THE STUDY OF PREVALENCE OF BURNOUT AND SECONDARY TRAUMATIZATION IN SERVICE PROVIDERS WORKING WITH REFUGEES IN SERBIA

Precursors and effects of secondary exposure to trauma and mechanisms of prevention

CONTENT

Strategic document Guidance on protection and improvement of mental health of refugees, asylum seekers, and migrants in Serbia (WHO, 2019), developed in cooperation between Institute for Mental health, Institute for Public health, Department of Psychology, University of Belgrade, Psychosocial Innovation Network (PIN), World Health Organization (WHO), and Commissariat for refugees and migration of Republic of Serbia, and adopted by the Ministry of Health, defines standards in provision of mental health services for refugees and systemic recommendations for improvement of mental health protection.

One of the recommendations defined by this document refers to the need for protection of service providers' mental health and well-being, and prevention of burnout and secondary trauma in persons involved in providing services to beneficiaries while ensuring evidence-based practice.

In accordance with recommendation defined by the Guidance, with the support of Open Society Foundation, World Health Organization, Institute of Psychology, University of Belgrade, and all relevant actors involved in provision of direct support to refugees and migrants in Serbia, PIN conducted a study on prevalence of burnout and secondary traumatization in service providers working with refugees in Serbia, its precursors and effects, and mechanisms of prevention. The main aim of the study was to provide the evidence needed for the creation of data-driven programs for the prevention of burnout and secondary trauma among service providers working with refugees and protection of their physical and mental health.

Research methodology

Presented data was collected during the period between 01.2019. and 05.2019. in Belgrade, Niš, Sjenica, and Pirot. The sample consisted of 215 professionals working in the refugee protection in a number of locations across Serbia (Belgrade, Niš, Pirot, Sjenica, Tutin, Bujanovac, Sombor, Subotica, Šid, etc.). Fifty-three percent of the total number of service providers of different educational backgrounds that took part in the study participated in trainings within this project. The remaining 46.5% of the sample consisted of medical staff working in community Health centres and public hospitals across Serbia that participated in the series of trainings on the topic of cultural sensitization of professionals providing medical care in multicultural context (as part of the WHO-implemented activities within the *European Union Support to Migration Management in the Republic of Serbia*).

DEMOGRAPHICS AND WORK-RELATED CHARACTERISTICS OF THE SAMPLE

Gender and age structure of the sample are depicted in Figures 1 and 2. The majority of the sample consisted of individuals between the ages of 26 – 40 (66%). At the time of data collection about half of the participants (48.4%) have been working in the refugee protection over two years, 15.2% have been working in the refugee protection between 18 and 24 months, 10.3% between 12 and 18 months, 15.2% between 6 and 12 months, and 10.9% have been working in the field of refugee protection for less than 6 months.

Figure 3 presents percentages of the type of help provided by participants included in this study.

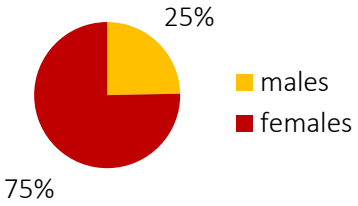

Figure 1. Gender structure of the sample

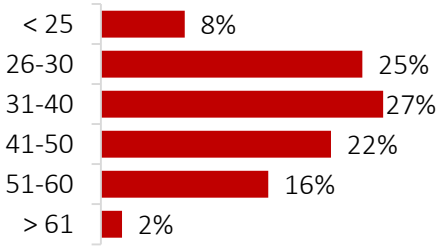

Figure 2. The age structure of the sample

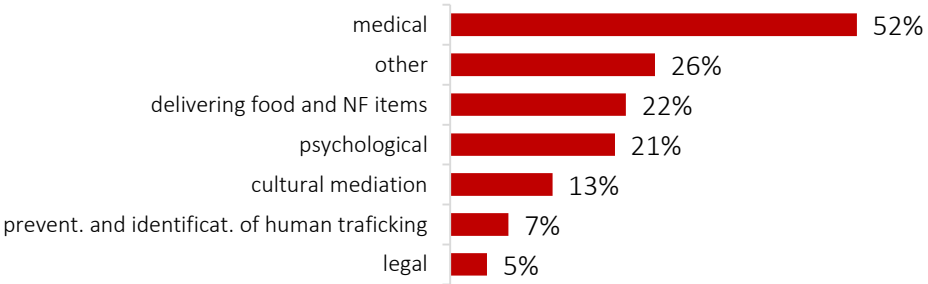

Figure 3. Type of help provided

INSTRUMENTS AND DATA COLLECTION METHODS

With the aim of comprehensive assessment of mental health, psychological protective and risk factors for various work-related psychological difficulties the participants completed a battery of psychological instruments assessing symptoms of burnout, the extent of secondary exposure to trauma, symptoms of secondary traumatic stress, depression and anxiety, most frequently employed strategies in dealing with stress (coping mechanisms), self-perceived quality of life, and posttraumatic growth.

The participants completed anonymized comprehensive battery of psychological tests during training sessions and had an opportunity to be debriefed on the main topics covered by questionnaires and were given overall feedback on their results so they could be aware of the level of psychological difficulties they are experiencing.

Secondary exposure to trauma

Secondary exposure to the traumatic events, i.e. the quantity and the quality of those experiences is a *condicio sine qua non* for the secondary traumatization. Therefore, higher exposure to traumatic content as well as exposure to some specific highly traumatized experiences of their clients can lead to the more severe symptoms of secondary traumatic stress and related psychological difficulties in service providers with whom these experiences were shared.

QUESTIONNAIRE

The adapted version of the Harvard Trauma Questionnaire, Part I – short form (HTQ SF) was used for the assessment of secondary exposure to traumatic experiences. HTQ SF is a cross-culturally validated and widely used check-list for measuring torture and trauma. The check-list consists of 17 traumatic experiences refugees could experience in their countries of origin or in travel was adapted for use with service providers. Namely, the participants were asked to report which of the traumatic experiences was directly shared with them by a person who experienced it.

RESULTS

The participants reported which of the traumatic experiences presented in Table 1 was shared with them directly by the person who experienced it. On average, service providers were faced with 75.2% of traumatic experiences of their clients from the check-list,. The vast majority of service providers were faced with clients who had *close to death experience, who lacked food and water* or *shelter*.

Among less frequently shared experiences were those of *brainwashing* and person being *lost or kidnapped* and *raped or sexualy abused*. Still, three to four out of ten service providers was directly faced with a person who experienced these traumas.

Table 1. *The relative frequency of secondary exposure to different traumatic experiences*

Did a person with whom you worked with experienced…	%
Forced separation from family members	61.5
Murder of family or friend	53.7
Murder of stranger(s)	48.6
Lack of food and water	73.8
Lack of shelter	70.4
Combat situation	58.6
Being close to death	74.8
Imprisonment/detention	50.3
Forced isolation from others	45.4
Torture	54.3
Ill health without access to medical care	60.5
Unnatural death of family or friend	61.9
Brainwashing	29.8
Lost or kidnapped	40.0
Serious injury	61.9
Rape or sexual abuse	44.3
Beating	61.3

Note. % - the percentage of service providers being faced with given traumatic experiences of their clients

Burnout

Burnout is a psychological syndrome that can be described along three relatively distinct but correlated dimensions, namely: exhaustion which represent a core dimension of burnout and which is characterized by loss of energy, feeling of wearing out, depletion, debilitation, and fatigue; feelings of cynicism and detachment from the job such as depersonalization, detached concern, loss of idealism, negative attitudes, withdrawal, irritability; and a lack of accomplishment; and a sense of professional inefficacy, i.e. reduced efficiency or capability, inability to cope with stressors, low morale, etc.

QUESTIONNAIRE

For the assessment of burnout syndrom the Copenhagen Burnout Scale (CBI) consisting of 19 items was used, measuring burnout in three domains – personal (the degree of overall physical and psychological fatigue and exhaustion experienced by a person), work-related (the level of physical and psychological fatigue and exhaustion that is perceived as related to service provider's work), and client-related (the degree of physical and psychological fatigue and exhaustion attributed to work with clients). Each of the domains of burnout assessed by the CBI captures one's attribution of physical and psychological fatigue and exhaustion.

RESULTS

On average, 26.5% of service providers demonstrated elevated levels of burnout. However, about a half of participants exhibited elevated burnout-related symptomatology in the personal domain (46.0%), 27.4% demonstrated elevated burnout-related difficulties in the work domain, while 26.0% attributed their difficulties to working with clients. The relative frequency of individual burnout-related difficulties is presented in Table 2.

In other words, pervasive psychophysical exhaustion and feelings of being worn out that are not necessarily attributed to specific aspects of work showed to be significantly higher that those attributed to work characteristics and clients *per se*. On the other hand, both work-related and client-related burnout showed to be approximately the same, significantly affecting around one-quarter of service providers. Therefore, it seems that work demands, insufficient work-life balance, and emotion-demanding people work achieve interactive and cumulative effect and lead to the fluid sense of personal burnout making it more pervading and less attributable to a single domain in particular (e.g. to work or clients).

Table 2. *The relative frequency of reported burnout-related difficulties*

	%
How often do you feel tired?	88.8
How often are you physically exhausted?	74.9
How often are you emotionally exhausted?	66.5
How often do you think: ”I can’t take it anymore”?	47.5
How often do you feel worn out?	58.1
How often do you feel weak and susceptible to illness?	41.4
Is your work emotionally exhausting?	72.6
Do you feel burnt out because of your work?	49.3
Does your work frustrate you?	39.1
Do you feel worn out at the end of the working day?	76.7
Are you exhausted in the morning at the thought of another day at work?	41.9
Do you feel that every working hour is tiring for you?	37.2
Do you lack energy for family and friends during leisure time?	34.0
Do you find it hard to work with clients/ beneficiaries?	29.8
Do you find it frustrating to work with clients/ beneficiaries?	31.2
Does it drain your energy to work with clients/ beneficiaries?	55.8
Do you feel that you give more than you get back when you work with clients/ beneficiaries?	54.9
Are you tired of working with clients/ beneficiaries?	52.6
Do you sometimes wonder how long you will be able to continue working with clients/ beneficiaries?	49.8

Secondary traumatic stress

Practitioners involved in the helping professions are often working with vulnerable populations and therefore are exposed to risk of secondary traumatic stress or secondary traumatization – a condition that results from helping or wanting to help traumatized individuals, and which mimics the symptoms of Post-Traumatic Stress Disorder (PTSD). More precisely, it includes wider dysphoric symptomatology which negatively distorts cognitions and mood, uncontrollable and unwilling imaginary of clients' traumatic experiences, i.e., *intrusions*, general psychophysical *hyperarousal*, and *avoidance* of people and places, i.e., cues which can trigger experienced traumatic content and negative emotions.

QUESTIONNAIRE

Secondary Traumatic Stress Scale (STSS) was used in order to assess the degree of secondary traumatization in service providers. STSS relies on DSM-4 nomenclature and consists of 17 items measuring PTSD-like symptoms of *hyperarousal* – experiencing dysphoric mood, sleep difficulties, feelings of tension, distress, concentration problems, irritability, etc, *avoidance* – intentional avoidance of thoughts, memories or stimuli associated with the traumatic experience, and *intrusions* – experiencing unwilling imagery and disturbing dreams related to the client's traumatic experiences.

RESULTS

The results have shown that 28.8% of professionals working with refugees in the current sample can be considered little or completely unaffected by secondary traumatic stress symptomatology; 39.1% are mildly affected by secondary traumatic stress-related difficulties; 14.0% can be considered as moderately secondary traumatized; 8.8% are suffering from highly pronounced secondary traumatic stress; while 9.3% exhibit severe secondary traumatic stress-related difficulties. Using the recommended cutoff score that indicates the need for taking steps in order to address secondary traumatic stress symptomatology showed that 32.1% of professionals who are working with refugees can be considered at risk of this syndrome. Table 3 presents the percentages of service providers who experienced disturbances by individual symptoms of secondary traumatic stress.

Service providers reported having the most dysphoric- and hyperarousal-related disturbances, followed by tendencies to avoid certain places and people that remind them to some of the traumatic stories they heard about. The least pronounced difficulties experienced by service providers are the one related to intrusive thoughts about traumatic content that was shared with them.

Table 3. *The relative frequency of reported secondary traumatic stress-related difficulties*

	%
I felt emotionally numb	32.6
My heart started pounding when I thought about my work with clients	10.2
It seemed as if I was reliving the trauma(s) experienced by my client(s)	30.2
I had trouble sleeping	30.7
I felt discouraged about the future	32.6
Reminders of my work with clients upset me	23.3
I had little interest in being around others	33.5
I felt jumpy	53.0
I was less active than usual	42.8
I thought about my work with clients when I didn't intend to	43.7
I had trouble concentrating	46.0
I avoided people, places, or things that reminded me of my work with clients	12.1
I had disturbing dreams about my work with clients	7.9
I wanted to avoid working with some clients	20.9
I was easily annoyed	32.6
I expected something bad to happen	30.2
I noticed gaps in my memory about client sessions	19.1

Anxiety and depression

Service providers were assessed for the frequency and severity of symptoms that are indicative of depression and anxiety (using two single-item measures). They reported the presence of these symptoms in the last seven days from the moment of assessment. Results have shown that the majority of service providers demonstrated either complete absence of anxiety- and depression-related difficulties or mostly negligible disturbances in negative mood spectrum (Table 4). However, 6% of participants reported having relatively pronounced anxiety-related disturbances, while around 8% reported having noticeable depressive symptoms during the last week.

Table 4. *The relative frequency of reported anxiety- and depression-related difficulties*

	never (%)	rarely (%)	occasionally (%)	often (%)	very often (%)
Anxiety	43.7	34.5	15.8	4.7	1.4
Depression	37.7	38.1	15.8	7.0	1.4

Furthermore, the results have shown that service providers who reported more frequently experiencing symptoms of burnout demonstrated more severe symptoms of anxiety *(*r = .454, p < .001) and depression (r = .443, p < .001). Likewise, participants experiencing higher levels of secondary traumatization demonstrated elevated levels of both anxiety- (r = .587, p < .001) and depression-related (r = .554, p < .001) disturbances. These syndromes taken together accounted for 35% and 30% of the variance of anxiety and depression symptomatology found in service providers, respectively.

Quality of life

QUESTIONNAIRE

Manchester Short Assessment of Quality of Life (MANSA) was used as the tool for the assessment of self-perceived quality of life. The instrument consists of 12 seven-point items and measures quality of life in a variety of domains such as social relationships, finances, safety, accommodation, living situation, leisure, work, etc.

RESULTS

The results have shown that the majority of service providers (61.9%) are predominantly satisfied with their life, while 37.2% of them see the place for improvement regarding their quality of life. Around 1% of service providers reported being mostly dissatisfied with their life. Service providers have shown to be the least satisfied with their financial situation and the quality and quantity of their leisure activities. On the other hand, they reported to be satisfied the most with their close social relationships.

The results have shown that the more frequent and severe symptoms of burnout (r = -.455, p < .001) and secondary traumatic stress are (r = -.472, p < .001), a person is less satisfied with his/her quality of life indicating that around one-quarter of the variance of service providers' quality of life is attributable to the negative effects of these syndromes, i.e., the effects of burnout and secondary traumatic stress on service providers' well-being.

Coping mechanisms

QUESTIONNAIRE

Brief COPE inventory was used as a measure of adaptive and maladaptive coping mechanisms, i.e., conscious strategies that people use in dealing with stress and/or trauma in order to alleviate negative emotions caused by the stressor and establish a psychological balance. COPE consists of 28 items that measure relative stabile tendencies in employing following 14 coping mechanisms: *Using emotional social support* – getting moral support, sympathy, or understanding; *Using instrumental social support* – seeking advice, assistance, or information; *Venting of emotions* – the tendency to ventilate distressing negative feelings; *Planning* – thinking about how to cope with a stressor, i.e. coming up with action strategies, thinking about what steps to take and how to handle the problem the best; *Acceptance* – accepting the reality of a stressful situation; *Humor* – coping with stress using humor; *Active coping* – taking active steps, in order to try to remove the stressor or to reduce its effects, includes initiating direct action, increasing one's own efforts, and trying to execute a coping strategy in a stepwise fashion; *Positive reframing* – coping aimed at managing distressful emotions rather than at dealing with the stressor itself and trying to see things in positive light; *Religious coping* – the tendency to turn to religion in times of stress; Behavioral disengagement – reducing one's effort to deal with the stressor, even giving up the attempt to attain goals with which the stressor is interfering (helplessness);

Denial – refuse to believe that the stressor exists or trying to act as though the stressor is not real; *Self-distraction* – using alternative activities to take one's mind off a problem such as daydreaming, escaping through sleep, or escaping by immersion in TV; *Self-blame* – a tendency to criticize and blame oneself for things that happened; and *Substance use* – using psychoactive substances in order to cope with the stress

RESULTS

Service providers were assessed for the frequency of usage of different coping mechanisms usually employed in the time of stress. Results are presented in Table 5. The majority of service providers reported using adaptive coping strategies, i.e. employing problem-orientated emotional and behavioral patterns (Problem-focused) and reaching out for help in order to mitigate stress-induced negative emotions when needed (Social and emotion-focused coping). On the other hand, most of them reported seldom using maladaptive coping mechanisms such as those that serve for either postponing, neglecting, or displacing the source of the stress and/or its psychological consequences (Avoidant coping).

Both adaptive and maladaptive coping mechanisms can be effective in alleviating stress and its effect in the short run, but adaptive coping mechanisms are much more efficient and useful than maladaptive in the long run, where predominant usage of maladaptive coping mechanisms can leave a person not being able to reduce, process, and overcome stress in a psychologically adaptive way.

Table 5. *The relative frequency of usage of different coping mechanisms*

	coping mechanisms	seldom (%)	occasionally (%)	frequently (%)
Problem-focused coping	Planning	8.4	49.3	42.3
	Acceptance	12.1	55.8	32.1
	Positive reframing	15.8	57.7	26.5
	Active coping	9.8	45.1	45.1
	Humor	36.7	36.7	26.5
Social- and emotion-focused coping	Emotional social support	28.4	52.1	19.5
	Instrumental social support	26.5	56.7	16.7
	Venting of emotions	28.4	57.2	14.4
Avoidant coping	Behavioral disengagement	86.0	12.1	1.9
	Denial	86.0	13.0	0.9
	Self-distraction	18.1	58.6	23.3
	Self-blame	59.1	34.9	6.0
	Substance use	95.3	4.7	0.0
	Religious coping	74.4	19.5	6.0

Regarding adaptive Problem-focused coping mechanisms *Planning* and *Acceptance* were most widely used amongst service providers. *Instrumental* and *Emotional social support* are employed occasionally and significantly more frequent than *Venting of emotions*. When it comes to maladaptive coping mechanisms, service providers are, when faced with stress, most prone to use *Self-distraction* – the mechanism that serves to alleviate distressing emotions dislocating one's attentional capacities from the source of stress.

Additionally, service providers showed to be somewhat prone to maladaptive coping mechanism of *Self-blaming*. Finally, highly maladaptive coping mechanisms of *Behavioral disengagement* and *Denial* have shown to be seldom employed by service providers, but still around 14% of participants reported using these mechanisms at least occasionally.

The results have shown that service providers who more frequently use any of the maladaptive coping mechanisms – *Behavioral disengagement* (r = .272, p < .001), Denial (r = .235, p < .001), *Self-distraction* (r = .188, p = .008), *Self-blame* (r = .321, p < .001), or *Substance use* (r = .194, p = .004) demonstrate more severe symptoms of secondary traumatization, i.e., they are not able to adequately process traumatic content with which they were faced with, which leave them in a vicious circle of distress. On the other hand, service providers that are prone to utilize mechanism of *Active coping* proved to be more resistant to the symptoms of secondary traumatization than those who never or seldom employ this coping mechanism.

Additionally, service providers who are more prone to use *Substances* (r = .160, p = .019), and maladaptive mechanisms *of Behavioral disengagement* (r = .143, p = .036) and *Self-blame* (r = .188, p = .006) demonstrated elevated levels of burnout pointing to the deleterious effects of this kind of coping with stress.

Posttraumatic growth

Working with traumatized individuals can lead to positive psychological effect on people who work with them. These psychological benefits can be observed in at least five interrelated domains – experiencing more appreciation of own life; experiencing increased personal strength and self-reliance; being able to perceive novel possibilities in life; experiencing increased closeness with other people, counting on people in the time of need, and emotion exchange; and experiencing spiritual changes as a result of being faced with traumatized people on a daily basis.

QUESTIONNAIRE

Posttraumatic growth, i.e. positive outcomes and changes in one's perception of self and the world that occurred as a result of working with traumatized individuals was assessed using the adapted version of Posttraumatic Growth Inventory (PGI). PGI consisting of 21 six-point scale items was adapted into service providers' form asking participants to report the degree of experienced positive outcomes of the work with traumatized individuals. PGI assesses global posttraumatic growth as well as five relatively distinct aspects of posttraumatic growth: *Relating to others* – increased relying on other people in the time of need, having greater sense of closeness, having more compassion for others, having more belief in people, *New possibilities* – development of new interests and perspectives and having a greater sense of confidence in personal capacities for devoting them, *Personal strength* – increasing sense of self-reliance and capacity in dealing with difficulties,

Spiritual change – deepening of spiritual beliefs, and *Appreciation of life* – changes in life priorities and increased appreciation for the value of own life.

RESULTS

The results have shown that close to one-third of service provides in total (30.2%) experienced complete absence or negligible benefits resulting from working with traumatized individuals, 39.5% experienced moderate levels of posttraumatic growth, while 30.2% experienced high levels of posttraumatic growth. Perceived posttraumatic growth by domains of change is presented in Table 6.

Table 6. *The relative frequency of perceived posttraumatic growth by domains of change*

domains of change	no change (%)	moderate change (%)	significant change (%)
Appreciation of life	30.2	26.5	43.3
Personal strength	27.9	30.7	41.4
New possibilities	31.6	35.3	33.0
Relating to others	34.4	32.6	33.0
Spiritual change	58.1	22.3	19.5

The least psychological gains service providers experienced in the domain of *Spiritual change* and *Relating to others*, while they have benefited the most when it comes to developing *Personal strength* and increased *Appreciation of life* and perceiving *New possibilities*.

Summary of the main results

SECONDARY EXPOSURE TO TRAUMA

- Professionals working with refugees, migrants and asylum seekers are to a great extent on a daily basis exposed to numerous traumatic experiences of beneficiaries. Results have shown that, on average, service providers were faced with 75.2% of the most severe traumatic experiences of their clients.

BURNOUT AND SECONDARY TRAUMATIC STRESS

- Results have shown that 26.5% of service providers demonstrated elevated levels of burnout, while 32.1% demonstrated noticeable difficulties indicative for secondary traumatic stress.

ANXIETY, DEPRESSION, AND QUALITY OF LIFE

- The majority of service providers demonstrated low anxiety- and depression-related difficulties and relatively high quality of life. However, those who exhibited elevated levels of secondary traumatic stress demonstrated more pronounced depression- and anxiety-related symptomatology as well as lower quality of life indicating the negative effects of these syndromes on their overall mental health and well-being.

COPING MECHANISMS

- The results have shown that the majority of service providers tend to use adaptive coping mechanisms (Problem-focused and Social and emotion-focused coping) before maladaptive ones (Avoidant coping). Service providers who more frequently use maladaptive coping mechanisms proved to have more severe symptoms of burnout and secondary traumatization. Therefore, usage of maladaptive coping mechanisms by disabling adequate processing of stressful and traumatic work-related content represent a risk factor for developing full-blown symptomatology of burnout and secondary traumatization.

POSTTRAUMATIC GROWTH

- 30.2% of service providers experience high levels of posttraumatic growth, i.e. positive psychological outcomes and changes in one's perception of self and the world that occurred as a result of working with traumatized individuals. Results have shown that service providers benefited the most in the domains of developing personal strength and self-reliance, increased appreciation of their own life, and perceiving novel possibilities in life as a result of working with beneficiaries.

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