STRESS DISORDER IN THOSE WHO TREAT THE TRAUMATIZED (Charles R. Figley ed., 1995).

45. Lila Petar Vrlevski & John Franklin, *Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material*, 14 TRAUMATOLOGY 106, 106–18 (2008) (finding that criminal lawyers had higher levels of vicarious trauma than lawyers who did not work with trauma survivors).

46. Karen H. Seal et al., *Bringing the War Back Home: Mental Health Disorders Among 103,788 U.S. Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities*, 167 ARCHIVES INTERNAL MED. 476 (2007).

47. Connorton et al., *supra* note 40, at 147. This study included among the articles it reviewed Holtz et al.'s 2002 study of human rights workers. Holtz et al., *supra* note 3.

48. Erol Armagan et al., *Frequency of Post-Traumatic Stress Disorder Among Relief Force Workers After the Tsunami in Asia: Do Rescuers Become Victims?*, 21 PREHOSPITAL & DISASTER MED. 168, 172 (2006).

of humanitarian or aid workers and many studies include a recommendation for increasing organizational support.[49]

Research on journalists, police officers, and veterans demonstrates some similar dynamics among these populations. A 2002 study of war correspondents found that they consumed more alcohol than non-war journalists and had higher rates of both PTSD and depression, yet were "not more likely to receive treatment."[50] Studies of police have shown that rates of mental health issues such as PTSD range from 7% to 19%.[51] Police officers' exposure to direct threats and use of force and killing in their work were significant predictors of PTSD symptoms.[52] In addition, an extensive body of research has shown that armed conflict and combat exposure is associated with an increased likelihood of developing PTSD. For example, although estimates vary, approximately 19% of individuals who served in Iraq

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49. *See, e.g.*, John H. Ehrenreich & Teri L. Elliott, *Managing Stress in Humanitarian Aid Workers: A Survey of Humanitarian Aid Agencies' Psychosocial Training and Support of Staff*, 10 PEACE & CONFLICT: J. PEACE PSYCHOL. 53, 62 (2004) (discussing results of a survey of humanitarian aid organizations' practices for mitigating and managing stress in field staff and recommending that NGOs be educated in the need for staff support and that NGOs be provided assistance in doing so); Siddharth Ashvin Shah, Elizabeth Garland & Craig Katz, *Secondary Traumatic Stress: Prevalence in Humanitarian Aid Workers in India*, 13 TRAUMATOLOGY 59, 68 (2007) (discussing results from a study evaluating secondary traumatic stress in humanitarian aid workers in India, and recommending that managers and team leaders integrate ways to identify and alleviate stress, and resources for professional help into their work culture); Alastair Ager et al., *Stress, Mental Health, and Burnout in National Humanitarian Aid Workers in Gulu, Northern Uganda*, 25 J. TRAUMATIC STRESS 713, 719 (2012) (discussing results from a mental health study of national humanitarian aid workers in northern Uganda and recommending that organizations promote social support mechanisms for employees); John P. Wilson & Hub Gielissen, *Managing Secondary PTSD Among Personnel Deployed in Post-Conflict Countries*, 13 DISASTER PREV. & MGMT. 199, 206 (2004) (discussing vicarious post-traumatic stress disorder within personnel of six Dutch organizations working in Rwanda, and identifying management and support as one component likely to help personnel deployed in post-conflict zones achieve their objectives).

50. Feinstein et al., *supra* note 43, at 1572. The study aimed to assess rates of PTSD and depression and alcohol intake and did not study factors other than trauma exposure that might be associated with negative mental health impacts in the population. The authors noted that they could find no other research on war correspondents at the time of their study.

51. Marmar, *Predictors of Posttraumatic Stress*, *supra* note 41, at 2.

52. Irina Komarovskaya et al., *The Impact of Killing and Injuring Others on Mental Health Symptoms Among Police Officers*, 45 J. PSYCHIATRIC RES. 1332, 1334 (2011).

and Afghanistan meet criteria for PTSD or depression.[53] Among the risk factors identified in the literature, exposure to combat is consistently linked with negative mental health outcomes.[54]

Research in the field of psychology on these and other trauma-exposed populations suggests a number of factors that can be associated with a risk of negative mental health impacts following trauma exposure, as well as strategies for resilience. Factors include: the type and duration of exposure to traumatic events; the individual's reactions during the events and their perception of threat at the time of exposure; an individual's prior history of trauma exposure and prior psychiatric history; family history of psychopathology; education level; amount of social support; actual or perceived lack of mental health training and emotional support within the workplace; general life stress; and the individual's cognitive style.[55]

Studies of police show that increased vulnerability to PTSD is associated with lack of role clarity, dysfunctional social interaction between colleagues, insufficient time given by employers to process events, concern for job security, lower levels of social support, and higher levels of stress hormones, e.g., cortisol.[56] Research on vicarious

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53. Terry L. Schell & Grant N. Marshall, *Survey of Individuals Previously Deployed for OEF/OIF*, *in* INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY 87, 96 (Terri Tanielian & Lisa H. Jaycox eds., 2008).

54. George A. Bonanno et al., *Trajectories of Trauma Symptoms and Resilience in Deployed U.S. Military Service Members: Prospective Cohort Study*, 200 BRIT. J. PSYCHIATRY 317, 317 (2012).

55. *See, e.g.*, Marmar, *Predictors of Posttraumatic Stress*, *supra* note 41, at 10 (discussing factors including peritraumatic distress and dissociation, problem-solving coping, general work stress, and levels of social support); Emily J. Ozer et al., *Predictors of Posttraumatic Stress Disorder and Symptoms in Adults: A Meta-Analysis*, 129 PSYCHOL. BULL. 52, 57–64 (2003) [hereinafter Ozer, *Predictors of PTSD and Symptoms in Adults*] (identifying history of prior trauma, prior psychiatric problems, family history of psychopathology, perceived life threat, perceived lower levels of social support, intensely negative emotional responses, and peritraumatic disassociation as being correlated with higher levels of PTSD); Chris R. Brewin, Bernice Andrews & John D. Valentine, *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING & CLINICAL PSYCHOL. 748, 754 (2000) (noting that there was significant heterogeneity in both military and civilian group risk factors for PTSD including lack of education, childhood adversity, trauma severity, and lack of social support, with these risk factors demonstrating stronger effect sizes on military studies, and also warning against trying to identify a common set of pretrauma predictors across different traumatized groups).

56. *See* Cheryl Regehr et al., *The Police Officer and the Public Inquiry: A Qualitative Inquiry into the Aftermath of Workplace Trauma*, 3 BRIEF TREATMENT

trauma among therapists suggests that inexperience, empathy with clients, and a desire to assist the survivor of abuse contribute to negative mental health impacts,[57] and that not dealing with vicarious trauma can lead to reduced effectiveness as a therapist as well as emotional detachment.[58] Studies of humanitarian aid workers emphasize a correlation between the nature and quantity of the trauma exposure and mental health effects. A 2009 study of Guatemalan aid workers found that those exposed to traumatic loss perpetrated by humans, as opposed to natural disasters, experienced "significantly higher levels of hyperarousal PTSD symptoms . . . ."[59] Similarly, an inquiry into the mental health of aid workers in Albania noted a "significant" association between the number of trauma events experienced and depression in aid workers.[60]

In other studies, researchers have identified correlations between higher secondary traumatic stress rates and lower socio-economic status[61] or identity characteristics, such as religious practice,[62] national identity and relationship to the victim group,[63] and

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& CRISIS INTERVENTION 383, 393–94 (2003); Ingrid V.E. Carlier, Regina D. Lamberts & Berthold P.R. Gersons, *Risk Factors for Posttraumatic Stress Symptomatology in Police Officers: A Prospective Analysis*, 185 J. NERVOUS MENTAL DISEASE 498, 504-06 (1997); Komarovskaya et al., *supra* note 52, at 1334–35; Sabra S. Inslicht et al., *Cortisol Awakening Response Prospectively Predicts Peritraumatic and Acute Stress Reactions in Police Officers*, 70 BIOLOGICAL PSYCHIATRY 1055, 1060–64 (2011); Isaac R. Galatzer-Levy et al., *Cortisol Response to an Experimental Stress Paradigm Prospectively Predicts Long-Term Distress and Resilience Trajectories in Response to Active Police Service*, 56 J. PSYCHIATRIC RES. 36, 41 (2014).

57. *See* I. Lisa McCann & Laurie Anne Pearlman, *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims*, 3 J. TRAUMATIC STRESS 131, 135–36 (1990) (suggesting therapists may suffer adverse mental health consequences when exposed to the experiences of trauma victims).

58. LAURIE A. PEARLMAN & KAREN W. SAAKVITNE, TRAUMA AND THE THERAPIST: COUNTERTRANSFERENCE AND VICARIOUS TRAUMATIZATION IN PSYCHOTHERAPY WITH INCEST SURVIVORS 21 (1995).

59. Katharine M. Putman et al., *Reports of Community Violence Exposure, Traumatic Loss, Posttraumatic Stress Disorder, and Complicated Grief Among Guatemalan Aid Workers*, 15 TRAUMATOLOGY 40, 45 (2009).

60. Barbara Lopes Cardozo et al., *The Mental Health of Expatriate and Kosovar Albanian Humanitarian Aid Workers*, 29 DISASTERS 152, 162 (2005).

61. Shah, Garland & Katz, *supra* note 49, at 66.

62. Cynthia B. Eriksson et al., *Social Support, Organisational Support, and Religious Support in Relation to Burnout in Expatriate Humanitarian Aid Workers*, 12 MENTAL HEALTH, RELIGION & CULTURE 671, 682–83 (2009).

63. Cardozo et al., *supra* note 60, at 165; *see also* Saif Ali Musa & Abdalla A.R.M. Hamid, *Psychological Problems Among Aid Workers Operating in Darfur*,

gender.[64] Existing research also indicates that a strong predictor of negative mental health effects following trauma exposure is the extent to which individuals believe that they have been permanently changed by the event and consequently make catastrophic negative appraisals about themselves and the world.[65] For example, cognitive models of PTSD assume that PTSD is more likely to emerge after a traumatic event when a person cognitively processes an event in a way that maintains a sense of current threat.[66] That is, rather than viewing the event as a time-limited event in the past, interpreting and conceptualizing the event and the aftermath through negative appraisals ("I attracted this to me," "it was my fault," "I deserved this," "I cannot cope," "I am going crazy") maintains PTSD by causing distressing negative emotions.[67] In addition, cognitively processing a traumatic event through negative self-appraisals may initiate a series of poorly-suited coping strategies aimed at reducing threat, which in turn, paradoxically, exacerbate symptoms.[68] For instance, a person who stays up all night to feel safe might experience more severe symptoms of PTSD due to a lack of sleep.

Another factor known to contribute to psychological disorders is perfectionism, which involves persistent striving for flawlessness alongside damning self-criticism of one's own behavior or performance.[69] Low levels of self-efficacy, the belief that one has the capacity to manage one's functions and cope with stress, has also been widely shown to be a predictor of poor psychological wellbeing.[70] Furthermore, it has been demonstrated that low levels of coping

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36 SOC. BEHAV. & PERSONALITY 407, 415 (2008) (comparing experiences of Sudanese aid workers in the Darfur region with those of international aid workers).

64. Armagan et al., *supra* note 48, at 171.

65. Anke Ehlers & David M. Clark, *A Cognitive Model of Posttraumatic Stress Disorder*, 38 BEHAVIOUR RES. & THERAPY 319, 321 (2000); Richard A. Bryant & Rachel M. Guthrie, *Maladaptive Appraisals as a Risk Factor for Posttraumatic Stress: A Study of Trainee Firefighters*, 16 PSYCHOL. SCI. 749, 749 (2005) [hereinafter Bryant & Guthrie, *Maladaptive Appraisals as a Risk Factor*]; Richard A. Bryant et al., *A Prospective Study of Appraisals in Childhood Posttraumatic Stress Disorder*, 45 BEHAVIOUR RES. & THERAPY 2502, 2503 (2007).

66. *E.g.*, Ehlers & Clark, *supra* note 65, at 320–21.

67. *Id.* at 321–22.

68. *Id.* at 323.

69. Randy O. Frost et al., *The Dimensions of Perfectionism*, 14 COGNITIVE THERAPY & RES. 449, 449–51 (1990).

70. *See generally* Charles C. Benight & Albert Bandura, *Social Cognitive Theory of Posttraumatic Recovery: The Role of Perceived Self-Efficacy*, 42 BEHAV. RES. THERAPY 1129 (2004) (reviewing the literature on the effects of self-efficacy in recovery from a variety of traumas).

flexibility—an ability to engage in and employ different kinds of coping styles in different contexts—is also associated with psychopathology.[71]

Considerable research has also been conducted on psychological and social factors that are associated with resilience in the face of adversity and trauma.[72] This research has identified a number of cognitive and emotional processes, personality traits, and coping styles that buffer negative mental outcomes following trauma. For example, in terms of cognitive and emotional processes, optimism has been linked with better outcomes among people exposed to combat[73] and terrorism.[74] In addition, higher levels of mindfulness, a cognitive process characterized by a nonjudgmental attention toward one's experience and internal state in the present moment, has been associated with lower levels of mental health issues following trauma.[75] For instance, a recent study found that urban firefighters with higher levels of mindfulness reported lower rates of PTSD symptoms,

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71. George A. Bonanno & Charles L. Burton, *Regulatory Flexibility: An Individual Differences Perspective on Coping and Emotion Regulation*, 8 PERSP. ON PSYCHOL. SCI. 591, 597 (2013).

72. *See, e.g.*, Robert H. Pietrzak et al., *Psychosocial Buffers of Traumatic Stress, Depressive Symptoms, and Psychosocial Difficulties in Veterans of Operations Enduring Freedom and Iraqi Freedom: The Role of Resilience, Unit Support, and Postdeployment Social Support*, 120 J. AFFECTIVE DISORDERS 188, 191 (2010) (studying the role of "protective factors" like post-deployment social support and psychological resilience in reducing PTSD symptoms in Iraq War veterans); Elias J. Duryea et al., *Psychological Immunization: Theory, Research, and Current Health Behavior Applications*, 17 HEALTH EDUC. Q. 169, 169–74 (1990) (exploring how health education utilizing inoculation theory impacts individual attitudes and behaviors in smoking, drinking, and diabetes).

73. *See* Laura Riolli et al., *Resilience in the Face of Catastrophe: Optimism, Personality, and Coping in the Kosovo Crisis*, 32 J. APPLIED SOC. PSYCHOL. 1604, 1616–18 (2002) (showing a correlation between lower levels of optimism and higher levels of "maladjustment"); Jeffrey L. Thomas et al., *Dispositional Optimism Buffers Combat Veterans From the Negative Effects of Warzone Stress on Mental Health Symptoms and Work Impairment*, 67 J. CLINICAL PSYCHOL. 866, 876 (2011) (showing that dispositional optimism buffers soldiers against the negative effects of certain stressors on PTSD and depression).

74. Amy L. Ai et al., *The Traumatic Impact of the September 11, 2001 Terrorist Attacks and the Potential Protection of Optimism*, 21 J. INTERPERSONAL VIOLENCE 689, 697 (2006).

75. *See* Rachel W. Thompson, Diane B. Arnkoff & Carol R. Glass, *Conceptualizing Mindfulness and Acceptance as Components of Psychological Resilience to Trauma*, 12 TRAUMA, VIOLENCE & ABUSE 220, 221–22, 229 (2011) (noting that mindfulness- and acceptance-based approaches have been successfully incorporated into treatment of a wide array of psychological disorders and that there is "considerable evidence to support the hypothesis that trait mindfulness and acceptance are associated with greater adjustment following trauma").

depression symptoms, physical symptoms, and problems with drinking.[76] Another cognitive process associated with resilience is cognitive reappraisal, the ability to reduce the negative intensity of an experience through reframing or reinterpreting the meaning of the situation.[77] Recent work found that although one's ability to engage in cognitive reappraisal was unrelated to mental health issues when exposed to low levels of stress, the ability to cognitively reappraise led to lower levels of depression following high levels of stress.[78] Considerable work has also found that self-efficacy has also been linked with resilience across a number of trauma-exposed populations.[79]

Emotional processes, such as the ability to engage in positive emotions and laughter, have been associated with better mental health outcomes following loss and trauma.[80] Bonanno and colleagues found that bereaved individuals who were able to genuinely laugh and smile when discussing their loss exhibited more resilience and elicited more positive responses in observers.[81] Moreover, among urban police officers, higher levels of negative emotion prior to trauma exposure were associated with worsening symptoms of distress over time, compared to those who exhibited a resilient trajectory.[82] A number of personality traits also appear to contribute to resilience, such as extraversion, as well as hardiness, which is the commitment to finding

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76. Bruce W. Smith et al., *Mindfulness is Associated with Fewer PTSD Symptoms, Depressive Symptoms, Physical Symptoms, and Alcohol Problems in Urban Firefighters*, 79 J. CONSULTING & CLINICAL PSYCHOL. 613, 615–16 (2011).

77. Kateri McRae, Bethany Ciesielski & James J. Gross, *Unpacking Cognitive Reappraisal: Goals, Tactics, and Outcomes*, 12 EMOTION 250, 250 (2012).

78. *See* Allison S. Troy et al., *Seeing the Silver Lining: Cognitive Reappraisal Ability Moderates the Relationship Between Stress and Depressive Symptoms*, 10 EMOTION 783 (2010) (presenting a study analyzing the correlation between cognitive reappraisal ability and depressive symptoms after exposure to different stress levels).

79. *See* Benight & Bandura, *supra* note 70, at 1135–44 (discussing the positive impact of self-efficacy on victims' mental health and wellbeing following various traumatic situations).

80. *See* George A. Bonanno & Dacher Keltner, *Facial Expressions of Emotion and the Course of Conjugal Bereavement*, 106 J. ABNORMAL PSYCHOL. 126 (1997) (describing a study that found positive facial expressions and accompanying behaviors, like laughter, predicted decreased grief in the months after trauma).

81. *Id.* at 129–34.

82. *See* Isaac R. Galatzer-Levy et al., *Positive and Negative Emotion Prospectively Predict Trajectories of Resilience and Distress Among High-Exposure Police Officers*, 13 EMOTION 545, 551 (2013).

meaningful purpose in life and the belief that one can influence the outcome of an event.[83]

Social support is linked with resilience following trauma-exposure. A growing body of work shows a link between social support and better psychological and physical wellbeing.[84] In contrast, lower levels of social support are associated with PTSD.[85] Existing research on strategies that may mitigate adverse mental health impacts suggests the importance of robust and systematized organizational support.[86] For example, a study of local and expatriate aid workers in Uganda found that workers affiliated with U.N. and related agencies reported the fewest symptoms of depression, anxiety, or PTSD.[87] Researchers hypothesized that these workers benefited from the organizations' "formalized structures . . . regarding human resource policy, staff support, and benefits" as well as from the "support and

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83. *See* Victor Florian, Mario Mikulincer & Orit Yaubman, *Does Hardiness Contribute to Mental Health During a Stressful Real-Life Situation? The Roles of Appraisal and Coping*, 68 J. PERSONALITY & SOC. PSYCHOL. 687, 687 (1995) (defining hardiness and detailing a study evaluating its impact on mental health); James A. Fauerbach et al., *Personality Predictors of Injury-Related Posttraumatic Stress Disorder*, 18 J. NERVOUS & MENTAL DISEASE 510, 514–15 (2000) (finding that particularly high levels of extraversion appear protective against PTSD symptomatology).

84. *See, e.g.*, Fatih Ozbay et al., *Social Support and Resilience to Stress Across the Life Span: A Neurobiologic Framework*, 10 CURRENT PSYCHIATRY REPORTS 304, 305–08 (2008) (reviewing literature indicating the positive correlation between social support and beneficial health outcomes at different life stages including pregnancy and adulthood).

85. Jack Tsai et al., *The Role of Coping, Resilience, and Social Support in Mediating the Relation Between PTSD and Social Functioning in Veterans Returning from Iraq and Afghanistan*, 75 PSYCHIATRY 135, 143 (2012).

86. *See, e.g.*, Cardozo et al., *supra* note 60, at 167 (noting that organizational intervention, including improving communication with family members at home and offering psychological support services, may prove effective in preventing or alleviating psychological morbidity); Musa & Hamid, *supra* note 63, at 415 (emphasizing the importance of organizations creating a positive work environment by providing adequate training, cultural orientation, and psychological support services); Cynthia B. Eriksson et al., *Trauma Exposure and PTSD Symptoms in International Relief and Development Personnel*, 14 J. TRAUMA STRESS 205, 211 (2001) (noting that because perceived social support is associated with fewer symptoms of PTSD in humanitarian aid workers exposed to life threatening events, sending organizations have an opportunity to provide valuable support to their returning staff); Wilson & Gielissen, *supra* note 49, at 206 (stating that "an integrated and comprehensive human resource management/ human resource development strategy is necessary for the effective functioning and well-being of employees").

87. Ager et al., *supra* note 49, at 713.

training provided for managers."[88] Regardless of the aid worker's affiliation, workers who had "higher levels of social support, stronger team cohesion, and reduced exposure to chronic stressors" experienced better mental health.[89] Similarly, many studies emphasize the importance of clear communication with workers about available resources and processes for self-care. A 2006 article related to the mental health of social workers suggests the creation of a "psychiatric disaster plan" that identifies the employees "responsible for each action that will occur after traumatic events," which can "eliminate confusion" and "ease apprehension."[90] Finally, many studies have found significant correlations between aid workers' social support networks and team relationships, and positive mental health.[91] One study found that aid workers preferred direct support from their peers to that from managers and mental health counselors.[92]

In addition to these individual and interpersonal processes, there is growing interest in the interaction between psychological and biological factors, such as genetics and neurotransmitters, that support resilience.[93] All of these findings hold potential insights for human rights advocates, but empirical data is needed to assess their relevance.

II. STUDY DESIGN

A. Goals and Methods

This study aimed to lay the groundwork for an examination of mental health impacts of human rights work on human rights advocates. In particular, we aimed to study what kinds of practices advocates commonly engage in, whether and how advocates were being

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88. *Id.*

89. *Id.*

90. Kimberly Strom-Gottfried & Nikki D. Mowbray, *Who Heals the Helper? Facilitating the Social Worker's Grief*, 87 FAMILIES SOC'Y 9, 13 (2006).

91. *See, e.g.*, Cynthia B. Eriksson et al., *Predeployment Mental Health and Trauma Exposure of Expatriate Humanitarian Aid Workers: Risk and Resilience Factors*, 19 TRAUMATOLOGY 41, 46 (2013) (noting that perceptions of social support were negatively correlated with severity of PTSD).

92. Niklas Serning, International Aid Workers' Experience of Support—An Interpretative Phenomenological Analysis 92–97 (Jun. 2011) (unpublished Ph.D. dissertation, Middlesex University), https://core.ac.uk/download/pdf/17301659.pdf [https://perma.cc/A426-MESP].

93. Gang Wu et al., *Understanding Resilience*, FRONTIERS BEHAV. NEUROSCIENCE, Feb. 2013, at 1, https://www.frontiersin.org/articles/10.3389/fnbeh.2013.00010/pdf [http://perma.cc/CV8D-N583].

exposed to trauma through their work, which types of work and personality factors were associated with different mental health outcomes, and the extent to which advocates were receiving training in promoting resilience and were able to access mental health assistance when needed. This information would support the design of subsequent studies exploring initial findings in more detail. We sought to build up the body of knowledge about mental health in the human rights field, and to work toward the longer-term goal of promoting greater awareness of mental health and sustainable human rights practices.

Two of the authors are human rights advocates as well as professors who teach students to become advocates through law school human rights clinics, which function as mixed education and human rights investigation and advocacy programs. We have all too frequently observed human rights work negatively impact our human rights colleagues. We have seen colleagues become extremely stressed and anxious in relation to their work, have nightmares or intrusive memories or feel haunted by interviews and experiences, become distant, express concerns about depression or vicarious trauma, and in some cases seem to simply burn out, leaving human rights work temporarily or permanently. At the same time, we also observed many exceptionally resilient colleagues, who, despite intensive and frequent exposure to trauma and human rights abuses, gain meaning and energy and inspire others through their work, as well as colleagues who responded to their work differently at various points in their careers. We have also worked with numerous promising law students as they entered the human rights field despite their awareness that their work will be difficult and potentially traumatic. What explains the differences between those who build resilience and those who burn out, become depressed, or suffer PTSD? And what explains an individual advocate's experience of periods of resilience or periods of adverse effects? How could we work toward more sustainable work practices across the profession?

As professors frequently working with students on emotionally difficult cases, we have felt an obligation to equip them to identify and respond to the signs of mental distress in themselves and others, and to promote resilience and sustainable human rights advocacy. But we often felt that available teaching materials did not speak sufficiently or directly to human rights advocates, or did not adequately draw upon existing psychology research. We also encountered a dearth of scientific studies that explained mental health issues in and to the human rights field. We could identify concerns in our field, and see the effects on

colleagues and on the work, but did not have adequate tools to understand and address them.

We came together as an interdisciplinary team with experts from the field of psychology in vicarious trauma, PTSD, and the study of cognitive, affective, and biological factors that underlie risk and resilience. The psychology authors have worked clinically and conducted research with myriad trauma-exposed populations.[94] Aware of the importance and kind of work done by human rights advocates, the psychology experts were surprised to learn that there had been few efforts to document, address, educate, and potentially treat mental health issues that might be associated with human rights work. We felt that variables and measures known to be associated with negative outcomes in other populations may help to shed light on vulnerability and resilience to mental health issues in this population, even as we expected to see some differences that might contribute to risk factors for mental health issues.

To conduct this study, we found it necessary to bring our disciplines together through exciting, enlightening, and sometimes very challenging conversations: about what the human rights advocates believed we were seeing in ourselves, our colleagues, and our students, and about what the psychologists thought possible, likely, or unlikely to find given existing research in psychology. The advocates shared in detail the kinds of work undertaken in the human rights field and the psychologists shared existing findings and research in their

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94. *See, e.g.*, Adam D. Brown et al., *Episodic and Semantic Components of Autobiographical Memories and Imagined Future Events in Post-Traumatic Stress Disorder*, 22 MEMORY 595 (2014) (examining autobiographical memories of combat veterans); Adam Brown & Christina Laitner, *Care of Children Exposed to the Traumatic Effects of Disaster*, 53 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 590 (2014) (book review) (analyzing book discussing how to deal with trauma-exposed children); Adam D. Brown et al., *Trauma Centrality and PTSD in Veterans Returning from Iraq and Afghanistan*, 23 J. TRAUMATIC STRESS 496 (2010) (working with Iraq and Afghanistan veterans); Galatzer-Levy et al., *supra* note 82, at 545–46 (studying resilience and distress among police officers); Amy Joscelyne, Sarah Knuckey, Margaret Satterthwaite, Richard A. Bryant, Meng Li, Meng Qian, Adam D. Brown, *Mental Health Functioning in the Human Rights Field: Findings from an International Internet-Based Survey*, PLOS ONE, Dec. 23, 2015, at 1 (writing on the impacts of trauma on human rights defenders); Press Release, Sarah Lawrence College, Psychology Faculty Member Adam Brown Develops Traumatic Stress Assessment of Refugees (Oct. 3, 2017), https://www.sarahlawrence.edu/news-events/news/2017-10-03-psychology-faculty-member-adam-brown-develops-traumatic-stress-assessment-of-refugees-nr.html [https://perma.cc/W7XR-EPYS] (explaining work with refugee populations in Europe).

field. The human rights advocates and psychologists gave numerous co-presentations to human rights law students about stress and trauma, and strategies for managing stress. These presentations provided important opportunities to discuss concerns and perspectives of those working in the human rights field. Through these conversations and presentations, we developed shared goals for the study, and a shared language with which to carry it out.

The conversations between our two disciplines enabled us to create a new survey instrument, drawing upon existing psychology research, which was specifically tailored to the nature of human rights work. The study was primarily implemented through this questionnaire, which was sent to human rights groups and advocates around the world. A wide net was cast: the researchers sent recruitment emails seeking survey participants to a broad array of international, national, and regional human rights organizations; contributed posts to online discussion groups; and posted notices on social media sites such as Facebook and Twitter.[95]

B. Key Concepts and Research Questions

The survey instrument sought to test for, first, *trauma exposure* in the human rights field. Second, we assessed mental health by asking a series of questions designed to measure symptoms of *anxiety, PTSD, depression*, as well as *burnout.* These questions would also help us to assess *resilience* among advocates. Third, we aimed to study how other factors, in addition to the trauma exposure itself, might contribute to negative or positive mental health, by asking a series of questions to assess *self-efficacy, perfectionism, coping flexibility,* and *appraisal style.* We also asked about the extent of *training or education* participants received about mental health and human rights work, organizational support, and access to mental health services. Each of these concepts, and how and why we studied them, is explained below.

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95. Participants were recruited through networks of human rights advocates and organizations, including U.N. agencies with human rights mandates, national human rights commissions, academic human rights centers, human rights list-servs, and blogs. Social media such as Facebook and Twitter were also used for participant recruitment. The survey was available online for completion from October 2012 to February 2013. In order to participate, participants provided informed consent and confirmed that they were at least 18 years old and had experience in the human rights field. All responses were entirely anonymous, as no identifiers were collected.

We tested for *trauma exposure* related to human rights work by constructing new sets of survey questions specific to the human rights field. We asked advocates how much they had engaged in a variety of practices common in human rights work through their career. These practices included those considered potentially traumatic by psychologists. Thus, for example, we asked about the extent to which participants listened to accounts of human rights violations, e.g., through interviewing victims or witnesses, a practice central to human rights advocacy; visited sites such as mass graves or crime scenes to investigate violations; reviewed documents evidencing human rights violations, such as human rights reports or autopsy findings; or viewed graphic videos or photos, which is increasingly common in the human rights field given the proliferation of smaller and more affordable cameras and smart phones and the common online sharing of such content by eyewitnesses to and participants in violent events. In addition, we asked about exposure to potentially traumatizing circumstances that could arise in the course of human rights work, such as the injury or death of a colleague because of his or her work, and threats or violence experienced by advocates themselves. We also asked about human rights advocacy practices that would generally involve minimal or no risk of direct or secondary trauma exposure, such as budgetary advocacy, quantitative analysis, and lobbying.

Ascertaining any direct exposure to trauma was crucial, given research in psychology linking such exposure to negative mental health impacts. Examining the role and impact of secondary or indirect exposure was also particularly important. This was in part because potential sources of vicarious trauma exposure, such as interviews with victims and witnesses, are a very common human rights practice,[96] and in part because studies of other professions, such as mental health clinicians and sexual assault counselors, have shown elevated PTSD rates "among those who work with traumatized populations."[97]

In addition, we asked participants about any exposure to trauma, such as natural disaster, car accident, or assault, before and

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96. *See, e.g.*, Margaret L. Satterthwaite & Justin C. Simeone, *A Conceptual Roadmap for Social Science Methods in Human Rights Fact-Finding*, *in* THE TRANSFORMATION OF HUMAN RIGHTS FACT-FINDING 321, 325 (Philip Alston & Sarah Knuckey eds., 2016) (finding that 98.4% of reports by Human Rights Watch and Amnesty International published in 2010 included testimonial evidence from victims, witnesses, or survivors).

97. Connorton et al., *supra* note 40, at 146 (and sources cited therein).

after the age of eighteen years not connected to their human rights work. There is extensive evidence that exposure to childhood trauma is a risk factor for adult mental health issues in general[98] and PTSD in particular.[99] In addition, greater exposure to traumatic stress in adulthood is also a risk factor for psychological distress.[100] We anticipated that advocates would be directly and indirectly exposed to potentially traumatic events through their work. We also expected that some advocates would be exposed to potentially traumatic events outside of work. Thus, we expected that if mental health issues were observed in advocates, they might be explained, in part, by exposures to trauma outside of work, and we sought to control for this factor in our analyses.

To assess whether and the extent to which each survey participant had symptoms of *post-traumatic stress disorder*, we used a standard measure for PTSD—the "Posttraumatic Stress Disorder Checklist" (PCL).[101] PTSD is a psychological reaction in response to "[e]xposure to actual or threatened death, serious injury, or sexual violence"—through direct experience, witnessing an event, learning that the event occurred to a close friend or family member, or experiencing exposure to details of the event—resulting in significant impairment in social and/or occupational functioning.[102] Symptoms are categorized into clusters of re-experiencing (e.g., intrusive memories,

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98. Valerie J. Edwards et al., *Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results From the Adverse Childhood Experiences Study*, 160 AM. J. PSYCHIATRY 1453, 1458 (2003).

99. *See* Brewin et al., *supra* note 55, at 755–56 (studying the effect of factors such as childhood abuse and adversity on different populations and noting that childhood abuse and early trauma could have effects on later PTSD).

100. Ozer, *Predictors of PTSD and Symptoms in Adults*, *supra* note 55, at 57.

101. The PCL is a seventeen-item self-report scale that evaluates the extent to which participants have experienced PTSD symptoms in the past month as a result of stressful life events. Each item is scored on a five-point scale (1 = "not at all," 5 = "extremely"). F.W. WEATHERS ET AL., NAT'L CTR. FOR PTSD, PTSD CHECKLIST—CIVILIAN VERSION (1994); Edward B. Blanchard et al., *Psychometric Properties of the PTSD Checklist (PCL)*, 34 BEHAV. RES. & THERAPY 669, 669 (1996); Paul D. Bliese et al., *Validating the Primary Care Posttraumatic Stress Disorder Screen and the Posttraumatic Stress Disorder Checklist with Soldiers Returning from Combat*, 76 J. CONSULTING & CLINICAL PSYCHOL. 272, 273 (2008); David Forbes et al., *The Validity of the PTSD Checklist as a Measure of Symptomatic Change in Combat-Related PTSD*, 39 BEHAV. RES. & THERAPY 977, 978 (2001).

102. AM. PSYCHIATRIC ASS'N, *Trauma- and Stressor-Related Disorders*, *in* DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 265, 271 (5th ed. 2013).

nightmares), avoidance (avoiding reminders), negative cognitions and mood (exaggerated blame of self or others for the trauma, alienation), and arousal (hypervigilance, insomnia, easily startled). The scale we used is a self-report measure commonly used to screen people for primary PTSD. The "gold standard" for diagnosing PTSD is a clinical interview, but the self-report measure used in this survey is often used for making preliminary diagnoses.[103]

We measured symptoms of *depression* similarly, using a validated and widely-used, self-administered depression diagnosis and severity test used for making initial diagnoses of major depressive disorder.[104] Depression is a mood disorder characterized by symptoms of depressed mood, irritability, changes in weight and sleep, loss of interest, unexplained aches and pains, difficulty concentrating, feelings of guilt and worthlessness, and thoughts of suicide.[105] Existing research has shown strong links between major depressive disorder, trauma exposure, and PTSD.[106] Studies estimate that approximately seven to nine percent of trauma-exposed individuals develop major

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103. Amanda L. Stuart et al., *Comparison of Self-Report and Structured Clinical Interview in the Identification of Depression*, 55 COMPREHENSIVE PSYCHIATRY 866, 867 (2014).

104. Depressive symptoms were measured using the Patient Health Questionnaire (PHQ-9). The PHQ is a self-administered questionnaire, i.e., not administered by a clinician). The measure consists of nine items, such as: "Over the last 2 weeks, how often have you been bothered by any of the following problems? – Little interest or pleasure in doing things . . . ," each rated on a four-point scale, from 0 = "not at all" to 3 = "nearly every day," resulting in total scores that range from zero to twenty-seven. The total PHQ-9 score was calculated by summing the responses for each symptom. A cut-off score of ten was used as an indicator of probable major depression. *See* Robert L. Spitzer, Kurt Kroenke & Janet B. Williams, *Validation and Utility of a Self-Report Version of PRIME-MD: The PHQ Primary Care Study*, 282 JAMA 1737, 1739 (1999); Kurt Kroenke & Robert L Spitzer, *The PHQ-9: A New Depression Diagnostic and Severity Measure*, 32 PSYCHIATRIC ANNALS 509, 510 (2002).

105. *Depression (Major Depressive Disorder)*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/depression/basics/definition/con-20032977[https://perma.cc/G2RK-9VB5] (last visited Feb. 20, 2018).

106. *See, e.g.*, Harriet L. MacMillan et al., *Childhood Abuse and Lifetime Psychopathology in a Community Sample*, 158 AM. J. PSYCHIATRY 1878, 1878 (2001); Arieh Y. Shalev et al., *Prospective Study of Posttraumatic Stress Disorder and Depression Following Trauma*, 155 AM. J. PSYCHIATRY 630, 634–36 (1998).

depressive disorder.[107] And among those who meet criteria for PTSD, thirty to ninety-five percent experience depression.[108]

We assessed *burnout* by asking whether individuals had ever taken a significant break from their human rights work of three months or more.[109] Participants were asked to specify the reasons for the break, and they could choose from a wide range of options, including that the "work was too distressing or demanding emotionally" or that they felt "burned out."[110]

Resilience refers to "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress—such as family and relationship problems, serious health problems or workplace and financial stressors. It means 'bouncing back' from difficult experiences."[111] Resilience has been understood as both a trait and a process, something that is both part of one's personality and also subject to development and accentuation through certain behaviors and practices.[112] In this way it is both an internal mechanism fostered by qualities such as a positive attitude and cognitive flexibility and a trait that can be produced and strengthened through external avenues such as exercise and robust social support.[113]

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107. Matthew C. Morris et al., *Relations Among Posttraumatic Stress Disorder, Comorbid Major Depression, and HPA Function: A Systematic Review and Meta-Analysis*, 32 CLINICAL PSYCHOL. REV. 301, 302 (2012).

108. *See, e.g.*, *id.* (noting studies have found rates of major depressive disorder to be as high as 37% in individuals meeting the criteria for PTSD); Shalev et al., *supra* note 106, at 630 (stating the co-occurrence rates of PTSD and major depression can be as high as fifty percent concurrently or ninety-five percent throughout a lifetime); s*ee also* Michelle Bedard-Gilligan et al., *An Investigation of Depression, Trauma History, and Symptom Severity in Individuals Enrolled in a Treatment Trial for Chronic PTSD*, 71 J. CLINICAL PSYCHOL. 725, 726 (2015) (citing several recent psychological studies finding links between PTSD and major depressive disorder).

109. The choice to use three months as the threshold for a significant break mirrors the cut-off for chronic mental health issues in the DSM. *See* AM. PSYCHIATRIC ASS'N, *supra* note 102.

110. Other options were unrelated to burnout, and included, for example, "financial reasons," "to study," "parental leave," and "unable to find work."

111. *The Road to Resilience,* AM. PSYCHOL. ASS'N, http://www.apa.org/helpcenter/road-resilience.aspx [https://perma.cc/DJJ5-UL6T] (last visited Feb. 24, 2018).

112. David Fletcher & Mustafa Sarkar, *Psychological Resilience: A Review and Critique of Definitions, Concepts, and Theory*, 18 EUR. PSYCHOL. 12, 12–16 (2013).

113. Ivan Robertson & Cary L. Cooper, Editorial, *Resilience*, 29 STRESS & HEALTH 175, 175–76 (2013).

In this study, we sought to assess the extent to which each of these mental health states—depression, PTSD, burnout, and resilience—was associated with various cognitive processes. There is a robust body of research in psychology demonstrating a link between how people think and their emotional reactions.[114] Research into mental health issues and treatments for psychological disorders, such as cognitive behavioral therapy, have shown that modifying cognitive processes is often one of the most effective ways to buffer and treat psychological distress.

The first cognitive process we measured was perceived *self-efficacy*.[115] In psychology, self-efficacy refers to an individual's belief in their "capability to exercise some measure of control in the face of taxing stressors."[116] The research indicates that individuals with higher perceived self-efficacy set higher goals for themselves and exhibit higher levels of motivation, and are less vulnerable to stress and depression.[117] It indicates that perceived self-efficacy "promotes resilience" to stressors.[118] Research also suggests that "[s]elf-appraisal of coping capabilities . . . determines, in large part, the subjective perilousness of environments," and that it "affects not only how threats are construed but how well people cope with them."[119] In one study of survivors of the Oklahoma City bombings, in which 168 people were

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114. *See, e.g.*, Richard A. Bryant & Rachel M. Guthrie, *Maladaptive Self-Appraisals Before Trauma Exposure Predict Posttraumatic Stress Disorder*, 75 J. CONSULTING & CLINICAL PSYCHOL. 812 (2007) [hereinafter Bryant & Guthrie, *Maladaptive Self-Appraisals Before Trauma Exposure*] (discussing how feelings of incompetence and self-blame make suffering PTSD after a traumatic experience more likely); Richard Meiser-Stedman et al., *Maladaptive Cognitive Appraisals Mediate the Evolution of Posttraumatic Stress Reactions: A 6-Month Follow-Up of Child and Adolescent Assault and Motor Vehicle Accident Survivors*, 118 J. ABNORMAL PSYCHOL. 778 (2009) (documenting how opinions of self affected adaptation following trauma).

115. We used the General Self-Efficacy (GSE) scale, which assesses personal agency and perceived ability to cope with challenges that one encounters in life. The scale consists of ten statements with a four-point scale (1 = "not at all true," 4 = "exactly true"). Ralf Schwarzer & Matthias Jerusalem, *Self-Efficacy Measurement: Generalized Self-Efficacy Scale (GSES)*, *reprinted in* MEASURES IN HEALTH PSYCHOLOGY: A USER'S PORTFOLIO 35 (John Weinman et al. eds., 1995).

116. Benight & Bandura, *supra* note 70, at 1131; *see also* Albert Bandura, *Self-Efficacy*, *in* 4 ENCYCLOPEDIA OF HUMAN BEHAVIOR 71, 81 (V.S. Ramachaudran ed., 1994) [hereinafter Bandura, *Self-Efficacy*] ("Perceived self-efficacy is concerned with people's beliefs in their capabilities to exercise control over their own functioning and over events that affect their lives.").

117. Bandura, *Self-Efficacy*, *supra* note 116, at 72–75.

118. Benight & Bandura, *supra* note 70, at 1131.

119. *Id.* at 1132.

killed and many others were injured, researchers found that "[p]erceived self-efficacy accounted for a significant share of the variance in experienced symptoms, intrusion of aversive thoughts, and frequency of posttraumatic stress reactions."[120] In summarizing the research on self-efficacy, Benight and Bandura write: "a robust sense of coping efficacy is accompanied by benign appraisals of potential threats, weaker stress reactions to them, less ruminative preoccupation with them, better behavioral management of threats, and faster recovery of wellbeing from any experienced distress over them."[121]

Because of the strength of existing research on the role of self-efficacy, we hypothesized that it would likely play a role in the mental health of human rights advocates. The human rights practitioner-academics on our research team were also interested in its role because human rights advocacy often involves working to address difficult, often seemingly intractable problems. We have observed varying levels of self-efficacy among human rights advocates, sometimes observing what seemed to be very high levels. For example, advocates intentionally put themselves in risky environments, work for many years to address endemic human rights abuses, and believe that they had at least some power to alter the circumstances that lead to abuse. We were also especially interested in self-efficacy because it is a positive, enabling factor: if it had a significant role in the resilience of human rights advocates, then perhaps we could seek ways to promote perceived self-efficacy among our students and colleagues, thereby fostering stronger advocates.[122]

We also studied *perfectionism*, which involves individuals setting for themselves "high standards of performance . . . accompanied by tendencies for overly critical evaluations of one's own behavior."[123] The critical evaluations may relate to "overconcern with mistakes and a tendency to doubt the quality of one's work," as well as an

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120. *Id.* at 1140.

121. *Id.* at 1133.

122. *See e.g.*, Bandura, *Self-Efficacy*, *supra* note 116, at 71–72, 76 (summarizing sources of self-efficacy, including experiencing success, particularly after overcoming obstacles, vicariously experiencing the success of others, and social persuasion, support from others, noting that "[t]he stronger the perceived self-efficacy, the higher the goal challenges people set for themselves and the firmer [] their commitment to them" and arguing that self-efficacy is necessary for social reform and innovation, because "those with a tenacious self-efficacy are likely to change [existing] realities").

123. Frost et al., *supra* note 69, at 450.

"overemphasis on precision, order, and organization."[124] Perfectionists often experience "uncertainty regarding when a task is done" because no job can be successfully completed in line with expectations,[125] and they may struggle with work avoidance since "[p]rocrastination allows the individual to avoid less than perfect performance."[126] We decided to include a measure for perfectionism following conversations about traits we had often noted in students and colleagues, many of whom set expectations for achievement that do not bend to the realities of often messy and chaotic human rights work, making them judge their performance as relentlessly and disappointingly sub-par. Further, prior research had linked perfectionism with depression,[127] as well as with PTSD following trauma,[128] suggesting that such dynamics could be at work among human rights advocates. We measured perfectionism using a common eight-question survey, which contains items such as "I feel there is constant pressure for me to achieve and get things done," "I often sacrifice pleasure and happiness to meet my own standards," and "I can't let myself off the hook easily or make excuses for my mistakes."[129]

We examined *coping flexibility*, which is the ability to adapt to potentially traumatic and adverse events by shifting between different cognitive processes, i.e., ways of thinking about the event, and by adopting a range of coping strategies. To assess coping flexibility, we modified the Perceived Ability to Cope with Trauma (PACT) scale, a self-report measure.[130] The measure included items assessing whether

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124. *Id.* at 451.

125. *Id.*

126. *Id.* at 462.

127. *Id.* at 467 ("Perfectionists also tend to have higher levels of Self-Critical Depression . . . and they are more frequently plagued by procrastination.").

128. Sarah J. Egan et al., *The Relationship Between Perfectionism and Rumination in Post Traumatic Stress Disorder*, 42 BEHAV. COGNITIVE PSYCHOTHERAPY 211, 218 (2014); Kathleen Y. Kawamura et al., *Perfectionism, Anxiety, and Depression: Are the Relationships Independent?*, 25 COGNITIVE THERAPY & RES. 291, 299 (2001).

129. Our study administered the "unrelenting" standards subscale of the Young Schema Questionnaire (YSQ). These eight items index the extent to which respondents make excessive demands upon themselves on a six-item scale (1 = "completely untrue of me," 6 = "describes me perfectly"). Norman B. Schmidt et al., *The Schema Questionnaire: Investigation of Psychometric Properties and the Hierarchical Structure of a Measure of Maladaptive Schemas*, 19 COGNITIVE THERAPY RES. 295, 300 (1995).

130. *See generally* George A. Bonanno, Ruth Pat-Horenczyk & Jennie Noll, *Coping Flexibility and Trauma: The Perceived Ability to Cope with Trauma (PACT) Scale*, 3 PSYCHOL. TRAUMA: THEORY, RES., PRAC. & POL'Y 117 (2011) (describing the PACT Scale and its development as a self-report measure).

individuals were "able to laugh," "remember the details of the event," "look for a silver lining," and "remind [themselves] that things will get better."[131] Recent work has found that on the PACT scale, those who report higher levels of focus on their traumatic memories *and* who focus on future-oriented processing such as optimism and moving forward appear to be at lower risk for developing mental health issues following loss and exposure to trauma.[132] The relation between coping flexibility and mental health outcomes has been observed in college students, recently bereaved adults, and Israelis with potential for trauma exposure.[133]

We also examined *appraisal style*, the way in which individuals interpret how and why an event occurred or the ways in which they appraise themselves or the world. Within the field of mental health, certain kinds of self-appraisal have been linked with the development and chronicity of mental health issues. Cognitive models of psychopathology have found that negative appraisals of one's self and the world can contribute to the onset of mental health issues[134] and can reinforce symptoms and impair recovery. For example, following exposure to a potentially traumatic event, exaggerated beliefs about the dangers of certain situations, catastrophic interpretations of events, beliefs that one is incompetent, and self-blame have been shown to predict the development of mental health problems and recovery time from stressful events.[135] In light of the importance of appraisal style in determining how people respond to trauma, a series of statements about working in human rights were constructed based on discussions with professionals in the field. These statements included sentences with either positive or negative valences. We created new survey questions to assess how advocates felt about their own work and about the human rights field generally. One question

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131. *Id.* at 120.

132. *Id.* at 117.

133. *Id.*

134. Margaret V. Sharrer, Ce Shen, & Thomas O'Hare, *Negative Appraisal and Traumatic Stress Symptoms in Community Clients With Serious Mental Illness*, 13 SOC. WORK & MENTAL HEALTH 216, 217–18 (2015).

135. Bryant & Guthrie, *Maladaptive Self-Appraisals Before Trauma Exposure*, *supra* note 114, at 812, 814; Patricia Frazier & Laura Schauben, *Causal Attributions and Recovery from Rape and Other Stressful Life Events*, 13 J. SOC. & CLINICAL PSYCHOL. 1, 2–3 (1994) (finding significant detrimental impacts to recovery when rape survivors feel self-blame); *see also* Meiser-Stedman et al., *supra* note 114, at 781–85 (finding that negative appraisals about a trauma, such as "My life has been destroyed by the frightening event," "Bad things always happen," and "I am a coward," significantly account for posttraumatic stress symptomatology and posttraumatic stress disorder at six months).

included a variety of items related to the advocate individually, such as "I feel that my work is pointless," "I feel inspired by my work," "I am an effective advocate," "My work has permanently changed me for the better," and "Because of my human rights work, I know that people can't be trusted." A second question related to the human rights field, and included items such as "On the whole, human rights efforts are successful at empowering victims of abuse," and "Human rights is often carried out in an imperialistic manner." We expected that appraisals with a negative valence about the advocate's work and the human rights field would be associated with greater mental health concerns.

We asked about the *extent of training, education, and support* survey participants had received with respect to mental health. In our experience, the human rights field has generally provided inadequate training about and support for mental health issues. Advocates are too often unaware of the potential psychological impacts of exposure to trauma and some advocates seem unwilling to acknowledge the need for, or to access, mental health services. Our perception of the lack of formal services in many human rights organizations stands in contrast to, for example, a variety of professions that pursue specific strategies[136] to help prevent vicarious trauma, such as limiting caseloads dealing with severe trauma for therapists working with victims of childhood sexual abuse,[137] and therapists and therapy student trainees who receive ongoing supervision when treating patients with PTSD.[138] The experience of the human rights advocates on our research team has been that when advance knowledge about common psychological responses was provided to students and peers, it has been enormously helpful for advocates themselves and also for advocates to better support their colleagues. Anecdotally, our

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136. *See, e.g.*, Holly Bell, Shanti Kulkarni & Lisa Dalton, *Organizational Prevention of Vicarious Trauma*, 84 FAM. SOC'Y: J. CONTEMP. HUM. SERV. 463, 463 (2003) (describing specific strategies gathered from growing literature to help staff deal with vicarious trauma in the workplace); Kelly R. Chrestman, *Secondary Exposure to Trauma and Self-Reported Distress Among Therapists*, *in* SECONDARY TRAUMATIC STRESS: SELF-CARE ISSUES FOR CLINICIANS, RESEARCHERS, & EDUCATORS 29, 33-35 (B. Hudnall Stamm ed., 1995) (recommending strategies for helping employees cope with secondary trauma).

137. *Confronting Vicarious Trauma: Different Ways of Approaching and Understanding This Work and How It Shapes Our Lives*, LIVING WELL, https://www.livingwell.org.au/professionals/confronting-vicarious-trauma/ [https://perma.cc/X7Z4-76KM] (last visited Mar. 22, 2018).

138. *See, e.g.*, Lori A. Zoellner et al., *Teaching Trauma-Focused Therapy for PTSD: Critical Clinical Lessons for Novice Exposure Therapists*, 3 PSYCHOL. TRAUMA: THEORY, RES., PRAC. & POL'Y 300 (2011) (providing their staff with information about the health risks associated with their work).

experience has been that training in these issues can help advocates to understand and 'normalize' what may otherwise be isolating or confusing psychological responses.

Although there remains a paucity of research on the benefits of psychoeducation in mitigating mental health issues following trauma exposure, a number of studies have found benefits to psychoeducation, especially for people exposed to more severe trauma.[139] Additionally, research has shown that stigmatizing and inaccurate beliefs about traumatic stress before trauma exposure predicts PTSD post-trauma exposure.[140] Thus, psychoeducation may be able to provide important corrective information to help prevent or mitigate adverse impacts. The normalization provided by education may allow human rights workers to accept and cope with their responses, put responses in perspective, communicate about their experiences, and prepare for future work that could trigger similar responses. Thus, in the survey, we sought information about how much training or education participants had received about potential emotional or psychological impacts of human rights work, and whether or how much psychological support had been made available by the individual's employer or school. We also asked how willing advocates would be to access psychological help if they felt it was needed and asked them to indicate which kinds of factors might prevent them from seeking or accessing help.[141]

C. Limitations

It is important to note that the study was designed to be an initial, exploratory, and broad-based study to inform further research and it has a number of limitations related to the sample, self-report format, cross-sectional design, language and mode of delivery, as well as limits in using "mental health" terminology in the survey.

First, while the survey participants are from diverse geographical settings, varied workplaces, report a broad range of time in the field, and possess a wide variety of human rights-related work experience, the study consisted of a self-selected convenience sample, introducing unknowable biases into sampling. It is thus not possible to make prevalence claims about mental health across the human rights

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139. Simon Wessely et al., *Does Psychoeducation Help Prevent Post Traumatic Psychological Distress?*, 71 PSYCHIATRY 287, 289–93 (2008).

140. Bryant & Guthrie, *Maladaptive Appraisals as a Risk Factor*, *supra* note 65, at 749–53.

141. Factors listed in the survey included: no information on how to access services, cost, concerns about people at work finding out, practical difficulties (remote location), did not believe it would be helpful, lack of time.

field from this survey, and we are unable to know whether, for example, individuals exposed to trauma and suffering from negative mental health were more or less likely than other human rights workers to decide to participate in the survey. Anecdotally, colleagues voiced a range of reasons for taking or not taking the survey including, on the one hand, not taking the survey because of their sense that they "were doing fine" and thus the survey was not relevant to them; as well as, on the other hand, not taking the survey because they thought it might "hit too close to home." Although voluntary and non-representative sampling has limitations, it is common in exploratory studies aimed at obtaining preliminary data about a field that can guide subsequent in-depth research and similar approaches have been used to document mental health issues with survivors of natural disasters, children and adolescents living in warzones, refugees, police, and veterans.[142] The survey findings cannot be generalized to the human rights field as a whole, but the high rates of trauma exposure and probable PTSD and depression within the sample are, in themselves, cause for concern, and suggest that some non-trivial sub-section of the human rights advocate population likely experiences adverse mental health associated with their work. In addition, the correlations that we explore among certain activities, cognitive styles, and specific mental health outcomes are valid within the sample itself, even if that sample is not generalizable to the whole population of advocates. Instead of setting out a definitive state of the field, the study aims to provide the starting point for investigations into the dynamics behind trauma exposure, mental health issues, and resilience.

Second, the survey used self-reported and online data collection as opposed to clinical interviews. Some studies suggest that online and face-to-face assessments can function comparably and self-report measures, such as those that assess PTSD, have been shown to have a high degree of agreement with clinical interviews.[143] However, other research suggests that self-report formats can lead to inflated rates of PTSD.[144] Also, symptoms of PTSD overlap considerably with those for other anxiety disorders, and some of the PTSD symptoms may

142. *See* Holtz et al., *supra* note 3, at 394 (referring to a number of studies on this point).

143. *See, e.g.*, Forbes et al., *supra* note 101, at 984 (concluding that the PTSD Checklist, a self-reporting measure, had a high level of diagnostic accuracy when compared to "gold standard" forms of diagnosis).

144. Iris M. Engelhard et al., *Low Specificity of Symptoms on the Post-Traumatic Stress Disorder (PTSD) Symptom Scale: A Comparison of Individuals With PTSD, Individuals With Other Anxiety Disorders and Individuals Without Psychopathology*, 46 BRIT. J. CLINICAL PSYCHOL. 449, 450, 453–54 (2007).

be due to another disorder. Further, the way in which questions on a self-report measure are understood can differ greatly within and between cultures, which might contribute to inflation.[145]

Third, the study was cross-sectional in nature: it largely captured levels of psychological wellbeing and related variables in one moment in time and we did not study individuals at different points in their careers. We do not have baseline data on psychological wellbeing among survey participants prior to starting human rights work and, although inferences may be drawn about how variables might influence each other, due to the design of the study, we cannot determine cause and effect. For example, the survey does not reveal whether perfectionism is a risk factor for PTSD or an outcome of PTSD; it might be that perfectionistic behaviors reflect a set of coping styles developed to manage one's response to a traumatic event. Future research could examine these issues and similar possibly explanatory dynamics.

Fourth, the survey was administered only in English and only online and thus likely skewed our sample to be over-inclusive of English speakers and under-inclusive of those who do not have routine access to the internet.

Finally, the language of "mental health" may have itself had a limiting effect on the study. Some human rights advocates have told us they find this framing to be overly medical, individualistic, or stigmatizing, preferring to discuss these issues as ones concerning "wellbeing" and "sustainability." Such individuals may have been less likely to participate in the survey as compared with those familiar and comfortable with "mental health" terminology.

III. STUDY FINDINGS

Following recruitment efforts using human rights advocacy networks and social media, 346 individuals who self-identified as currently or previously working in the human rights field completed all or almost all of the online survey.[146] A large proportion of the

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145. Devon E. Hinton & Roberto Lewis-Fernandez, *Idioms of Distress Among Trauma Survivors: Subtypes and Clinical Utility*, 34 CULTURE, MED. & PSYCHIATRY 209, 210 (2010); Arthur Kleinman & Joan Kleinman, *Suffering and Its Professional Transformation: Toward an Ethnography of Interpersonal Experience*, 15 CULTURE, MED. & PSYCHIATRY 275, 284–85 (1991).

146. In total, 524 participants began the survey and 346 participants completed all or almost all the values, resulting in a completion rate of sixty-six percent. The analysis in this paper therefore focuses on the 346 completers.

completers—256—were female, and 75 were male. The mean age for completers was 37.73 years and our sample included individuals with fifty-one different nationalities.[147] Although this was a convenience sample, and thus more work will need to be done to determine its generalizability, the findings for those who completed the survey are cause for serious concern. Among the human rights workers who completed the survey, 19.4% reported symptoms that would qualify them as having PTSD; 18.8% reported some symptoms of PTSD but not enough for a diagnosis; and 14.7% reported symptoms that would indicate that they had depression. When we controlled for depression symptoms, two factors were associated with *severe* symptoms of PTSD: exposure to trauma in connection with human rights work, and negative assessments about the efficacy and usefulness of their human rights work. When we controlled for PTSD symptoms, three factors were associated with symptoms of depression: exposure to trauma in connection with human rights work, perfectionism, and a decreased sense of self-efficacy. While these findings are disturbing, our results also contained some good news. Many of the human rights workers who completed the survey appear to be quite resilient to trauma: 43% of all respondents had minimal or no symptoms of PTSD despite the nature of their work. When we categorized these respondents according to exposure to direct trauma, defined as an event in which a person was directly threatened or attacked, however, only 28% of the direct trauma-exposed group was resilient. Together, these findings suggest that human rights work may be associated with increased rates of PTSD and depression, but that many advocates are resilient in the face of work-related threats to their mental health.

A. Exposure to Trauma

The great majority of survey respondents (89.3%) were exposed to one or more of a wide range of potentially traumatic events in the course of their work. As illustrated in Table 1, some respondents directly witnessed violence (34.4%) while others were indirectly exposed to trauma through interviewing clients, survivors, and witnesses (89.3%), visiting sites of violations (63.3%), responding to an emergency (54.6%), or witnessing violations of basic needs (78.9%).[148]

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147. While this sample is not representative, it does match some demographic trends that have been anecdotally noted in the human rights field, which many experience to be characterized by an overrepresentation of women and relatively younger workers.

148. Although survey respondents were asked about these types of potentially traumatic events in connection with their human rights work, many

In addition, a significant minority of respondents were themselves victims of violence, having been taken hostage, beaten, or assaulted (6.4%), or arrested (20.2%) in connection with their human rights work. Similarly, many (20.5%) had been directly threatened with violence related to their work. A considerable percentage of participants were exposed to non-human rights work-related trauma, such as natural disasters (14.5% before age eighteen; 24.6% after age eighteen), motor vehicle accidents (19.9% before age eighteen; 32.7% after age eighteen), and physical or sexual assault (20.8% before age eighteen; 21.7% after age eighteen). It is significant that this exposure occurred both prior to and following the respondents attaining eighteen years of age (see Table 2): numerous studies have shown that exposure to adversity and trauma during childhood, as well as ongoing exposure to trauma and stress in adulthood, increases one's likelihood of developing PTSD when exposed to a potentially traumatic event in later life.[149] Therefore, the rates of trauma exposure outside of human rights work may play a role in the levels of mental health issues observed in this study.

The rates of non-human rights-related trauma exposure are similar to levels among the general population for children and adults. For example, a survey of nationally or regionally representative adults in twelve countries found that thirty-eight to thirty-nine percent of individuals reported an adverse event during childhood across high, low, and middle income countries, including five to eleven percent having been exposed to physical abuse.[150] Among those who had experienced an adverse event, a majority reported exposure to multiple childhood adversities (fifty-nine to sixty-six percent).[151] Epidemiological studies have also shown similar rates of trauma exposure among adults. For example, 43.7% of individuals reported exposure to physical assault and 29.7% reported exposure to sexual assault in a study conducted with a large sample recruited from an online panel of U.S. adults.[152]

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human rights advocates work in contexts which themselves carry risks of potentially traumatic events, making it difficult to separate work-related and non-work-related exposure.

149. *See supra* notes 99–100 and accompanying text.

150. Ronald C. Kessler et al., *Childhood Adversities and Adult Psychopathology in the WHO World Mental Health Surveys*, 197 BRIT. J. PSYCHIATRY 378, 379 (2010).

151. *Id.*

152. Dean G. Kilpatrick et al., *National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-5 Criteria*, 26 J. TRAUMATIC STRESS 537, 541 (2013).

B. Mental Health: PTSD, Depression, Burnout, and Resilience

Many survey respondents reported that they had recently experienced symptoms that would qualify them for a full diagnosis of PTSD (19.4%) or a partial diagnosis in which they met criteria for some but not all of the symptom clusters entailed in a PTSD diagnosis (referred to as subthreshold PTSD) (18.8%). This is considerably higher than the general population. For example, a recent epidemiological study aimed at estimating the prevalence of PTSD in the United States found that 8.3% of survey respondents met criteria for PTSD over the course of their lifetime and 4.7% met criteria within the past twelve months.[153] In a study of 21,425 adults from six European countries (Belgium, France, Germany, Italy, the Netherlands and Spain), PTSD lifetime prevalence averaged 1.9%.[154]

We considered an individual as having PTSD for the purpose of this study if they reported experiencing a "moderate" or more intense level of a specific cluster of symptoms within the month before taking the survey. In line with the criteria and scoring guidelines for a diagnosis of PTSD in the DSM IV,[155] respondents were considered to have PTSD if they reported the following: one or more experiences of "intrusion" (nightmares, flashbacks, etc.); three or more symptoms of "avoidance" (avoiding people, places, or things that are associated with the traumatic event); and at least two experiences of "negative cognition" or negative mood symptoms (exaggerated negative beliefs or extended feelings of horror, guilt, shame, etc.). Those who reported experiencing two of these three types of symptoms were included among those with sub-threshold PTSD.

A significant number (14.7%) of survey respondents reported symptoms that qualified them as having major depression for the purposes of the study. Respondents were treated as likely to have major depression if they scored ten out of a possible twenty-seven points on a measure that asked about how frequently (from "not at all" to "nearly every day") they experienced nine different depressive symptoms. These symptoms included loss of pleasure, feeling hopeless, loss of energy, appetite, or concentration, and the desire to hurt or kill oneself.

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153. *Id.* at 542.

154. J. Alonso et al., *Prevalence of Mental Disorders in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) Project*, 109 ACTA PSYCHIATRICA SCANDINAVICA 21, 24 (2004).

155. AM. PSYCHIATRIC ASS'N, DSM-IV SOURCEBOOK § 309.81 (Thomas A. Widiger ed., 1st ed. 1994).

Nineteen percent of survey respondents reported that they had experienced a time during their human rights career when they felt burned out and had taken a break of three months or more. We examined whether different kinds of direct or secondary trauma exposure would be more strongly associated with burnout and found that secondary trauma exposure (e.g., conducting interviews, reviewing evidence, working with traumatized clients) and witnessing trauma (e.g., direct exposure through witnessing human rights violations) were the strongest predictors of burnout.

Resilience was defined in the study as the absence of persistent psychological distress despite exposure to trauma (as distinct from the absence of a mental disorder). Consistent with previous resilience studies, we defined resilience as almost no PTSD symptoms on the online assessment measure used in this study.[156] In this case, it was a score of less than or equal to twenty-five on the Posttraumatic Stress Disorder Checklist. In this study we found that forty-three percent of the survey respondents exhibited few to no symptoms of PTSD, and twenty-eight percent of survey respondents who reported direct exposure to trauma had few to no symptoms of PTSD.

C. Factors Assessed for Association with Mental Health Outcomes

To shed some light on the dynamics underlying the development of mental health issues in human rights advocates, we analyzed the survey data to identify correlations between symptoms of distress and specific work-related experiences and duties, as well as cognitive styles. We were eager to learn whether specific types of human rights work activities were more or less psychologically "risky." It is important to note that the existence of correlations between symptoms and work-related duties does not demonstrate a causal relationship. Instead, such correlations invite further research into the dynamics among the variables studied, as well as those factors the survey may not have captured. In this section, we present the main findings about these issues from our analysis of the survey data.

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156. Dorthe Berntsen et al., *Peace and War: Trajectories of Posttraumatic Stress Disorder Before, During, and After Deployment in Afghanistan*, 23 PSYCHOL. SCI. 1557, 1558 (2012); Isaac R. Galatzer-Levy et al., *Peritraumatic and Trait Dissociation Differentiate Police Officers with Resilient Versus Symptomatic Trajectories of Posttraumatic Stress Symptoms*, 24 J. TRAUMATIC STRESS 557, 560 (2009).

1. Human Rights-Related Trauma Exposure, Duties, and Mental Health

Ten diverse human rights work-related duties were examined for correlation with PTSD symptom severity. These duties involved a range of potential exposure to trauma, including: monitoring, litigation, lobbying, education, quantitative analysis, handling evidence, conducting interviews, visiting sites, working with human rights victims, and providing direct aid or medical care (see Table 3, *infra*). Some of these tasks, e.g., visiting sites, conducting interviews, would appear to be more likely to involve direct exposure to traumatic material, while others, e.g., human rights education, quantitative analysis, might seem less likely to include such exposure. Interestingly, notwithstanding the wide range of these occupational tasks, all but two of the tasks were correlated with PTSD severity. Perhaps surprisingly, only engagement in litigation and providing direct aid and medical care to human rights victims were not associated with PTSD. Further research is required to understand this finding, which might be connected to different occupational structures for action in the face of abuse, to perceptions of concrete accomplishment, or to direct assistance to specific individuals, which might provide a buffer against PTSD by improving the advocate's sense of self-efficacy, personal satisfaction, or connection to others. Also, clarity of role for a litigator or aid worker may assist workers in defining and accepting their own limits, perhaps mitigating the impacts of perfectionism or protecting against burnout and unrealistic expectations. There may be other explanatory dynamics at work, and future research would benefit from exploring the specifics of work tasks and their relationship with mental health.

2. Non-Human Rights Work-Related Trauma Exposure and Mental Health

We examined whether exposure to trauma outside the context of human rights work was a predictor for mental health issues. As described above, many human rights advocates who participated in this survey were exposed to non-work-related trauma as children and as adults at rates roughly comparable to the general population in countries where this data has been collected and published.[157] The psychological literature makes clear that individuals who experience greater levels of exposure to trauma are more likely to develop PTSD;

157. *See supra* Part III.A.

this phenomenon may be relevant to our data as well.[158] Consistent with the literature relating exposure to childhood adversity with vulnerability to PTSD in adulthood,[159] there was an association found in our data between exposure to non-human rights related trauma exposure before the age of eighteen and current PTSD symptom severity. However, the relationship between these two variables was no longer significant when controlling for other variables. Future studies would benefit from examining whether other variables mediate or moderate the link between early childhood adversity and current PTSD among human rights advocates.

Our study also found that depression could likewise be predicted by trauma exposure both as an adult and by trauma experienced prior to the age of eighteen. This is because trauma exposure during childhood potentially places an individual at higher risk of depression in adult years,[160] presumably because it may lead to biological alterations in systems that regulate emotion and stress and tends to foster patterns of thought that lead to depression—such as a sense of helplessness or negative self-worth.[161] While our survey did not seek to explain these issues, human rights workers have anecdotally observed that people may enter the human rights profession as a way of coping with their own sense of helplessness or low self-worth, since "doing good" may provide a salve and sense of meaning. This suggested dynamic deserves to be examined empirically in future work.

3. Appraisal Style

Our study found that human rights advocates who took our survey and were more likely to endorse "negative appraisals" of their own work were more likely to meet criteria for PTSD. However, despite many individuals in our survey endorsing positive appraisals about their own work in the field, these positive appraisals were not associated with lower levels of PTSD and depression.

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158. *See supra* notes 99–100 and accompanying text.

159. *See supra* note 99 and accompanying text.

160. Alexa Negele et al., *Childhood Trauma and Its Relation to Chronic Depression in Adulthood*, 2015 DEPRESSION, RES. & TREATMENT, 2015, at 1, 7, HINDAWI, Article ID 650804; *See* Jeremiah A. Schumm et al., *Changes in Posttraumatic Cognitions Predict Changes in Posttraumatic Stress Disorder Symptoms During Cognitive Processing Therapy*, 83 J. CONSULTING & CLINICAL PSYCHOL. 1161, 1162 tbl.1 (2015).

161. Christine Heim et al., *The Link Between Childhood Trauma and Depression: Insights from HPA Axis Studies in Humans*, 33 PSYCHONEUROENDOCRINOLOGY 693, 700 (2008).

On the whole, survey participants had mixed responses to negative appraisals about their human rights work and the human rights field. For example, in response to the appraisal "I feel burned out or overwhelmed," 38.7% disagreed, 36.1% agreed, and 25.2% were neutral. Similar splits were observed for other negative appraisal prompts: "I feel like my friends who don't do this kind of work don't understand me" (39.6% disagreed, 39.5% agreed, 21.9% were neutral); "Human rights generally treats symptoms rather than root causes" (39.4% disagreed, 34.4% agreed, 26.2% were neutral). 58.5% agreed with the statement "Human rights are easily and frequently co-opted by abusive states and corporations," and 45.5% agreed that "I feel anxious that I can't stop bad things from happening to others."

Strong trends were observed in participant responses to positive appraisals about their work and the field. 71% agreed that "[h]uman rights are generally a useful tool for challenging unequal economic systems;" 72.1% with "I am able to cope with the difficult things I see happening in my work;" 84.6% with "I gain a sense of meaning through my work;" and 72.7% with "I feel inspired by my work."

Despite difficulties in human rights work, and high reported exposure to trauma, many survey respondents feel positive about their work. In future research, it will be important to examine how the social justice values and goals of the human rights movement might be helping to buffer against harmful impacts of stress and trauma exposure.

These findings converge with other research showing that negative appraisals about one's self, trauma, and ability to cope with stress is associated with increased vulnerability to PTSD.[162] In this study, we focused our inquiry about negative appraisals on human rights-related issues. This allowed us to find that the way in which human rights advocates think about the impact their work has on them, the efficacy of human rights advocacy as a field, and their ability to manage occupational stressors and challenges, are important cognitive processes that may contribute to symptoms of PTSD.

The link between negative appraisals and poor outcomes is not limited to human rights advocacy. In fact, the identification and

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162. *See supra* note 114; *see also* Emma Dunmore, David M. Clark & Anke Ehlers, *Cognitive Factors Involved in the Onset and Maintenance of Posttraumatic Stress Disorder (PTSD) After Physical or Sexual Assault*, 37 BEHAV. RES. & THERAPY 809, 825–27 (1999) (noting how cognitive factors may contribute to the onset and persistence of PTSD).

modification of negative appraisals is a core tenet in cognitive behavioral therapy in general and for the treatment of PTSD in particular.[163] Studies that have looked at cognitive-behavioral therapy for PTSD have found that changes in negative appraisals are a key process underlying a significant reduction of PTSD symptoms in therapy.[164] In the case of human rights advocates, individual cognitive therapy may not be needed to help advocates learn how to identify and modify negative appraisals that may be impacting their psychological wellbeing. Workshops, trainings, and the dissemination of educational materials may be effective methods for helping advocates learn about the links between cognition and emotion and how cognitive processes, such as negative appraisals, may negatively impact mood and wellbeing, as well as strategies for modifying these thought patterns. This is not to suggest that human rights advocates should replace realistic, negative, and/or critical thinking about their work or the field. Rather, we believe that educating human rights advocates, especially those advocates who may be experiencing emotional distress and/or burnout, would help decrease the impact of negative appraisals on work-related emotional distress.

4. Perfectionism

We found that perfectionism predicted symptom severity for both PTSD and depression among human rights advocates who took our survey. The finding that perfectionism is associated with poor mental health is consistent with other studies showing that it predicts increased levels of anxiety.[165]

Although the survey cannot explain the association discovered in the analysis, it is possible that overly high expectations of oneself as a human rights advocate, despite the limited capacity to influence all situations, may place advocates at increased risk. This finding is consistent with evidence that self-blame predicts PTSD.[166] Having excessively high expectations about one's ability to meaningfully impact the people and situations entailed in human rights work may compound the stress of this work, and seems to be one individual difference that renders some advocates more at risk of mental health difficulties. The interplay between perfectionism, self-efficacy, and

163. Meiser-Stedman et al., *supra* note 114, at 784–85.

164. Birgit Kleim et al., *Cognitive Change Predicts Symptom Reduction With Cognitive Therapy for Posttraumatic Stress Disorder*, 81 J. CONSULTING & CLINICAL PSYCHOL. 383, 388 (2013).

165. *See, e.g.*, Kawamura et al., *supra* note 128, at 299.

166. Schumm et al., *supra* note 160, at 1162.

negative mental health impacts is an area where more empirical work would be especially valuable.

Interestingly, this appears to be one of the first studies to demonstrate a link between PTSD and perfectionism. However, perfectionism, more generally, has emerged as an important cognitive process associated with a wide range of mental health issues including anxiety, depression, and eating disorders.[167] To date, research has found that perfectionistic beliefs may be less likely to be risk factors for anxiety and depression, but may be more involved in the ongoing maintenance of the symptoms.[168] This is, in part, supported by studies showing that depressed and anxious patients who show high levels of perfectionism at the beginning of treatment benefit less from therapy.[169] A number of theories have been posited as to why perfectionistic beliefs contribute to symptoms of anxiety and depression including unrealistically high performance-related behaviors (such as constantly comparing one's performance to others), avoidance, procrastination, and counterproductive behaviors, such as being excessively thorough.[170] Additionally, studies have found that rigid thinking, high levels of self-criticism, shame, guilt following failure, rules, and avoidance are linked with clinical levels of perfectionism.[171] Despite the negative impact of perfectionism on mental health, a growing number of studies show that treatments aimed at helping patients to identify and modify perfectionistic thinking are often successful, and that these reductions in perfectionism often correspond with lower levels of depression and anxiety.[172] Such findings have been observed across a number of studies in which patients received individual cognitive therapy.[173] Additionally, help to reduce perfectionistic thinking does not appear to require individual psychotherapy, as emerging research shows a reduction in perfectionism following group therapy, and

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167. Egan et al., *supra* note 128, at 212.

168. Sarah J. Egan, Tracy D. Wade & Roz Shafran, *Perfectionism as a Transdiagnostic Process: A Clinical Review*, 32 CLINICAL PSYCHOL. REV. 203, 207 (2011).

169. *Id.* at 208.

170. *Id.* at 207.

171. *Id.*

172. *See id.* at 209–10 (assessing the existing body of research focused on treatment directly targeting perfectionism and discussing the clinical implications of the studies).

173. *Id.* at 209.

mindfulness.[174] As in the case of negative appraisals, most human rights advocates will not need clinical interventions for perfectionistic thinking or tendencies. In fact, given the detail-oriented work involved in human rights advocacy, a certain amount of perfectionism is necessary and required for one's work. However, if an advocate begins to experience depression, anxiety, or other mental health changes that impact their functioning, it might be helpful to examine whether perfectionistic thinking may be contributing to those changes. Furthermore, as with negative appraisals, workshops and training may help educate advocates about perfectionistic thinking. This approach might help empower advocates to identify and monitor their own thoughts and behaviors and, in turn, to develop strategies for counteracting these thought processes.[175]

5. Self-Efficacy

The study found that low self-efficacy was associated with PTSD and depression among those who took the survey. These findings are consistent with a robust literature showing that lower levels of self-efficacy are associated with poor mental health outcomes after exposure to traumatic stress.[176] Additionally, an emerging body of literature shows that self-efficacy can be associated with a person's resilience when confronted with adversity and potentially traumatic events. For example, a study of 2,860 Australian operating room nurses found that self-efficacy was one of the strongest predictors of resilience.[177] Additionally, higher levels of self-efficacy have been

174. *See* Cheri A. Levinson, *Perfectionism Group Treatment for Eating Disorders in an Inpatient, Partial Hospitalization, and Outpatient Setting*, 25 EUR. EATING DISORDERS REV. 579, 582 (2017) (noting that perfectionism group treatment resulted in a decrease of high standards); Ann R. Beck et al., *A Mindfulness Practice for Communication Sciences and Disorders Undergraduate and Speech-Language Pathology Graduate Students: Effects on Stress, Self-Compassion, and Perfectionism*, 26 AM. J. SPEECH-LANGUAGE PATHOLOGY 893, 894, 903–904 (2017) (showing that mindfulness sessions contributed to a reduction in maladaptive perfectionism).

175. Samantha Lloyd et al., *Can Psychological Interventions Reduce Perfectionism? A Systematic Review and Meta-Analysis*, 43 BEHAV. COGNITIVE PSYCHOTHERAPY 705, 726–27 (2015).

176. Benight & Bandura, *supra* note 70, at 1144–45.

177. Brigid M. Gillespie et al., *Resilience in the Operating Room: Developing and Testing of a Resilience Model*, 59 J. ADVANCED NURSING 427, 434 (2007).

associated with greater confidence in managing challenging workplace stressors.[178]

Self-efficacy has long been understood to be associated with better management of adversity, while a sense of lack of control is known to inhibit recovery after trauma.[179] Future research could explore whether particular features of the human rights field exacerbate poor self-efficacy among advocates. For example, human rights advocates frequently work in difficult and unpredictable situations and on issues that may be intractable, worsening, or only likely to improve after decades of work. Advocates may thus often be in situations that they cannot control or impact to the extent that they wish. The sense that one cannot adequately remedy human rights violations may contribute to a heightened sense of helplessness, leading to a poor psychological response. This may help to explain why only two types of human rights work, providing direct aid and medical care to human rights victims and engaging in litigation, were not associated with PTSD. Both of these types of work may involve clearer tasks and have a positive short-term impact, characteristics advocates can find lacking in other types of human rights work.

These survey findings are particularly important, as they suggest that techniques designed to improve a sense of self-efficacy may help promote resilient advocacy. For example, self-efficacy could be improved through training and education, pre-travel protocols, investigation guidelines, exposure simulations and practice, and peer mentoring and guidance. Valuable future research could be directed at experimenting with such tactics to strengthen self-efficacy. To date, we are not aware of PTSD treatments that specifically seek to increase self-efficacy. However, it is believed to be a key process underlying resilience and recovery. People with lower levels of self-efficacy are often more likely to develop PTSD in the wake of a traumatic event[180] and lower levels of self-efficacy reduce improvement in treatment.[181]

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178. Rosalind Lau et al., *Development of Self-Efficacy of Newly Graduated Registered Nurses in an Aged Care Program,* 34 AUSTRALASIAN J. ON AGEING 224, 227 (2015).

179. Benight & Bandura, *supra* note 70, at 1131–32.

180. *See* Anke Ehlers et al., *Posttraumatic Stress Disorder Following Political Imprisonment: The Role of Mental Defeat, Alienation, and Perceived Permanent Change*, 109 J. ABNORMAL PSYCHOL. 45, 51 (2000) (finding that "mental defeat" in torture victims served as a "unique predictor of PTSD symptom severity").

181. Anke Ehlers et al., *Predicting Response to Exposure Treatment in PTSD: The Role of Mental Defeat and Alienation*, 11 J. TRAUMATIC STRESS 457, 463–64 (1998) (referring to self-efficacy as "mental planning").

For example, in a sample of East German political prisoners, low levels of
self-efficacy (in this case referred to as "mental defeat") were associated with more severe PTSD symptomatology.[182] In this case, the authors suggested that maintaining higher levels of perceived self-efficacy helped individuals to cope more effectively because perceptions of controllability are associated with better regulation of one's emotions and physiological processes.[183] Higher levels of perceived self-efficacy may have also helped prisoners to think more clearly throughout the process, and may have allowed them to maintain a sense of autonomy despite their captivity.[184] Future research on human rights advocates would benefit from a more refined understanding of how beliefs about self-efficacy may protect advocates from negative mental health impacts.

6. Coping Flexibility

Studies have shown that coping styles are an important factor underlying the likelihood that one will develop mental health issues, such as PTSD and Major Depressive Disorder, after a traumatic event. A growing body of research suggests that individuals who employ diverse coping styles may be more resistant to negative mental health outcomes following trauma.[185] Consistent with these findings, we found that individuals with PTSD who were more likely to use "trauma-focused" coping styles (remaining focused on and fully experiencing the emotional and cognitive significance of a potentially traumatic event) and "forward-focused" coping styles (remaining optimistic, helping others, and maintaining goal-oriented thinking) also reported lower levels of PTSD symptom severity. Symptoms of Major Depressive Disorder, however, were associated with "forward-focused" coping styles, but not "trauma-focused" coping styles. The findings may suggest that alterations in future thinking may be a common cognitive process underlying resilience after trauma. However, the extent to which a person engages in processing a traumatic event may be more relevant to PTSD than Major Depressive Disorder.

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182. Ehlers et al., *supra* note 180, at 51.
183. *Id.* at 51–52.
184. *Id.*
185. *See, e.g.*, George A. Bonanno et al., *The Importance of Being Flexible: The Ability to Both Enhance and Suppress Emotional Expression Predicts Long-Term Adjustment*, 15 PSYCHOL. SCI. 482, 482, 485–86 (2004) (finding participants were able to better adapt to trauma when they had the ability "to flexibly enhance or suppress emotional expression in accord with situational demands").

Research on coping flexibility is new and studies have not yet tested how flexibility can be increased or modified to reduce mental health issues, but this work emphasizes the need to consider the variety of ways that people cope and to help people identify coping strategies that are best for them, rather than assuming that there is a one-size-fits-all approach to coping.

7. Silver Linings–Resilience

The study found that a large percentage of participants appeared resilient in terms of their psychological functioning, despite exposure to significant levels of trauma and adversity. Resilience is defined here as the absence of persistent psychological distress, despite exposure to trauma (as distinct from the absence of a mental disorder).[186] Based on this metric, 43% of respondents indicated that they were resilient despite the nature of their work. When categorized according to exposure, 28% of the participants who were exposed to severe trauma could be characterized as resilient, a significant number given the scale of violations witnessed and experienced by human rights advocates who took our survey.

D. Existing Mental Health Education and Support

Survey respondents reported little existing training and support for mental health in the human rights field. 70.6% reported that they had received "none" or "minimal" training or education about the potential impact of human rights work on their mental health; only 6.3% reported having "a lot." 74.7% said that their employer or school had offered or made available "none" or "minimal" psychological support; 2.7% said that they had been offered "a lot." 83.3% said that they had received "none" or "minimal" counseling in relation to their work; 2.3% said that they had received "a lot."

Advocates reported that a range of factors prevented them from seeking or accessing help, including cost (47.5%), time constraints (42.9%), no information on how to access services (28.8%), practical difficulties (22.6%), the employer did not make services seem acceptable (14.1%), and concerns about people finding out (13.3%), about self-disclosure (13.1%), or about confidentiality and legal privilege (12.4%).

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186. *See generally* George A. Bonanno, *Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?,* 59 AM. PSYCHOLOGIST 20 (2004) (exploring the meaning of resilience).

Yet advocates reported willingness to access services: 64.3% said that they would "definitely" or "very likely" access psychological help if it were available and if they needed it; just 4.5% said they were "not at all likely" to do so, and 9.1% said that their reason for not accessing available support was a belief that services would not actually help.

Our survey did not find a link between training or education and mental health outcomes. This may be due to the fact that so few people in the study had previously received training or education on mental health issues. As more and more organizations begin to incorporate mental health and wellbeing initiatives into their workforce, it will be important for them to assess whether such initiatives lead to a reduction in mental health issues and burnout.

Survey respondents made a range of suggestions for what organizations could do to help their employees. Suggestions included that counseling and support be made routine rather than requiring employees to single themselves out, instituting team counseling or check-ins, building peer support, ensuring that professional support is affordable and accessible, providing regular self-care training, enforcing breaks and leave, and reducing the "always available" work culture.[187]

IN LIEU OF A CONCLUSION: A RESEARCH AGENDA TO ADVANCE RESILIENT ADVOCACY

Given the findings of this study as well as the growing body of literature showing elevated rates of mental health concerns among those working in human rights and humanitarian contexts, we propose a series of next steps to better understand the factors that underlie mental health risks and promote resilience in the field of human rights. We also propose developing and testing interventions to increase resilience and promote long-term, sustainable, and resilient human rights advocacy practices.

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187. These findings are consistent with research on humanitarian workers, which has found that "predeployment preparation to prevent psychological stress in the field was limited, stress management practices in the field varied widely, and staff support resources were underdeveloped." *See* Connorton et al., *supra* note 40, at 147.

A. Empirical Mapping of Existing Policies, Training, and Support

Although the issue of mental health and wellbeing is just emerging as a topic of conversation in many parts of the human rights field, some organizations have already put in place policies, training programs, and psycho-social support structures for their staff.[188] While some use a mental health paradigm, others have taken explicitly feminist, holistic, or transformative approaches to wellbeing.[189] To better understand the state of the field, we are undertaking a mapping exercise aimed at exploring the practices employed—and not employed—by organizations engaged in human rights work. Interviewing staff from a geographically diverse sample of human rights organizations, we will identify tools, opportunities, and gaps in preventive and responsive measures aimed at enhancing wellbeing in these potentially traumatic contexts. Through this examination of existing practices, we hope to locate promising organizational practices that could be more broadly used in the human rights field.

B. Further Research on the Prevalence and Nature of Mental Health Impacts and Resilience

The data collected from the study described in this article was an important initial step in identifying mental health concerns in the human rights field. However, the limits in administration of the survey—such as limiting our respondents to those who speak English, online distribution and administration, and the use of a convenience sample, makes it difficult to determine whether these findings are representative of the field of human rights advocates. Future research

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188. *See, e.g.*, TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7, at 114 (graphing results from a survey conducted in Mexico and Central America on institutional mental health policies); MAIK MÜLLER & CLEMENCIA CORREA, BENEFICIOS DE LA INTEGRACIÓN DE UN ENFOQUE PSICOSOCIAL EN EL TRABAJO DE DERECHOS HUMANOS EN CONTEXTOS DE VIOLENCIA SOCIOPOLÍTICA 26–43 (2017) (recounting PBI Mexico's process of developing an institutional mental health policy); PROTECTION INTERNATIONAL, EL ENFOQUE DE GÉNERO EN LA PROTECCIÓN A DEFENSORES DE DERECHOS HUMANOS: LAS EXPERIENCIAS DE MÉXICO Y HONDURAS 54–59 (2016) (providing examples of different institutional mental health policies used by organizations in Mexico and Honduras).

189. *See, e.g.*, Kristin Antin, *Community Discussion: Holistic Security in Practice*, HURIDOCS (Mar. 14, 2017), https://www.huridocs.org/2017/03/community-discussion-holistic-security-in-practice/ [https://perma.cc/WQZ3-3RB7] (discussing the importance of mental health within the context of holistic security); TRAVERSÍAS PARA PENSAR Y ACTUAR, *supra* note 7, at 25, 45 (discussing feminist approaches to self-care); MÜLLER & CORREA, *supra* note 188, at 8, 11, 20 (discussing a psychosocial approach to wellbeing).

would benefit from additional survey research conducted in multiple languages, and in-person as well as online. Surveys could be administered with specific human rights organizations and movements that can inform whether the composition of those participating in the study are representative of their group. Additional options include the pooling of data from multiple organizations, as well as the use of probabilistic sampling where possible.[190] In addition, studies should seek to examine the prevalence of mental health concerns among different types of advocates (paid and unpaid, frontline and headquarters, situated within communities at risk and those far away, etc.) and among advocates engaged in different types of work, which will help organizations to understand areas of particular risk.

Studies that examine the movement-level, communal, and organizational aspects of burnout and trauma are also needed to complement the anecdotal evidence that human rights "culture" can exacerbate or—where positive dynamics are at work—mitigate distress. Further, although the magnitude and nature of the psychological distress observed in this study was disturbing, a large proportion of participants demonstrated resilience and strength in the face of adversity. This highlights the need for further research to understand the factors associated with resilience among human rights advocates, which could in turn inform the evidence base for measures aimed not only at preventing and reducing distress, but also at enhancing career longevity and preventing burnout. A better understanding of the prevalence of resilience and negative impacts in this population will allow mental health professionals and human rights advocates to work together to design preventive and responsive steps.

C. Longitudinal Research with Human Rights Organizations and Movements

Cross-sectional methods are useful in providing a snapshot of a population, but longitudinal methods will offer important insights into mental health and trauma exposure prior to human rights work and how human rights advocates respond to different events over the course of their human rights work. Longitudinal studies would provide the ability to model resilience and vulnerability over time. Such findings will play a critical role in determining what individual,

190. If designed well, probabilistic sampling would allow researchers to draw conclusions generalizable to the whole field.

organizational, environmental, situational, and occupational factors contribute to mental health outcomes. The cultural and communal aspects of human rights-related stress and burnout may be especially well understood through longitudinal research, since these factors may manifest more clearly over longer periods.

D. Study of Low-Cost, Non-Stigmatizing Interventions

Given these findings, human rights advocates must have access to psychological or psychosocial support that is tailored to their specific needs. Human rights advocates are exposed to direct and indirect dangers, as well as secondary trauma through the suffering of others. Their work may leave them isolated from common sources of psychological and social support and may prevent them from easily accessing mental health care. Furthermore, although systematic studies have yet to be conducted with human rights advocates, a small qualitative study[191] recently revealed a "martyr culture" among human rights advocates that comports with anecdotal information reported by workers in informal discussions. Further, studies of personnel in professions such as the military reveal high levels of stigma concerning mental health issues within the work culture of these populations.[192] With this in mind, effective interventions will need to consider the unique experiences, concerns, and range of psychological reactions that human rights advocates experience. Interventions are likely to be most effective if they are developed through active partnerships between psychosocial professionals and human rights advocates. Given successes in other fields, low-cost, highly accessible, and stigma-reducing strategies may be effective methods for meeting this population's mental health needs. Specifically, expressive writing and mindfulness practice have shown promise[193] and may be well-suited to

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191. Gorski & Chen, *supra* note 17, at 397.

192. *See* Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13, 16 (2004) (reporting results of a study about mental health conditions and barriers to care among combat infantry units in the U.S. military); Irina Komarovskaya et al., *Early Physical Victimization is a Risk Factor for Posttraumatic Stress Disorder Symptoms Among Mississippi Police and Firefighter First Responders to Hurricane Katrina*, 6 PSYCHOL. TRAUMA: THEORY, RES., PRAC. & POL'Y 92, 92, 94–95 (2014) (studying the risk of PTSD in first responders).

193. On expressive writing, *see* Nina A. Sayer et al., *Randomized Controlled Trial of Online Expressive Writing to Address Readjustment Difficulties Among U.S. Afghanistan and Iraq War Veterans,* 28 J. TRAUMATIC STRESS 381, 387–89 (2015) (finding expressive writing to be a promising intervention for war veterans experiencing reintegration difficulties); on mindfulness practice, *see* Yi-Yuan Tang

the human rights field. These measures are inexpensive and easy to implement. They do not require a large commitment of time, and advocates could continue using these practices on their own should they find them to be useful.

E. Building a Community of Practice to Transform the Culture of Human Rights Work

Based on data collected from this study and feedback from presentations to human rights advocates and students, more needs to be done to build infrastructure, improve training, and increase knowledge about mental health issues, preventive measures, coping techniques, and organizational dysfunction associated with stress and trauma. Furthermore, survey and anecdotal data suggests that although human rights advocates are interested and motivated to pursue wellbeing and mental health support, a number of barriers to assistance are consistently identified, such as cost, perceived stigma, lack of time, and lack of organizational support. Therefore, this field would benefit from the development and cultivation of partnerships and systems to share information on strategies and practices being used by human rights advocates. It would also be wise to import findings from allied fields that would help boost mental health education and literacy as well as teaching concrete coping skills to help manage stress in the context of human rights work. It is also important to identify and share tools for human resources personnel and managers within human rights organizations and for leaders of social movements. Protocols and policies from other fields could be used as the basis to develop human rights-specific approaches to prevention and response. A community of practice is needed, and has begun to emerge through meetings, seminars, and formal and informal networking. These steps need to be adequately funded at the individual, organizational, and field or movement level, and donors and other partners should consider steps they can take to build and support these resources.

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et al., *Short-Term Meditation Training Improves Attention and Self-Regulation,* 104 PROC. NAT'L ACAD. SCI., 17152, 17154–55 (2007) (indicating short-term integrative body-mind training improves responses to mental stress); *see also* Yi-Yuan Tang et al., *The Neuroscience of Mindfulness Meditation*, 16 NEUROSCIENCE 213, 220 (2015) (finding mindfulness meditation might cause changes in the "the core regions involved in self-regulation of attention, emotion and awareness . . .").

APPENDICES

Table 1: Frequency and Type of Trauma Exposure Reported in Human Rights Advocates

Exposure Type	Frequency
Conducting Interviews	89.3%
Visiting Sites of Violations	63.3%
Witnessing Violence	34.4%
Witnessing Violations of Basic Needs	78.9%
Taken Hostage, Beaten, Assaulted	6.4%
Threatened with Being Taken Hostage, Beaten, or Assaulted	20.5%
Arrested by a Government	20.2%

Table 2: Frequency and Type of Non-Human Rights Work Trauma Exposure

Non-Human Rights Work Exposure	Before 18	After 18
Natural Disaster	14.5%	24.6%
Accident (e.g., motor vehicle)	19.9%	32.7%
Physical or Sexual Assault	20.8%	21.7%
Combat	3.8%	6.9%

Table 3: Correlations Between Occupational Task and Symptoms of PTSD[194]

		1	2	3	4	5	6	7	8	9	10	11
1.	PCL-C[195]	1										
2.	Monitoring	.28**	1									
3.	Litigation	.09	.19**	1								
4.	Lobbying	·13*	.24**	.07	1							
5.	Education	.15**	.16**	.24**	.31**	1						
6.	Quantitative analysis	.20**	.13*	·01	.17**	.16**	1					
7.	Aid or medical care	.04	.10	-·03	.01	.20**	.08	1				
8.	Handling evidence	.26**	.28**	.33**	·17**	.11	.21**	-.04	1			
9.	Conducting interviews	.24**	.34**	·32**	·15**	.15**	.11	.06	.50**	1		
10.	Visiting sites	.31**	.46**	·14*	.18**	.14*	.25**	.11	.50**	.49**	1	
11.	Working with victims	.30**	.25**	.04	.26**	.13*	.19**	.05	.18**	.21**	.30**	1

194. *$p < .05$; ** $p < .01$.
195. PCL-C = PTSD Checklist-Civilian Version.