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RESEARCH ARTICLE

Predictors of Traumatization Among Humanitarian Aid Workers Working With Refugees and Asylum Seekers in Türkiye

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ABSTRACT

Refugees and asylum-seekers flee their countries due to conflict, violence or persecution and seek safety in another country. Professionals working with refugees in host countries are being exposed to the narratives of their traumatic experiences, an important risk factor for vicarious posttraumatic stress. The current study examined predictors for traumatic stress in humanitarian aid workers working with refugees and asylum seekers in Türkiye. We surveyed 156 participants (67.3% women) from various disciplines (psychologists, social workers, interpreters, lawyers etc.) to examine their traumatic stress, resilience and stress coping mechanisms. We used Secondary Traumatic Stress Scale (STSS), Adult Resilience Measure (ARM) and Coping Styles Inventory (CSI) for data collection. In this cross-sectional study, data were collected online from participants who were contacted through snowball sampling method, starting with the participants working with refugees at public agencies and NGOs. The regression analyses showed that the level of traumatic stress is predicted by feelings of fatigue, number of years worked with the refugees, presence of previous psychological problems and being a social worker. The "relational resources" subdimension of resilience and "helpless coping style" are also significantly associated with traumatic stress. Considering the rapidly developing phenomenon of migration all over the world, the findings of the current study could contribute to improve protective and preventive interventions for the psychological wellbeing of humanitarian aid workers.

By the end of year 2023, approximately 110 million people were forced to flee their homes and over 36.4 million of them are refugees. Currently, Türkiye hosts more than 4 million registered refugees and asylum-seekers (United Nations High Commissioner for Refugees 2023). Türkiye is the major hosting country for 6.8 million Syrians who are away from their homes. In April 2011, the number of the first Syrians who entered in Türkiye was 252, which raised up to 3.9 million by mid-2023 (Syrians in Türkiye 2023; United Nations High Commissioner for Refugees 2023). The 54% of the Syrian population in Türkiye are men and the number of refugee children who were born in Türkiye is more than one million (Refugees Association 2023; Syrians in Türkiye 2023).

Considering the high level of migration mobility to Türkiye, due to reasons of conflict, war or natural disasters, there has been a significant increase in the number of humanitarian aid workers and volunteers serving to refugees in the last decade (Aktel and Kaygısız 2018). The Presidency of Migration Management is the leading governmental office for all the refugees and asylum-seekers. The number of registered nongovernmental organizations (NGOs) in Türkiye activating in the humanitarian relief is given as 5,888 by the General Directorate for Relations with Civil Society (2023). Apart from international organizations such as UNHCR, United Nations Development Program (UNDP) or International Organization for Migration (IOM), almost 100 local NGOs are specifically serving refugees or

asylum seekers (Istanbul Bilgi University Center for Migration Research 2023).

According to the Staff Well-Being and Mental Health Report published by United Nations High Commissioner for Refugees (2016), among the staff working directly with refugees, between 25% and 38% of the participants were considered as at risk for anxiety, depression, posttraumatic stress disorder (PTSD), secondary stress and alcohol misuse, whereas between 9% and 43% were at risk for burnout. Due to the nature of the helping relationship, exposure to traumatic stress is an important risk factor for the mental health of humanitarian aid workers (Connorton et al. 2012; Jachens, Houdmont, and Thomas 2018; Kahil and Palabıyıkoğlu 2018a; MacRitchie and Leibowitz 2010). Humanitarian aid workers from various disciplines (e.g., health workers, search and rescue teams, fire-fighters, mental healthcare providers, psychological support workers, social workers, child protection workers, forensic experts and court officials, interpreters and the police force) displayed traumatic stress symptoms (Bastug et al. 2019; Bride 2007; Brooks et al. 2015; Carlier, Voerman, and Gersons 2000; Çolak et al. 2012; Kahil and Palabıyıkoğlu 2018a; Özkul and Çalık Var 2019; Rienks 2020).

The earlier versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III and DSM-IV) required direct experiencing or witnessing a traumatic event for the diagnosis of PTSD (American Psychiatric Association 1980, 1994). Although not existent in those classifications, researchers highlighted PTSD symptoms, such as aversion, intrusion, arousal, or dissociative symptoms, seen among people who were not trauma victims themselves but working with traumatized individuals (Figley 1995; Solomon et al. 1992). Figley (1995) used the term "secondary traumatic stress" or "compassion fatigue" to describe the emotional distress that the individuals in helping professions experience because of being exposed to people that were traumatized (witnessing directly or listening to the pains and/or stories of traumatic experiences of the trauma survivors) and not from direct exposure to the traumatic event itself. In addition to being exposed to painful life stories, secondary traumatic stress is also brought on by the empathy that develops between the trauma survivors and the person providing support (Devilly, Wright, and Varker 2009; Mordeno, Go, and Yangson-Serondo 2017) or due to the psychological identification of the helper with a trauma survivor (Acar 2021; Ludick and Figley 2017). Secondary trauma is considered as an emotional pressure that occurs when encountering people who have experienced first-hand trauma and is considered as an occupational hazard of working in the field of mental health (Figley 2002). In 2013, PTSD criteria were changed in DSM-5 (American Psychiatric Association 2013), and it included exposure to traumatic events either as direct experiencing, witnessing in person, learning the trauma of a loved one or being exposed to the aversive details of traumatic events or material through one's work environment. With the DSM-5 criteria A4 ["Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)"] indirect exposure to trauma is no longer a separate condition that needs to be addressed but a solid symptom of PTSD. With this change it seems that the term secondary traumatic stress is inert, but we encounter alternative terms such as secondary traumatization, indirect trauma, vicarious trauma or occupational trauma being actively used in the latest literature (Biggs, Tehrani, and Billings 2021; Lemieux-Cumberlege et al. 2023; Leshem, Keha, and Kalanthroff 2023; Lu, Jian, and Yang 2023; Sprang et al. 2023; Sprang and Garcia 2022; Vang et al. 2023). To be relevant to the current DSM classification, we prefer to use the term "traumatic stress" throughout this article.

One of the important concepts in dealing with trauma is resilience (McCleary and Figley 2017). Resilience is conceptualized as the ability to recover and maintain the capacity to adapt and continue to develop in the face of daily familial, social, work or economic problems or more difficult experiences such as serious illnesses, accidents, natural disasters or the death of a loved one (American Psychological Association 2014; American Psychological Association n.d.). Resilience is the feature that enables a person to overcome traumatic events as it is related to the ability of adapting to challenging experiences (Brooks et al. 2015). Resilience refers to the qualities that strengthen the positive development arising from both the individual and the individual's environment. While individual-based resilience includes features such as assertiveness and problem-solving ability, environmentally based resilience emphasizes the role of social support (Ungar and Liebenberg 2011). In the study conducted by Bensimon (2012), resilience was negatively associated with posttraumatic stress and positively associated with posttraumatic growth. Accordingly, it was noted that resilience is a protective factor for mental health and that the acquisition of skills to increase resilience also increases the posttraumatic recovery levels and decreases the vulnerability to traumatic events (Lee et al. 2016; Masten 2001; Van der Spek et al. 2013). Other studies have shown that resilience is indirectly related to secondary trauma through perceived social support from colleagues, supervisors, and significant others outside of the workplace (Truter, Theron, and Fouché 2018; Xu et al. 2023).

Psychological resilience is the process of successfully adapting to difficult life experiences and it functions as a protective mechanism against negative stressful situations (Gooding et al. 2012). Smith et al. (2008) defined resilience as "the ability to recover from stress" and offered three stages such as, facing the stressful situation, thinking about the positive consequences of that stressful experience, and trying to cope with stress. In this context, it is thought that the concept of resilience creates a protective structure and functions as a buffer in coping with stress. It is also stated that the concept of resilience is not innate and has a variable structure, and dimensions such as problem solving, active coping with problems, confrontation and planning skills are emphasized as signs of the formation of resilience (Cicchetti 2010). Lazarus and Folkman (1984, p. 141) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person". Although there are many forms of coping (Cleveland et al. 2022), it is basically categorized in two ways. The first is problem-focused coping, which refers to managing or changing the person-environment relationship that is the source of stress. The second is emotion-focused coping, which refers to the regulation of stressful emotions (Garcia 2010; Folkman and Lazarus 1980; Di Nota et al. 2021). Most of the time, these coping styles are functional, they help to manage stress. On the other hand, sometimes, individuals engage in ineffective ways

of coping which do not help. Studies with emergency service and disaster workers who have stressful working routines showed that effective coping styles (especially optimistic, self-confident, and seeking social support approaches) play a positive role in posttraumatic growth (Haksal 2007; Yılmaz and Hisli 2007). Besides, some studies revealed that organizational support and especially problem-focused coping strategies reduce the level of secondary traumatic stress (Rienks 2020; Vagni et al. 2020). On the other hand, coping strategies focused on emotion and avoidance, past traumatic experiences, and working with trauma were associated with high levels of secondary traumatic stress (Gil and Weinberg 2015).

International literature has often focused on the indirect trauma exposure experienced by humanitarian aid workers in the migration field (Brooks et al. 2015; Ebren et al. 2021; Guskovict and Potocky 2018, UNHCR report 2016). However, in the literature on Türkiye, there are limited studies focused on the aid workers serving refugees. Acar (2021) studied the predictive effects of identification with the victim, emotional labor, and demographics on the secondary traumatic stress of professionals who work with refugees. The results indicated that identification with the victim had a predictive value on the secondary traumatic stress, but occupational variables did not. Turgut (2014) found that exposure frequency to trauma stories, perceived distress of working with refugees, and perceived insufficiency of training and supervision were the risk factors for the secondary traumatic stress of case workers working with organizations providing legal services to refugees and asylum-seekers. In a study conducted by Durdyyeva and Erbay (2021), secondary traumatic stress was negatively related with psychological resilience and with perceived social support in a group of professionals who work with refugees in state and private agencies.

1 | Study Objective

The aim of the current study is to determine how demographic and occupational variables, resilience, and coping with stress predict traumatic stress levels of humanitarian aid workers working with refugees and asylum-seekers. Our hypotheses are as follows:

H1 *The individual, relational and cultural/contextual resources subdimensions of resilience are negatively related with traumatic stress.*

H2 *The self-confident, optimistic, and seeking social support subdimensions of coping style are negatively related with traumatic stress.*

H3 *The helpless and submissive subdimensions of coping style are positively related to traumatic stress.*

2 | Methods

2.1 | Participants

The sample consisted of professionals from various professions who work with refugees and asylum seekers in Türkiye. To reach the participants, the researchers contacted the employees of the local branches of the Presidency of Migration Management and the NGOs serving in the field. The study was completed with 105 women (67.3%) and 51 men (32.7%), a total of 156 individuals who are social workers (29.5%), psychologists (27.6%), interpreters (13.5%), protection officers (9.0%), lawyers (3.8%), health trainers ([1.9%] any health care professional who give training about basic health, hygiene etc.) and others. Their ages ranged from 21 to 56 years ($M = 29.06$, $SD = 5.68$).

2.2 | Measures

2.2.1 | Demographic Information Form

Demographic information such as age, gender, marital status, education level, and questions about their professional duties at the institution they work, number of years worked with refugees or asylum-seekers, number and duration of traumatic experiences they were exposed to during the workload, frequency of being exposed to trauma narratives, perception of trauma severity of narratives, feelings of fatigue and existence of previous personal trauma were included.

2.2.2 | Secondary Traumatic Stress Scale (STSS)

The scale was initially developed by Bride et al. (2004) to investigate the stressful situations experienced by the social workers at child protection services. The scale includes 17 items scored on a 5-point Likert scale (1 = never - 5 = very often). The STSS has three subscales, namely intrusion ('Reminders of my work with clients upset me'), avoidance ('I had little interest in being around others'), and arousal ('I had trouble sleeping'). The Turkish version of the scale was adapted by Kahil and Palabıyıkoğlu (2018b). In their study, the Cronbach's alpha coefficient for STSS total was found to be 0.94. The Cronbach's alpha coefficient of the total scale in our study is 0.93, and the coefficients of the subscales are 0.81, 0.81 and 0.86 for STSS Intrusion, STSS Avoidance and STSS Arousal respectively. In our study, only the total score was added to the analyses. Statements about the emotional experiences of humanitarian aid workers affected by working with traumatized clients were presented to the participants. Participants were asked to indicate the frequency of experiencing the content of the statements during the past 7 days.

2.2.3 | Adult Resilience Measure (ARM)

The scale was created by Liebenberg and Moore (2018) based on the Child and Youth Resilience Measure (Ungar and Liebenberg 2011). The scale includes 28 items scored on a 5-point Likert scale (1 = not at all - 5 = a lot). ARM has three subscales, namely individual ("I cooperate with the people around me"), relational ("I feel supported by my friends"), and cultural/contextual ("I like the culture and traditions of the society that I live in") resources. However, in the Turkish adaption (Arslan 2015), a fourth subscale is identified as family resources ("I feel safe when I am with my family"). Cronbach's

alpha coefficient for scale was 0.94, and subscales ranged between 0.82 and 0.86.

2.2.4 | Coping Styles Inventory (CSI)

The original scale was developed by Folkman and Lazarus (1980). The 30-item shortened version was adapted by Şahin and Durak (1995). The 4-point Likert scale (0 = Not used - 3 = Used a great deal) questionnaire has five subscales, namely self-confident ('When I'm in trouble, I try to solve the problems step by step'), optimistic ('When I'm in trouble, I try to be optimistic'), helpless ('When I'm in trouble, I expect a miracle'), submissive ('When I have a problem, I give up the fight'), and social support seeking ('When I'm in trouble, I don't want anyone to know'). Cronbach's alpha for Turkish CSI was 0.93, and for self-confident, optimistic, helpless, submissive and social support seeking were between 0.62–0.80, 0.49–0.68; 0.64–0.73, 0.47–0.72, 0.45–0.47 respectively. The high scores obtained from the self-confident, optimistic, and seeking social support sub-scales express active coping with stress, whereas the high scores obtained from the helpless and submissive sub-scales represent passive/ineffective methods used in dealing with stress (Şahin and Durak 1995).

2.3 | Procedure

Upon receiving the approval of the Dicle University Ethics Committee (dated March 6th, 2020, and numbered 4985), all the public agencies and NGOs in Türkiye serving refugees were contacted via e-mail or telephone and asked to distribute the link of the study survey to all levels of personnel directly working with refugees. The targeted group were informed about the study, anonymity, and the voluntary basis of participation. Professionals who agreed to participate were encouraged to send the link to their colleagues and friends. We reached 159 people actively working with refugees through snowball sampling and 156 of them completed online questionnaires in a single session between May 2020 and May 2021.

2.4 | Data Analysis

A cross-sectional self-administered survey was conducted to examine the relations between secondary traumatic stress, psychological resilience, and coping styles. Descriptive statistical methods, reliability analysis, correlation analysis, and stepwise regression analysis were performed to analyze the data. The IBM SPSS-22 (Statistical Package for Social Sciences) was used for data analyses. As the data were collected online, stepping to the next item was not permitted unless it was answered, therefore we had no missing data.

3 | Results

The demographic characteristics of the participants are presented in Table 1. Among the participants, 38.5% of them

TABLE 1 | Demographic characteristics of the participants.

Variables		*N*	%
Gender	Women	105	67.3
	Men	51	32.7
Education	High school	9	5.8
	Graduate	105	67.3
	Master's degree	42	26.9
Occupation	Social worker	46	29.5
	Psychologist	43	27.6
	Interpreter	21	13.5
	Protection officer	14	9.0
	Lawyer	6	3.8
	Health trainer	3	1.9
	Other	23	14.7
Number of years worked with refugees or asylum-seekers	0–3 years	87	55.8
	3–6 years	54	34.6
	6–9 years	9	5.8
	9–12 years	5	3.2
	12 + years	1	.6
Hours/week of working with refugees	10–15 h	42	26.9
	15–20 h	24	15.4
	20–25 h	20	12.8
	25–30 h	13	8.3
	30+ hours	57	36.5
Number of clients per week	0–15	59	37.8
	15–25	36	23.1
	25–35	15	9.6
	35–45	14	9.0
	45+	32	20.5
Frequency of being exposed to trauma narratives of the refugees	Never	3	1.9
	Rarely	10	6.4
	Sometimes	18	11.5
	Often	57	36.5
	Always	68	43.6
Trauma severity of narratives	Mild	5	3.2
	Moderate	33	21.2
	Severe	84	53.8
	Very severe	34	21.8
Feelings of fatigue	Never	4	2.6
	Somewhat	35	22.4
	Moderate	46	29.5
	Much	56	35.9
	Too much	15	9.6

(Continues)

TABLE 1 | (Continued)

Variables		N	%
Perceived quality of supervision received	Very Poor	21	13.5
	Below Average	22	14.1
	Average	55	35.3
	Above Average	48	30.8
	Excellent	10	6.4
Psychological support offered by the institution	Never	41	26.3
	Seldom	40	25.6
	Sometimes	27	17.3
	Often	26	16.7
	Always	22	14.1
Psychological problem	Yes	37	23.7
	No	119	76.3
Previous personal trauma	Yes	60	38.5
	No	96	61.5

Note: $N = 156$

reported a previous personal trauma experience whereas 61.5% stated none. The differences between these two groups (with or without previous personal trauma) on all the scales were found to be nonsignificant.

The data met the assumptions necessary for the normal distribution. Kurtosis, skewness values and the descriptive statistics related to the research variables are presented in Table 2. The lowest and highest values obtained from the Secondary Traumatic Stress Scale (STSS) are in the range of 17–81 points and the mean value is 38.46. For the Adult Resilience Measure (ARM), the minimum and maximum values are between 56 and 105 where the mean value is calculated as 83.12. The minimum and maximum values of Coping Styles Inventory (CSI) ranged between 18 and 68, where the mean value is 44.44.

3.1 | Correlations

According to the correlation analysis findings, there were significant relations between STSS total and ARM relational resources ($r = -0.33$, $p < 0.01$), ARM cultural/contextual resources ($r = -0.18$, $p < 0.05$), CSI self-confident ($r = -0.23$, $p < 0.01$), CSI optimistic ($r = -0.26$, $p < 0.01$), CSI helpless ($r = 0.44$, $p < 0.01$), CSI submissive ($r = 0.24$, $p < 0.01$) sub-scales. The details of the correlation analyses are given in Table 2.

3.2 | Regression Analyses

We conducted a stepwise regression analysis to identify the predictor variables for traumatic stress. STSS total score was used as the dependent variable and demographic variables, subscales of ARM and CSI were entered as predictives into the stepwise regression. The findings based on the predictive power are given in Table 3.

According to the regression model in the final step, traumatic stress score was significantly predicted by the variables in the model $F(6, 149) = 23.73$, $p < 0.001$). The calculated R^2 value showed that 49% of the variance in the traumatic stress score could be explained by the regression equation. The amount of variance of STSS total predicted by the feelings of fatigue was 29%, CSI helpless 10%, ARM relational resources 4%, number of years worked with the refugees 3%, presence of psychological problems 2% and being a social worker 2%. According to the regression model in the final step, as the feelings of fatigue ($\beta = 0.47$, $p < 0.001$), CSI helpless ($\beta = 0.22$, $p < 0.01$), number of years worked with the refugees ($\beta = 0.20$, $p < 0.01$), presence of psychological problems ($\beta = 0.16$, $p < 0.01$) increased and as the ARM relational resources ($\beta = -0.18$, $p < 0.01$) decreased, the STSS total score increased. Among the professions only being a social worker ($\beta = 0.16$, $p < 0.05$) was found as a risk factor for STSS.

4 | Discussion

The current study aims to examine the relations between traumatic stress symptoms, resilience, and coping styles of humanitarian aid workers in the migration area. Therefore, the predictive effects of the participants' demographic and occupational characteristics, resilience and stress coping styles on secondary traumatic stress levels were examined. Results showed that traumatic stress was predicted by the feelings of fatigue, number of years worked with the refugees, presence of self-reported psychological problems and being a social worker as well as the relational resources subdimension of resilience and helpless coping style.

Humanitarian aid workers and trauma therapists who work with traumatized refugees report more compassion fatigue and secondary traumatic stress (Craig and Sprang 2010; Perrin et al. 2007; Thormar et al. 2013). Figley (2002) stated that the factors affecting compassion fatigue include being skilled in empathy, being willing to help the client, making an effort to reduce the client's pain, being exposed to traumatic stories and increased exposure time. As part of their work, these professionals listen to trauma stories. Almost three quarters of our participants rated the trauma stories of the refugees as "severe" or "very severe." It is likely that helping and providing support to traumatized individuals leads to emotional exhaustion and fatigue over time. In a study conducted by Turgut (2014) with professionals working with refugees, the level of secondary traumatic stress increased in professionals who listened to the trauma-related stories of individuals with traumatic experiences.

Our findings suggest that the longer the participants worked with the refugees, the more trauma-related stress they experienced. It seems that the time spent in the profession is a risk factor as shown in other studies. In studies conducted with humanitarian aid workers, it was found that long working hours (United Nations High Commissioner for Refugees 2016) as well as longer years of experience in the field make aid workers more vulnerable to PTSD (Holtz et al. 2002; Perrin et al. 2007). In a study conducted by Kahil and Palabıyıkoğlu (2018b), it was found that the traumatic stress symptoms of the participants who have been in their profession for 11–15 years were higher than

TABLE 2 | Means, standard deviations, range and correlations for variables ($n = 156$).

	1	2	3	4	5	6	7	8	9	10
1- STSS Total	—	**−0.33****	−0.13	−0.06	**−0.18***	**−0.23****	**−0.26****	**0.44****	**0.24****	0.01
2-ARM relational resources		—	**0.57****	**0.41****	0.41**	**0.45****	0.43**	−0.31	−0.02	0.12
3-ARM individual resources			—	**0.42****	0.18*	0.40**	**0.38****	**−0.25****	−0.16	0.16
4-ARM family resources				—	**0.25****	0.18*	0.14	−0.12	0.01	0.12
5-ARM cultural/ contextual resources					—	**0.27****	0.27**	0.08	0.32**	**0.19***
6-CSI self-confident						—	**0.75****	−0.38	−0.15	**0.40****
7-CSI optimistic							—	**−0.41****	−0.09	**0.29****
8-CSI helpless								—	**0.43****	0.16
9-CSI submissive									—	0.15
10-CSI seeking of social support										—
M	38.46	24.59	22.48	20.75	15.30	14.85	8.76	9.25	4.82	6.75
S	13.81	3.84	2.46	3.73	5.79	3.61	3.05	4.31	2.71	1.61
Minimum	17.00	11.00	16.00	7.00	5.00	6.00	0.00	1.00	0.00	1.00
Maximum	81.00	30.00	25.00	25.00	25.00	21.00	15.00	23.00	12.00	12.00
Skewness	0.57	−0.73	−0.86	−0.69	0.16	−0.31	−0.07	0.58	0.27	0.13
Kurtosis	−0.34	0.68	−0.03	0.16	−1.01	−0.26	−0.27	0.05	−0.47	0.66
Cronbach alfa	0.93	0.75	0.71	0.82	0.88	0.88	0.82	0.77	0.58	0.20

Abbreviations: ARM, adult resilience measure; CSI, coping styles inventory; STSS, secondary traumatic stress scale.
*$p < 0.05$.; **$p < 0.01$.

TABLE 3 | Regression results for traumatic stress.

Variable	B	95% CI		*SE* B	β	R^2	ΔR^2
		LL	UL				
Constant	20.19**	6.08	34.30	7.14			
Feelings of fatigue	6.47***	4.76	8.19	0.87	0.47***	0.29	0.29
CSI Helpless	0.79***	0.38	1.21	0.21	0.25***	0.39	0.10
ARM Relational resources	−0.68**	−1.12	−0.24	0.22	− 0.19**	0.42	0.04
Number of years worked with refugees	3.00**	0.96	5.04	1.03	0.17**	0.45	0.03
Self-reported psychological problems	4.66*	0.64	8.67	2.03	0.14*	0.47	0.02
Being a social worker	6.64*	0.79	12.49	2.96	0.14*	0.49	0.02

Abbreviations: ARM, adult resilience measure; CI, confidence interval; CSI, coping styles inventory; LL, lower limit; UL, upper limit.
*$p < 0.05$.; **$p < 0.01$.; ***$p < 0.001$.

the participants who have been in their profession for 1–5 years. Ludick and Figley (2017), in their functioning model on secondary traumatic stress, stated that the level of secondary traumatic stress increases in people who are exposed to traumatic stimuli for a long time due to their work.

The participants' reported history of psychological problems that needed treatment was another factor that contributed to traumatic stress disorder in our study. This result is consistent with previous research findings showing that the history of mental illness predicted PTSD in humanitarian aid workers (Lopes Cardozo et al. 2012) and in disaster volunteers (Thormar et al. 2013). This indicates that the previous psychological problem makes these groups more vulnerable to posttraumatic stress.

Being a social worker is found to be an important predictive factor for trauma related stress in our study. A review study on social workers working with refugees underlined the prevalence of mental health problems such as secondary traumatic stress, burnout and compassion fatigue in this population (Wirth et al. 2019). It was suggested that the prevalence of these concerns among social workers, as demonstrated by earlier research, was linked to fatigue, lack of supervision, difficulties

mentally shutting off after work, and taking clients' problems home. Job description of a trauma psychologist involves working with a refugee on a one-on-one basis, having individual or group sessions related to their traumatic experiences or psychological problems. On the other hand, a social worker needs to deal with social welfare problems of the refugee and the family by making home (shelter) or school visits. This makes a social worker witness more of the refugee's daily life and vulnerable to their trauma.

Our results also showed that the participants' traumatic stress is significantly negatively related to the presence of relational resources, a subdimension of resilience. Relational resources are defined as physical and psychological support from significant others (Ungar and Liebenberg 2011). Similarly, studies stated that traumatic stress is negatively correlated with resilience (Çalık Var and Büyükbodur 2017; Erdener 2019; Özbay and Bülbül 2024; Pak, Özcan, and İçağasıoğlu Çoban 2017) and social support (Galek et al. 2011; MacRitchie and Leibowitz 2010; Măirean 2016). Literature suggests that social support is a protective factor for secondary trauma among professionals working with trauma (Hensel et al. 2015) whereas lack of interpersonal and professional support is a dominant risk factor (Leshem et al. 2024). Social support from families, friends and/or colleagues is a mechanism that helps to protect mental health by creating a buffer effect against stressful situations and therefore it increases resilience (Nowicki et al. 2020). Hesse (2002) emphasized that family and friends have a critical role in coping with trauma related stress for mental health professionals. However, in our study the family resources did not predict traumatic stress. Therefore, it is reasonable to differentiate family ties from friends and other close relations. Our participants were mostly young and single, whose relations with friends and significant others might be a determinant relational factor. Our findings indicate that relational resources are the most important dimension of resilience in terms of predicting traumatic stress in humanitarian aid workers who participated in our study.

In terms of coping with stress, in the current study, helpless coping style significantly predicted traumatic stress. The findings are consistent with the findings of many other studies that revealed a positive relationship between passive coping and posttraumatic stress (Gil and Weinberg 2015; Hamid and Musa 2017; Karanci and Acarturk 2005; Kelle Dikbaş 2020; Ratrout and Hamdan-Mansour 2020; Riley and Park 2014; Taiwo 2015). The use of positive coping styles such as seeking social support and problem solving has been associated with lower traumatic stress, psychological distress, and stress symptoms (Babore et al. 2020; Nie et al. 2020). On the other hand, the use of negative coping skills such as avoidance was associated with increased stress levels, PTSD symptoms, and fatigue (Chew et al. 2020; Hou et al. 2020). Şahin and Durak (1995) stated that people who perceive events as uncontrollable tend to use more passive coping styles. One reason for our participants to engage in helpless coping style might be the frequency of working with trauma, working hours with refugees per week and the extent they perceived the severity of the trauma narratives of the refugees. Our participants might have perceived the situation beyond their control and used a helpless coping style which makes them more vulnerable to traumatic stress.

4.1 | Limitations

Although we believe the focus and sample are the strong side of the study, we see some limitations. First, the causality is restricted by nonexperimental design. In addition, the small sample size and the unequal gender distribution negatively affects the generalizability of the study findings. Second, the participants were not evaluated for the possible PTSD diagnosis and previous psychological problems, but rather, they were asked to report their symptoms of traumatic stress and the history of previous psychological problems. In terms of sampling, all the participants were actively working with refugees at the time of data collection. We did not collect data from the humanitarian aid workers who were retired or changed jobs. We can never know the reason for quitting and estimate the level of traumatic stress they were experiencing. It is likely that the ones who suffered less stayed in their positions. Also, the aid workers who preferred not to participate in the study, might be the ones who were avoiding the negative feelings of traumatic stress. Another limitation is that the amount and content of the professional support the agencies offered to their staff is unknown, only the subjective information given by the participants is available.

4.2 | Future Directions and Practical Implications

In the context of the results obtained, it is seen that the time spent in the profession is a risk factor whereas perceived support is a protective factor. In this context, the number of cases interviewed may increase over the years and as a natural consequence of this situation, the rates of exposure may increase. Given that over half of our participants reported that they did not receive enough psychological support from the organization to which they were affiliated and that a sizable portion of them thought the supervision they received from their organization was of below-average quality. Future research must ascertain the traumatic stress levels of humanitarian aid workers and the degree of support offered by the organization. It is possible to research the degree to which individuals gain from active coping strategies for traumatic stress by utilizing the institution's professional and psychological support. Future research may take into consideration the refugees' trauma narratives since the content may have an impact on the participants' levels of traumatic stress. On the other hand, as social workers in our study were more vulnerable to traumatic stress, future research, and preventive measures should focus on this population.

Institutions can provide their staff members with psychoeducation, debriefing, training, or peer and above supervision to prevent or lessen traumatic stress by improving resilience and positive ways of coping. Psychological well-being can be enhanced by taking the appropriate precautions against mental health risks associated with their line of work. It may also be advised to regularly check for potential threats, offer professional therapy services when needed, conduct motivational activities, and provide in-service training to support professional competence. Additionally, rotations among aid workers could reduce the amount of time spent with refugees in the same pattern and potentially reduce traumatic stress.

5 | Conclusion

This study is about investigating the traumatic stress among professionals working with refugees and asylum seekers in Türkiye. Our results showed that the level of traumatic stress is predicted by the feelings of fatigue, number of years worked with the refugees, presence of psychological problems and being a social worker. The relational resources subdimension of resilience and helpless coping style were also found significantly associated with traumatic stress. The findings of our study may contribute to improving protective and preventive interventions for the well-being of humanitarian aid workers, considering the growing number of migrations all over the world. We believe our study would contribute to community work by drawing attention to the risk of traumatization among humanitarian aid workers, as it points to the needs for enhancing the working conditions, providing support and supervision to improve the psychological well-being of the humanitarian aid workers, that would lead to high quality professional service for refugees.

Author Contributions

All the authors agree with the content of the manuscript and with the order of authorship. C.K. conceptualized and designed the study. C.K. and Ö.Ç.T. performed initial data analysis and initial draft of the article. A.E.T. conducted the advanced statistical analyses, contributed to writing findings and discussion, and reviewed the final version of the article. İ.A.D. contributed to the final version of the article to be submitted, including re-writing introduction and discussion and editing the whole text.

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The authors have nothing to report.

Ethics Statement

Ethics approval is obtained for this study and available upon request.

Consent

Participant consents were obtained online before data collection and available upon request.

Conflicts of Interest

The authors declare no conflicts of interest.

Peer Review

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Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author.

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