

RESEARCH ARTICLE

A neglected aspect of refugee relief works: Secondary and vicarious traumatic stress

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Abstract

The literature demonstrates evidence that secondary traumatic stress (STS) and vicarious traumatic stress (VTS) may adversely affect the well-being of refugee relief workers and, thus, the quality of their services. The present review offers an exploration of (a) the theoretical background of STS and VTS, (b) their appearance among refugee relief workers, (c) intervention studies available, (d) common points among intervention studies and guidelines on STS and VTS released by local and international nongovernmental organizations (NGOs), and (e) the potential problems that can be associated with the insufficiency of standardized intervention programs as assessed in effectiveness studies. This review may help mental health professionals in countries that host large numbers of refugees and asylum seekers, such as Turkey, Lebanon, and Jordan, to design more effective intervention programs targeting STS and VTS.

A neglected aspect of refugee relief works: Secondary and vicarious traumatic stress

According to the United Nations High Commissioner for Refugees (UNHCR; 2021) database, by the end of 2020, there were 80,000,000 forcibly displaced people worldwide. Among these individuals, 26,300,000 were classified as refugees and 4,200,000 as asylum seekers. Various occupational groups (e.g., psychologists, counselors, doctors, lawyers, interpreters) work with refugee populations as service providers, and many mental health and psychosocial aid workers assist individuals in need of help following both humanitarian crises and natural disasters. During humanitarian relief work, service providers are frequently exposed to traumatic events both directly and indirectly. Evidence suggests that such exposure may result in mental health problems, such as secondary traumatic stress (STS), vicarious traumatic stress (VTS), depression, anxiety, and burnout. For instance, the UNHCR Staff Wellbeing and Mental Health Report (2016) indicates that among a sample of 2,431 humanitarian aid workers (HAWs), 31% experienced symptoms of anxiety and 25% experienced symp-

toms of depression. Similarly, in a study conducted with 376 aid workers in Uganda, the prevalence rates for depression and anxiety were 68% and 53%, respectively (Ager et al., 2012). In addition to anxiety and depression, HAWs also commonly display sleep disturbance (Lusk & Terrazas, 2015), and evidence suggests associations among STS, anxiety, and depression (Bock et al., 2020; Kindermann et al., 2020).

When considering the psychological symptoms displayed by HAWs, it is essential to consider the importance of the occupational context, which can also be a major source of stress within this group. In fact, difficulties that are directly related to one's job are often a precursor or major contributor to the previously described mental health concerns. Although the literature on HAWs has emphasized job-related traumatic stress, evidence indicates that occupational stressors, such as workplace concerns and relationships with colleagues and supervisors, can result in emotional distress and burnout (Jachens et al., 2018; Manning & Preston, 2003). The UNHCR Mental Health and Psychosocial Support Report (2013) suggested that the top stressors among UNHCR staff included

workload (76%), feeling undervalued (58%), contract status (54%), and relationships with supervisors (44%; Welton-Mitchell, 2013). Financial concerns constitute another major occupational stressor. The fact that staff are often working on externally funded, short-term projects, resulting in employment insecurity contribute to the problems they report.

The association between occupational difficulties and mental health outcomes among HAWs can be explained via occupational health models. The most common occupational health models used in the field of humanitarian aid are the effort–reward imbalance model (ERI) and organizational support theory (Foo et al., 2021). Coined by Siegrist (1996), the ERI posits that the imbalance between effort (i.e., long working hours, possible threat) and reward (i.e., physical security, financial security) may cause emotional distress and burnout among this population. Studies have shown that perceived ERI more strongly impacts mental health than trauma exposure (Foo et al., 2021). In another report by the UNHCR (2016), 72% of service providers reported perceived ERI; in the same report, the prevalence of diminished personal accomplishment was 43%, and the prevalence of secondary trauma was 38%.

The organizational support theory (Eisenberger et al., 1986) involves perceived organizational support (POS), representing staff members' beliefs about how much their organization cares for their well-being and values their contributions. Evidence suggests that low POS is associated with mental health problems (Foo et al., 2021).

Burnout is a common psychological problem associated with workplace difficulties. According to the *International Classification of Diseases* (11th rev.; *ICD-II*; World Health Organization [WHO], 2019), burnout is the result of unmanaged, constant workplace stress and comprises three dimensions: emotional exhaustion (i.e., chronic physical and emotional depletion), depersonalization (i.e., distant attitudes toward beneficiaries of service), and reduced personal accomplishment (i.e., feelings of lack of achievement; Foo et al., 2021). In a sample of 2,431 UNHCR staff members, the prevalence of emotional exhaustion and depersonalization was 31% and 9%, respectively (UNHCR, 2016). In another study conducted with 376 service providers in Uganda, the rates of emotional exhaustion, reduced personal accomplishment, and depersonalization were 45%, 24%, and 30%, respectively (Ager et al., 2012). Similarly, Eriksson et al. (2009) found that 40% of HAWs had a high risk of burnout in at least one dimension.

HAWs work in various contexts, such as postdisaster areas or conflict zones. Although there are similarities between the psychological difficulties HAWs who work in diverse contexts experience, a small but potentially significant difference lies in the impact that manmade disasters (e.g., war) versus natural disasters (e.g., earthquake)

can have on mental health. Research has demonstrated that man-made disasters have a more severe impact on mental health than natural disasters and interpersonal trauma (e.g., rape, violence) has been shown to have a greater emotional impact than noninterpersonal violence (Berger, 2015). The findings from a study conducted with archival data revealed that individuals who were exposed to a man-made disaster reported more severe traumatization than those who are exposed to a natural disaster (Merrell, 2013). Similarly, Norris et al. (2002) reported that the psychological consequences of mass violence on survivors were more serious than the consequences imparted by natural disasters. Kumar and Fonagy (2013) conducted a study using a sample of Indian children to examine the differences between the impact of an earthquake and a riot on mental health. The results revealed that 38% of the riot-exposed children scored above the clinical cutoff on the Strength and Difficulties Questionnaire, whereas the prevalence of clinically significant symptoms was 7% among earthquake-exposed children. Because a large proportion of refugees are forcibly displaced as a result of man-made disasters (e.g., persecution, war), it is likely that refugee service providers experience a different degree of secondary trauma exposure compared with those who work in the context of natural disasters. Given that some service providers may be refugees themselves (e.g., interpreters), it is important to generate an intervention model aimed specifically at refugee service providers.

Many cross-sectional and correlational studies have focused on the appearance of STS and VTS among refugee relief workers, but there are no studies that aim to develop and assess intervention or prevention programs. They have not attracted wide attention, likely due to a lack of controlled intervention studies. In the present narrative review, we explored (a) the theoretical background of STS and VTS, (b) their appearance among refugee relief workers, (c) the available intervention studies, (d) common points among these intervention studies and guidelines on STS and VTS released by local and international nongovernmental organizations (NGOs), and (e) the potential problems associated with the insufficiency of standardized intervention programs and relevant effectiveness studies.

OVERVIEW

Terminology

STS

The term STS was first introduced by Figley (1995), who criticized the criteria for posttraumatic stress disorder (PTSD) in the *Diagnostic and Statistical Manual of*

Mental Disorders (third ed.; *DSM-III*; 1980) for only including individuals who were directly affected by traumatic events. He suggested that interpersonal networks, such as family, friends, and therapists, “can be traumatized by concern” (Figley, 1995, p. 5). STS is defined as stress that results from knowledge about another individual’s traumatic experience (Bride et al., 2004). Symptoms of STS are similar to those of PTSD and include intrusive thoughts, avoidance and numbing, and arousal (Bride et al., 2004). Taking this similarity into account, Figley suggested that PTSD should stand for primary traumatic stress disorder rather than posttraumatic stress disorder.

VTS

Vicarious trauma is defined as the cumulative effect of working with a traumatized individual (Branson, 2019). Vicarious traumatization occurs in the context of a therapeutic relationship in which the client discloses information about the traumatic event in detail (Possick et al., 2015). VTS is characterized by symptoms similar to PTSD, such as intrusive thoughts, avoidance and pessimistic worldviews, and hopelessness (Aparicio et al., 2013). According to McCann and Pearlman (1990), therapists may incorporate clients’ memories into their memory systems, affecting the therapist’s self-perception. In addition, VTS may lead to ethical issues, such as avoiding talking about traumatic events in therapy, poor decision-making, and difficulty maintaining boundaries (Branson, 2019; Iqbal, 2015).

Differences between STS and VTS

The terms STS and VTS are used interchangeably in the literature, although they differ in theory. The main difference between VTS and STS involves how the terms were conceptualized by different theorists. McCann and Pearlman (1990) focused on the theoretical foundation of VTS and used the constructivist self-development theory to explain the changes in the therapist’s self-perception, whereas Figley (1995) focused on observable symptoms that are similar to those seen in PTSD (Jenkins & Baird, 2002). In other words, whereas VTS focuses mainly on the helper’s (e.g., therapist, aid worker) changes in self-perception (i.e., a change in their worldview), STS focuses more on symptoms.

STS and VTS among refugee service providers

There is growing evidence that service providers who work in a refugee context are at risk of developing STS and

VTS. Evidence suggests that various occupational groups working with refugees, such as interpreters (Kindermann et al., 2017; Živanović & Marković 2020), psychologists (Denkinger et al., 2018), lawyers (Harris & Mellinger 2021), social workers (Espinosa et al., 2018), and medical professionals (Mishori et al., 2013) are prone to developing symptoms of STS and VTS.

As the gravity of this issue has gained attention, the number of empirical studies on this topic has also increased. As noted, 38% of UNHCR staff members were shown to report symptoms of STS (UNHCR, 2016), and a study of 270 lawyers, psychologists, interpreters, and medical doctors found that 30% of participants suffered from mild STS symptoms, whereas 11% displayed symptoms of severe STS (Živanović & Marković 2020). Similarly, a study conducted with 210 refugee service providers revealed the presence of severe STS symptoms in 31.7% of the sample (Espinosa et al., 2018). In another study, Denkinger and colleagues (2018) examined the psychological effects of working with refugees among a sample of caregivers (i.e., social workers, psychotherapists, and interpreters) and found secondary traumatization in 22.9% of the participants, with moderate and severe STS symptoms present in 14.3% and 8.6% of participants, respectively. Additionally, the authors reported a significant association between personal trauma history and symptom severity, indicating that having a history of trauma exposure was a risk factor for developing secondary traumatization.

Studies have focused on STS and VTS among different occupational groups in the refugee context. Harris and Mellinger (2021) conducted a comprehensive study focusing on the psychological effects of working directly with refugees among a sample of lawyers ($N = 718$). Participants completed the Secondary Traumatic Stress Scale (STSS; Harris & Mellinger, 2021) and reported a mean overall score of 2.95, which is above the midpoint (i.e., 2.5) and closer to the high end of the possible score range. Another study revealed that symptoms of STS were present in 21% of participating interpreters working directly with refugees (Kindermann et al., 2017). Like the findings reported by Denkinger and colleagues’ (2018), these results revealed a significant correlation between interpreters’ trauma history and STS symptom severity (Kindermann et al., 2017). Parallel with these findings, a recent meta-analysis of 15 studies demonstrated a pooled STS prevalence of 45% among professionals and volunteers working with forcibly displaced people (Roberts et al., 2021). Finally, Mishori and colleagues (2013) examined the prevalence of VTS among asylum evaluators (i.e., doctors and psychiatrists asked to document the evidence of torture and persecution) and found that 26.2% of the 192 participants reported having experienced vicarious trauma. Turgut (2014) examined symptoms of STS and VTS among refugee service providers

in Turkey and found that participants presented symptoms of reexperiencing (28.9%), avoidance and emotional numbing (15.6%), and hyperarousal (18.5%). In addition, participants commonly reported feelings of helplessness, being worried about the safety of loved ones, feeling changed, and loss of faith in humanity. In a sample of 116 refugee service providers in Turkey, Güzey (2020) found that scores on a measure of STS significantly lower among workers who received in-service training are compared with those who did not receive such training; as noted, these studies were descriptive, and no detailed information about the content of such in-service training was provided.

Although cross-sectional investigations exist in the literature, there is a dearth of studies that have aimed to develop and evaluate standardized intervention programs. Therefore, it is impossible to conclude which components of STS and VTS interventions are effective. A recent report by Potocky and Guskovict (2020) underscores the sparse literature of intervention studies focusing on refugee service providers. The authors reviewed studies that examined interventions for STS and divided them into three categories, characterized as best, promising, and emerging practices. In addition, they provide information about the country where each study was conducted, the target occupational group for the intervention, and the provider population (i.e., which individuals apply the intervention). It is notable that “refugee service providers” are not on the list of target occupational groups, suggesting the authors did not identify any intervention studies that targeted this population. Because of the lack of studies focusing on standardized interventions, program guidelines released by NGOs coupled with a limited number of empirical studies are the major sources of information on the content of STS and VTS intervention programs.

NGO guidelines

Despite the lack of scientific studies, many NGOs have published guidelines to help protect service providers against the detrimental effects of STS and VTS (See [Supplementary Materials](#)). The Antares Foundation and Centers for Disease Control and Prevention (CDC) have, perhaps, generated the most comprehensive guidelines for staff care, including a comprehensive method for organizations to deliver psychological support to their staff. The guidelines include generally accepted methods used in other occupational sectors, and the authors note that the recommendations are not universal and need to be modified for different contexts and professions (Antares Foundation, 2012).

In addition to guidelines for NGOs regarding staff support, some organizations have produced guidelines for

staff to use directly, such as the Deutsche Gesellschaft für Internationale Zusammenarbeit’s (GIZ) *Handbook of Staff Care and Self-Care for the Ministry of Health* (Alqudah, 2020). These guidelines aim to introduce concepts such as stress, secondary trauma, burnout, vicarious trauma, and compassion fatigue; integrate self-care measures into the work of health professionals working in refugee contexts; provide examples of self-care measures (e.g., deep breathing, guided imagery, emotion management); and explain the organizational context for staff care. These guidelines were developed as a part of the Psychosocial Support and Trauma Work in Jordan project, a collaboration between the German Ministry of Health and GIZ (GIZ) that aims to increase psychosocial support in Jordan in the context of the Syrian refugee crisis (Alqudah, 2020). The guidelines also provide information about self-care assessment tools, such as the Professional Quality of Life Scale (ProQol) and Self-Care Assessment Tool (SCAT). In addition, the United Nations Human Rights Office of The High Commissioner (OHCHR) published the *Manual on Human Rights Monitoring* (2011), which includes a chapter focused on guiding service providers in interacting with and assisting trauma survivors. This chapter also provides information about the possible consequences of working with trauma survivors and outlines stress management techniques, such as breathing exercises, physical exercises, and nutrition. These published guidelines share some common characteristics: Each recommends scientifically studied techniques, and the authors represent experienced field workers and scholars. However, the included techniques are not specific to refugee service providers; rather, they encompass generally accepted methods with demonstrated efficacy in other occupational sectors and contexts.

Although NGO reports and guidelines contain information about the prevalence of STS and VTS among service providers, they typically lack information about the delivery and efficacy of practical intervention and prevention programs. To our knowledge, one exception is the Stronger When Together Project implemented by Bir İZ Foundation (2020), an NGO serving asylum seekers in Turkey. The project includes 5 NGOs and more than 500 participants and is aimed at bringing together NGOs that work with Syrian asylum seekers and providing program participants with psychological assistance through group therapy and self-improvement workshops. The project’s organizers implemented activities (e.g., workshops, group therapies), conducted statistical analyses for their group therapy program, and reported the results of these analyses. The findings suggested that participants scored higher on a measure of well-being following group therapy compared with baseline, but the difference was not significant (Bir İZ Foundation, 2020). The Bir İZ Foundation did not report

results regarding efficacy for other activities included in the project.

Staff care has been an important topic within humanitarian aid organizations for the past decade. Several international conferences have addressed this issue (e.g., the European Conference on Traumatic Stress), and conferences specific to this topic have been organized (e.g., 2002–2011 Antares/CDC conferences in Amsterdam; Antares Foundation, 2012). Undoubtedly, the previously described guidelines provide beneficial guidance for organizations and valuable techniques for staff members with regard to reducing the psychological impacts of working with trauma survivors. However, there remains a need to develop standardized intervention and prevention programs and empirically analyze their efficacy.

Intervention studies

We reviewed the Web of Science, Open Science Framework, Google Scholar, Pubmed, ScienceDirect, E-journals, and PsycInfo databases and indexes in February and March 2021 to identify intervention and prevention studies targeting STS and VTS among refugee service providers. We also reviewed the National Thesis Center of the Council of Higher Education of Turkey to identify other relevant material, such as master's theses and doctoral dissertations. The keywords used were "secondary trauma," "vicarious trauma," "refugee service providers," "intervention," "prevention," "psychological support," "refugees," "asylum seekers," "humanitarian aid," and "forcibly displaced." The keywords were combined with coordinating conjunctions (i.e., "or," "and," "for"). This search identified 55 studies. We then searched "critical incident stress debriefing" to our search, which revealed 10 additional studies. Among these 65 initial studies, only two reported on interventions specifically designed for refugee service providers and contained information about the content of the intervention implemented. The results of the review demonstrated that despite the importance of STS and VTS in the context of refugee aid work, there is a marked lack of available studies, and those that exist have shortcomings.

For example, the Multidimensional Support Intervention and Burnout Prevention Program (MSIBPP), an intervention and prevention program aimed at secondary traumatization and burnout, was implemented with 30 psychologists, psychological counselors, and social workers serving refugees and asylum seekers in a pilot investigation (Demircioğlu, 2020). The program was developed combining elements of cognitive behavioral therapy, positive psychotherapy, and acceptance and commitment therapy. The MSIBPP guidelines consist of six modules, with each module focused on particular themes and based

on different delivery techniques, including psychoeducation, visual presentations, video demonstrations, animation, experiential learning, intragroup verbal interaction, paper-and-pencil exercises, and homework. These modules are delivered over three sessions, each of which last 3 hr, with providers utilizing various techniques and materials depending on the session content. MSIBPP effectiveness was evaluated using assessments administered at pretreatment, posttreatment, and 1-month follow-up. The results indicated that although all scale scores differed between the intervention and control groups, the only statistically significant between-group findings was in reducing symptoms of burnout (Demircioğlu, 2020). Although the researcher discussed potential reasons for this finding in detail, the MSIBPP was not found to yield significant reductions on traumatic stress, perceived stress, psychological resilience, and well-being in the sample.

Another intervention study (Anonymous, 2010), which mainly employed an observational and subjective methodology to examine participant responses, revealed some promising findings regarding caretakers' mental health. The 2-day stress management intervention described in the study was implemented with two groups ($N = 23$) of local staff from an international NGO working in camps for displaced persons. The program was implemented in an Asian country and based on stress management techniques derived from Western sources. The authors, who were three psychosocial workers, preferred anonymity for political reasons; it is likely that they also preferred to withhold details about participants' qualifications based on similar security concerns. Although the report gave a detailed description of the program's structure, the strategies used, and participants' behavioral and verbal responses, no objective measurements regarding the evaluation of the program's effectiveness were presented. This last point raises concerns regarding the authors' goals precludes solid conclusions about caretakers' traumatic experiences. In sum, the study did not provide quantitative information on the effectiveness of interventions.

DISCUSSION

As the review results demonstrate, professionals who serve the more than 85,000,000 refugees, asylum seekers, and displaced people over the world are prone to negative mental health consequences, including STS and VTS. Sprang and colleagues (2019) stated that STS can be distinguished from other work-related stress, such as burnout and work-related mental health issues, as well as from preexisting or emerging psychiatric problems unrelated to work. To properly assess refugee aid workers and employ prevention and intervention techniques in a theoretically sound and

practical way, it is necessary to identify the shared and distinct features of STS that differentiate it from other psychiatric concerns. Although theoretical debate continues, it is evident that (a) there is an urgent need to support refugee aid workers' mental health, especially regarding consequences of STS and VTS, and (b) although there are guidelines published by national and international NGOs, those guidelines need to be validated in terms of effectiveness. Herein, we present three major issues that may stem from this lack of research regarding the efficacy of interventions for STS and VTS.

The first issue involves the adverse effects of STS, VTS, and similar concerns on service providers' mental health. In addition to problems related to secondary traumatization, other psychological disturbances, such as anxiety and depression, have also been observed among refugee relief workers. In a sample of 270 refugee relief workers, 20% of participants reported anxiety symptoms and 22.6% of the participants showed symptoms of major depression (Živanović & Marković, 2020). Similarly, the prevalence of depression among refugee relief workers has ranged from 17.3% to 19.5% in other surveys (Jobst et al., 2018; Cardozo et al., 2012). Among a sample of interpreters, the prevalence of depressive symptoms was not significantly higher than that found in the general population, but the prevalence of anxiety symptoms was significantly higher (Kindermann et al., 2018). In addition to symptoms of depression and anxiety, sleep problems are common among individuals who work with refugees. For example, in a sample of service providers working with Mexican refugees, Lusk and Terrazas (2015) found that 83.8% of participants reported sleep difficulties.

In their sample of interpreters, Kindermann and colleagues (2020) reported strong correlations between STS and both depression (.62) and anxiety (.80). Previous research has consistently demonstrated remarkably high prevalence rates for comorbid PTSD and major depressive disorder in various populations (e.g., Breslau et al., 1997; Caramanica et al., 2014; Forchuk et al., 2020; Rytwinski et al., 2013). A few studies have examined the direct associations among STS, anxiety, and depression. For instance, Bock et al. (2020) found that higher reported levels of STS were significantly associated with generalized anxiety disorder and depression in a sample of 320 nurses. Taken together, effective prevention and intervention programs for STS and VTS may also be protective against depression, anxiety, and other psychiatric symptoms.

The second potential consequence of the lack of research on intervention and prevention strategies for STS and VTS in refugee aid workers is a decline in professional competence. Evidence from previous studies suggests that the presence of STS and VTS is not rare among refugee service providers. A valid concern is that staff competence will

decrease in the long term if effective interventions do not address STS and VTS in refugee relief workers. In 2009, People in Aid and Interhealth published a report on services provided by international NGOs for their staff. The report revealed that 55% of organizations have no system for face-to-face psychological support (i.e., only phone support), 50% have employee assistance programs (EAPs) that provide 24-hr psychological support on the phone, 30% have in-house professional psychologists, and 40% provide a referral list of professional psychologists; no NGOs included in the report provided or endorsed standardized intervention or prevention programs. The report also included service providers' ideas regarding their organization's provision of psychological support. Service providers stated that EAPs were not an effective tool for psychological support, as the counselor on the other end of the phone often did not understand the provider's situation, making them feel even more lonely. This report exemplifies the problem that refugee relief workers often do not receive enough personal and professional support to help them buffer the adverse psychological effects of STS and VTS, potentially decreasing their professional competency. In turn, this lack of support initiates a vicious cycle of the negative perception of personal competency and poor service delivery.

Among refugee aid workers, STS and VTS may result in intrusive thoughts, avoidance, sleep problems, nightmares, difficulty focusing, and an increase in negative thoughts. In addition, social isolation, dysfunctional coping skills, increased worry about one's safety and the safety of loved ones, pessimistic worldviews, a lack of motivation and ethical consideration, anger toward the people they assist, problems with maintaining boundaries, and a decrease in the quality of service (Branson, 2019; Figley, 1995). There is evidence of associations between STS symptoms and a tendency to become more distant toward clients, which may lead to poor service delivery and a decrease in perceptions of professional competency (Harrison & Westwood, 2009). Killian (2008) found that mental health therapists working with traumatized clients reported symptoms including being easily distracted, having difficulty concentrating, sleep disturbances, and mood changes. These symptoms may affect service providers' well-being and compassion toward their clients.

Considering this evidence, addressing STS and VTS should be taken seriously among refugee relief workers. Although research has shown that the level of traumatization among staff may be affected by various factors, such as experience, supervision, workload, trauma history, coping skills, and social support, STS and VTS should be addressed holistically (Foo et al; 2021; Kindermann et al., 2018). Comprehensive intervention and prevention studies that include the efficacy of education, supervision, and

manualized interventions are needed to reduce the risk of traumatization and protect service providers from declines in personal competence.

Finally, workforce loss and staff turnover represent a potential consequence of a lack of research on effective strategies to prevent and treat STS and VTS. Bride (2007) proposed that the adverse psychological effects of STS and VTS may be a significant factor in HAWs' decisions to terminate their employment. Refugee service providers are likely to work with individuals who have a history of trauma exposure. To become a qualified expert, it takes time and effort to fulfill the requirements needed to assist these individuals, such as additional theoretical training after completing an undergraduate degree and, sometimes, graduate studies, hands-on practice in the field, and the supervised application of skills. Therefore, knowledgeable, experienced refugee service providers and others who provide posttraumatic, disaster- or crisis-related, and psychosocial aid comprise a significant part of the workforce. However, an inadequate ability to cope with the psychological effects of STS and VTS may lead to a workforce departure or strengthen one's inclination to leave work. Even though leaving one's job may provide immediate relief from the psychological burden of the work, former service providers may still need professional support to cope with the effects of STS and VTS. Therefore, the implementation of prevention and intervention strategies within humanitarian organizations is crucial to decrease the harmful effects of STS and VTS among workers.

Issues related to humanitarian projects in the field further highlight the need for an increased focus on preventing and treating symptoms of STS and VTS. There has been a significant increase in the number of humanitarian aid projects in countries like Turkey, which took in large numbers of asylum seekers over a short period. Most of these time-limited projects are funded by international NGOs or government agencies. The discontinuation of these projects sometimes results in the loss of an experienced workforce in other fields. However, the duration of the assignments is typically long enough for workers to develop symptoms of STS and VTS. Due to the lack of intervention programs targeting STS and VTS in aid workers, service providers working on these projects may not get the support they need when their responsibilities come to an end. In addition, the literature clearly shows that STS has been more widely studied than VTS. This may be because STS is more symptom-focused than VTS, thus making STS more observable and easier to operationalize with quantitative methods.

HAWs face many difficulties related to different facets of their job. Bearing witness to others' traumatic experiences may result in STS and VTS. Additionally, occupa-

tional stressors, such as financial concerns, feeling undervalued, and the status of one's contract have been shown to be precursors for burnout, depression, and anxiety. Moreover, HAWs are sometimes refugees themselves, which may place them at a high risk of developing psychological problems, as they are additionally faced with the challenge of being a victim of violence themselves (Foo et al., 2021), and encountering physical violence (Stoddard et al., 2011). Furthermore, studies have shown that the prevalence of anxiety and depression are higher among national NGO staff (i.e., staff who are refugees themselves and/or have been affected by the traumatic event) as compared to staff who work for United Nations-related agencies (Foo et al., 2021). Foo and colleagues (2021) found that almost 90% of field personnel comprises national staff, and Bunny (2017) reported that national staff is paid less than other HAWs who work with international NGOs. Notably, interpreters are often refugees, as they typically speak the same language as the refugees they are serving (Engstrom et al., 2010; Miller et al., 2005). Given that a history of trauma exposure is a major risk factor for developing STS or VTS, it is likely that service providers who are refugees themselves have a high risk of developing symptoms.

Given the evidence in the literature, it is clear that a standalone approach will not be sufficient for interventions targeting service providers. A holistic approach comprising risk assessment and interventions for occupational stressors, personal trauma exposure, staff inequality, common mental disorders, and STS and VTS is needed. In addition, the timing when an intervention is delivered (e.g., pre- or postdeployment) should be considered as an important factor, as this has been shown to impact the severity of anxiety and depression symptoms in HAWs (Lopes Cardozo et al., 2012; Okanoya et al., 2015).

Although some published intervention studies have explored treatments or interventions aimed at reducing the symptoms of stress, burnout, and STS in professionals who provide mental health services and psychosocial support or in the context of other professions (Asplund, 2019; Berger & Gelkopf 2011; Brinkborg, 2011; Feldman, 2019; Gardner, 2005; Ghannam, 2020; Iyamuremye & Brysiewicz, 2015; Koehler, 2012; Powell et al., 2019; Roby, 2008; Wersebe et al., 2018), there is a paucity of intervention studies specifically focused on the prevention of or treatment for secondary traumatization or indirect trauma among refugee service providers. In the light of the findings from the present review, it is clear that there is an insufficient number of intervention studies focused on this population.

Some limitations of the present review must be highlighted. The narrative format may not be as comprehensive

and rigorous as a systematic review. We did not set the goal to systematically review the literature; instead, our main goal was to demonstrate the importance of providing psychological aid for this occupational group and the need for governmental and nongovernmental organizations to take action to develop statistically standardized intervention programs for service providers. The focus on STS and VTS in the refugee context does not fully cover all aspects of psychological difficulties (e.g., depression, anxiety, occupational stress, burnout, compassion fatigue, PTSD) that HAWs face. It is also possible that cultural and geographical features were not taken into account in this review. For instance, whereas Turkey hosts 4,000,000 refugees, Denmark hosts 35,000; there is a possibility that demographic, cultural, and geographic differences affect psychological difficulties among HAWs.

There is robust evidence in the literature that STS and VTS may adversely affect the well-being of refugee relief workers and, thus, the quality of the services they provide. It has become considerably difficult to meet the increasing demand for psychosocial support needed in the wake of disasters, domestic violence, human trafficking, terrorism, and pandemics. Although the literature and field practices recommend and implement self-care practices for refugee relief workers, there is an urgent need to develop comprehensive and reliable interventions supported by empirical effectiveness studies. As a result, a potentially more sustainable system can be established wherein refugees and asylum-seekers will be provided with high-quality services that require less time, a smaller labor force, and fewer resources than the current standard.

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