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Ana Janković

The Experiences of Humanitarian Aid Workers in Serbia:
Testing the Impact of Organisational Support on Mental Health Outcomes

ERMA, European Regional Master's Programme in Democracy and Human Rights in South East Europe

ANA JANCOVIĆ

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TESTING THE IMPACT OF ORGANISATIONAL SUPPORT ON MENTAL HEALTH OUTCOMES

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• Janković, Ana, *The Experiences of Humanitarian Aid Workers in Serbia: Testing the Impact of Organisational Support on Mental Health Outcomes*, Supervisor: Anna Krasteva, New Bulgarian University. European Regional Master's Programme in Democracy and Human Rights in South East Europe (ERMA), coordinated by University of Sarajevo and University of Bologna.

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This publication includes the thesis *The Experiences of Humanitarian Aid Workers in Serbia: Testing the Impact of Organisational Support on Mental Health Outcomes* written by Ana Janković and supervised by Anna Krasteva, New Bulgarian University.

BIOGRAPHY

Ana holds a bachelor's degree in Political Science and International Relations from the University of Buckingham and Sarajevo School of Science and Technology (dual degree) and a master's degree in Democracy and Human Rights in Southeastern Europe from the University of Bologna and the University of Sarajevo (dual degree). Together with co-authors, she published several social science research papers, including *The Power of the Media on Peace and Reconciliation Processes: Representing Former Enemy Groups as Moral versus Immoral Matters study*. Currently, Ana is a Senior Program Associate at International Republican Institute. IRI advances democracy and freedom, links people with their governments, guides politicians to be responsive to citizens, and motivates people to engage in the political process. Ana works at IRI's field office in Bosnia and Herzegovina.

ABSTRACT

This study analysed the issue of mental health of humanitarian aid workers in Serbia. It explored the prevalence of secondary traumatic stress (STS) and burnout as negative mental health outcomes and posttraumatic growth (PTG) as positive mental health outcome. In addition, it analysed the relevance of three organisational factors, perceived organisational support (POS), perceived supervisor support (PSS) and team support (TS). A total of 61 participants took part in the study. The results showed that 34.4% of the participants demonstrated a high level of STS and 27.9% a high level of burnout. Also, 46.4% of the participant reported increased PTG. The analysis showed that POS, PSS and TS were negatively correlated with STS; POS and TS were negatively correlated with burnout. There were no relevant correlations between PTG and other variables. Thus, the research identified organisational factors as important protection and preventive mechanisms against negative mental health outcomes.

Key words: mental health, humanitarian aid workers, organisational support theory, supervisor support, team support, secondary traumatic stress, burnout, posttraumatic growth

TABLE OF ABBREVIATIONS

CBI	Copenhagen Burnout Inventory
IDPs	Internally displaced people
PIN	Psychosocial Innovation Network
POS	Perceived organisational support
PSS	Perceived supervisor support
PTG	Posttraumatic growth
PTSD	Posttraumatic stress disorder
ST	Secondary traumatisation
STS	Secondary traumatic stress disorder
STSS	Secondary Traumatic Stress Scale
TS	Team support
VPTG	Vicarious posttraumatic growth
WHO	World Health Organization

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

According to the United Nations High Commissioner for Refugees (UNHCR), at the end of 2020, 82.4 million people were forcibly displaced due to conflict, prosecution and violence.[1] Thus, the majority of them have experienced traumatic life events such as torture, genocide, political imprisonment and other human rights violations. Consequently, people experiencing such events are at significant risk of developing different mental health conditions. The theory of social trauma provides an important framework for examining this phenomenon. According to the theory, trauma includes two aspects: personal and social. The personal aspect refers to an intra-psychical level that manifests in posttraumatic stress disorder (PTSD) symptoms.[2] PTSD is a mental disorder that can occur as a result of exposure to a very stressful or threatening event(s).[3] The social aspect refers to an extra-psychical level that involves the social environment, targeted victim social group and perpetrator group.[4]

Initially, the theory addressed only direct traumatisation. However, in the course of time, scholars have recognised that the scope of the impact of trauma extends well beyond individuals and groups who are directly affected. Thus, instead of the initial focus on perpetrators and

[1] UNHCR, 'Figures at a Glance' (*UNHCR*, 2021) <www.unhcr.org/figures-at-a-glance.html> accessed 19 August 2021.

[2] Jean-Jacques Petrucci and Andreas Hamburger, 'Social Trauma in International Refugee Legislation' in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 30.

[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, American Psychiatric Association 2013) 60.

[4] Jean-Jacques Petrucci and Andreas Hamburger, 'Social Trauma in International Refugee Legislation' in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 30.

victim groups only, the theory of social trauma extended the complex social matrix of groups to another layer. This layer is the individuals who engage with trauma survivors.[5] Therefore, refugees, migrants and asylum-seekers are not the only groups exposed to social trauma. Individuals who engage with them are at risk of developing mental health conditions as well. This group of individuals, among others, includes humanitarian aid workers. As a result of their work with refugees, the relief workers are at risk of secondary traumatic stress disorder (STS). The STS is a disorder that mimics symptoms of PTSD.[6]

Humanitarian aid workers, according to the definition, are individuals who provide help for vulnerable people in difficult situations. In Serbia, refugees, internally displaced people (IDPs) and 'social cases' are considered to be most vulnerable.[7] Recently, Serbia has been faced with one of the biggest humanitarian and security challenge – the European refugee crisis. Since 2015, over 1.5 million migrants have crossed the territory of Serbia.[8] Although Serbia's role has primarily been that of a transit country, the influx of migrants has put significant humanitarian and financial pressure on the country's asylum and refugee protection system. The circumstances undoubtedly have affected humanitarian aid workers already working under difficult conditions. As a result, beside the above-mentioned STS, another issue that has been identified among professionals working with trauma populations is professional burnout. On the other, exposure to trauma does not cause exclusively negative outcomes. The scholars have also identified positive outcomes such as posttraumatic growth (PTG). The PTG refers to positive psychological effects that may result from traumatic experiences.[9]

[5] Andreas Hamburger, 'Introduction' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan (eds), *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) vii <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021.

[6] Charles R Figley, *Treating Compassion Fatigue* (Brunner-Routledge 2002) 124.

[7] Charles-Antoine Hofmann, 'HPG Background Paper - Needs and Vulnerability in the Balkans: The Case of Serbia' (Overseas Development Institute, 2003) <https://cdn.odi.org/media/documents/444.pdf> accessed 17 August 2021.

[8] UNHCR, 'UNHCR Serbia Update, June 2021' (*Relief Web,* 2021) <https://reliefweb.int/report/serbia/unhcr-serbia-update-june-2021> accessed 18 August 2021.

[9] Catarina Ramos and Isabel Leal, 'Posttraumatic Growth in the Aftermath of Trauma: A Literature Review about Related Factors and Application Contexts' (2013) 2(1) Psychology, Community & Health 43, 44-45, <https://doi.org/10.5964/pch.v2i1.39> accessed 17 August 2021.

The objective of this study is to analyse the issue of protection of mental health of humanitarian aid workers in Serbia, and, thus, contribute to efforts aimed at addressing this problem. Within this overall objective, there are three sub-objectives:

- First sub-objective is to analyse the prevalence of negative mental health outcomes, specifically, secondary traumatic stress and burnout in relief workers in Serbia.
- Second sub-objective is to report on the prevalence of positive mental health outcomes, specifically, PTG in humanitarian aid workers in Serbia.
- Third sub-objective is to identify the potential mechanism that could protect the mental health of these workers by (a) preventing negative mental health outcomes and (b) inducing positive mental health outcomes. Thus, the study will test the impact of organisational factors: perceived organisational support (POS), perceived supervisor support (PSS) and team support (TS) along with other possibly relevant factors on mental health outcomes.[10]

Therefore, this study will seek to provide answers to three research questions:

- First, the research will strive to answer the question: *do humanitarian aid workers in Serbia suffer from posttraumatic stress and burnout on the one hand, and do they experience PTG on the other hand*? Through answering this question, it will be possible to compare and test consistency of the obtained result with the discoveries of other similar studies, to identify potential changes in mental health of relief workers in Serbia that occurred over time, and to target somewhat different sample than previous studies in order to include experiences of humanitarian aid workers as well.
- Second, the research will seek to answer the question: *do organisational factors, POS, PSS and TS, affect the experience of the STS and burnout on the one hand, and PTG on the other*. Here, it will be possible to test

[10] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

organisational support theory and thus identify a potential mechanism for (a) preventing negative and (b) inducing positive psychological effects. Based on the discovery of such mechanisms, important recommendations could be made for addressing the problem.

- Third, the study will pose a question: *do other factors such as type and frequency of contact with beneficiaries, type of organisation, organisations (not) providing psychological help and support to its employees and/or demographic characteristics affect workers' experience*. Through answering this question, it will be possible to identify other relevant factors in these processes.

To answer these research questions, the study will implement multi-method approach. Thus, methodology will include desk research and surveying. Therefore, the following methods will be implemented:

- Firstly, it will mobilise the theory of social trauma that includes views from different disciplines in order to get a comprehensive perspective on the trauma of refugees as a wider context and then trauma of humanitarian aid workers.
- Secondly, it will collect and interpret the data obtained by other empirical studies that analysed the problem.
- Thirdly, methodology will include own and original primary data collection gathered through surveys in order to (re)confirm and expand existing knowledge on mental health of humanitarian aid workers in Serbia.

Therefore, the first chapter will examine the theory of social trauma within which phenomenon of trauma (1), migration and trauma, that is, traumatisation of refugees (2) and traumatisation of humanitarian aid workers working with refugees (and other vulnerable groups), including secondary traumatic stress and burnout concepts, (3) will be explained. The second chapter will identify and analyse protective trauma processes and interventions, firstly by explaining the post-traumatic growth, a positive psychological effect that goes beyond the ability to resist trauma experience (1), and then by examining the relevance of organisational factors in the process of protection of mental health of humanitarian aid workers (2). The third chapter will focus on the experiences of humanitarian aid workers in Serbia specifically. The context and existing research, including interpretation of empirical

discoveries made in other studies, will be first discussed (1). Then, methodology (2), results (3), discussion (4), recommendations and limitations (5) of this study will be presented. Therefore, the study will have a unique approach in analysing the issue since it will address problems discovered by the one set of studies but including, to some extent, different sample. Thus, it will presumably (re)confirm the existence and extent of the problem. In addition, it will seek to identify mechanisms that could address discovered problems based on evidence found in another set of studies.

1.

THEORY OF SOCIAL TRAUMA

Human societies are continuously progressing and achieving scientific and technological improvements. However, in spite of these improvements, humankind has not yet found a method to permanently resolve one of the greatest global issues: violence. Collective violence has been recurring throughout history and still is present in different parts of the world. Conflicts, terrorism, forced migrations and other forms of collective violence deeply affect social groups causing traumatic consequences not only to the individual members but to groups as a whole. In psychology, the field of traumatology analyses traumatic situations and individuals' responses to them. American Psychiatric Association (APA) explains (psychological) trauma as 'events or experiences that are shocking and overwhelming, typically involving major threat to the physical, emotional, or psychological safety and well-being of the individual victim(s) and loved ones and friends'.[11] The publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 by the APA induced significant developments in (psycho) traumatology.[12] Following the issuing of the manual, the nature and characteristics of traumatic stress have been researched and documented in numerous books and scholarly articles as a part of major professional publications.

As Kumpfmüller explained, there is a difference between random and (wo)man-made trauma.[13] Traumatic events such as natural

[11] American Psychological Association, 'Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults' (*American Psychological Association*, 2017) 6 <www.apa.org/ptsd-guideline> accessed 2 August 2021.

[12] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, American Psychiatric Association 1980) 1-15.

[13] Marcus Kumpfmüller, 'Political Traumatization and Trauma-Discourse' in in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 19.

disasters are classified as random trauma; they differ from man-made trauma, that is, violence, abuse, war, expulsion and torture, since the latter always includes particular social actors. (Wo)man-made trauma involves a specific individual, group and/or institution. Therefore, the individuals who suffer such traumatisation are not only referred to as ill persons but also as victims. The theory of social trauma provides a specific perspective and framework for understanding this trauma.[14] Therefore, the aim of this chapter is to explain and explore the theory of social trauma. In addition, it will also include a discussion on social trauma and migration from the perspective of this theory. Lastly, it will analyse the issue of traumatisation in individuals working with migrants, that is, traumatised populations.

1.1 Main theoretical models

According to the social trauma theory, trauma needs to be studied from perspectives of different disciplines, particularly bringing together two different yet interrelated theoretical models. It explains trauma as both a clinical and socio-psychological phenomenon. As a clinical phenomenon, trauma refers to a set of posttraumatic disorders that arise out of collective, systematically targeted violence against a social group. As a socio-psychological phenomenon, social trauma includes the impact of the initial trauma on long-term social processes.[15]

1.1.1 Clinical theories of trauma and PTSD

The discussion on the manifestation and triggers of mental health disorders has been present in history. The major developments in trauma theory emerged in the late 20th century with the publication of the *Diagnostic Statistical Manual of Mental Disorder*. However, it evolved from Freud's classical psychoanalytic trauma theory when the founder of psychoanalysis initially adopted and then rejected the idea

[14] Marcus Kumpfmüller, 'Political Traumatization and Trauma-Discourse' in in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 19.

[15] Andreas Hamburger, 'Social Trauma: A Bridging Concept' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan (eds), *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) 3 <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021.

that hysteria has traumatic origins.[16] Moreover, Ferenczi's understanding that trauma is the core of much neurotic and character pathology significantly contributed to the development of the field.[17] Modern psychoanalytic trauma theory expanded to include social consequences as well. However, integration of the experience of mass murder of Jewish people under the German Nazi regime into the general psychoanalytic trauma theory took more time than expected. Nevertheless, clinical theories of trauma continue to over-emphasise individual approaches overlooking inter-group and inter-individual dynamics.[18]

PTSD is a mental disorder that can occur as a result of exposure to a very stressful or threatening event(s). People who suffer from the disorder may have intense, upsetting thoughts and sensations related to the traumatic event they experienced. The *Diagnostic Statistical Manual of Mental Disorder* (third edition) defined PTSD as caused by 'a recognizable stressor that would evoke significant symptoms of distress in almost anyone'.[19] Symptoms of PTSD include intrusion, avoidance and negative changes in thinking and mood. The state of being unable to keep memories of the incident from returning is known as intrusion. Avoidance is an approach for avoiding stimuli and triggers that could evoke memories. Negative changes in thinking and mood include persistent negative sentiments towards others or oneself, such as guilt and anger, as well as inability to experience good emotions.[20]

1.1.2 Social theories of trauma

Since the 1980s, there has been an extensive discussion in the social sciences on trauma. Corresponding to the aforementioned broadening

[16] Andreas Hamburger, 'Social Trauma: A Bridging Concept' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan (eds), *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) 4 <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021.

[17] Jay B Frankel, 'Ferenczi's Trauma Theory' (1998) 58 The American Journal of Psychoanalysis 41, 41-42 <https://doi.org/10.1023/A:1022522031707> accessed 5 August 2021.

[18] Andreas Hamburger, 'Social Trauma: A Bridging Concept' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan, *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) 4 <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021.

[19] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, American Psychiatric Association 1980) 238.

[20] Zahava Solomon and Mario Mikulincer, 'Posttraumatic Intrusion, Avoidance, and Social Functioning: A 20-Year Longitudinal Study' (2007) 75(2) Journal of Consulting and Clinical Psychology 316, 316-18 <https://doi.org/10.1037/0022-006X.75.2.316> accessed 9 August 2021.

of the scope of the terminology in the clinical trauma conceptions, this has provoked broad and incautious usage of the term.[21] In sociology, the word trauma is even more metaphorical because social trauma is regarded as collective construction rather than a reaction to a historic occasion. To a person, trauma is what he/she/they perceive and experience as overwhelming or terrifying. Hamburger explained that:

> trauma as an intuitively understood term is a social fact in itself, and it points to some underlying social experience which can be sociologically reflected. Using trauma in everyday language as a predicate for a societal fact is metaphorical, as it implies a quasi-natural impact that causes a symptom, while in reality social trauma is an ex-post construct.[22]

In this discussion, Hamburger also includes Prager's classification of social trauma on traumas of lethality, traumas of violence and bodily harm, and traumas of personal invisibility.

1.1.3 The definition of social trauma

Therefore, the theory of social trauma connects individual and group processes. Social trauma cannot be defined only as a specific case of trauma experience (clinical perspective). On the contrary, it involves the traumatic experience of an individual where this experience is shared with other members of the social group (victims of collective violence). Moreover, traumatisation does not only include one social group – group of victims but also group of perpetrators and both are part of a wider social context. At the same time, it reminds us that groups are units of individual members, and individual experiences should not be overlooked when examining group dynamics and social behaviour. The individual social trauma victims are traumatised in the clinical sense of the expression, that is, they (may) suffer from PTSD (DSM-5 A2 criterion).[23] Petrucci and Hamburger provided a comprehensive definition of social trauma that includes these elements. They explained that the social trauma:

[21] Andreas Hamburger, 'Social Trauma: A Bridging Concept' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan (eds), *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) 4 <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021.

[22] ibid.

[23] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, American Psychiatric Association 2013) 60.

A. On an intra-psychical level:
1. requires posttraumatic symptoms of PTSD ([A2 criteria] in a clinical sense), but not necessarily personal exposure to physical or sexual assault, which then is replaced by membership in a social group having been exposed to social trauma; and

B. On an extra-psychical level:
1. requires the involvement of the social environment;
2. is aimed (through persecution) at an entire group, possessing a clear, defined identity;
3. is inflicted (through persecution) by perpetrators usually belonging to the same overreaching society, as the victims themselves (i.e., which make up the persecuted group);
4. is brought about (through persecution) by such perpetrators in a collective and contemporaneous manner against the victims making up the applicable group being persecuted;
5. destroys or profoundly modifies the nature and character of the society in which such social trauma takes place;
6. destroys reparative networks and mechanisms which existed prior to such social trauma.[24]

1.2 Migration and social trauma

When addressing the topic of migration, social trauma should not be overlooked. The discussions on forced migrations and the issue of refugees and asylum seekers must include awareness of this phenomenon. As it was discussed above, social trauma includes both social and personal perspectives. The refugees, migrants and asylum-seekers encounter international legislation, national regulations, media, policies and institutions. At the same time, they are fleeing prosecution, violence and conflict, and are faced with dramatic life events. Therefore, when addressing the problem, the personal experiences of refugees need to be included. Refugee Health Technical Assistance Center based on discoveries of different studies reported that 10-40% of

[24] Jean-Jacques Petrucci and Andreas Hamburger, 'Social Trauma in International Refugee Legislation' in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 30.

refugees experienced PTSD symptomatology.[25] In the following section, traumatic experiences of refugees will be discussed. Traumatisation they face can be divided into three stages: pre-displacement, during and post-displacement exposures to violence and uncertainties.[26] During all of these stages, refugees are exposed to different mental, physical and socio-economic stressors. Below, each of the phases will be discussed separately.

1.2.1 Pre-displacement trauma experiences

The pre-displacement or pre-flight phase conditions are established in the sociotraumatic background of migration. A decision to flee is typically made under difficult and traumatic circumstances. In some cases, this decision was being made over a longer period of time, while in others, it was an urgent and immediate response to the circumstances. The people deciding to leave their country of origin are most often under a threat of prosecution, murder, loss of means of existence and/or witnessing social upheaval and conflict. Voluntarily or not, it is possible that they took part in committing violent acts as well.[27] Hamburger and Hancheva noted that caution must be taken when classifying groups of refugees, particularly when discussing economic migrants as opposed to war refugees.[28] They emphasised that there are different aspects of the economy, and thus, very often, a decision to flee due to economic reasons was not 'a happy choice' as well.[29]

1.2.2 During displacement trauma experiences

After the decision to flee is made, the traumatic situations do not cease. The uncertain journey starts with the origin country and ends with the host country. The journey includes difficult travel, borders

[25] Refugee Health Technical Assistance Center, 'Mental Health' (*Refugee Health Technical Assistance Center*, 2011) <https://refugeehealthta.org/physical-mental-health/mental-health/> accessed 8 August 2021.
[26] ibid.
[27] ibid.
[28] Andreas Hamburger and Camelia Hancheva, 'Trauma and Migration. Psychological Aspects of Forced Migration and Mental Health' in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 81.
[29] ibid.

crossing, camps and/or detention centres for refugees.[30] Many people lose their lives or companions during this phase.[31] Hamburger and Hancheva discussed one specific aspect of social trauma that manifests in this stage. This aspect is a clash between host cultures and refugees' cultural identity.[32] They particularly focus on Eastern Europe stating that:

> if a huge emigration drain as in many East European countries threatens the social and economic stability as well as the cultural identity of a population, then the confrontation with 'the refugee' will trigger quite a different set of feelings than in an economically saturated country like Germany, where the concept of being received and safeguarded as a refugee from a dictatorial system bears a positive historical connotation.[33]

1.2.3 Post-displacement trauma experiences

When refugees finally reach a host country, the aim appears to be accomplished. However, the struggle does not end there since different unforeseen problems may occur. The expectation is that the target country would be a safe place where they are protected from harm or danger. Nevertheless, refugees may encounter difficulties arising from adjustment to a new and foreign culture. The mental and economic environment might seem unknown to them. Loss of culture, language and community are the obstacles they face as a part of the resettlement process. All of these factors may, on the one hand, contribute to the development of mental health disorders and, on the other, be addressed to prevent these conditions from occurring.[34] Therefore, these experiences that appear in this third and second phase can be characterised as retraumatisation.

[30] Refugee Health Technical Assistance Center, 'Mental Health' (*Refugee Health Technical Assistance Center*, 2011) <https://refugeehealthta.org/physical-mental-health/mental-health/> accessed 8 August 2021.

[31] Teresa Puvimanasinghe and others, 'Narrative and Silence: How Former Refugees Talk about Loss and Past Trauma' (2014) 28(1) Journal of Refugee Studies 69, 69-72 <https://doi.org/10.1093/jrs/feu019> accessed 10 August 2021.

[32] Andreas Hamburger and Camelia Hancheva, 'Trauma and Migration. Psychological Aspects of Forced Migration and Mental Health' in Andreas Hamburger and others (eds), *Forced Migration and Social Trauma* (Routledge 2019) 82.

[33] ibid.

[34] Refugee Health Technical Assistance Center, 'Mental Health' (*Refugee Health Technical Assistance Center*, 2011) <https://refugeehealthta.org/physical-mental-health/mental-health/> accessed 8 August 2021.

1.3 Secondary social trauma – humanitarian aid workers

The scholars have recognised that consequences of traumatic events extend well beyond individuals and groups who are immediately affected. Initially, social trauma has been analysed focusing on perpetrators and victim groups. Recently, the theory of social trauma extended the complex social matrix of perpetrators and victims to an additional layer.[35] This layer is the group of professionals who, as part of their work, engage with trauma survivors. As we have seen, refugees are continuously exposed to risks and uncertainties, from making a decision to resettle to resettlement process and even across and beyond the three discussed stages. Those who come in contact with them are repetitively observing the traumatic life events they have experienced.

Different studies researched the impact of work with trauma survivors on professionals, providing empirical evidence for secondary exposure to trauma. The focus of these studies has primarily been on the mental health professionals (that is, psychiatrists, psychologists and therapists). In addition, a number of research studies analysed psychological consequences caused by work with trauma populations in social workers, health care providers, and accident and emergency staff.[36] However, fewer studies addressed staff and professionals working in more supportive and practical roles such as humanitarian aid workers. Therefore, this study aims to contribute to limited but growing awareness of the difficulties humanitarian aid workers face. Humanitarian work is inherently demanding. Working in areas where violence or natural disasters are taking place and witnessing suffering, poverty, famine and death is challenging in itself. Additionally, aid workers are continuously exposed to different physical and psychological risks. This study will address the psychological risks humanitarian aid workers are exposed to as a result of working with trauma survivors.

1.3.1 Theory of secondary traumatic stress

There are different theoretical constructs that explain this effect of indirect exposure to social trauma. One of the most commonly used and

[35] Andreas Hamburger, 'Introduction' in Andreas Hamburger, Camellia Hancheva and Vamık D Volkan, *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) vii <https://doi.org/10.1007/978-3-030-47817-9> (hccessed 3 August 2021.

[36] ibid.

well recognised is secondary traumatisation (ST). Figley was one of the first scholars who proposed the construct of secondary traumatisation to explain a condition that may occur as a consequence of engagement with traumatised individuals. The scholar defined secondary traumatic stress (STS) as 'the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person'.[37] Furthermore, Figley explained that symptoms of STS mimic symptoms of PTSD.[38] PTSD is a mental disorder that can occur as a result of exposure to a very stressful or threatening event(s).[39] Working with traumatised individuals usually includes engaging with individuals suffering from PTSD. Symptoms of PTSD include intrusion, avoidance and negative changes in thinking and mood.[40] As a result of STS, these symptoms may appear in workers as well.

1.3.2 Professional burnout

Related to the STS, another issue that has been identified among professionals working with trauma populations is professional burnout. The World Health Organization (WHO) identifies burnout as an occupational phenomenon and defines it as a 'syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed'.[41] Although burnout may appear in any profession, here we are interested in the phenomenon in relation to social trauma and exposure to traumatic content at work. In fact, the syndrome was identified for the first time in the 1970s exactly among workers in helping

[37] Charles R Figley, 'Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview' in Charles R Figley (ed), *Compassion Fatigue : Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (Routledge 1995) 7.

[38] Charles R Figley *Treating Compassion Fatigue* (Brunner-Routledge 2002) 124.

[39] National Institutes of Health, 'Post-Traumatic Stress Disorder' (US Department of Mental Health Services, National Institutes of Health 2020) <www.nimh.nih.gov/sites/default/files/documents/health/publications/post-traumatic-stress-disorder-ptsd/20-mh-8124-ptsd.pdf> accessed 4 August 2021.

[40] Grant J Devilly, Renee Wright and Tracey Varker, 'Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals' (2009) 43(4) Australian & New Zealand Journal of Psychiatry 375 <https://doi.org/10.1080/00048670902721079> accessed 4 August 2021.

[41] World Health Organization, 'Burn-out an "Occupational Phenomenon": International Classification of Diseases' (*World Health Organization*, 2019) <www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases> accessed 15 August 2021.

professions.[42] Newell and MacNeil examined potential conditions helping professionals may suffer from as a result of indirect exposure to (social) trauma; in this context, they defined professional burnout as 'a state of physical, emotional, psychological, and spiritual exhaustion resulting from chronic exposure to (or practice with) populations that are vulnerable or suffering'.[43] It is a state that develops gradually and increases over time. Three different dimensions comprise burnout: emotional exhaustion, depersonalisation (helpers' defence mechanism for emotional distancing from trauma survivors) and a reduced sense of personal accomplishment.[44]

Therefore, as we have seen from this chapter, social trauma includes individual and group processes. The populations that are significantly impacted by the social trauma are refugees, migrants and asylum-seekers. The traumatisation they face occur in all fleeing stages: pre-displacement, during and post-displacement. During these stages refugees are exposed to different physical, mental and socio-economic stressors. Furthermore, they are not the only victims of this trauma. Humanitarian aid workers who engage with these populations are at a significant risk as well. Thus, there is a high probability that these workers suffer from symptoms of STS. These symptoms mimic those of PTSD. In addition, as we have seen, another problem that frequently occurs among relief workers is burnout. In the next chapter, there will be a discussion and analysis on protective mechanisms against such experiences.

[42] Ayala Pines and Christina Maslach, 'Characteristics of Staff Burnout in Mental Health Settings' (1978) 29(4) Hospital & Community Psychiatry 233 <https://doi.org/10.1176/ps.29.4.233 accessed 16 August 2021.

[43] Jason M Newell and Gordon A MacNeil, 'Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers' (2010) 6(2) Best Practices in Mental Health: An International Journal 57, 57-68.

[44] Kathleen Galek and others, 'Burnout, Secondary Traumatic Stress, and Social Support' (2011) 60 Pastoral Psychology 633 <https://doi.org/10.1007/s11089-011-0346-7> accessed 16 August 2021.

2.

TRAUMA INTERVENTIONS – PATHWAYS TO RESILIENCE

As we have seen from Chapter I, migrants, refugees and asylum-seekers are at significant risk of developing mental health disorders as a consequence of trauma. Different studies measured psychological distress among refugees and all identified a devastating impact on their well-being caused by violent conflicts and displacement. Responding to these studies, recent research has been addressing protective mechanisms and resilience processes that result in positive psychological effects. Likewise, as trauma research identified corresponding negative effects among humanitarian aid workers as a consequence of working with these populations, the studies have been tackling pathways to resilience among them as well. Therefore, the aim of this chapter is to explain these processes by focusing on two mechanisms founded on two theories: PTG theory and organisational support theory. PTG is applicable to any population experiencing trauma while organisational factors are potentially relevant and will be discussed in reference to workers engaging with trauma survivors.

2.1 Posttraumatic growth theory

The PTG theory explains that possible consequences of the experience of social trauma are not exclusively negative. PTG is a positive psychological effect that goes beyond the capacity to recover and resist difficulties caused by trauma. Certainly, the focus of scholars and field professionals has predominantly been on the damaging effects of trauma experience. However, positive psychological effects may result from traumatic experiences as well. Although this idea has been present in different disciplines such as philosophy, history and biology,

Tedeschi and Calhoun introduced the term in 1995 which later induced systematic research and greater scientific interest in the phenomenon.[45] Thus, to be able to cope with difficult situations, individuals make psychological and cognitive efforts. The result of these efforts is PTG. As Tedeschi and Calhoun explained, PTG 'is the individual's struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs'.[46]

2.1.1 Domains of posttraumatic growth

There are five PTG dimensions in which positive changes may occur. Those are: (1) greater appreciation of life and changed sense of priorities, (2) more intimate relationships with others, (3) a greater sense of personal strength, (4) spiritual development and (5) new possibilities.[47] First, as a result of the experience of trauma, cognitive reconstruction occurs and leads to vulnerability and understanding that events may not be controlled or predicted. Recognising the volatility of life, significance previously assigned to specific events starts to change. Therefore, the individuals learn to be mindful of small things that were previously overlooked or regarded as unimportant. The result of this process is a change in sense of priorities and greater appreciation for life.[48] Second, following the difficult situation, the individuals will need to comprehend the traumatic event and cope with loss and stress. Thus, they might seek support and help from people close to them. Because of enhanced self-disclosure about their own negative experiences, they might experience a greater emotional connection with others and closeness in interpersonal relationships. Consequently, the individuals

[45] Catarina Ramos and Isabel Leal, 'Posttraumatic Growth in the Aftermath of Trauma: A Literature Review about Related Factors and Application Contexts' (2013) 2(1) Psychology, Community & Health 43, 44-45 <https://doi.org/10.5964/pch.v2i1.39> accessed 17 August 2021.

[46] Richard G Tedeschi and Lawrence G Calhoun, 'Posttraumatic Growth: Conceptual Foundations and Empirical Evidence' (2004) 15(1) Psychological Inquiry 1, 5 <https://doi.org/10.1207/s15327965pli1501_01 accessed 1 September 2021.

[47] Catarina Ramos and Isabel Leal, 'Posttraumatic Growth in the Aftermath of Trauma: A Literature Review about Related Factors and Application Contexts' (2013) 2(1) Psychology, Community & Health 43, 44-45 <https://doi.org/10.5964/pch.v2i1.39> accessed 17 August 2021.

[48] Cassie M Lindstrom and others, 'The Relationship of Core Belief Challenge, Rumination, Disclosure, and Sociocultural Elements to Posttraumatic Growth' (2013) 5(1) Psychological Trauma: Theory, Research, Practice, and Policy 50, 51-53 <https://doi.org/10.1037/a0022030> accessed 30 August 2021.

may learn to receive help from others more readily and to take advantage of existing social networks, as well as to invest in new ones.[49]

Third, greater sense of personal strength may result from the increased awareness of own capability to cope with difficulties. In comparison to the self before the trauma, the individuals recognise that, after the event, they have greater strengths and better skills.[50] Forth, following the traumatic experience, individuals may experience spiritual or religious growth. The faith in all moral authority or the supreme being(s) may increase and may also serve as a coping mechanism in the cognitive process of meaning-making. Also, the domain of spiritual growth is not limited to religious individuals; nonreligious people might experience it as well. However, the growth might be determined by the commitment to spirituality and religiosity before the trauma.[51] Finally, the trauma survivors might discover new life possibilities. As Ramos and Leal explained, 'The creation of a new life path is related with a perception of a new philosophy of life that changes the past assumptions and core beliefs leading to new possibilities and opportunities that did not exist before the trauma'.[52]

2.1.2 Secondary posttraumatic growth

PTG that is the result of direct exposure to social trauma can occur in the same way as a consequence of indirect exposure to trauma. This phenomenon in literature is known as secondary (or vicarious) PTG; it refers to the effect of indirect trauma exposure. Witnessing others' trauma, hearing their stories, engaging with them, beside secondary posttraumatic stress, can result in secondary PTG.[53] Thus, this also applies to humanitarian aid workers. Secondary PTG may manifest in the same manner as PTG does. The distinction is that the individuals who report PTG changes did not experience the trauma first-hand.[54] Here is how Tedeschi and others explain secondary and vicarious PTG:

[49] Catarina Ramos and Isabel Leal, 'Posttraumatic Growth in the Aftermath of Trauma: A Literature Review about Related Factors and Application Contexts' (2013) 2(1) Psychology, Community & Health 43, 44 <https://doi.org/10.5964/pch.v2i1.39> accessed 17 August 2021.

[50] ibid 45.

[51] ibid 45.

[52] ibid.

[53] Richard G Tedeschi and others, *Posttraumatic Growth: Theory, Research and Applications* (Routledge 2018) 183.

[54] ibid.

> The terms secondary and vicarious trauma are often used interchangeably. Both terms refer to the impact of indirect exposure to trauma. Such exposure can be in the form of hearing the narrative of another person's trauma, as is the case with therapists who work with traumatised clients, or witnessing the trauma of others, as is the case for people working in emergency services and the military. However, there are differences in the definition of these terms. Secondary trauma refers to symptoms of PTSD experienced as a result of hearing or seeing the trauma of others. Vicarious trauma refers to internal changes such as shifts in cognition. These shifts in cognition are a result of empathic engagement with another person. When PTG occurs in people with indirect exposure to trauma, vicarious PTG is the preferred term. Vicarious PTG (VPTG) can manifest itself in the same ways PTG does; the difference is that the person reporting PTG did not directly experience the traumatic event. However, when family members report VPTG, the boundary between VPTG and PTG may not always be clear. In these cases, there may be a mixture of direct emotional impact from living in an intimate relationship with a traumatized person, and also learning the lessons of post-trauma life from observations and interactions with that person.[55]

Therefore, secondary PTG is an important resilience process that results in positive psychological effects. Furthermore, it is not only relevant protective mechanism for secondary traumatic stress (STS) but to burnout as well. We have seen in Chapter I that burnout is a chronic condition that results from a person's employment. The research showed that experience of secondary PTG is of great importance in reducing the risk of burnout. Gibbons, Murphy and Joseph discovered a significant negative relationship between burnout and secondary PTG in social workers (N=62).[56] The degree to which workers valued themselves and perceived valuable by others appeared to mediate this relationship.[57] This relationship is best explained by Tedeschi and others including the above mentioned research. Here are their words:

> Unlike vicarious and secondary trauma, burnout is a chronic condition that is usually associated with a person's employment and is characterized by a gradual depletion of resources, and loss of motivation and commitment to the role. Burnout suggests that a person

[55] Richard G Tedeschi and others, *Posttraumatic Growth: Theory, Research and Applications* (Routledge 2018) 183. .

[56] Sarah Gibbons, David Murphy and Stephen Joseph, 'Countertransference and Positive Growth in Social Workers' (2011) 25(1) Journal of Social Work Practice 17, 17-18 <https://doi.org/10.1080/02650530903579246> accessed 2 September 2021.

[57] ibid 25-30.

becomes increasingly exhausted. Taku (2014) sampled 289 physicians investigating determinants of VPTG and burnout, including family support, dispositional resilience, marital status, and age. Higher levels of resilience, growth, and family support were inversely related to burnout. Taku suggested that for those physicians who did not have much family support, or were not inherently resilient, VPTG experiences are important in buffering the potential for burnout. Gibbons, Murphy and Joseph examined a number of factors influencing the mental health of 61 social workers, including PTG and burnout. They found that the social workers reported high levels of burnout and moderate levels of PTG, and that there was a significant negative relationship between PTG and burnout (r = -.30). The factor that seemed to account for higher levels of growth and lower levels of burnout was the extent to which the social workers valued themselves and perceived themselves to be valued by others. Linley and Joseph (2007) examined burnout, compassion satisfaction, compassion fatigue, and PTG in a sample of 156 therapists; a number of factors were predicted to influence these states, including the type of training that they had and their current practice orientation. Therapists who had transpersonal therapy training and used that approach in their practice reported greater PTG, whereas burnout was more likely in those who were trained in and practiced cognitive behavioral therapy (CBT). In addition, therapists with a history of trauma reported more personal growth.[58]

2.2 Organisational interventions

In literature, individual and organisational factors have been identified as intervention methods to address the problems. Although the variables that induce negative mental health outcomes among workers engaging with trauma populations have been researched, causation is still unclear. The personal or individual factors historically have been the central concern of these studies.[59] Demographic variables such as the experience of professionals, gender and age were examined and appeared to have an impact to a certain extent. The influence of personal trauma history, self-care strategies and personal coping style were analysed as well. Here, the focus will be on another set of relevant factors – organisational interventions.

[58] Richard G Tedeschi and others, *Posttraumatic Growth: Theory, Research and Applications* (Routledge 2018) 189.

[59] Ted Bober and Cheryl Reghehr, 'Strategies for Reducing Secondary or Vicarious Trauma: Do They Work?' (2006) 6(1) Brief Treatment and Crisis Intervention 1, 1-9 <http://dx.doi.org/10.1093/brief-treatment/mhj001> accessed 12 September 2021.

2.2.1 Organisational support theory

Eisenberger and others developed Organizational Support Theory (OST) in 1986. The theory explains the concept of perceived organisational support (POS) as a degree to which workers believe that their organisation values their efforts and cares about their well-being.[60] Adhering to the norm of reciprocity, workers tend to perform better and commit themselves toward accomplishing the goals of the organisation in exchange for proper treatment and benefits from the organisation. Thus, employees feel an increased duty to assist the company achieve its goals, greater emotional connection to the organisation and the anticipation that increased performance would be rewarded as a result of such POS. Positive behavioural effects of POS would be increased in in-role and extra-role performances as well as decreased withdrawal behaviours (absenteeism and turnover) and reduced stress.

Recently, scholars have been implementing and testing the theory as a major determinant of the mental health of humanitarian aid workers. Cardozo and others analysed the impact of organisational support on depression, anxiety and PTSD symptoms among humanitarian aid workers in Sri Lanka. They discovered that POS was significantly associated with these negative mental health effects.[61] Likewise, similar results were discovered among aid workers in Northern Uganda.[62]

2.2.2 Supervisor and team support

Furthermore, Aldamman and others, in addition to POS, examined PSS and TS as potentially relevant organisational factors. Indeed, they discovered that three organisational factors had a significant impact on mental well-being (measured with mental well-being scale) and adverse mental health outcomes (measured with anxiety and depressive disorder

[60] Robert Eisenberger and others, 'Perceived Organizational Support' (1986) 71(3) Journal of Applied Psychology 500.

[61] Barbara Lopes Cardozo and others, 'Factors Affecting Mental Health of Local Staff Working in the Vanni Region, Sri Lanka' (2013) 5(6) Psychological Trauma: Theory, Research, Practice, and Policy 581, 581-82. <https://doi.org/10.1037/a0030969 accessed 12 September 2021.

[62] Alastair Ager and others, 'Stress, Mental Health, and Burnout in National Humanitarian Aid Workers in Gulu, Northern Uganda' (2012) 25(6) Journal of Traumatic Stress 713, 713-720 <https://doi.org/10.1002/jts.21764> accessed 12 September 2021.

symptoms scales) in relief workers.[63] However, regarding organisational factors, they obtained mixed results and suggested further research. The research results showed that POS, PSS and TS were significantly correlated in positive direction with values $r = .56\text{-}.70$ and $p < .05$.[64]

To conclude, in this chapter, the focus was on protective mechanisms and positive psychological effects that may develop as a result of indirect exposure to social trauma. As we have seen, PTG may result from cognitive processes occurred as coping efforts caused by traumatic experience. The PTG may occur in five dimensions: (1) greater appreciation of life and changed sense of priorities, (2) more intimate relationships with others, (3) a greater sense of personal strength, (4) spiritual development and (5) new possibilities. The PTG as a consequence of direct exposure to social trauma can occur in the same way as a consequence of indirect exposure to trauma; this is known as secondary PTG. Secondary PTG is relevant phenomenon to any subject experiencing social trauma directly or indirectly. Therefore, it can be applied and examined among humanitarian workers as well. On the other hand, organisational factors, as protective and intervention mechanisms, are relevant for the professionals working with trauma survivors rather than direct victims. The research showed that these factors need to be considered as important determinants of mental health outcomes in humanitarian aid workers. Many studies included variable of POS; recent research extended the organisational factors by including PSS and TS as well.

[63] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology, 1-3 <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

[64] ibid 10.

3.

CASE STUDY – TRAUMA AND MENTAL HEALTH OF HUMANITARIAN AID WORKERS IN SERBIA

People who are leaving their countries to escape conflicts, violence, and war are experiencing traumatic life events. Therefore, majority of refugees, migrants, and asylum-seekers become victims of social trauma. However, they are not the only group affected by this trauma. Professionals who, as part of their work, engage with trauma survivors become victims themselves. In Chapter I, within the theory of social trauma, secondary traumatic stress and burnout were discussed as frequent problems aid workers experience. In Chapter II, resilience processes that result in positive psychological effects (secondary PTG) and potential protective mechanisms against STS and burnout (organisational factors) were addressed. Here, in Chapter III, the focus will be on the experiences of humanitarian aid workers in Serbia. Thus, the first part of the chapter will provide an overview of humanitarian aid work in Serbia including research on mental health of aid workers in this country. Next, it will present methodology and results of this study including the discussion of obtained results and limitations and recommendations.

There has been an extensive research on the impact of work with trauma survivors on professionals, providing empirical evidence for theoretical constructions discussed in previous chapters. The focus of these studies has primarily been on the mental health professionals, that is, therapists. As Guhan and Helen Liebling-Kalifani explain, many research studies analysed psychological consequences caused by work with trauma populations in social workers health care providers and accident and emergency staff.[65] However, few studies have addressed

[65] Rebecca Guhan and Helen Liebling-Kalifani, 'The Experiences of Staff Working with Refugees and Asylum Seekers in the United Kingdom: A Grounded Theory Exploration' (2011) 9(3) Journal of Immigrant & Refugee Studies 205, 206 <https://doi.org/10.1080/15562948.2011.592804> accessed 17 August 2021.

staff and professionals working in more supportive and practical roles such as humanitarian aid workers. Even fewer studies examined experiences of humanitarian aid workers in Serbia. Therefore, this study aims to contribute to raising limited but growing awareness of the difficulties Serbian humanitarian aid workers face and suggest potential mechanisms to address the problem.

3.1 Humanitarian aid work in Serbia

Working in area where violence (or natural disasters) is taking place and witnessing suffering, poverty, famine and death is challenging in itself. In addition, aid workers are continuously exposed to different physical and psychological risks. Humanitarian engagement in Serbia went through different changes affected by the political regime(s) and needs of the most vulnerable groups. Following NATO's air campaign in 1999, massive amounts of humanitarian support were sent to different Western Balkan countries while Serbia was excluded.[66] Due to the sanctions imposed by the United States of America, the European Union and the United Nations caused by Milosevic's politics, Serbia remained isolated. Thus, it received significantly less humanitarian aid than other countries. At the time, Serbia had fewer humanitarian organisations and agencies operating than other countries in the region. In order to receive funding, the agencies had to make a strong case. Humanitarian assistance was pushed to its limits due to these challenges that went beyond its basic duties. It was divided between donors' monitoring who favoured a rigorous implementation of the sanctions and pressure to respond to widespread and diverse urgent needs.[67]

Following the collapse of Milosevic's regime in 2000, sanctions were lifted. Subsequently, Serbia received massive international aid.[68] The refugees, IDPs and 'social cases' are considered to be most vulnerable groups. Thus, humanitarian aid is primarily directed toward these three groups.[69] After the dissolution of Yugoslavia, it is estimated that country

[66] Charles-Antoine Hofmann, 'HPG Background Paper - Needs and Vulnerability in the Balkans: The Case of Serbia' (Overseas Development Institute, 2003) 3 <https://cdn.odi.org/media/documents/444.pdf> accessed 17 August 2021.
[67] ibid.
[68] ibid 4.
[69] ibid.

received over 560,000 refugees from Bosnia and Herzegovina and Croatia and 210,000 IDPs from Kosovo.[70] To respond to this crisis, different governmental and non-governmental humanitarian aid organisations were established and many of them are active today. Another refugee and migrant crisis occurred recently and it has significantly affected the humanitarian situation not only in Serbia but in Europe and wider. This is how Beznec, Speer and Stojic Mitrovic describe this crisis:

> Before summer 2015, the prevailing representation of irregularized migration to the EU concerned maritime migration routes. The dominant images depicted overcrowded boats in distress and tragedies like the capsizing of a boat just off the coast of Lampedusa on 3 October 2013, when more than 300 people drowned. In summer 2015, however, the focus in the portrayal of migration shifted abruptly to the Balkan route. Media reports showed exhausted migrants walking down railway tracks through Macedonia and migrant families waiting in Belgrade parks or at the Keleti train station in Budapest. Later in the year, widely disseminated images showed migrants walking in long lines through fields or traveling on crowded trains in Croatia and Slovenia. The Balkan route is not a new phenomenon. It has a long history, marked by successive transformations in scope and visibility. However, the unique development of a formalized corridor, established in early summer 2015, constituted an unprecedented and significant rupture in its long existence. The formalized corridor enabled refugees to cross the Balkans from northern Greece to Western Europe within two or three days, in special trains and buses.[71]

3.1.1 Mental health of humanitarian aid workers in Serbia

The Guidance for Protection and Improvement of The Mental Health of Refugees, Asylum Seekers and Migrants in Serbia, the strategic document produced by the WHO, addressed the issue of psychological health and well-being of persons working with refugees. The document identified difficulties workers often encounter such as the requirement of services exceeding available resources and capabilities leading to overtime work, frequent requests to quickly and effectively adjust working methods to respond to urgent needs, mobility needs

[70] UNHCR, 'Serbia' (*UNHCR*, 2021) <www.unhcr.org/see/where-we-work/serbia> accessed 29 September 2021.

[71] Barbara Beznec, Marc Speer and Marta Stojić Mitrović, 'Governing the Balkan Route: Macedonia, Serbia and the European Border Regime' (Rosa Luxemburg Stiftung Southeast Europe 2016) <https://bordermonitoring.eu/wp-content/uploads/2017/01/5-Governing-the-Balkan-Route-web.pdf> accessed 4 August 2021.

and prolonged stay requests.[72] One of the recommendations made in the document was taking measures to protect mental health and prevent burnout and secondary traumatic stress in persons involved in providing services to migrants and refugees. As a part of the response to this recommendation, the Psychosocial Innovation Network (PIN) published research on the prevalence of burnout and STS in persons working with refugees in Serbia with the aim of producing evidence necessary for developing data-driven strategies recommended in WHO's guidelines. Over half of the participants in the study were medical staff working in health facilities. The results showed that 32.1% of these participants were at risk of STS, 26.5% of them reported high levels of burnout and 30.2% showed increased PTG.[73]

This study aims to contribute to these efforts of addressing the issue of protection of mental health and prevention of secondary traumatic stress and burnout in humanitarian aid workers in Serbia. In contrast to PIN's research, targeted participants in this study will be humanitarian aid workers who perform more practical and supportive roles. Besides prevalence results, the intention is to extend the research by identifying the potential mechanism that would decrease and prevent negative and induce positive mental health outcomes while providing data-driven empirical evidence for its relevance. In literature, individual and organisational factors have been identified as intervention methods to address this problem. Here, the focus will primarily be on organisational elements.

Aldamman and others discovered that organisational factors, perceived organisational support (POS), PSS and TS, had a significant impact on mental well-being (measured with mental well-being scale) and adverse mental health outcomes (measured with anxiety and

[72] Snežana Svetozarević and others, 'The Guidance for Protection and Improvement of the Mental Health of Refugees, Asylum Seekers and Migrants in Serbia' (World Health Organization 2019) 31 <https://kirs.gov.rs/media/uploads/4_%D0%A1%D0%BC%D0%B5%D1%80%D0%BD%D0%B8%D1%86%D0%B5_%D0%B7%D0%B0_%D0%B7%D0%B0%D1%88%D1%82%D0%B8%D1%82%D1%83_%D0%B8_%D1%83%D0%BD%D0%B0%D0%BF%D1%80%D0%B5%D1%92.pdf> accessed 15 August 2021.

[73] Marko Zivanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN) 2019) 24-25 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

depressive disorder symptoms scales) in relief workers.[74] Therefore, in an effort to identify mechanism that could address problems discovered by the WHO and PIN, this study will test the impact of organisational support, including POS, PSS and TS on mental health of humanitarian aid workers in Serbia. Instead of measures for mental health outcomes Aldamman and others implemented in their research, this study will analyse the impact of the organisational factors on specifically secondary traumatic stress, burnout and PTG. In addition, the study will include other factors such as demographics (individual variables), type and frequency of contact with beneficiaries and type of organisation as potential relevant elements of the experience of humanitarian aid workers in Serbia.

3.2 Methodology

This sub-chapter will present and discuss design process, that is, methods and procedures used for carrying out this research. In the study, a mixed research design was implemented combining descriptive and correlational research approach. Thus, the study is descriptive, quantitative and exploratory; the main instrument for data collection was survey. Below, the first sub-sub chapter will provide description of the participants. The second part will provide detailed analysis of the used materials where all measures and scales used in the survey will be discussed. The last part will provide an overview of the procedure, that is, how data was collected.

3.2.1 Participants

The total of 61 participants took part in the study. All participants indicated that they are humanitarian aid workers. Likewise, all participants reported that they are paid humanitarian aid workers and not volunteers. There were 39 (63.9%) female and 21 (34.4%) male participants. One person (1.6%) chose option 'I prefer not to say'.

[74] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

Furthermore, 2 (3.3%) participants were aged under 25 years, 13 (21.3%) were aged between 26 and 30 years, 24 (39.3%) were aged between 31 and 40 years, 9 (14.8%) were aged between 41 and 50 years, 12 (19.7%) were aged between 51 and 60 years and, finally, 1 (1.6%) was aged over 61 years. Moreover, 3 (4.9%) participants reported they had worked less than six months for the organisation, 2 (3.3%) between 6 and 12 months, 2 (3.3%) between 12 and 18 months, 3 (4.9%) between 18 and 24 months, and 51 (83.6%) more than two years.

The majority of the participants, that is, 54 of them (88.5%) primarily work in the field of migrants/refugees protection. Others stated providing help and services to IDPs, Roma, elderly and/or human trafficking victims as the main focus of their jobs. The majority of the participants, 41 (67.2), indicated they work for non-governmental national organisations, then 8 (13.1%) for non-governmental international organisations followed by 7 (11.5%) participants who reported they work for a UN agency. The lowest number of the participants, 5 (8.2%), stated they work for a governmental organisation. The results showed that participants work in different positions providing diverse types of services to beneficiaries. Thus, 14 (23.0%) stated they provide psychological and psychosocial assistance, 13 (21.3%) provide legal assistance, 8 (13.1%) work in the management and administration sector, 3 (4.9%) in procurement, 7 (11.5%) work as cultural mediators, 6 (9.8%) as social workers, 2 (3.3%) as educators, the same number, which is 2 (3.3%), as translators, 3 (4.9%) work on issues of migrant integration and 3 (4.9%) on humanitarian advocacy.

3.2.2 Materials

In order to collect necessary data based on witch analyses and conclusions about the issue in question could be made, a specific instrument was designed. This instrument was a survey. The survey was made of four parts. The first part was designed to measure negative mental health outcomes: STS and burnout. The second part was designed to measure positive mental health outcome, that is, secondary PTG. The third part was designed to measure organisational factors: POS, PSS and TS. The fourth and final part was designed to collect demographic data as well as work and organisation related questions. Each of these parts, including specific scales and all items on the scales, will be discussed below.

In 2004 Bride and others developed the Secondary Traumatic Stress Scale (STSS).[75] It was created in order to evaluate stress service providers possibly experience as a result of their work with trauma populations. The scale includes measures of three domains: intrusion, avoidance and arousal. It has been used extensively in the studies analysing this issue. Furthermore, it has been proven that the scale has strong discriminant, convergent and factor validity as well as internal consistency and reliability.[76] In total, it has 17 items; 5 for intrusion, 7 for avoidance and 5 for arousal evaluation. The items are in the form of statements and participants should self-report applicable value from 0 to 4 levels where 0 is 'never', 1 is 'rarely', 2 is 'occasionally', 3 is 'often' and 4 is 'very often'. These items are: I felt emotionally numb (1), my heart started pounding when I thought about my work with clients (2), it seemed as if I was reliving the trauma(s) experienced by my client(s) (3), I had trouble sleeping (4), I felt discouraged about the future (5), reminders of my work with clients upset me (6), I had little interest in being around others (7), I felt jumpy (8), I was less active than usual (9), I thought about my work with clients when I didn't intend to (10), I had trouble concentrating (11), I avoided people, places or things that reminded me of my work with clients (12), I had disturbing dreams about my work with clients (13), I wanted to avoid working with some clients (14), I was easily annoyed (15), I expected something bad to happen (16) and I noticed gaps in my memory about clients sessions (17).[77] This scale was used in the survey. The STSS was implemented in PIN's survey as well. The scale for this research was adjusted according to the input of the supervisor and tutor. In the survey, the participants were asked to 'think about your direct work with the clients/beneficiaries as you respond to the following questions. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by choosing the corresponding number next to the statement'. Also, it was noted that 'when in a question word "client" appears, it refers to the beneficiaries, that is, to the receivers of the services organization you work for and you as an employee provide (for example, refugees)'.

[75] Brian Bride and others, 'Development and Validation of the Secondary Traumatic Stress Scale' (2004) 14(1) Research on Social Work Practice 27 <https://doi.org/10.1177/1049731503254106> accessed 3 June 2021.

[76] Laura Ting and others, 'The Secondary Traumatic Stress Scale (STSS)' (2005) 11(3-4) Journal of Human Behavior in the Social Environment 177, 177-78 <https://doi.org/10.1300/J137v11n03_09> accessed 3 June 2021.

[77] Brian Bride and others, 'Development and Validation of the Secondary Traumatic Stress Scale' (2004) 14(1) Research on Social Work Practice 27, 27-35 <https://doi.org/10.1177/1049731503254106> accessed 3 June 2021.

The Copenhagen Burnout Inventory (CBI) is one of the well-established scales for measuring burnout.[78] Strong validity and internal reliability of the scale has been confirmed.[79] The inventory includes measures of personal burnout, work-related burnout and client-related burnout. Out of 19 items on the scale, 6 are designed to evaluate personal burnout, 7 to evaluate work-related burnout and 6 to evaluate client-related burnout. The items are in form of statements and participants are supposed to self-report one of the five values applicable to them. Those values are 'always', 'often', 'sometimes', 'seldom' and 'never/almost never' or 'to a very high degree', 'to a high degree', 'somewhat', 'to a low degree' and 'to a very low degree'. The statements are: how often do you feel tired (1), how often are you physically exhausted (2), how often are you emotionally exhausted (3), how often do you think: 'I can't take it anymore' (4), how often do you feel worn out (5) and how often do you feel weak and susceptible to illness (6). These statements measure personal burnout. Furthermore, is your work emotionally exhausting (7), do you feel burnt out because of your work (8), does your work frustrate you (9), do you feel worn out at the end of the working day (10), are you exhausted in the morning at the thought of another day at work (11), do you feel that every working hour is tiring for you (12) and do you have enough energy for family and friends during leisure time (13). These statements measure work-related burnout. Finally, do you find it hard to work with clients (14), do you find it frustrating to work with clients (15), does it drain your energy to work with clients (16), do you feel that you give more than you get back when you work with clients (17), are you tired of working with clients (18) and do you sometimes wonder how long you will be able to continue working with clients (19). These statements measure client-related burnout.[80] This scale was implemented as a part of the survey used in this study. The PIN used the CBI as well.[81]

[78] Tage S Kristensen and others, 'The Copenhagen Burnout Inventory: A New Tool for the Assessment of Burnout, Work & Stress' (2005) 19(3) An International Journal of Work, Health & Organisations 192 <https://doi.org/10.1080/02678370500297720> accessed 3 June 2021.

[79] ibid.

[80] ibid192-207.

[81] Marko Zivanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN) 2019) 23 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

For evaluating secondary PTG as a positive mental health outcome, this study implemented the Posttraumatic Growth Inventory. It is a 21-item scale developed by Tedeschi and Calhoun.[82] However, since the PIN reported that they discovered the most significant positive changes in the domain of personal strength and greater appreciation of life, the survey included only these measures.[83] Therefore, the following items were included in the survey: I changed my priorities about what is important in life (1), I have a greater appreciation for the value of my own life (2), I have a greater feeling of self-reliance (3), I can handle difficulties (4), I am better able to accept the way things work out (5), I can better appreciate each day (6) and I discovered that I'm stronger than I thought I was (7). The participants were asked to 'indicate for each of the statements the degree to which this change occurred in your life as a result of your job, specifically, of work with traumatized individuals'. They were asked to choose an answer from 0 to 5 where: 0 = I did not experience this change as a result of my job, 1 = I experienced this change to a very small degree as a result of my job, 2 = I experienced this change to a small degree as a result of my job, 3 = I experienced this change to a moderate degree as a result of my job, 4 = I experienced this change to a great degree as a result of my job and 5 = I experienced this change to a very great degree as a result of my job.

Moreover, the three scales were used for organisational measures. All three scales were implemented in research conducted by Aldamman and others as well.[84] However, original scales were adapted and adjusted for this research according to my supervisor's and tutor's comments and suggestions. Thus, for the perceived organisational support, the eight-item POS scale developed by Eisenberger and others was used.[85] The scale comprised of the following statements: the organisation

[82] Richard G Tedeschi and Lawrence G Calhoun, 'The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma' (1996) 9(3) Journal of Traumatic Stress 455 <https://doi.org/10.1002/jts.2490090305> accessed 3 June 2021.

[83] Marko Živanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN) 2019) 23 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

[84] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology, 4 <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

[85] ibid.

values my contribution to its well-being (1), the organisation fails to appreciate any extra effort from me (2), the organisation would ignore any complaint from me (3), the organisation really cares about my well-being (4), even if I did the best job possible, the organisation would fail to notice (5), the organisation cares about my general satisfaction at work (6), the organisation shows very little concern for me (7) and the organisation takes pride in my accomplishments at work (8). The participants were asked to indicate their level of agreement by choosing the number from 0 to 6 where 0 represented 'strongly disagree', 1 was 'slightly disagree', 2 was 'moderately disagree', 3 was 'neither agree nor disagree', 4 was 'slightly agree', 5 was 'moderately agree' and 6 was 'strongly agree'. Furthermore, the PSS was measured with shortened version of the PSS scale created by Vallières and others.[86] There were three items: my supervisor meets with me regularly to discuss problems and solutions (1), my supervisor takes into consideration my views and ideas (2) and my supervisor appreciates me (3). The participants were asked to assess their level of agreement with the statements by choosing a number from 1 (strongly disagree) to 5 (strongly agree). Finally, for measuring TS, the survey included shortened version of scale created by Rodwell and others.[87] The used items were: there is a lot of support and encouragement within my work group (1), it is very difficult to settle problems in my work group (2) and group members keep their thoughts to themselves, rather than risk speaking out (3). The items were valued by participants by choosing a number from 1 (strongly disagree) to 5 (strongly agree).

Lastly, the fourth part included demographic questions (age and gender), verification question, field and duration of work, type of services they offer, type of employment, type of organisation, whether an organisation provides psychological help and supervision to employees, and question on frequency of contact. The questions measuring these values were created in the form of closed-ended questions. Here is the detailed overview of these items: I am humanitarian aid worker; in other words, your job includes providing humanitarian assistance intended to save lives, alleviate suffering and maintain human dignity during and

[86] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology, 4 <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

[87] ibid 5.

after man-made and/or natural crises and disasters (offered answers: yes and no) (1), I primarily work in the field of: ___ (your job may include other fields and types of assistance; however, the question refers to your main scope of work; for example, home care for the sick and elderly, advocating for the rights of people in area of mental care, youth drug prevention, peacebuilding programs) (offered answers: refugee and migrant protection and other (please specify)) (2), I am ___ (offered answers: volunteer and paid humanitarian worker) (3), I have been working for my organisation ___ (offered answers: less than 6 months, between 6 and 12 months, between 12 and 18 months, between 18 months and 24 months, and more than two years) (4), my organisation is ___ (offered answers: governmental organisation, non-governmental international organisation, non-governmental national organisation and UN agency) (5), my organisation provides psychological help/supervision to its employees (offered answers: yes and no) (6), I am aware of the potential impact of my job on my psychological wellbeing (offered answers: yes and no) (7), I am ___ (gender) (offered answers: female, male and other) (8), I am ___ years old (offered answers: < 25, 26-30, 31-40, 41-50, 51-60, > 61) (9), my job includes providing ___ (type of assistance) (offered answers: legal, prevention and identification of trafficking in human beings, cultural mediation, psychological, delivery of food and non-food items, medical and other) (10), I work ___ with beneficiaries (receivers of humanitarian assistance) (offered answers: directly and indirectly) (11), as part of my job, I meet (that is, I am in a direct contact) with beneficiaries (receivers of humanitarian assistance) on a ___ basis (offered answers: daily, weekly, monthly, quarterly and never) (12).

3.2.3 Procedure

First, the procedure included the creation of the instrument phase. After the survey was created, the phase of data collection was initiated. Since all humanity is suffering the consequences of the ongoing COVID-19 pandemic and all of us are feeling limitations because of it, the decision was made to collect data via online means. Due to the restrictions and increased travel risks, the researcher (that is, student and author of this work) was attending online instead of an in-person internship in July and August 2021 as a mandatory part of the ERMA programme. Thus, it was unfeasible to personally collect the data.

Therefore, the survey was uploaded to the Google Forms platform. Two versions of the instrument were created, one in English and one in the local (that is, Serbian) language. With the tremendous help and assistance provided by Crisis Response and Policy Centre (CRPC), the organisation in which the student/author completed the internship, data was collected online. The staff, particularly Maja Dragojević, Information Manager at the CRPC, provided necessary contacts to the student. The student e-mailed the contacts, adhering to ethical guidelines and asking them to participate in the study. In the e-mail, links to the surveys in both languages were provided. Thus, the participants choose the language they prefer. The first paragraph of the survey contained following information:

> participation in this study is completely voluntary. If you feel uncomfortable answering any question, you can withdraw from the survey at any point. The participation is completely ANONYMIZED, including your name, organization you work for, and all data provided. Obtained information will be used for the purpose of this research exclusively. Please strive to answer the questions as honestly as possible, in accordance with your attitudes and perceptions.

Therefore, a non-probability sampling method was implemented, combining convenience and snowball sampling. The data was collected over a period of three weeks. The first response was received on 20 July 2021 and the last on 3 August 2021.

3.3 Results

In this sub-chapter, the results of this research and findings obtained by surveying humanitarian aid workers in Serbia will be presented. The section will show collected data in detail. Relevance of the results, comparison with findings of other studies, relevance and importance of discovered relationships between variables will be addressed in the Discussion sub-chapter that follows this section. Therefore, (1) prevalence of mental health outcomes humanitarian aid workers report they experienced and (2) relationship between these mental health outcomes and organisational factors will be reported below.

3.3.1 Mental health outcomes

The research instrument was designed to measure negative and positive mental health outcomes. The aim was to assess STS and burnout as negative psychological effects humanitarian aid workers may experience as a result of their job. In addition, the survey included measure for secondary PTG as a potential positive psychological effect of experiencing secondary trauma. The obtained results of frequencies of (1) STS, (2) burnout, (3) secondary PTG and (4) the relationships between these outcomes will be shown below.

3.3.1.1 Secondary traumatic stress

The participants reported how often they experience each of the symptoms on secondary traumatic stress scale. The obtained values of each item were summed up. The scores were interpreted using the following method:

- score < 28 = little or no STS
- score 28-37 = mild STS
- score 38-43 = moderate STS
- score 44-48 = high STS
- score > 49 = severe STS

Table 1. Frequency and percentage of secondary traumatic stress (STS)

	Frequency	**Percent %**
Little or no STS	22	36.1%
Mild STS	24	39.3%
Moderate STS	4	6.6%
High STS	4	6.6%
Severe STS	7	11.5%
Total	61	100.0%

Thus, the numbers indicated that 36.1% of the humanitarian aid workers in Serbia who participated in the study experienced little or no STS symptoms; 39.3% of them reported mild STS symptoms. The same percentage of the participants, which is 6.6%, suffer from moderate and high STS. Lastly, 11.5% of the humanitarian aid workers experienced severe STS. These results including frequencies (that is,

values) are shown in Table 1. Furthermore, different cut-off scores are suggested by different scholars. However, they always need to range between 28 and 37. The cut-off scores are implemented to identify cases where the risk is significant and there is a need for intervention. For the purpose of this study, a cut-off score of 33 was used.[88] The result showed that 34.4% (n = 21) of the participants were at risk of this syndrome. Moreover, the most frequently occurring symptoms were arousal disturbances (36.7%); followed by avoidant behaviours (30.5%). The least experienced were intrusive thoughts and images (14.8%). Mean values and relative percentages (reoccurrence of 3, 4 and 5 values) for each item on the scale are presented in Table 2 below.

Table 2. Mean values and percentages of STS items

Statement	**Mean (1-5)**	**Percent %**
I felt emotionally numb.	2.262	37.7%
My heart started pounding when I thought about my work with clients.	1.541	13.1%
It seemed as if I was reliving the trauma(s) experienced by my client(s).	2.033	27.9%
I had trouble sleeping.	2.377	41.0%
I felt discouraged about the future.	2.033	31.1%
Reminders of my work with clients upset me.	1.771	18.0%
I had little interest in being around others.	2.197	41.0%
I felt jumpy.	2.410	44.3%
I was less active than usual.	2.312	45.9%
I had trouble concentrating.	2.361	44.3%
I avoided people, places, or things that reminded me of my work with clients.	1.721	23.0%
I had disturbing dreams about my work with clients.	1.672	19.7%
I wanted to avoid working with some clients.	1.754	19.7%
I was easily annoyed.	2.148	31.1%
I expected something bad to happen.	1.705	23.0%
I noticed gaps in my memory about client sessions.	1.492	14.8%

[88] Ingo Jacobs and others, 'Validity, Reliability, and Factor Structure of the Secondary Traumatic Stress Scale-French Version' (2019) 191(10) Frontiers in Psychiatry 1, 6 <https://doi.org/10.3389/fpsyt.2019.00191> accessed 5 September 2021.

3.3.1.2 Burnout

To evaluate burnout among humanitarian aid workers in Serbia, the CBI was used. The obtained results were scored using the following scale:

- Always = 100
- Often = 75
- Sometimes = 50
- Seldom = 25
- Never/almost never = 0

The mean values for each item are shown in Table 3. Moreover, by implementing a cut-off score of 75 and above, the findings showed that 27.9% of participants reported high levels of total burnout. The results revealed that humanitarian aid workers suffer predominantly from the personal burnout since 42.9% reported elevated levels of this symptomatology; 30.0% of them experienced work-related burnout, while 13.1% reported client-related difficulties. In Table 3, the column % shows percentage of participants who reported high (often=75) and very high (always=100) level of each burnout symptom on the scale.

Table 3. Mean values and percentages of burnout items

Item	**Mean (0-100)**	**Percent %**
How often do you feel tired?	65.1	64.4 %
How often are you physically exhausted?	64.8	63.9%
How often are you emotionally exhausted?	62.7	54.1%
How often do you think: 'I can't take it anymore'?	43.4	29.5%
How often do you feel worn out?	57.8	49.2%
How often do you feel weak and susceptible to illness?	39.8	18.0%
Is your work emotionally exhausting?	62.7	47.5%
Do you feel burnt out because of your work?	49.6	31.1%
Does your work frustrate you?	42.2	21.3%
Do you feel worn out at the end of the working day?	59.0	42.6%
Are you exhausted in the morning at the thought of another day at work?	43.0	23.0%
Do you feel that every working hour is tiring for you?	31.6	8.2%
Do you have enough energy for family and friends during leisure time?	47.5	36.1%

Item	Mean (0-100)	Percent %
Do you find it hard to work with clients?	32.8	9.8%
Do you find it frustrating to work with clients?	29.1	3.3%
Does it drain your energy to work with clients?	44.7	21.3%
Do you feel that you give more than you get back when you work with clients?	30.3	16.4%
Are you tired of working with clients?	33.2	8.2%
Do you sometimes wonder how long you will be able to continue working with clients?	40.2	19.7%

3.3.1.3 Posttraumatic growth

The effects of exposure to social trauma through work with trauma populations are not exclusively negative. The positive posttraumatic consequences can occur as a result of secondary exposure to trauma as well. The Posttraumatic Growth Inventory shortened to two domains (instead of five) was implemented in the study to assess these consequences. The results showed that 46.4% of the humanitarian workers in Serbia experienced significant change. In addition, 36.4% of them demonstrated moderate change, while 23.2% reported absence or insignificant levels of change. Also, the degrees of PTG were experienced similarly in the domain of appreciation of life and in the domain of personal strength. These results, together with findings for each item, can be found in Table 4.

Table 4. Mean values, percentages of reported change, and the overall score of reported posttraumatic growth (PTG)

Item	Mean (0-6)	No change %	Moderate change %	Significant change %
I changed my priorities about what is important in life.	2.869	18.0%	42.6%	39.3%
I have a greater appreciation for the value of my own life.	2.836	24.6%	31.1%	44.3%
I have a greater feeling of self-reliance.	2.639	32.8%	26.2%	41.0%
I can handle difficulties.	3.049	19.7%	27.9%	52.5%

Item	Mean (0-6)	No change %	Moderate change %	Significant change %
I am better able to accept the way things work out.	2.869	23.0%	26.2%	50.8%
I can better appreciate each day.	2.803	23.0%	34.4%	42.6%
I discovered that I'm stronger than I thought I was.	3.148	21.3%	24.6%	54.1%
PTG OVERALL	2.888	23.2%	30.4%	46.4%
Personal strength domain	2.926	24.2%	26.2%	49.6%
Appreciation of life domain	2.836	21.9%	36.0%	42.1%

3.3.1.4 Relationships between STS, burnout and PTG

A Pearson product-moment correlation coefficient was computed to assess the relationships between burnout, STS and secondary PTG. The results showed that there is one correlation. This correlation occurred between STS and burnout in positive direction, $r = .607$, $p < .05$.

Table 5. Relationships between burnout, STS, and secondary PTG

		Burnout	STS	PTG
Burnout	Pearson Correlation	1	.607*	.025
	Sig. (2-tailed)		.000	.849
	N	61	61	61
STS	Pearson Correlation	.607*	1	.097
	Sig. (2-tailed)	.000		.455
	N	61	61	61
PTG	Pearson Correlation	.025	.097	1
	Sig. (2-tailed)	.849	.455	
	N	61	61	61

*.Correlation is significant

3.3.2 Organisational factors as determinants of mental health outcomes

Above were presented frequencies of symptoms and indicators of STS, burnout and PTG and their correlations. However, besides examining the prevalence of the STS, burnout and PTG among humanitarian aid workers in Serbia, the goal of this study was to identify potential determining factors that influence occurrence of these mental health outcomes. Therefore, the impact of POS, PSS and TS were tested as possible factors that determine aid worker's mental health. In the next section, the obtained results and analysis of the relationship between organisational factors (POS, PSS and TS) and (1) STS, (2) burnout, and (3) PTG will be reported. Before presenting the analysis of those correlations, below is Table 6 which shows relationships between organisational factors. Thus, organisational factor TS was positively correlated with POS ($r = .750$, $p < .05$) and (PSS, $r = .365$, $p < .05$). However, such relationship was not identified between POS and PSS.

Table 6. Relationships between organisational factors (POS, PSS, and TS)

		POS	**PSS**	**TS**
POS	Pearson Correlation	1	.253	.750*
	Sig. (2-tailed)		.065	.000
	N	61	54	61
PSS	Pearson Correlation	.253	1	.365*
	Sig. (2-tailed)	.065		.007
	N	54	54	54
TS	Pearson Correlation	.750*	.365*	1
	Sig. (2-tailed)	.000	.007	
	N	61	54	61

*.Correlation is significant

3.3.2.1 Organisational factors and STS

A Pearson product-moment correlation coefficient was computed to assess the relationship between these three organisational factors and STS. The results showed that there was a negative correlation between POS and STS, $r = -.424$, $p < .05$. Likewise, PSS, $r = -.288$, $p < .05$, and TS, $r = -.406$, $p < .05$, were negatively correlated with STS (Table 7).

Table 7. Relationship between organisational factors (POS, PSS, and TS) and secondary traumatic stress STS

		POS	PSS	TS
STS	Pearson Correlation	-.424*	-.288*	-.406*
	Sig. (2-tailed)	.001	.035	.001
	N	61	54	61

*.Correlation is significant

In addition to prevalence of the condition, based on the cut-off score, two groups in previous section were identified: those who reported significantly high levels of the STS and require diagnosis/intervention (34.4%) and those who reported low or no the STS symptoms. An independent-samples t-test was conducted to compare the STS levels in these two groups. As shown in Table 8, 21 participants who experienced high levels of the STS (M = 3.62, SD = .98) compared to the 40 participants in the second group (M = 4.51, SD = 1.09) reported significantly lower scores of POS, t (59) = 3.10, $p < .05$, PSS t (52) = 2.32, $p < .05$, (M = 3.12, SD = .50; M = 3.54, SD = .70) and TS t (59) = 2.64, $p < .05$ (M = 3.44, SD = .92; M = 4.00, SD = .70).

Table 8. Comparison of the mean values of organizational factors between the group who reported high levels of STS and the group who reported low or no STS symptoms

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
POS	EVA	2.243	.140	3.104	59	.003	0.881	0.284	0.313	1.449
	EVNA			3.207	44.602	.002	0.881	0.275	0.328	1.435
PSS	EVA	.885	.351	2.322	52	.024	0.420	0.181	0.057	0.783
	EVNA			2.558	47.811	.014	0.420	0.164	0.090	0.750
TS	EVA	1.805	.184	2.637	59	.011	0.556	0.211	0.134	0.977
	EVNA			2.421	32.442	.021	0.556	0.229	0.088	1.023

a. EVA – equal variances assumed
b. EVNA – equal variances not assumed

3.3.2.2 Organisational factors and burnout

The analysis showed that organisational factors are not only relevant for the experience of secondary traumatic stress but also for the experience of burnout. A Pearson correlation coefficient (Table 9) indicated that POS, $r = -.365$, $p < .05$ and TS $r = -.300$, $p < .05$ were negatively associated with overall value of burnout. Furthermore, relationships between personal, work-related and client-related burnout and organisational factors were analysed. The PSS was not correlated with overall or any type of burnout. On the other hand, the results showed that the POS was negatively related with work ($r = -.328$, $p < .05$), client ($r = -.346$, $p < .05$, $r = -.346$, $p < .05$) but not personal burnout. The TS was negatively correlated only with work-related burnout ($r = -.315$, $p < .05$). Thus, as expected, none of the organisational factors was related to the personal burnout. On the other hand, personal burnout was positively correlated with overall burnout, $r = .807$, $p < .05$.

Table 9. Correlation between organisational factors and burnout

		POS	**PSS**	**TS**	**Personal burnout**	**Work burnout**	**Client burnout**	**Overall burnout**
Personal burnout	Pearson Correlation	-.250	-.081	-.197	1	.632*	.509*	.807*
	Sig. (2-tailed)	.052	.559	.128		.000	.000	.000
	N	61	54	61	61	61	61	61
Work burnout	Pearson Correlation	-.328*	-.077	-.315*	.632	1	.640*	.883*
	Sig. (2-tailed)	.010	.578	.014	.000		.000	.000
	N	61	54	61	61	61	61	61
Client burnout	Pearson Correlation	-.346*	.057	-.251	.509	.640*	1	.867*
	Sig. (2-tailed)	.006	.685	.051	.000	.000		.000
	N	61	54	61	61	61	61	61
Overall burnout	Pearson Correlation	-.365*	-.032	-.300*	.807	.883*	.867*	1
	Sig. (2-tailed)	.004	.818	.019				
	N	61	54	61				

*.Correlation is significant

In accordance with the above analysis of the STS, the t-test (Table 10) was run to compare means of reported organisational factors between the participants who experienced high or very high degree of burnout symptoms and those who experienced lower degrees. The results showed that the participants who suffer from burnout condition (M = 3.65, SD = .98) received significantly less organisational support than participants who do not suffer from the condition (M = 4.58, SD = 1.07), t (59) = -3.43, p < .05. Also, they received significantly less TS (M = 3.55, SD = .90) than those who did not experience high level of symptoms (M = 3.99, SD = .71), t (59) = -2.14, p < .05. There was no relevant difference between values of perceived supervisor support between these two groups.

Table 10. Comparison of mean values of organisational factors between the group experiencing a high or very high degree of burnout symptoms and the group experiencing milder or no symptoms

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
POS	EVA	1.615	.209	-3.439	59	.001	-0.928	0.270	-1.469	-0.388
	EVNA			-3.492	54.460	.001	-0.928	0.266	-1.461	-0.396
PSS	EVA	.004	.948	-.449	52	.655	-0.082	0.183	-0.450	0.285
	EVNA			-.442	44.456	.661	-0.082	0.186	-0.457	0.293
TS	EVA	1.510	.224	-2.142	59	.036	-0.444	0.207	-0.859	-0.029
	EVNA			-2.054	43.788	.046	-0.444	0.216	-0.880	-0.008

a. EVA – equal variances assumed
b. EVNA – equal variances not assumed

3.3.2.3 Organisational factors and PTG

As it can be seen from Table 11, analysis of a Pearson correlation coefficient did not show any relevant and statistically significant relationships between secondary PTG and organisational factors.

Table 11. Correlation between organisational factors and PTG

		POS	PSS	TS
PTG	Pearson Correlation	.023	-.076	.002
	Sig. (2-tailed)	.860	.585	.985
	N	61	54	61

*.Correlation is significant

3.3.3 Other factors as determinants of mental health outcomes

Different analyses were run in order to identify other potentially relevant factors that influence the mental health outcomes of humanitarian aid workers in Serbia. However, the results showed that age and gender as demographic factors were not significant in these processes. In addition, the type of help they provide (legal, psychological and other types), length of time they working for an organisation (less or more than two years) and type of an organisation (governmental, non-governmental and others) were not relevant as well. Interestingly, there was no significant difference in mental health outcomes or organisational factors between employees whose organisations offer psychological support and those whose organisations do not provide such support (Table 12).

Table 12. Comparison of mean values of health outcomes and organisational factors between the group whose employer offers psychological support and the group whose employer does not offer such support

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Burnout	EVA	.037	.848	-1.048	59	.299	-3.75	3.58	-10.92	3.41
	EVNA			-1.047	57.182	.299	-3.75	3.58	-10.93	3.42
STS	EVA	7.894	.007	-.827	59	.412	-2.24	2.71	-7.67	3.19
	EVNA			-.805	48.012	.425	-2.24	2.79	-7.84	3.36
PTG	EVA	.659	.420	.378	59	.707	0.13	0.35	-0.57	0.83
	EVNA			.381	58.591	.705	0.13	0.35	-0.56	0.82
POS	EVA	.797	.376	1.392	59	.169	0.40	0.29	-0.18	0.97
	EVNA			1.395	57.819	.168	0.40	0.29	-0.17	0.97
PSS	EVA	1.025	.316	-.102	52	.919	-0.02	0.18	-0.39	0.35
	EVNA			-.099	41.410	.922	-0.02	0.19	-0.40	0.36
PTS	EVA	1.005	.320	1.580	59	.120	0.33	0.21	-0.09	0.74
	EVNA			1.558	53.147	.125	0.33	0.21	-0.09	0.75

a. EVA – equal variances assumed
b. EVNA – equal variances not assumed

On the other hand, significant correlation was discovered between frequency of contact with help receivers, that is, refugees, and burnout, secondary PTG but not secondary traumatic stress (Table 13).

Table 13. Correlation between mental health outcomes and frequency of contact with beneficiaries

		Frequency of contact	Burnout	PTG	STS
Frequency of contact	Pearson Correlation	1	.273*	.253*	.093
	Sig. (2-tailed)		.034	.049	.474
	N	61	61	61	61
Burnout	Pearson Correlation	.273*	1	.025	.607*
	Sig. (2-tailed)	.034		.849	.000
	N	61	61	61	61
PTG	Pearson Correlation	.253*	.025	1	.097
	Sig. (2-tailed)	.049	.849		.455
	N	61	61	61	61
STS	Pearson Correlation	.093	.607*	.097	1
	Sig. (2-tailed)	.474	.000	.455	
	N	61	61	61	61

*. Correlation is significant at the 0.05 level (2-tailed).

3.4 Discussion

3.4.1 Prevalence of the STS, burnout and the PTG

The results reported in the previous section showed that 36.1% of the participants in this study reported little or no secondary traumatic stress symptoms. Moreover, 39.3% of humanitarian aid workers in Serbia reported mild STS symptoms. The moderate and high levels of the STS were confirmed in 6.6% of participants. Finally, 11.5% experienced severe symptoms of STS. The PIN conducted a study on the prevalence of these symptoms as well. However, more than half of their participants

(52%) were medical workers. [89] Here the goal was to target humanitarian aid workers specifically and analyse the pervasiveness of the STS among them. Thus, the sample included professionals who perform more supportive and practical roles. The obtained results described above were, to a great degree, consistent with the PIN's findings. From the lowest to the highest level of experience of the STS symptoms, the PIN obtained these percentages: 28.8%, 39.1%, 14.0%, 8.8% and 9.3% of the participants.[90] In addition, while PIN discovered that 32.1% of the service providers working with refugees suffer from the syndrome, this study revealed that slightly more of the professionals, that is, 34.4% (cut-off: 33 score and above), would benefit from the treatment for the condition. Moreover, corresponding to the PIN's results, the most frequently occurring symptoms were arousal disturbances followed by avoidant behaviours. The least experienced were intrusive thoughts and images.

Furthermore, the PIN discovered that, on average, 26.5% service providers working with migrant and refugees in Serbia (out of which 52% participants of the whole sample N were doctors and nurses) reported high levels of burnout.[91] This study revealed that 27.9% of the humanitarian workers in Serbia suffer from burnout condition. It is important to note that a cut-off score of 75 was implemented. In other words, this percentage shows part of the sample that reported only high ('often') and severe ('always') experience of burnout symptoms. Moreover, the PIN reported that burnout-related difficulties were primarily occurring in the personal domain (46.0%), then in work-related domain (27.4%) and lastly in client-related domain (26.0%).[92] This study discovered this trend in burnout symptoms as well but with, to a certain degree, different percentages. Thus, humanitarian aid workers in Serbia suffer predominantly from personal burnout (42.9%), then work-related burnout (30.0%) and reported client-related burnout (13.1%).

[89] Marko Zivanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN), 2019) 6 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

[90] ibid 14.

[91] ibid 11.

[92] ibid.

Beside negative mental health outcomes, the results showed that humanitarian aid workers in Serbia experience positive mental health outcomes. Thus, the findings demonstrated that 76.8% of the participants reported at least moderate positive psychological effects of their work. The number includes 46.4% participants who experienced significant change and 36.4% of the participants who experienced moderate change. In comparison to the PIN's study, humanitarian aid workers experienced somewhat greater degree of PTG than service providers included in the PIN's research. Their results showed that 67.8% of the participants demonstrated PTG, including 43.3% participants who experienced significant change and 26.5% participants who experienced moderate change.[93]

In addition, the humanitarian aid workers perform very important but very difficult jobs. As a theory of social trauma explains, traumatic events affect not only the direct victims of social trauma but professionals who engage with the survivors as well. Zivanovic and Vukcevic Marovic annotated that social trauma is often a primary cause of forced migrations.[94] The people who leave their homes are most often victims of traumatic experiences, human rights violations and different forms of violence. Through the transmission of social trauma, those who provide help and services to these populations become exposed and victims as well. In Serbia, humanitarian work is primarily focused on providing help to refugees. The recent refugee crisis put additional pressure on the relief workers.

When approaching the issue, the humanitarian aid workers are often overlooked. The report, analysis and comparison of the results provided above undoubtedly demonstrate that providing care for the caregivers is necessary. The problem of negative psychological effects humanitarian aid workers in Serbia experience needs to be addressed not only to safeguard the mental health, human rights and well-being of helpers but to ensure the protection of the help receivers as well. Both the PIN's and this study showed that about one-third of the professionals working

[93] Marko Zivanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN), 2019) 23 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

[94] ibid 264-65.

with vulnerable populations endure negative mental health outcomes, specifically, they suffer from secondary traumatic stress and burnout. The PIN collected data between January and May in 2019.[95] The data for this study was collected in August 2021. Thus, more than two years have passed since the PIN identified the problem and no improvements occurred. The strategic document published by the World Health Organization in 2019, besides addressing the mental health of refugees, asylum seekers and migrants in Serbia, made recommendations for improving the well-being of aid workers.[96] According to the results of this study, no effective approaches for addressing the problem were implemented. Therefore, in the following section, we will seek to identify potential factors that determine these mental health outcomes. Through managing these factors, a possible method for addressing the psychological effects of humanitarian aid work could be identified.

3.4.2 The significance of organisational factors

The three organisational factors were assessed and correlated with other variables: POS, PSS and TS. Before discussing their relationships with other factors, let's first look into their interrelationships. The results showed that TS is positively correlated with PSS and POS. On the other hand, there was no significant correlation between POS and PSS. This can be interpreted as an indication that an increase in POS would not be accompanied by an increase in PSS and vice versa. Thus, the variables act as two independent factors. However, increases in each of these would result in the rise of TS. Therefore, it could be claimed that workers perceive support from the organisation differently from support they receive from a supervisor. On the other hand, they perceive an organisation as an entity and supervisor to be part of their work team experience.

[95] Marko Zivanović, Maša Vukčević Marković and Irena Stojadinovic, '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' (Psychosocial Innovation Network (PIN) 2019) 5 <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021.

[96] Snežana Svetozarević and others, 'The Guidance for Protection and Improvement of the Mental Health of Refugees, Asylum Seekers and Migrants in Serbia' (World Health Organization 2019) 31 <https://kirs.gov.rs/media/uploads/4_%D0%A1%D0%BC%D0%B5%D1%80%D0%BD%D0%B8%D1%86%D0%B5_%D0%B7%D0%B0_%D0%B7%D0%B0%D1%88%D1%82%D0%B8%D1%82%D1%83_%D0%B8_%D1%83%D0%BD%D0%B0%D0%BF%D1%80%D0%B5%D1%92.pdf> accessed 15 August 2021.

Consistent with the findings of Aldamman and others, the analysis from the previous sections showed that all three organisational factors were negatively correlated with STS.[97] Therefore, the results indicate that as the humanitarian aid worker receive less support from their organisation (1), supervisor (2) and team (3), they will experience increased levels of STS. Indeed, the findings showed that the participants who reported high levels of STS and require intervention and diagnosis received significantly less support from an organisation, supervisor and work team.

On the other hand, not all three organisational factors were significantly correlated with burnout. While the results showed a relevant negative correlation of POS and TS with burnout, the values of PSS and burnout did not affect each other. Thus, this indicates that receiving less support from the organisation and the team will probably result in increased levels of burnout. However, the support of a supervisor will not affect the experience of burnout. Accordingly, the results demonstrated that participants who were classified as a group suffering from high and very high levels of burnout received significantly less amount of support from their organisation and the team. On the other hand, there was no significant difference in the support they received from their supervisors. From this, we can draw a conclusion that an effort to manage organisational factors in order to decrease and prevent burnout should be focused on the support humanitarian aid workers receive from the organisation as a whole and their team, rather than from a supervisor. On the other hand, it should not be forgotten that it was proved that PSS has an impact on STS and thus needs to be considered as relevant in the overall process.

The findings demonstrated that the highest experienced burnout by humanitarian aid professionals in Serbia is not related to work. Nevertheless, analysis of the relationship between organisational factors and the types of burnout discovered that two out of three organisational elements were relevant for the experience of overall and within it work and client-related burnout. On the other hand, as expected, organisational factors were not significantly related to personal burnout. Since the analysis also showed that all types of burnout are positively correlated, this indicates that organisational intervention, that is, managing POS and

[97] Kinan Aldamman and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology, 1-12 <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021.

TS, will result in a decrease of work-related and client-related burnout. As a result, it will lead to reduction and possible prevention of personal, and, thus, overall burnout.

Interestingly, the analysis of the results provided in the results section discovered that secondary PTG was not related to any other variable included in this study. Thus, it manifested as a completely independent factor. This implies that management and control of organisational factors would not induce the experience of this positive mental health outcome. Furthermore, contrary to the results of studies such as that of Bober and Reghehr, these results indicate that experience of PTG would not prevent nor decrease the level of burnout.[98] The results presented in the previous sub-chapter showed that burnout and secondary traumatic stress were positively correlated. However, this was the only correlation that appeared among mental health outcomes since PTG was not correlated with negative mental health outcomes.

3.4.3 Relevance of other factors

The analyses presented in the other factors as determinants of mental health outcomes section did not reveal many significant results. Individual factors, including demographic characteristics, did not appear to be relevant in the experiences of humanitarian aid workers in Serbia. However, one factor was discovered as relevant. This factor is the frequency of contact with receivers of services, that is, in most cases, refugees. The results indicate that aid workers who perform positions that include more frequent contact with beneficiaries are at higher risk of burnout but not STS than those whose job roles include less contact. Interestingly, they also appear to experience an increased level of PTG. This was the only correlation of PTG with other variables that was statistically significant.

Finally, it is important to highlight one analysis that surprisingly did not show any significant correlations. This is the analysis on the relevance of organisations having psychological support mechanisms incorporated in their policies and services to employees. The results showed that this factor was not correlated with a positive mental health outcome, which is PTG, negative mental health outcomes, burnout and STS, or experience of organisational support factors.

[98] Ted Bober and Cheryl Reghehr, 'Strategies for Reducing Secondary or Vicarious Trauma: Do They Work?' (2006) 6(1) Brief Treatment and Crisis Intervention 1, 1-9 <http://dx.doi.org/10.1093/brief-treatment/mhj001> accessed 12 September 2021.

3.5 Recommendations and limitations

The final goal of the process of collecting, analysing, and reporting the data was to make evidence-driven conclusions and recommendations for addressing the problem. As we have seen, humanitarian aid workers in Serbia experience significant levels of burnout and secondary traumatic stress. The WHO made a recommendation for stakeholders to address the problem of negative psychological effects that aid workers in Serbia experience.[99] The interventions would not only improve the well-being of relief workers but of receivers of their services as well. However, no significant change or improvement in addressing the problem was identified. Based on the results of this study, several general recommendations for addressing this problem could be made. These are:

- The organisations providing humanitarian aid should re-examine their internal policies and relationships with their employees in order to assess support they offer to their employees.
- Subsequently, specific interventions should be designed and implemented in these organisations that would increase the organisational, supervisor and TS employees receive.
- The organisations that provide psychological help and support to its employees should re-examine the quality and extent of this support in order to provide and include protective measures against secondary traumatic stress and burnout.
- The organisations that do not provide psychological help and support to its employees should include such support but focus it on effective management of burnout and secondary traumatic stress.
- The intervention efforts should be focused on organisational elements rather than positive psychological effects as prevention and protection mechanisms.
- These interventions should particularly be directed toward employees performing job roles that include frequent contact with beneficiaries.

[99] Snežana Svetozarević and others, 'The Guidance for Protection and Improvement of the Mental Health of Refugees, Asylum Seekers and Migrants in Serbia' (World Health Organization 2019) 31 <https://kirs.gov.rs/media/uploads/4_%D0%A1%D0%BC%D0%B5%D1%80%D0%BD%D0%B8%D1%86%D0%B5_%D0%B7%D0%B0_%D0%B7%D0%B0%D1%88%D1%82%D0%B8%D1%82%D1%83_%D0%B8_%D1%83%D0%BD%D0%B0%D0%BF%D1%80%D0%B5%D1%92.pdf> accessed 15 August 2021.

Furthermore, as with every research, this study has its limitations as well. First, it is important to state that although organisational factors were analysed and regarded as determinants of mental health outcomes, no causal analyses were run to determine this relationship. In order to make such conclusions, further research that would implement experimental research design is necessary. Second, qualitative insight into the issue would probably provide important complementary conclusions. However, due to different limitations of this research as student work, it was unfeasible to include it. Also, the future research should focus on exploration of the internal relationship between organisational factors and their relevance to other factors as mixed results were obtained (PSS was relevant for the experience of STS, but not of burnout; POS and PSS were not correlated).

CONCLUSION

Humanity is in a continuous progression process achieving different technological and scientific improvements. In spite of this, human societies have not yet found a solution to permanently end one of the most destructive global problems: collective violence. Wars, terrorism, forced migrations and other similar violent occurrences have been continuously present in human history. Such events cause deep and widespread traumatic consequences. The theory of social trauma provides a specific perspective and framework for understanding these consequences.

In agreement with theory, trauma needs to be studied from the perspectives of different disciplines. This theory brings together two different but interrelated points of view. It explains trauma as both a clinical and socio-psychological phenomenon. As a clinical phenomenon, trauma represents a collection of posttraumatic disorders that resulted from collective, systematically targeted violence against a social group. As a socio-psychological phenomenon, social trauma refers to the impact of the trauma on social processes over an extended period of time. In other words, the theory of social trauma brings together individual and group processes. Thus, social trauma is the traumatic experience of an individual where this experience is shared with other members of the social group (victims of collective violence) and is part of a wider social context. Concurrently, it reminds us that groups are sets of individual members and that individual experiences should be considered when examining group dynamics and social behaviour.

Initially, the theory of social trauma addressed only direct traumatisation, but as the study has grown, scholars have recognised that consequences of traumatic events extend beyond groups and individuals who are immediately affected. Thus, in the beginning, social

trauma has been analysed focusing on perpetrators and victims. Later, the theory extended the complex social matrix of perpetrators and victims to an additional layer. This layer is the professionals who, as part of their work, engage with trauma populations. Thus, the humanitarian aid professionals who work with trauma survivors are at the significant risk to be affected by social trauma.

Before focusing on the traumatisation of relief workers, let's first review the experiences of migrants, refugees and asylum seekers as first and direct victims of this trauma. An encounter with international legislation, national regulations, media, policies, institutions and all other social elements is part of their experience. Simultaneously, they are faced with and escaping traumatic events such as conflicts, prosecution and/or violence. The traumatic situations occur in all three fleeing stages of the displacement process, in pre-migration, transit and post-migration period. Thus, all these elements should be considered when addressing their experiences.

However, as we have seen, the focus of this study was on humanitarian aid workers as indirect victims of this traumatisation. Different theoretical constructs explain and address this secondary impact of social trauma. One of the well-known constructs that explain a condition that may occur as a consequence of engagement with trauma survivors is secondary traumatisation (ST). The ST is result of extreme confrontation or frequent and recurring details of traumatic events that were experienced by somebody else. The symptoms of STS appear in the same way as the symptoms of PTSD. Another issue that has been identified among humanitarian aid workers is burnout. It is a state of exhaustion caused by chronic and excessive level of stress. On the other hand, possible consequences of the experience of social trauma are not exclusively negative. Indeed, the focus of scholars and field professionals has predominantly been on the damaging effects of trauma experience. However, PTG is a positive psychological effect that may result from traumatic experience.

The overall objective of this study was to address the issue of the protection of mental health of humanitarian aid workers in Serbia. The first sub-objective was to report on the prevalence of two negative mental health outcomes, secondary traumatic stress and burnout. The second sub-objective was to analyse secondary PTG as a positive mental health outcome. The third sub-objective was to identify the potential protective mechanism and determining factors of mental health outcomes.

The first objective was fulfilled by analysing the data collected via the surveying process. It was discovered that 36.1% of the participants reported little or no secondary traumatic stress symptoms, 39.3% reported mild STS symptoms and 6.6% reported moderate and high levels of the STS. In addition, the results showed that 34.4% of the participants would benefit from the treatment for the STS disorder. Furthermore, the analysis revealed that 27.9% of the humanitarian workers in Serbia suffer from burnout condition. The results were to a large extent consistent with PIN's discoveries.

The second objective was fulfilled by discovering that 46.4% of the humanitarian workers in Serbia experienced significant positive change in form of PTG, 36.4% of them experienced moderate change, and 23.2% experienced no or insignificant change. Moreover, the levels of PTG were experienced similarly in the domain of appreciation of life and the domain of personal strength. These results were consistent with the findings of PIN's study as well.

The third objective was fulfilled by analysing the relations between organisational factors and mental health outcomes in order to identify organisational interventions as a potential protective and preventive mechanism. It was discovered that perceived organisational support (POS), PSS, and TS were negatively correlated with STS. This indicates that as the organisational support increase, the symptoms of STS decrease. Also, the results showed that two of three these factors, POS and TS, were an insignificant negative correlation with burnout. Thus, as support by the organisation and team grows, burnout reduces. In addition, it was discovered that the PTG was not correlated with negative psychological effects and thus cannot be regarded as a prevention mechanism nor organisational factors can induce positive mental health outcomes.

Therefore, it can be claimed that the contribution of the study in addressing the problem is the identification of organisational intervention through organisational factors as a protective and preventive mechanism against adverse psychological effects that may develop in humanitarian aid professionals as a result of their work with trauma populations. Although the causality was not analysed and thus cannot be confirmed, there is significant evidence to claim that these factors determine mental health outcomes. In addition, the frequency of contact with beneficiaries appeared as a relevant factor in this process while the variable that represents whether the organisation provides or does not provide psychological support showed as irrelevant.

Based on the above findings, following recommendations were made: the organisations should re-examine their internal policies and relationships with their employees in order to assess support they offer to their employees (1), specific interventions should be designed and implemented in these organisations that would increase organisational, supervisor and TS employees receive (2), the organisations that provide psychological help and support to its employees should re-examine the quality and extent of this support in order to provide and include protective measures against secondary traumatic stress and burnout (3), the organisations that do not provide psychological help and support to its employees should include such support but focus it on effective management of burnout and secondary traumatic stress (4), the intervention efforts should be focused on organisational elements rather than positive psychological effects as prevention and protection mechanisms (5) and these interventions should particularly be directed toward employees performing job roles that include frequent contact with beneficiaries (6).

BIBLIOGRAPHY

BOOKS AND ARTICLES

Ager A and others, 'Stress, Mental Health, and Burnout in National Humanitarian Aid Workers in Gulu, Northern Uganda' (2012) 25(6) Journal of Traumatic Stress 713 <https://doi.org/10.1002/jts.21764> accessed 12 September 2021

Aldamman K and others, 'Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support' (2019) 10(1) European Journal of Psychotraumatology 1-12 <https://doi.org/10.1080/20008198.2019.1694811> accessed 19 August 2021

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, American Psychiatric Association 1980)

— American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, American Psychiatric Association 2013)

Bober T and Reghehr C, 'Strategies for Reducing Secondary or Vicarious Trauma: Do They Work?' (2006) 6(1) Brief Treatment and Crisis Intervention 1 <http://dx.doi.org/10.1093/brief-treatment/mhj001> accessed 12 September 2021

Bride B and others, 'Development and Validation of the Secondary Traumatic Stress Scale' (2004) 14(1) Research on Social Work Practice 27 <https://doi.org/10.1177/1049731503254106> accessed 3 June 2021

Cardozo BL and others, 'Factors Affecting Mental Health of Local Staff Working in the Vanni Region, Sri Lanka' (2013) 5(6) Psychological Trauma: Theory, Research, Practice, and Policy 581 <https://doi.org/10.1037/a0030969> accessed 12 September 2021

Devilly GJ, Wright R and Varker T, 'Vicarious Trauma, Secondary Traumatic Stress or Simply Burnout? Effect of Trauma Therapy on Mental Health Professionals' (2009) 43(4) Australian & New Zealand Journal of Psychiatry 375 <https://doi.org/10.1080/00048670902721079> accessed 4 August 2021

Eisenberger R and others, 'Perceived Organizational Support' (1986) 71(3) Journal of Applied Psychology 500

Figley CR, 'Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview' in Figley CR (ed), *Compassion Fatigue : Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (Routledge 1995)

—*Treating Compassion Fatigue* (Brunner-Routledge 2002)

Frankel JB, 'Ferenczi's Trauma Theory' (1998(58 The American Journal of Psychoanalysis 41-61 <https://doi.org/10.1023/A:1022522031707> accessed 5 August 2021

Galek K and others, 'Burnout, Secondary Traumatic Stress, and Social Support' (2011) 60 Pastoral Psychology 633 <https://doi.org/10.1007/s11089-011-0346-7> accessed 16 August 2021

Gibbons S, Murphy D and Joseph S, 'Countertransference and Positive Growth in Social Workers' (2011) 25(1) Journal of Social Work Practice 17 <https://doi.org/10.1080/02650530903579246> accessed 2 September 2021

Guhan R and Liebling-Kalifani H, 'The Experiences of Staff Working with Refugees and Asylum Seekers in the United Kingdom: A Grounded Theory Exploration' (2011) 9(3) Journal of Immigrant & Refugee Studies 205 <https://doi.org/10.1080/15562948.2011.592804> accessed 17 August 2021

Hamburger A, 'Introduction' in Hamburger A, Hancheva C and Volkan VD, *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021

—'Social Trauma: A Bridging Concept' in Hamburger A, Hancheva C and Volkan VD, *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021

—and Hancheva C, 'Trauma and Migration. Psychological Aspects of Forced Migration and Mental Health' in Hamburger A and others (eds), *Forced Migration and Social Trauma* (Routledge 2019)

Jacobs I and others, 'Validity, Reliability, and Factor Structure of the Secondary Traumatic Stress Scale-French Version' (2019) 191(10) Frontiers in Psychiatry 1 <https://doi.org/10.3389/fpsyt.2019.00191> accessed 5 September 2021

Kristensen TS and others, 'The Copenhagen Burnout Inventory: A New Tool for the Assessment of Burnout, Work & Stress' (2005) 19(3) An International Journal of Work, Health & Organisations 192 <https://doi.org/10.1080/02678370500297720> accessed 3 June 2021

Kumpfmüller M, 'Political Traumatization and Trauma-Discourse' in Hamburger A and others, *Forced Migration and Social Trauma* (Routledge, 2019)

Lindstrom Cassie M and others, 'The Relationship of Core Belief Challenge, Rumination, Disclosure, and Sociocultural Elements to Posttraumatic Growth' (2013) 5(1) Psychological Trauma: Theory, Research, Practice, and Policy 50 <https://doi.org/10.1037/a0022030> accessed 30 August 2021

Newell JM and MacNeil GA, 'Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers' (2010) 6(2) Best Practices in Mental Health: An International Journal 57

Petrucci J-J and Hamburger A, 'Social Trauma in International Refugee Legislation' in Hamburger A and others (eds), *Forced Migration and Social Trauma* (Routledge 2019)

Pines A and Maslach C, 'Characteristics of Staff Burnout in Mental Health Settings' (1978) 29(4) Hospital & Community Psychiatry 233 <https://doi.org/10.1176/ps.29.4.233> accessed 16 August 2021

Puvimanasinghe T and others, 'Narrative and Silence: How Former Refugees Talk about Loss and Past Trauma' (2014) 28(1) Journal of Refugee Studies 69 <https://doi.org/10.1093/jrs/feu019> accessed 10 August 2021

Ramos C and Leal I, 'Posttraumatic Growth in the Aftermath of Trauma: A Literature Review about Related Factors and Application Contexts' (2013) 2(1) Psychology, Community & Health 43 <https://doi.org/10.5964/pch.v2i1.39> accessed 17 August 2021

Solomon Z and Mikulincer M, 'Posttraumatic Intrusion, Avoidance, and Social Functioning: A 20-Year Longitudinal Study' (2007) 75(2) Journal of Consulting and Clinical Psychology 316 <https://doi.org/10.1037/0022-006X.75.2.316> accessed 9 August 2021

Tedeschi RG and others, *Posttraumatic Growth: Theory, Research and Applications* (Routledge 2018)

Tedeschi RG and Calhoun LG, 'Posttraumatic Growth: Conceptual Foundations and Empirical Evidence' (2004) 15(1) Psychological Inquiry 1 <https://doi.org/10.1207/s15327965pli1501_01> accessed 1 September 2021

Tedeschi RG and Calhoun LG, 'The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma' (1996) 9(3) Journal of Traumatic Stress 455 <https://doi.org/10.1002/jts.2490090305> accessed 3 June 2021

Ting L and others, 'The Secondary Traumatic Stress Scale (STSS)' (2005) 11(3-4) Journal of Human Behavior in the Social Environment 177 <https://doi.org/10.1300/J137v11n03_09> accessed 3 June 2021

Zivanovic M and Vukcevic Markovic M, 'Secondary Traumatization' in Hamburger A, Hancheva C and Volkan VD (eds), *Social Trauma – An Interdisciplinary Textbook* (Springer Cham 2021) <https://doi.org/10.1007/978-3-030-47817-9> accessed 3 August 2021

INTERNET SOURCES

American Psychological Association, 'Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults' (*American Psychological Association*, 2017) <www.apa.org/ptsd-guideline) accessed 2 August 2021

Beznec B, Speer M and Stojić Mitrović M, 'Governing the Balkan Route: Macedonia, Serbia and the European Border Regime' (Rosa Luxemburg Stiftung Southeast Europe 2016) <https://bordermonitoring.eu/wp-content/uploads/2017/01/5-Governing-the-Balkan-Route-web.pdf> accessed 4 August 2021

Hofmann C-A, 'HPG Background Paper - Needs and Vulnerability in the Balkans: The Case of Serbia' (Overseas Development Institute 2003) 3 <https://cdn.odi.org/media/documents/444.pdf> accessed 17 August 2021

National Institutes of Health, 'Post-Traumatic Stress Disorder' (US Department of Mental Health Services, National Institutes of Health 2020) <www.nimh.nih.gov/sites/default/files/documents/health/publications/post-traumatic-stress-disorder-ptsd/20-mh-8124-ptsd.pdf> accessed 4 August 2021

Refugee Health Technical Assistance Center, 'Mental Health' (*Refugee Health Technical Assistance Center*, 2011) <https://refugeehealthta.org/physical-mental-health/mental-health/> accessed 8 August 2021

Svetozarević S and others, 'The Guidance for Protection and Improvement of the Mental Health of Refugees, Asylum Seekers and Migrants in Serbia' (World Health Organization 2019) <https://kirs.gov.rs/media/uploads/4_%D0%A1%D0%BC%D0%B5%D1%80%D0%BD%D0%B8%D1%86%D0%B5_%D0%B7%D0%B0_%D0%B7%D0%B0%D1%88%D1%82%D0%B8%D1%82%D1%83_%D0%B8_%D1%83%D0%BD%D0%B0%D0%BF%D1%80%D0%B5%D1%92.pdf> accessed 15 August 2021

UNHCR, 'Figures at a Glance' (*UNHCR*, 2021) <www.unhcr.org/figures-at-a-glance.html> accessed 1 August 2021

—'Serbia' (*UNHCR*, 2021) <www.unhcr.org/see/where-we-work/serbia> accessed 29 September 2021

—'UNHCR Serbia Update, June 2021' (*Relief Web*, 2021) <https://reliefweb.int/report/serbia/unhcr-serbia-update-june-2021> accessed 18 August 2021

World Health Organization, 'Burn-out an "Occupational Phenomenon": International Classification of Diseases' (*World Health Organization*, 2019) <www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases> accessed 15 August 2021

Zivanović M, Vukčević Marković M and Stojadinovic I, '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' (Psychosocial Innovation Network (PIN) 2019) <https://psychosocialinnovation.net/wp-content/uploads/2017/09/PIN_The-Study-on-Prevalence-of-ENG-Burnout-and-Secondary.pdf> accessed 3 June 2021

APPENDIX

SURVEY

Dear participant,

I am a student of the GC SEE/ERMA program. I am currently an intern at Crisis Response and Policy Centre. I am doing a research for my dissertation. My topic is the Mental Health of Humanitarian Aid Workers in Serbia. I would truly appreciate your contribution in researching this important topic.

Your participation in this study is completely voluntary. If you feel uncomfortable answering any question, you can withdraw from the survey at any point. The participation is completely ANONYMIZED, including your name, organization you work for, and all data provided. Obtained information will be used for the purpose of this research exclusively. Please strive to answer the questions as honestly as possible, in accordance with your attitudes and perceptions.

If you have any questions, you can contact me at ana.jankovic543@gmail.com.

Thank you very much for your time and support.
Ana Jankovic

Answer the following questions/statements by circling the response that best describes your experiences. Choose a number from 1 to 5. Please answer each question as honestly as possible. If you need, take a moment to think about your feelings and experiences before answering a question.

Please note when in a question word 'client' appears, it refers to the beneficiaries, that is, to the receivers of the services organization you work for and you as an employee provide (for example, refugees).

	Never/ almost never	Seldom	Sometimes	Often	Always
1. How often do you feel tired?	1	2	3	4	5
2. How often are you physically exhausted?	1	2	3	4	5
3. How often are you emotionally exhausted?	1	2	3	4	5
4. How often do you think: 'I can't take it anymore'?	1	2	3	4	5
5. How often do you feel worn out?	1	2	3	4	5
6. How often do you feel weak and susceptible to illness?	1	2	3	4	5
7. Do you feel worn out at the end of the working day?	1	2	3	4	5
8. Are you exhausted in the morning at the thought of another day at work?	1	2	3	4	5
9. Do you feel that every working hour is tiring for you?	1	2	3	4	5

	Never/ almost never	Seldom	Sometimes	Often	Always
10. Do you have enough energy for family and friends during leisure time?	1	2	3	4	5
11. Are you tired of working with clients?	1	2	3	4	5
12. Do you sometimes wonder how long you will be able to continue working with clients?	1	2	3	4	5
	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
13. Is your work emotionally exhausting?	1	2	3	4	5
14. Do you feel burnt out because of your work?	1	2	3	4	5
15. Does your work frustrate you?	1	2	3	4	5
16. Do you find it hard to work with clients?	1	2	3	4	5
17. Do you find it frustrating to work with clients?	1	2	3	4	5
18. Does it drain your energy to work with clients?	1	2	3	4	5
19. Do you feel that you give more than you get back when you work with clients?	1	2	3	4	5

Please think about your direct work with the clients/beneficiaries as you respond to the following questions. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

	Never	Rarely	Occasio-nally	Often	Very Often
1. I felt emotionally numb.	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).	1	2	3	4	5
4. I had trouble sleeping.	1	2	3	4	5
5. I felt discouraged about the future.	1	2	3	4	5
6. Reminders of my work with clients upset me.	1	2	3	4	5
7. I had little interest in being around others.	1	2	3	4	5
8. I felt jumpy.	1	2	3	4	5
9. I was less active than usual.	1	2	3	4	5
10. I had trouble concentrating.	1	2	3	4	5
11. I avoided people, places, or things that reminded me of my work with clients.	1	2	3	4	5

	Never	Rarely	Occasio-nally	Often	Very Often
12. I had disturbing dreams about my work with clients.	1	2	3	4	5
13. I wanted to avoid working with some clients.	1	2	3	4	5
14. I was easily annoyed.	1	2	3	4	5
15. I expected something bad to happen.	1	2	3	4	5
16. I noticed gaps in my memory about client sessions.	1	2	3	4	5

Listed below are statements that represent possible opinions that YOU may have about working at your organization. Please indicate the degree of your agreement or disagreement with each statement by circling the number that best represents your response on the scale from 0 (Strongly Disagree) to 6 (Strongly Agree).

1. The organization values my contribution to its well-being.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

2. The organization fails to appreciate any extra effort from me.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

3. The organization would ignore any complaint from me.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

4. The organization really cares about my well-being.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

5. Even if I did the best job possible, the organization would fail to notice.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

6. The organization cares about my general satisfaction at work.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

7. The organization shows very little concern for me.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

8. The organization takes pride in my accomplishments at work.

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

Please indicate the extent to which you agree or disagree with the following statements in regards to your supervisor (*a person who is in charge of overseeing and directing your work activities*). If you do not have a supervisor please skip this section. If you do have, answer every question by circling the number that best represents your response on the scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Please note that the survey is completely anonymous (neither researcher nor anybody else can know who filled the survey). There is no need for your supervisor's name or any other information on the supervisor or you. We are only interested in your perceptions.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. My supervisor meets with me regularly to discuss problems and solutions.	1	2	3	4	5
2. My supervisor takes into consideration my views and ideas.	1	2	3	4	5
3. My supervisor appreciates me.	1	2	3	4	5

Please think about being a member of your work group as you respond to the following questions. For each question, circle the number that best represents your response on the scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. There is a lot of support and encouragement within my work group.	1	2	3	4	5
2. It is very difficult to settle problems in my work group.	1	2	3	4	5
3. Group members keep their thoughts to themselves, rather than risk speaking out.	1	2	3	4	5

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your job, using the following scale.

0 = I did not experience this change as a result of my crisis.

1 = I experienced this change to a very small degree as a result of my crisis.

2 = I experienced this change to a small degree as a result of my crisis.

3 = I experienced this change to a moderate degree as a result of my crisis.

4 = I experienced this change to a great degree as a result of my crisis.

5 = I experienced this change to a very great degree as a result of my crisis.

1. I changed my priorities about what is important in life.	1	2	3	4	5
2. I have a greater appreciation for the value of my own life.	1	2	3	4	5
3. I have a greater feeling of self-reliance.	1	2	3	4	5
4. I can handle difficulties.	1	2	3	4	5
5. I am better able to accept the way things work out.	1	2	3	4	5
6. I can better appreciate each day.	1	2	3	4	5
7. I discovered that I'm stronger than I thought I was.	1	2	3	4	5

Please answer following questions by putting "X" or "✓" in ONE of the boxes O**.**

1. I am humanitarian aid worker.

   In other words, your job includes providing humanitarian assistance intended to save lives, alleviate suffering and maintain human dignity during and after man-made or/and natural crises and disasters.

O Yes
O No

2. I primarily work in the field of:

   (Your job may include other fields and types of assistance; however, the question refers to your main scope of work)

O Refugee and migrant protection
Other (please cify):_____

O *(for example, home care for the sick and elderly, advocating for the rights of people in area of mental care, youth drug prevention, peacebuilding programs…)*

3. I am:

O Volunteer
O Paid humanitarian worker

4. I have been working for my organization:

O Less than 6 months
O Between 6 and 12 months
O Between 12 and 18 months
O Between 18 months and 24 months
O More than two years

5. My organization is:

O Governmental organization
O Non-governmental international organization
O Non-governmental national organization
O UN agency

6. My organization provides psychological help/supervision to its employees.

O Yes
O No

7. I am aware of the potential impact of my job on my psychological wellbeing.

O Yes
O No

8. I am (gender):

O Female
O Male
O Other

9. I am _____ years old.

O < 25
O 26-30
O 31-40
O 41-50
O 51-60
O > 61

10. My job includes providing _____ (type of assistance):

O Legal
O Prevention and identification of trafficking in human beings
O Cultural mediation
O Psychological
O Delivery of food and non-food items
O Medical
O Other

11. I work _____ with beneficiaries (receivers of humanitarian assistance).

O Directly
O Indirectly

12. As part of my job, I meet (that is, I am in a direct contact) with beneficiaries (receivers of humanitarian assistance) on a _____ basis.

O Daily
O Weekly
O Monthly
O Quarterly
O Never

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