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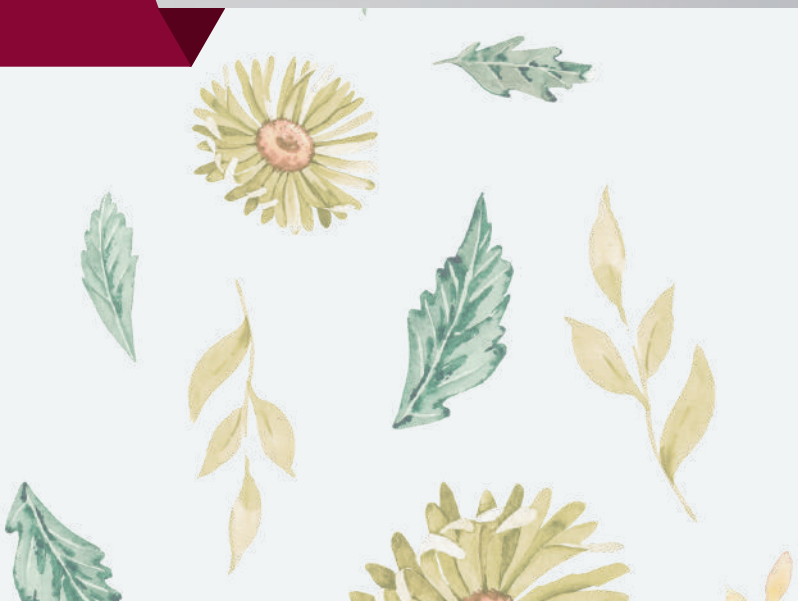
Mental Health of Service Providers Working with Refugees, Migrants and Asylum Seekers

2023 Research Report



Mentalno zdravlje pružalaca usluga koji rade sa izbeglicama, migrantima i tražiocima azila: Istraživački izveštaj za 2023. godinu
Mental health of service providers working with refugees, migrants and asylum seekers: 2023 Research report

Authors
Jana Dimoski (*PIN – Psychosocial Innovation Network and LIRA lab, Faculty of Philosophy, University of Belgrade)*
Maša Vukčević Marković (*Department of Psychology LIRA lab, Faculty of Philosophy, University of Belgrade and PIN – Psychosocial Innovation Network)*

Editor
Irena Stanković

Publisher
Psychosocial Innovation Network - PIN

For the publisher
Irena Stojadinović

Translated by
Translation Agency Lexica

Proofreading
Irena Stanković

Design and press fraction
Sara Dojčinović

The primary objective of this report is to provide information on the psychological difficulties of service providers who work with people forced to flee their home countries for different reasons. For better readability and simplicity, the term *refugee* will hereinafter be used to refer to all beneficiaries of service providers, regardless of their legal status at the time of the research.

For better readability and simplicity, the term *organization* will hereinafter be used to refer to the workplace of all respondents, regardless of whether they work in a civil society organization, a state institution, or the private sector.

The terms in grammatical masculine gender refer to both the masculine and feminine genders of the persons to whom they refer.

Content

Summary

Service providers working with refugees face great challenges in their work as they often witness people's testimonies that include difficulties and suffering. Hence, it is not surprising that previous research shows that service providers working with refugees are at an increased risk of developing mental health difficulties. Therefore, the aim of this research is to examine the mental health of service providers working with refugees, focusing on the work-related characteristics that could contribute to psychological difficulties. In addition to the above, the aim is to compare the results with the previous study on the mental health of service providers working with refugees in Serbia, conducted by PIN in 2019, which can be used to gain insight into possible changes in trends. The results show that service providers are highly exposed to the traumatic experiences of beneficiaries – on average, they witness as many as 15 out of a maximum of 19 traumatic experiences. Additionally, mental health screening shows that 69% of respondents have elevated secondary traumatization symptoms, 25% have burnout symptoms, and 53% and 35% have symptoms of depression and anxiety, respectively. These data indicate that at least 7 out of 10 service providers need additional psychological and psychosocial support. In parallel with the existence of psychological difficulties, a relatively preserved quality of life was also registered, as well as pronounced secondary posttraumatic growth, mostly in the domain of Appreciation of life. As to the domains in which it was possible to compare data on psychological difficulties with data from 2019, there is a relative stagnation in the severity thereof. Research results show that younger service providers are at particular risk, while the most important factors of the working environment that contribute to psychological difficulties are working overtime, less satisfaction with the results of the organization's work, less pronounced feeling that one's work is appreciated in their organizations, and fewer opportunities to achieve long-term professional goals within the current organization, and a less pronounced perception that organization has a tendency and will to provide employees with earnings as high as possible. Based on the results, practical recommendations were given for evidence-based improvement of policies and practices aimed at the protection of service providers' mental health.

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01 INTRODUCTION AND AIM OF THE STUDY

Mental health of service providers

Service providers working with vulnerable groups, including refugees, face great challenges in their work as they often witness people's testimonies that include difficulties and suffering, as well as basic human rights violations. Given that almost every refugee experiences at least one traumatic experience only during transit, and 10 on average (Vukčević Marković et al., 2021), service providers themselves are indirectly exposed to trauma. This *secondary exposure to trauma* represents a risk to the overall functioning and quality of life of service providers (Makadia et al., 2017). The current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5; APA, 2013) states secondary exposure to trauma during work as a source of posttraumatic stress disorder. As secondary exposure to trauma includes both direct conversation with the traumatized person and textual content (Weitkamp et al., 2014), and very brief exposure to trauma (Baird & Kracen, 2006), service providers of different roles are exposed to potential mental health difficulties, including those who provide psychological, legal or medical support, information, integration activities, provision of basic life necessities, and others.

Previous research has consistently shown that service providers are at increased risk of developing psychological difficulties such as secondary traumatization and burnout (Alqudah & Sheese, 2020), compassion fatigue, depression, anxiety, and somatic symptoms (Wirth et al., 2019) which are associated with impaired quality of life (Živanović & Vukčević Marković, 2020). Also, previous research conducted by PIN that focused on service providers to refugees in Serbia confirmed a high rate of psychological difficulties among them (Živanović et al., 2019).

Mental health of service providers

The results showed high levels of secondary exposure to trauma, whereas the service providers witnessed most of the traumatic experiences of the beneficiaries that were offered in the questionnaire. In addition to the above, as many as 7 in 10 respondents showed high levels of secondary traumatic stress, with frequent burnout, depression and anxiety symptoms. The intensity of symptoms of psychological difficulties was also associated with a reduced quality of life in service providers. Finally, in addition to the stated psychological difficulties, service providers also showed the preservation of positive psychological capacities such as secondary posttraumatic growth (Živanović et al., 2019).

Many studies have been conducted to map groups of factors (in addition to secondary exposure to trauma) that can explain the psychological difficulties observed in service providers. For example, sociodemographic predictors were explored – e.g. age (Ghahramanlou & Brodbeck, 2000) and gender (Sprang et al., 2007); and personality predictors – e.g. coping strategies (Vukčević Marković & Živanović, 2019). However, there are fewer studies that directly examined work-related characteristics as predictors of psychological difficulties, although the importance of some characteristics has been demonstrated – such as lack of support in the organization, overtime work, and poorer work organization (Vukčević Marković & Živanović, 2019), as well as the organizational climate and job requirements (Hensel et al., 2015).

Therefore, the aim of this study is to examine mental health in service providers while focusing on work-related characteristics that can contribute to psychological difficulties. Additionally, the goal is to make a comparison with previous results from 2019, which shall provide insight into possible changes in trends when it comes to the mental health of service providers.

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02 METHODOLOGY

Method

Method and procedure

As part of the study, we collected quantitative data on :

- secondary exposure to trauma
- psychological difficulties: depression, anxiety, burnout and secondary traumatization
- indicators of positive psychological functioning: quality of life, secondary posttraumatic growth
- work-related characteristics

The data presented was collected online from March to August 2023, by distributing questionnaires via individual email invitations. Invitations were sent to the official emails of institutions and organizations working with refugees, and individual contacts, with a request to forward the invitation to other persons who currently work or used to work as direct service providers to refugees.

All of the respondents were informed of their rights while filling out the questionnaires, the main aim of the study, the instructions, the ways in which their data will be used and stored, and the contact information of the lead researchers. In line with the research topic, at the end of filling out the questionnaires, the respondents were given contacts of institutions that provide free-of-charge mental health counseling and therapy services, if needed.

Instruments

Secondary exposure to trauma and indicators of psychological difficulties

We used the *Stressful Experiences in Transit – Short Form* (Purić & Vukčević Marković, 2019) questionnaire adapted to measure the number and nature of traumatic experiences service providers were vicariously exposed to, i.e. that they heard about from their beneficiaries, to measure the secondary exposure to trauma. The questionnaire has a total of 19 stressful and traumatic experiences stated (e.g. threat to life, death of a close person), and the respondents were to give "yes" or "no" answers, indicating whether they had beneficiaries with the respective experiences that directly talked about them to the service provider. The last question was open-ended, and the respondent could add another stressful and traumatic experience their beneficiaries had experienced.

To assess burnout symptoms, we used the *Copenhagen Burnout Inventory* (Kristensen et al., 2005) with a total of 19 items that measure burnout with three focus points: personal burnout, work-related burnout, and client-related burnout. The respondents indicated how often had they experienced or felt the symptom described in each statement, using a scale from 1 ("never") to 5 ("always").

To assess the occurrence of secondary traumatic stress, we used the *Secondary Traumatic Stress Scale* (Bride et al., 2004) with a total of 17 items that measure secondary traumatic stress symptoms. This questionnaire was used only for respondents who currently work as direct service providers to refugees. The respondents indicated how often had they experienced or felt the respective symptom using a 5-point scale (where 1 means "never", and 5 means "very often").

Instruments

Indicators of psychological difficulties

In order to assess symptoms of depression, we used the *Patient Health Questionnaire – 9* (PHQ9) (Kroenke et al., 2001) which has 9 items that measure depressive symptoms. The respondents needed to indicate how often had they been bothered by any of the listed problems in the previous two weeks, using a four-point scale (0 – "not at all", 1 – "several days", 2 – "more than half the days", 3 – "nearly every day"). The total score of depression is calculated by summing the responses given to each item, while different cut-off scores are used for different levels of depression: 5 (mild symptoms), 10 (moderate), 15 (moderately severe), and 20 (severe symptoms) (Kroenke et al., 2001).

In order to assess symptoms of anxiety, we used the *Generalized Anxiety Disorder - 7* (GAD7) (Spitzer et al., 2006) which has 7 items that measure anxiety symptoms. The respondents needed to indicate how often had they been bothered by any of the listed problems in the previous two weeks, using a four-point scale (0 – "not at all", 1 – "several days", 2 – "more than half the days", 3 – "nearly every day"). The total score is calculated by summing the responses given to each item, while different cut-off scores are used for different levels of anxiety: 5 (mild symptoms), 10 (moderate), and 15 (severe symptoms) (Spitzer et al., 2006).

Although these two instruments measure symptoms of depression and anxiety, it is important to note that these data are used only for the purpose of providing an initial screening of mental health, and do not imply that people who reach cutoff scores have a diagnosis of mental disorder (e.g. depression or anxiety-related disorders).

Instruments

Indicators of positive psychological functioning

Quality of life was measured as an indicator of positive psychological functioning by using the *Manchester Short Assessment Of Quality of Life* (MANSA)(Priebe et al., 1999) which has 12 items related to the assessment of the quality of life in different domains (e.g. work, financial situation, family relationships, mental health, etc.). The respondents rated their satisfaction with each given aspect of life individually, using a seven-point scale (1 - “it couldn't be worse“, 7 – “it couldn't be better“). The total score is determined by adding up the score for each item.

Additionally, we measured secondary posttraumatic growth using the *Posttraumatic Growth Inventory Scale* (PTGI)(Tedeschi & Calhoun, 1996) we adapted so that it refers to service providers, i.e. to measure positive changes resulting from work with traumatized users in a total of 5 domains. The first domain is *Relating to others*, i.e. an increased sense of trust in other people, and ability to express emotions. The second domain is *New Possibilities* presented to the service provider, including new ways of living, new interests, and new perspectives. Furthermore, we measured changes related to *Personal strength* that represent increased resilience and self-reliance. The fourth domain is *Spiritual change* in terms of having deeply developed religious beliefs; and the last domain is focused on the *Appreciation of life*, i.e. changes in priorities, increased gratitude, and appreciation for each new day. Next to each potential item representing change, the respondents indicated the extent to which they think it has occurred as a result of working with traumatized beneficiaries.

Instruments

Work-related characteristics

The questionnaire about the work-related characteristics was designed by the research authors specifically for the purposes of this research.

We measured different aspects of work :

- *Objective characteristics of work environment*: including overtime work, if overtime is paid, the possibility of financial and professional advancement, achievement of long-term goals, and similar characteristics in their organization
- *Support*: instrumental (in performing duties and responsibilities) and emotional (providing comfort, agreeableness, solidarity) by different stakeholders within the organization (coworkers, superiors, persons to whom the service provider is superior) and external stakeholders with whom the service provider cooperates (state institutions, external associates, donors, international agencies)
- *The functioning of the organization*: i.e. meaning that there is a clear structure, fair and equal distribution of duties and responsibilities, transparency in relation to the planning of duties and responsibilities, participation of employees in decision-making processes
- *Satisfaction with work results and a sense of respect* by the organization and the broader environment

Respondents

The final sample includes 111 direct service providers to refugees, out of which 65% currently work, while the rest of the respondents used to work with refugees in earlier stages of their career, but no longer do. Those who no longer provide services, on average, stopped doing this job 33 months ago*. In addition to the above, 23% of those who are no longer service providers still work with refugees, but in a different professional role (e.g. as a project coordinator or in a managerial role).

The majority of the total sample consists of women (71%), while the rest are men. The average age of the respondents is 35**; most respondents work in civil society organizations (67%), in the private sector (21%), and 12% of respondents work in the public sector. The majority of respondents have a master's degree as the highest acquired level of education (62%), college or undergraduate studies (32%), 2% have doctoral degrees, and 4% have secondary education. When it comes to relationship status, most respondents have a partner – 32% are married, 19% are in a relationship, and 8% are in a relationship and live with their partners. The rest of the respondents were divorced (7%) or single (33%). The monthly income of current and former service providers is shown in Table 1.

Table 1. Monthly income

Under RSD 40,000	4%
RSD 40,000 - RSD 60,000	4%
RSD 60,000 - RSD 80,000	17%
RSD 80000 - RSD 100,000	25%
RSD 100,000 - RSD 120,000	25%
RSD 120,000 - RSD 140,000	12%
Over RSD 140.000	13%

*M=33.33, SD=26.04; **M=35.53, SD=8.51

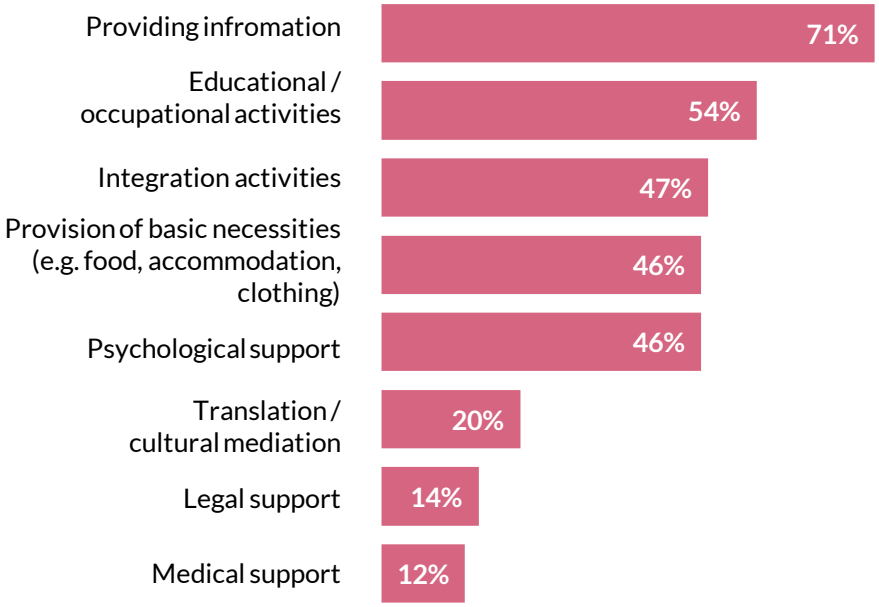
Respondents

As presented in Table 1, most respondents have a monthly income ranging between RSD 80,000 and 120,000. Furthermore, 43% of respondents were satisfied with their income, 35% felt both satisfied and dissatisfied, and approximately 21% reported that they were not satisfied with their income.

When it comes to direct work with beneficiaries, there is a big difference among the respondents regarding the length of work, which ranges from 2 months to 34 years. However, on average, respondents work or have worked as service providers for 60 months (i.e. 5 years)***.

Chart 1 shows the services that the respondents provide to refugees, as well as the frequency thereof. Although service providers generally provide more than one service within their professional role, the most common services are providing information and educational or occupational activities, with medical and legal support are least represented.

Chart 1. Frequency of the type of service



***M=60.07, SD=59.42

Data analysis

Statistical analysis

Descriptive measures were presented throughout the report – frequencies, means (M), and standard deviations (SD). An independent samples t-test was used to make comparisons between two groups, whereas univariate analysis of variance (ANOVA) was used when comparing several groups. Linear regression was used to predict psychological difficulties. Those variables that had a significant correlation (threshold value $p<.05$) or trend-level association ($p<.10$) with a criterion variable in the correlation analysis were entered as a predictor block. All of the analyses were performed for the entire sample, with the exception of the analysis related to secondary traumatization where only current service providers were included. In all analyses, the threshold value of $p<.10$ was interpreted as a trend level. All of the analyses were done using the IBM SPSS V 22 software.

The research was approved by the Institutional Review Board within the Department of Psychology at the Faculty of Philosophy, University of Belgrade (protocol #2023-023).

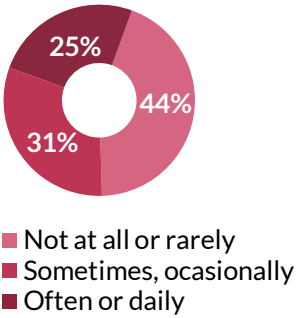
03 RESULTS

Work-related characteristics

Overtime

Most respondents reported that they worked overtime occasionally, often or daily (Chart 2), and 7 hours a week on average*. Almost two-thirds of the respondents reported that they were not paid for overtime work (65%), and only 18% get paid on a regular basis, whereas 17% get paid sometimes.

Chart 2. Frequency of overtime



Furthermore, the results show that the majority of respondents believe that the organizations they work for make every effort to minimize overtime or make it predictable. However, roughly one in five respondents disagreed with these statements, as shown in the charts below.

Chart 3. Minimization of overtime

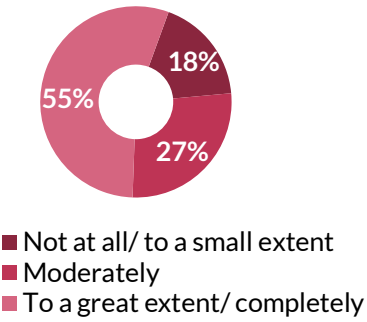
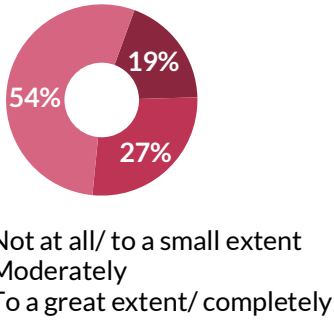


Chart 4. Predictability of overtime



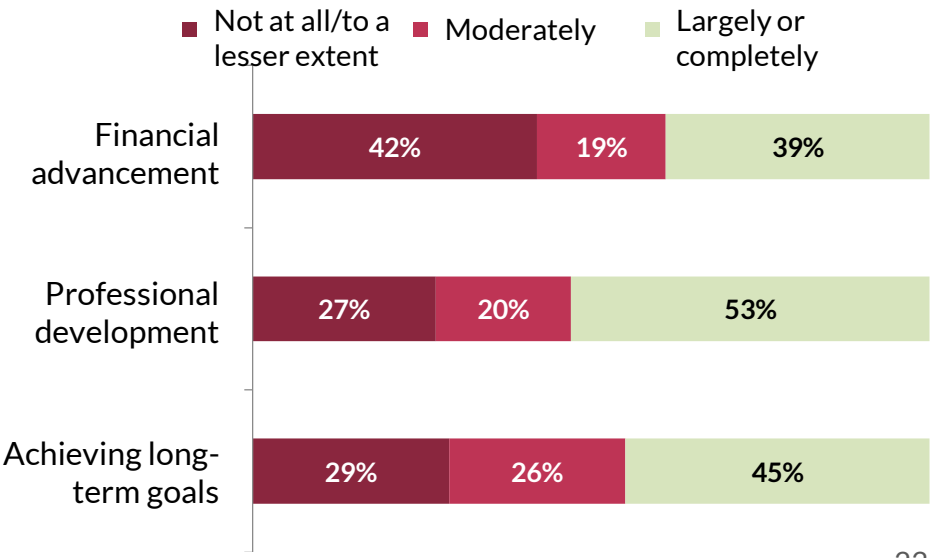
*M=7.11, SD=10.37

Work-related characteristics

Possibility of advancement

Chart 5 shows the assessments of the respondents regarding the extent to which they can advance in various fields within their organizations. It can be noted that there are differences between service providers, i.e. that the respondents are grouped along the entire scale. However, it can be concluded that the respondents more often perceive that they have the opportunity to professionally advance, and to advance in terms of long-term professional objectives, yet their financial advancement is enabled to a lesser extent. It is important to stress that in all three cases, there is a significant proportion of respondents who believe that their advancement is not possible. There is an open question regarding the reasons for non-advancement, and they can be sought in the internal dynamics of each organization, but also in the regulation of the area of work of service providers.

Chart 5. Possibility of advancement

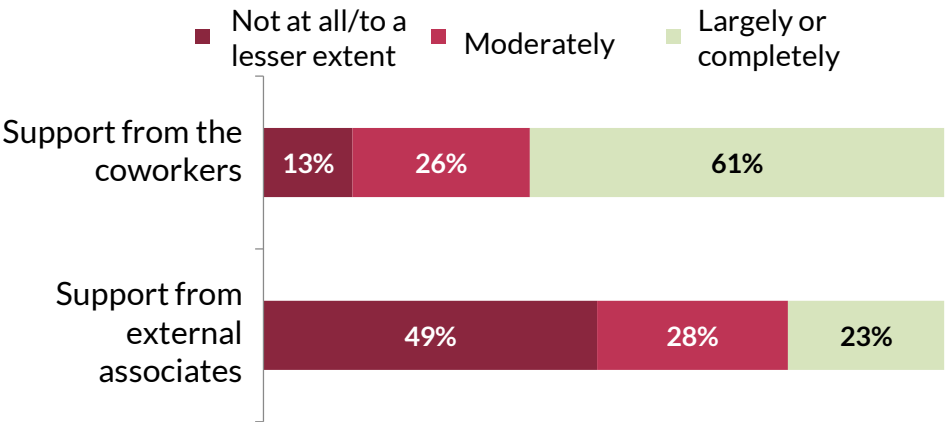


Work-related characteristics

Instrumental and emotional support

Chart 6 shows results on the extent to which the respondents have available support from various stakeholders they cooperate with, directly or indirectly. Support included instrumental support (related to performing work tasks or decision-making) and emotional support (understanding, encouragement, solidarity, as well as caring for the wellbeing of service providers and offering them help). We measured the perceived support in relation to a) coworkers in the organization – associates, superiors, and employees to whom the service provider is superior, and b) external associates and stakeholders – representatives of state institutions, international agencies, donors, and external experts. The Chart shows that the percentage of medium-ranged answers is very similar in both cases, while the percentage of more extreme answers is notably different. Namely, the majority of the respondents believe that they have support from their coworkers within the organizations, while on the other hand, they more often believe that they do not have support from external stakeholders.

Chart 6. Degree of support from different stakeholders

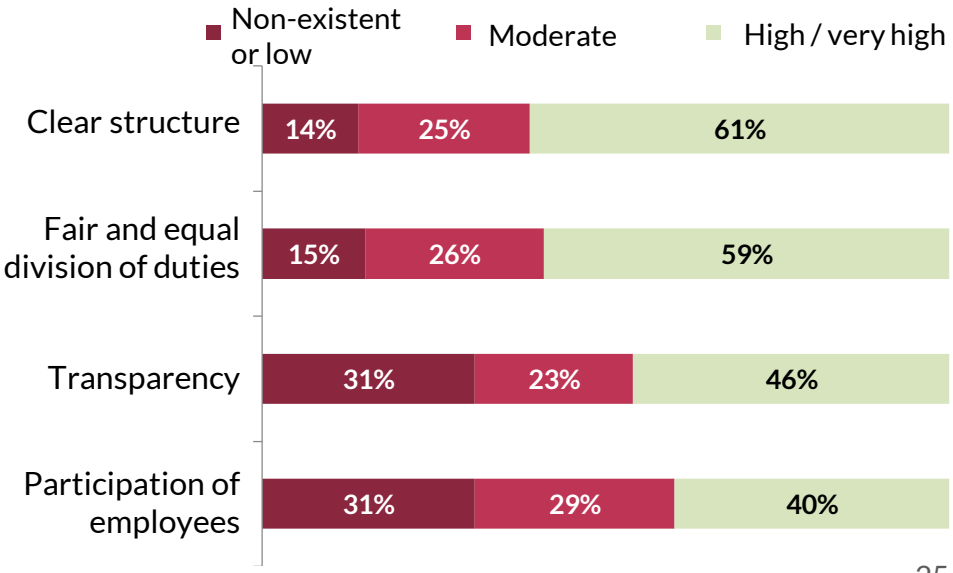


Work-related characteristics

Organizational functioning

Chart 7 shows the assessments regarding the different features of organizational functioning: clear *structure* within the organization (a clear division of tasks and responsibilities among team members); *fair and equal division of duties*, tasks, and responsibilities among team members; *transparency* as to planning and execution of duties (e.g. whether employees are informed about current events in the organization); and employee *participation* in decision-making and strategic planning of the organizational development. It can be seen on the Chart that the respondents rated the levels of structure and fair and equal division of duties higher than the transparency and participation of employees. Although the majority rated them positively, about one-third of respondents rated the transparency and participation of employees as very low.

Chart 7. Organizational functioning



Work-related characteristics

Satisfaction with personal and organizational contribution

The last block of the work-related characteristics we measured was the subjective feeling of the service providers regarding: a) personal contribution to the work of the organization, b) whether they feel that their personal contribution is appreciated by their coworkers, c) satisfaction with the results of the organization's work, and d) whether they believe that their organization's work is recognized and appreciated by the broader society.

The results show that all four dimensions are highly present among service providers, i.e. there is a highly developed sense of the purpose of personal and collective work, as well as a supportive environment at the workplace.

73% Respondents were satisfied with their contribution to the organization

Respondents believed that their contribution is appreciated by their coworkers **69%**

72% Respondents were satisfied with the results of their organization's work

Respondents believed that their organization's work is appreciated by the broader society **62%**

Psychological difficulties

Secondary exposure to trauma

Service providers working with refugees often work in a highly stressful environment where they are exposed to their beneficiaries' stories involving extreme human suffering, and stressful and traumatic events. Such secondary exposure to trauma can be a risk factor for the development of various psychological difficulties, primarily secondary traumatic stress (see page 34). Therefore, examining the quantity and nature of traumatic experiences is important for understanding the service providers' mental health.

Service providers are often exposed to the stressful and traumatic experiences of their beneficiaries – on average, they were exposed to 15 of the maximum 19* traumatic events of beneficiaries. As shown in Table 1, all mentioned experiences are highly represented among the service providers – and most often they include separation from family and close friends, psychological violence, discrimination, illegal and violent taking of property, and death of a close person. The rarest, but also experienced by the majority, are stressful and traumatic experiences where a smuggler requested additional services from the refugees, deprivation of basic living conditions during detention, as well as denial of legally guaranteed rights during detention. However, as mentioned, even these rarest experiences have been experienced by at least one-half of service providers. The secondary exposure to trauma was measured in PIN's 2019 report (Živanović et al., 2019). Although a different questionnaire was used thereupon, a comparison of analogous items shows an increase in service providers who were secondarily exposed to the lack of food and water (+14%), lack of shelter (+20%), and being in a life-threatening position (+3%). Table 2 shows the frequency of secondary exposure to trauma.

*M=15.60, SD=3.83

Table 2. Frequency of secondary traumatic stress

Has any refugee, migrant and/or asylum seeker you worked with experienced and shared with you that they experienced:

Traumatic experience:	**% service providers who heard about the respective experience from the beneficiaries:**
Getting lost (not knowing where he/she is nor where he/she has to go)?	83%
Lack of shelter	90%
Lack of food /water	88%
Suffering severe physical injury	85%
His/her life being threatened	78%
Death of a close person	92%
Being separated from family / close friends	98%
A smuggler not fulfilling the deal (e.g. asking for extra money or not leaving your beneficiary at an agreed location)	79%
A smuggler requesting additional services (transporting drugs, recruitment of others, presenting other people's children as your beneficiary's children)	57%
Detention	77%
While in detention, has your beneficiary experienced deprivation of his/her legal rights (being detained with no legal basis, legal assistance, not being released in the legally prescribed timeframe)	63%
While in detention, has your beneficiary experienced deprivation of basic living conditions (food, water, heating, bunk, possibility of movement in the premises, possibility of maintaining personal hygiene, medical assistance, etc.)	59%
Deportation	73%
Being a victim of discrimination	94%
Being a victim of psychological violence (being insulted, humiliated, threatened, etc.)	97%
Being a victim of physical violence	90%
Being a victim of sexual violence	73%
Having personal property or money taken from him/her illegally or violently	92%
Deprivation of the relevant information	92%

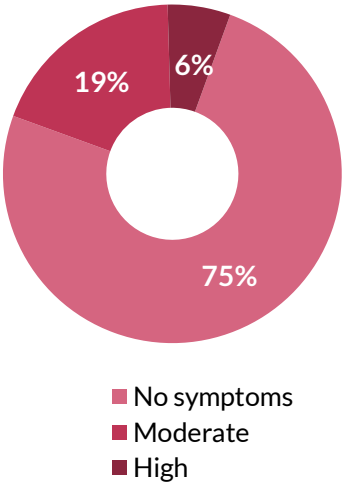
Psychological difficulties

Burnout

Burnout is a state of great physical and emotional exhaustion that occurs as a result of continuous stress associated with the person's job. A person experiencing burnout feels tired, exhausted, overwhelmed, helpless, has a cynical attitude towards work, and feels detached. Also, a person may feel ineffective or unsuccessful at work.

Screening results show that 25% of respondents, i.e. between 2 and 3 out of 10 people have pronounced burnout symptoms.

Chart 8. Burnout symptoms



As shown in Chart 8, moderate symptoms are most common, while no respondents had severe symptoms of burnout.

Additional analyses showed that younger service providers have higher levels of burnout*, while there is no difference in burnout levels between men and women**.

*r=-.31, p<.01
**t(109)=-0.194, p=.847

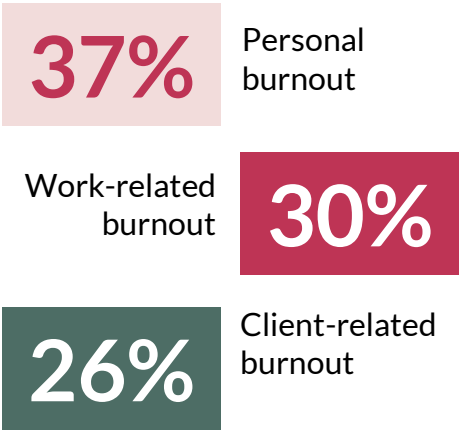
Psychological difficulties

Burnout

We can describe burnout in terms of what it is primarily centered around, which allows us to better understand its dominant features. Therefore, *personal burnout* includes symptoms concerning the overall condition of the respondent (e.g. "I often feel tired"); *work-related burnout* emphasizes the symptoms that are more specifically related to the work being performed (e.g. "My work frustrates me"); and *client-related burnout* that includes a feeling of being burnt out when dealing with clients at work (e.g. "Sometimes I wonder how long will I be able to continue working with clients"). Thus, burnout in general includes all of the three aforementioned components, and therefore, we can talk about one general burnout factor (see page 30). However, dividing it into personal, work-related, and client-related burnout helps us gain a more detailed insight into the different burnout layers.

The most common symptoms are those of personal burnout that are pronounced in 37% of respondents; while the lowest frequency is reported in client-related burnout.

Additional analyses showed that younger individuals had higher symptoms of all three burnout aspects*, with no differences in terms of gender**.



*personal: r=-.31, p<.01; work-related: r=-.26, p<.01; client-related: r=-.25, p<.05 ; **personal : t(78.184)=-1.460, p=.148; work-related: t(109)=-0.142, p=.887; client-related: t(102)=-0.770, p=.443

Psychological difficulties

Burnout

Chart 9 shows this year's results in comparison with the results from the 2019 study, whereby burnout in service providers was measured using the same questionnaire, allowing a comparison. It can be observed in the Chart that there have been no major changes over the years, i.e., approximately 1 in 4 service providers had pronounced burnout symptoms in both studies (26% in 2019 vs. 25% in 2023). On the other hand, there is a significant decrease in personal burnout, with relative stagnation in terms of work-related and client-related burnout (+3% as to work-related burnout and client-related burnout).

Chart 9. Burnout symptoms of service providers to refugees in 2019. and 2023.

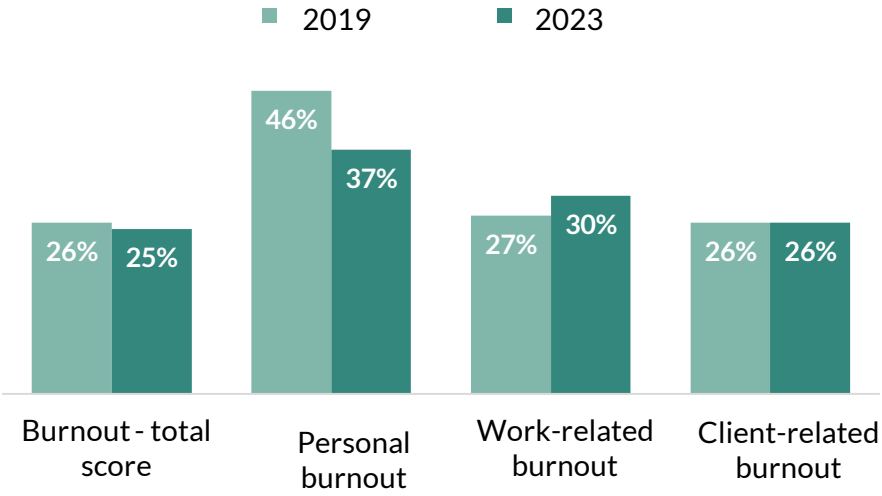


Table 3 shows relative frequency of burnout symptoms.

Table 3. Relative frequency of reported burnout symptoms

How often do you feel tired?	40%
How often do you feel physically exhausted?	26%
How often do you feel emotionally exhausted?	31%
How often do you think: "I can't take it anymore”?	13%
How often do you feel worn out?	28%
How often do you feel weak and susceptible to illness?	12%
Is your job emotionally exhausting?	40%
Do you feel burnt out because of your work?	25%
Does your work frustrate you?	20%
Do you feel worn out at the end of the working day?	27%
Are you exhausted in the morning at the thought of another day at work?	19%
Do you feel that every working hour is tiring for you?	9%
Do you have enough energy for family and friends during leisure time?	31%
Do you find it hard to work with clients?	9%
Do you find it frustrating to work with clients?	8%
Does it drain your energy to work with clients?	24%
Do you feel that you give more than you get back when you work with clients?	19%
Are you tired of working with clients?	12%
Do you sometimes wonder how long you will be able to continue working with clients?	19%

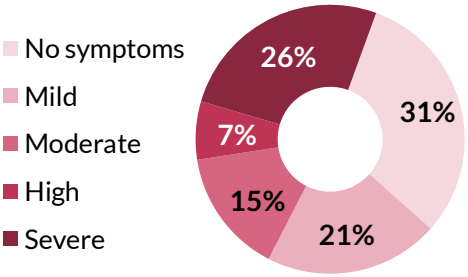
Psychological difficulties

Secondary traumatization

In their work, service providers often witness personal testimonies that include a whole range of traumatic experiences. Therefore, they are at increased risk of developing symptoms of posttraumatic stress, which we refer to as secondary traumatization. The symptoms of secondary traumatization include intrusive and repetitive thoughts about the traumatic experience of the beneficiaries; avoiding persons, situations, and things that remind them of the traumatic experience and work with the beneficiaries; emotional numbness, irritability, and agitation or anger outbursts.

Screening results show that 69%, i.e. 7 in 10 respondents have high symptoms of secondary traumatization.

Chart 10. Symptoms of secondary traumatization



As shown in Chart 10, one in four respondents have pronounced symptoms of secondary traumatization.

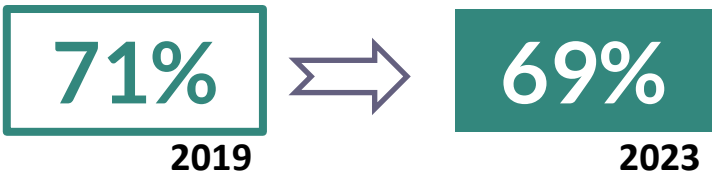
Additional analyses showed that younger service providers reported higher levels*, with no difference between men and women**.

*r=-.30, p<.05
**t(70)=1.111, p=.270

Psychological difficulties

Secondary traumatization

As part of the PIN's research from 2019, the same questionnaire was used to measure secondary traumatization in service providers, thus allowing comparison with the present data. By comparing the data from these two studies, it can be seen that there is a relative stagnation in the percentage of respondents with high symptoms – i.e., a slight 2% decrease.



The relative intensity of specific symptom subgroups of secondary traumatization is also similar in the two studies. Thus, both studies show that the most pronounced symptoms are related to increased agitation (problems with sleeping and concentration, irritability, anxiety); followed by avoidant symptoms (e.g. avoiding places, people, and objects that remind them of the beneficiaries' traumatic experiences, social withdrawal, less activity); while the least pronounced were the symptoms that include intrusive thoughts, dreams and memories of working with the beneficiaries. However, it is important to note that the differences in groups of symptoms were not particularly pronounced*.

Table 4 shows the relative frequency of individual symptoms.

*respectively: M=2.35, SD=1.07; M=2.30, SD=1.02; M=2.09, SD=0.89

Table 4. Relative frequency of secondary traumatization symptoms

I felt emotionally numb.	29%
My heart started pounding when I thought about my work with clients.	10%
It seemed as if I was reliving the trauma(s) experienced by my client(s).	17%
I had trouble sleeping.	24%
I felt discouraged about the future.	28%
Reminders of my work with clients upset me.	15%
I had little interest in being around others.	22%
I felt jumpy.	29%
I was less active than usual.	19%
I thought about my work with clients when I didn't intend to.	28%
I had trouble concentrating.	25%
I avoided people, places, or things that reminded me of my work with clients.	12%
I had disturbing dreams about my work with clients.	8%
I wanted to avoid working with some clients.	24%
I was easily annoyed.	15%
I expected something bad to happen.	11%
I noticed gaps in my memory about client sessions.	15%

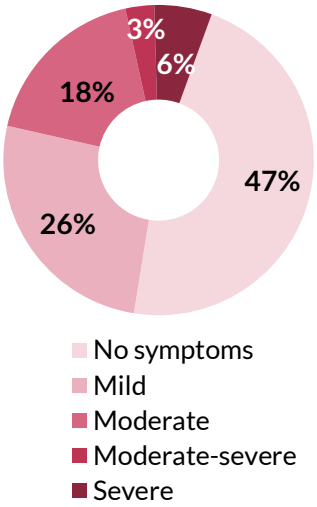
Psychological difficulties

Depression

Depressive symptoms include low mood, feelings of emptiness or hopelessness, decreased interest in activities that used to bring pleasure, and negative thoughts about oneself. In addition to the above, the following may also occur: problems with appetite and sleep, slowness of movement or speech, and lack of energy.

Screening results showed that 53%, i.e. approximately 5 in 10 service providers reported high levels of depressive symptoms.

Chart 11. Depressive symptoms



As shown in Chart 11, the most common are mild depressive symptoms, while approximately one in ten respondents reported moderate-severe or severe symptoms.

Additional analyses showed that younger people have higher levels of depression*, while there are no differences in intensities in men and women**.

*r=-.31, p<.01
**t(109)=-0.034, p=.973

Psychological difficulties

Depression

Table 5 shows relative frequency of individual symptoms of depression, i.e. the percentage of service providers who reported that they had experienced these symptoms more than half of the days or almost every day in the previous two weeks. The most common symptom is sudden fatigue and loss of energy, while the respondents rarely reported having suicidal thoughts (i.e. thinking that it would be better if they were gone).

Table 5. % respondents who experienced the listed symptoms "more than half of the days" or "almost every day" in the previous two weeks

How often did you experience some of the following in the last two weeks (14 days)?	
Little interest or pleasure in doing things	21%
Feeling down, depressed, or hopeless	15%
Poor appetite or overeating	19%
Trouble falling or staying asleep, or sleeping too much	24%
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	8%
Feeling tired or having little energy	31%
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	17%
Trouble concentrating on things, such as reading the newspaper or watching television	20%
Thoughts that you would be better off dead or of hurting yourself in some way	5%

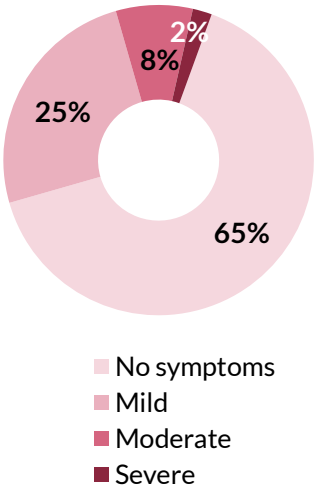
Psychological difficulties

Anxiety

Anxiety is an umbrella term for problems such as constant and excessive worrying that is perceived as being beyond the person's control, feeling nervous, agitated, or being “on the edge". Additionally, an anxious person may be nervous, irritable, fearful, and it may be difficult for them to calm down.

Screening results showed that 35%, i.e. approximately 3 or 4 in 10 service providers have pronounced symptoms of anxiety.

Chart 12. Symptoms of anxiety



Looking at Chart 12, it can be noted that mild symptoms of anxiety are the most common ones.

Additional analyses showed that younger age is associated with more pronounced anxiety symptoms*, while there have been no differences in the intensity of symptoms in men and women**.

*r=-.29, p<.01
**t(109)=-0.453, p=.652

Psychological difficulties

Anxiety

Table 6 shows the relative frequency of individual anxiety symptoms, i.e., the percentage of service providers who reported experiencing the symptoms described in the below statements more than half of the days or almost every day in the previous two weeks. As shown, the respondents largely reported that they had a feeling of persistent worry about different things, and they were nervous in general, while the symptoms of being restless and not being able to sit still were relatively rare among the respondents.

Table 6. % respondents who experienced the listed symptoms "more than half of the days" or "nearly every day" in the previous two weeks

How often did you experience some of the following in the last two weeks (14 days)?	
Feeling nervous, anxious, or "on edge"	17%
Not being able to stop or control worrying	9%
Worrying too much about different things	18%
Trouble relaxing	6%
Being so restless that it is hard to sit still	4%
Becoming easily annoyed or irritable	13%
Feeling afraid as if something awful might happen	9%

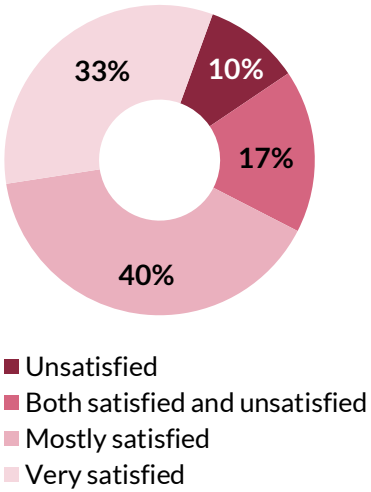
Positive psychological functioning

Quality of life

In order to understand the current state of service providers, as well as their needs, it is important to take into account both psychological difficulties and the examination of indicators of positive psychological functioning, such as the subjective quality of life. Quality of life can be seen as a person's overall satisfaction with their life at the time of the study, but also in different individual aspects of life (e.g. work, leisure activities, etc.).

In Chart 13 it can be noted that the vast majority of the respondents are predominantly or very satisfied with their lives. On the other hand, 1 in 10 persons reported that they are not satisfied, while there is also a certain share of those who are "both satisfied and unsatisfied", which suggests that there is a need for additional improvement as to their quality of life.

Chart 13. Satisfaction with life – total score



Additional analyses were conducted to examine whether there were differences between specific subgroups of providers in terms of overall quality of life.

What has been shown is that the quality of life is not related to age* or gender**.

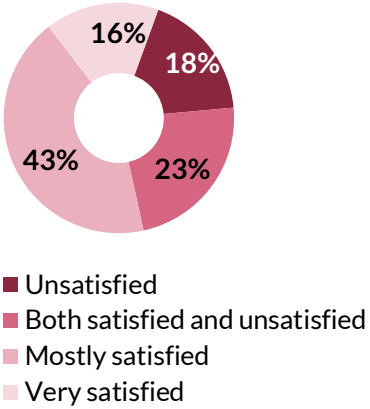
*r=-.13, p=.182
**t(109)=-1.256, p=.212

Positive psychological functioning

Quality of life

What is interesting is that the majority of the respondents reported they were satisfied with their mental health, as shown in Chart 14, despite experiencing relatively frequent psychological difficulties. Due to this discrepancy, the question is whether the service providers have, to some extent, normalized the psychological difficulties they face.

Chart 14. Satisfaction with mental health



Service providers were mostly satisfied with all aspects of life, whereas the lowest average score can be classified as "both satisfied and unsatisfied." The respondents were mostly satisfied with the people they live with (5.87*), personal safety (5.85), family relationships (5.39), the number and quality of their friendships (5.35), accommodation (5.32) and health (5.01). This is followed by satisfaction with mental health (4.87) and satisfaction with their jobs (4.75). The respondents were least satisfied with their financial situation (4.40), leisure activities (4.36) and their sex life (4.21**).

*The average score on a scale from 1 (minimum) to 7 (maximum satisfaction) is shown.
**standard deviations, respectively: SD= 1.38; SD= 1.15; SD= 1.39; SD= 1.44; SD= 1.35; SD= 1.35; SD= 1.51; SD= 1.36; SD= 1.32; SD= 1.49: SD= 1.94

Positive psychological functioning

Secondary posttraumatic growth

Exposure to stories of other people's traumatic experiences can lead to an increased risk of developing various psychological difficulties in service providers. However, there are also certain positive capacities that can be developed and strengthened as a result of working with trauma, which we refer to as posttraumatic growth. In service providers, posttraumatic growth is *secondary* as they did not personally experience the trauma, but they heard about it from their beneficiaries.

There are five domains of posttraumatic growth:

1) Appreciation of life: experiencing greater appreciation of one's own life, people prioritize things in life differently
2) Personal strength: a feeling of increased resilience and self-reliance
3) New possibilities: experiencing new ways of living, new interests, and adopting new perspectives
4) Relating to others: improving relationships with others, having an increased sense of trust in other people, and ability to express emotions
5) Spiritual change: experiencing an increase in religious beliefs and having deeper developed spiritual beliefs

Positive psychological functioning

Secondary posttraumatic growth

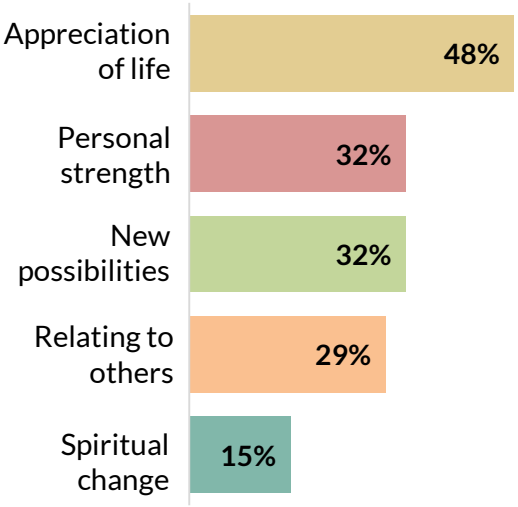
As shown in Chart 15, secondary posttraumatic growth is present among service providers. The most commonly registered changes in appreciation and respect for one's own life are experienced by almost 1 in 2 service providers. This is followed by approximately equally reported changes in the experience of personal strength, new opportunities, as well as changes in relationships with other people, which are experienced by slightly less than one-third of service providers. Finally, spiritual changes, i.e. the strengthening of religious beliefs are the least widespread. The intensity of different domains of posttraumatic growth was reported in the same order in the 2019 study.

Additional analyses showed that younger people have more pronounced growth in all domains, except for spiritual changes*. Also, women experienced more pronounced changes in the domain of personal strength, while no other gender differences were observed**.

*r(AoL)=-.28, p<.01; r(PS)=-.25, p<.01; r(NP)=-.21, p<.05; r(RtO)= -.17, p=.072; r(SC)=-.11, p=.236

**AoL: t(108)=-1.378, p=.171; PS: t(108)=-2.039, p<.05; NP: t(108)=-1.047, p=.297; RtO: t(108)=0.654, p=.303; SC: t(107)=-0.453, p=.514

Chart 15. Prominence of the posttraumatic growth domains



What contributes to the psychological difficulties of service providers?

In order to better understand the dynamics between work environment, socio-demographic characteristics of an individual (e.g. age, gender), and psychological difficulties, we conducted statistical analyses that can answer the question on the basis of which factors, inter alia, we can explain the psychological difficulties of service providers.

The analyses have shown that the following factors contribute to higher symptoms of psychological difficulties:

- **Younger age** of a service provider
- **Less** pronounced perception of service providers that their **work is recognized and appreciated by the members of the organization** they are employed in

The following factors contribute at the trend level:

- **Working overtime**
- **Less** pronounced perception of service providers that the organization they are employed in can provide them with the opportunity to fulfill their **long-term professional goals**, aspirations, and ambitions
- **Less satisfaction with the results** of the organization's work
- **Less** pronounced perception of service providers that their organization has a tendency and will **to provide employees with salaries as high as possible**

Given the small sample of respondents, these preliminary results provide only general guidelines for understanding the service providers' mental health risk factors, as well as guidelines for areas in which service providers' work environment need to be improved. See Appendix A for a detailed description of the statistical analyses.

04 CONCLUSION AND PRACTICAL IMPLICATIONS

Mental health of service providers

Persons who directly provide services to refugees are at risk of developing psychological difficulties. The results showed that as many as 7 in 10 respondents have high symptoms of secondary traumatization, most often those related to increased agitation, reactivity, and anxiety. These results are not surprising given the high exposure of service providers to the traumatic experiences of the beneficiaries – the respondents have heard testimonies of 15 out of a total of 19 traumatic experiences listed in the questionnaire, on average. Additionally, one-half of respondents had frequent symptoms of depression, while approximately one-third were identified as having elevated symptoms of anxiety. Finally, burnout was reported in one in four respondents, with the symptoms of personal burnout being the most prominent. In addition to the above, where it was possible to compare the data on psychological difficulties with the data from 2019, there is no improvement, but relative stagnation in the severity thereof.

The results also show that younger people are more reactive to the content and circumstances to which they are exposed, given that younger people reported higher levels of psychological difficulties, as well as posttraumatic growth. This data suggests that it is necessary to pay special attention to younger service providers, and ensure that their needs are properly addressed.

Research results can serve as guidelines for designing policies and practices that will more adequately protect mental health of service providers.

- Given the high risk of psychological difficulties, it is necessary to **increase the availability of psychosocial support services** for service providers within their workplaces, whether they work in a civil society organization, a state institution, or a private company.

- It is necessary to provide a **wide range of services** aimed at the mental health of service providers and to enable continuity thereof. For example, it is recommended to provide regular **support groups** for service providers from the same organization, where the participants would have space to process the stressful and traumatic experiences they had been exposed to. An additional recommendation is the provision of **individual psychotherapy sessions** if the service provider feels the need therefor, which would be complementary to the group sessions.
- It is necessary to provide **instrumental support** to service providers in solving complex professional dilemmas and challenges in working with the beneficiaries. For example, when it is in line with the type of service being provided (e.g. psychological, legal support), it is necessary to ensure regular **supervision and intervision sessions**. Supervision includes group or individual consultations with an external expert for a given topic, with whom current problems and dilemmas related to working with the beneficiaries are shared and resolved, while intervision includes a group of service providers of similar seniority (e.g. coworkers from the same organization) who share and resolve the respective dilemmas in working with the beneficiaries.
- Providing regular **psychoeducational trainings** for service providers, which focus on the topics of mental health at work, prevention of psychological difficulties, coping strategies and similar skills that would increase their capacities to do everything in their power to prevent psychological difficulties related to their work, as well as to recognize them in a timely manner and react adequalty in case they occur.

- These measures of protecting mental health at work should be **formalized in statutes and strategic documents** of organizations, so as to encourage mental health care as an integral part of service providers' professional role and obligation. Additional safeguarding procedures should be developed for cases of extreme stress (e.g. suicide of a beneficiary)

- In order to prevent the risk of psychological difficulties among newly employed service providers, especially if they are young people who have just started working, it is necessary to implement **carefully designed onboarding procedures**, within which the person would acquire certain expectations from the job and become familiar with the potential risks.

In parallel with pronounced psychological difficulties, service providers also reported indicators of positive psychological functioning such as quality of life. In addition to the above, respondents not only demonstrated *maintenance* of positive functioning but also *growth* and positive changes as a result of working with trauma. Therefore, although working with traumatized people like refugees carries certain mental health risks, it also provides room for further growth, development, and enrichment. In line with that, it has been shown that working with trauma does not necessarily represent a risk for the mental health of service providers, regardless of different work-related characteristics. Furthermore, in statistical analyses, the amount of secondary traumatic stress was less important for mental health than the work-related factors. It is possible to assume that this is due to the fact that service providers *choose* to work with refugees and other vulnerable groups for personal reasons, including altruism, solidarity, and professional aspirations, and that an integral part of such professional commitment is the readiness to face the difficult experiences of people who are in need of support (Guskovict & Potocky, 2018). On the other hand, unfavorable work-related characteristics are not a necessary part of the work of service providers, it is not something that a person chose, combined with an understanding that, unlike the difficult experiences of the beneficiaries, they are controllable and can be avoided (Guskovict & Potocky, 2018). Therefore, it is also possible that the stress they generate has a more striking effect on mental health.

Work-related characteristics

When it comes to more specific characteristics of the work environment, working overtime has been identified as an important factor that may contribute to the impaired mental health of service providers.

Additionally, it was shown that the factor of subjective feeling of support within the organization contributes to the mental health of service providers, i.e. by acknowledging that others value and appreciate the work of the service provider, as well as the feeling that the organization strives to provide all employees with the highest monthly income possible. It is interesting to note that these subjective factors were more important in terms of the mental health of service providers than objective factors such as the precise amount of monthly salary.

Besides the above, the importance of satisfaction with the results of the organization's work was highlighted as relevant, as well as the employees' ability to fulfill their long-term goals and ambitions, which may suggest the importance of service providers' feeling that their work is meaningful in long-term, and contributes to the personal and collective goals they value. This result is not surprising if one takes into account the humanitarian and helping professions of service providers.

Understanding the characteristics of the workplace that may contribute to the mental health of service providers can serve as a guideline for the areas in which the work environment of service providers needs to be improved so as to better protect their mental health.

- It is important to work on abolishing the practice of **working overtime**, which is currently, as the data shows, common among service providers. Although overtime is often beyond the control of the organizations, there are certain measures that can be adopted at the organizational level to reduce overtime, such as prioritizing and scheduling assignments on a regular basis,

- business strategy aimed at increasing the number of employees, as well as establishing an atmosphere in the team where overtime work is not encouraged, but on the contrary, where all members encourage each other in reducing and ultimately – abolishing overtime. Some of these changes would be most effective if they would come "from the top", if the management would by its behavior, i.e. by adhering to the agreed working hours, set an example for other employees. Finally, all measures protecting mental health at work (e.g. psychoeducation, support groups) should be organized during, not outside of usual working hours.

- Although the subjective perception of the appreciation of personal efforts by the organization, the results of the organization's work, the possibility of achieving long-term goals, as well as the organization's efforts to provide employees with the highest monthly income possible are complex phenomena that depend on various factors, there are certain measures that can be implemented in order to encourage these feelings of the meaningfulness and overall care for the wellbeing of employees. For example, management can establish a practice of giving regular and individual feedback on the performance of each employee, whereby the efforts of each individual team member would be acknowledged and appreciated. Additionally, it is important to foster an atmosphere that is supportive of the interests, ideas, initiatives, and suggestions of team members, by which employees become involved in the long-term development of the organization. Finally, a global approach of fostering the professional development of each employee and strengthening their capacities can contribute to the overall wellbeing of service providers. For example, an open and direct conversation about the long-term wishes and ambitions of employees, finding ways for the organization to play a role in achieving long-term plans, as well as opening the possibility for employees to plan professional development within their working hours through various trainings, seminars, professional and scientific conferences, and other types of knowledge and skills acquisition.

Broader societal systems

Although there are certain measures that organizations, institutions, companies, and individuals can implement so as to contribute to better care for mental health at work, it is equally important to recognize how broader systems can shape the view of mental health at work in general, and in service providers.

It is necessary to promote a change in the perspective that mental health at work is not a privilege or added value, but a moral and professional duty of the employer, and an integral part of the functioning of an organization, which should be reflected in their policies and daily practices. Changing the understanding of the role mental health at work plays is a prerequisite necessary to provide organizations with the space to make mental health a priority, and allocate time and financial resources therefor, as well as to formalize these matters. Therefore, it is necessary to implement strategies that would lead to these changes in the long term. One way towards this can be a **specific focus on decision-makers** (e.g. donors, state institutions) and designing advocacy initiatives that would highlight the problems and needs of employees in the context of direct work with vulnerable groups, including refugees. Advocacy initiatives could also be aimed at introducing educational programs for decision-makers, as well as improving communication mechanisms between decision-makers and service providers.

The mental health of service providers working with refugees is a complex phenomenon, and improvement thereof requires complex changes, not only at the level of organizations and individual service providers but also at the level of broader societal systems.

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Appendix A

A series of regression analyses were conducted to examine the predictive power of work-related factors in the prediction of psychological difficulties in service providers (burnout, secondary trauma, depression, and anxiety).

The analyses showed that the predictor block explained 18% of the variance of burnout, with younger age being the significant predictor ($p<.05$), and the perception that personal contribution is valued in the organization ($p<.05$), while marginally significant were the efforts of the organization to provide higher earnings for employees ($p=.071$), possibility of achieving long-term goals ($p=.062$) and satisfaction with the results of the organization's work ($p=.096$).

The predictor block explained 11% of the variance of secondary traumatization, whereas younger age was the only marginally significant predictor ($p=.070$).

A total of 7.5% of the variance of anxiety was explained by the predictor block, where younger age was a significant predictor ($p<.05$), and working overtime was marginally significant ($p=.069$) as well as the average number of overtime hours per week ($p=.065$).

Finally, the predictor block explained 14% of the variance of depression, where significant predictors were younger age ($p<.05$) and the feeling that personal contribution is valued in the organization ($p<.01$).


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