Displaced Syrian Mental Health Workers: An Investigation of Professional Quality of Life

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Abstract

This study investigates levels of secondary traumatic stress, burnout and compassion satisfaction in Syrian mental health workers in a low-resource post-conflict environment. Sixty-one Syrian mental health workers completed a cross-sectional questionnaire, in Arabic, incorporating the professional quality of life scale. Our Arabic-translated professional quality of life scale showed acceptable internal consistency estimates of reliability for all subscales. Relative to population norms and other samples of mental health workers, the Syrian mental health workers showed similar levels of burnout and higher levels of secondary traumatic stress and compassion satisfaction. Those with no psychology-related educational background showed significantly higher secondary traumatic stress and burnout scores and significantly lower compassion satisfaction scores relative to those with a relevant educational background. Our findings indicate acceptable levels of professional quality of life in Syrian mental health workers, with the exception of those with no educational background in psychology. Training Syrian mental health workers, with an emphasis on increasing the availability of educational training and adequate supervision and support, provides a sustainable solution to the provision of culturally and language-specific care in low resource conflict settings.

Background

Since 2011, the ongoing Syrian conflict has forced 5.2 million people to flee to neighbouring countries, 6.1 million to become internally displaced and 13.1 million in need of humanitarian assistance (United Nations Office for the Coordination of Humanitarian Affairs 2017). Turkey is the largest host of Syrian refugees worldwide, with over 3.6 million Syrian refugees (United Nations High Commissioner for Refugees 2018). A systematic review assessing the health needs of Syrians displaced to neighbouring countries identified mental health and women's health as the greatest health needs overall (El Arnaout et al. 2019).

Prevalence of post-traumatic stress disorder (PTSD) amongst Syrians is reported at over 80% (Acarturk et al. 2018; Vukcevic et al. 2014), although some studies have lower estimates (Chung et al. 2018) likely due to variability among survey tools (Steel et al. 2009) and inadequate translation practice leading to a lack of scientific and conceptual validity (Wells et al. 2015).

Literature on mental health interventions for Syrians affected by the conflict is scarce. Studies tend to describe specialised, individual trauma-focused work (Acarturk et al. 2015; 2016; Jefee-Bahloul et al. 2014). Interventions that target individual dysfunction may undervalue community-based coping incorporating cultural and spiritual content. Instead, health pluralism recognises a range of multi-layered explanatory health beliefs with a concomitant range of help-seeking behaviours and diversity of helpers and resources (Tribe 2007), as recognised in global mental health programmes such as the WHO's mental health

GAP action (WHO 2015). Where specialised interventions are required, recommendations involve the use of trained and supervised therapists in, for instance, evidence-based trauma therapies (WHO 2015; WHO and United Nations High Commissioner for Refugees 2013).

In Syria, even before the conflict, there were virtually no frameworks for professional clinical psychology or related specialised services (Abo-Hilal and Hoogstad 2013). The conflict generated initiatives by expatriate Syrian mental health workers (MHWs), with Syrian non-governmental organisations in neighbouring countries, to train and supervise evidence-based supportive methods (Almoshmosh et al. 2016, El-Khani et al 2018; Zaghrout-Hodali 2014).

While this model of training mobilises resources, reduces language barriers and enhances cultural sensitivity, it also comes with challenges. Need far outstrips resources in mental health services (Jefee-Bahloul et al. 2014; Sevinç et al. 2016). Turkish healthcare workers show a high level of turnover since the influx of displaced Syrians (Savas et al. 2016), and the pressures that lead many to resign may also affect displaced Syrian MHWs in Turkey.

There is an emerging interest in the wellbeing of humanitarian workers in conflict settings. The majority of international medical aid workers reported burnout caused by overwork, overwhelming emotional exposure combined with lack of self-care and poor personnel management (Asgary and Lawrence 2014). In workers who are from the same culture and location as their clients, 'shared traumatic reality' describes exposure of both to the same communal disaster; 'double exposure' refers to professionals' exposure both as professionals providing a service and as members of the community (Baum 2010; Nuttman-Shwartz and Dekel 2008).

Direct exposure to war and conflict may increase professionals' vulnerability to developing PTSD, as found in nurses and doctors working in hospitals in the Gaza strip during Israeli offences (Abu-El-Noor et al. 2016). 'Vicarious traumatisation' can also result from cumulative empathic engagement with clients' traumatic experiences (McCann and Pearlman 1990; Pearlman and Saakvitne 1995).

Medical personnel inside Syria are overworked, demoralised and consistently affected by trauma and secondary trauma (Rubenstein et al. 2015) and burnout (Baker and Heisler 2015). The peer-reviewed literature on Syrian healthcare workers raises concerns about the safety and wellbeing of medical personnel of those inside Syria, given the weaponisation of healthcare and workers' experience of systematic violations of international humanitarian law (Footer et al. 2018; Fouad et al. 2016). However, these issues have not been quantitatively investigated in Syrian healthcare workers and only one study currently exists with a focus on Syrian mental health professionals (MHPs). This qualitative investigation of forcibly displaced Syrian MHWs providing mental healthcare to Syrian clients in Turkey found that a shared reality was helpful in therapy while also creating a vulnerability in the Syrian MHWs (Hamid, Scior & Williams, in press).

The Professional Quality of Life scale (ProQOL) is a 30-item measure developed in the US (Stamm 2010) that captures both negative aspects (including secondary traumatic stress and burnout) and positive aspects (including compassion satisfaction (Stamm 2010). The ProQOL is widely used, mainly for Western health professionals, for whom it shows reasonable validity. To the researcher's knowledge, no peer-reviewed literature exists on the use of the ProQOL with a Syrian sample, nor on an Arabic version of the ProQOL.

Many Syrian MHWs are themselves forcibly displaced, have witnessed and experienced traumatic events (Hamid et al., in press) and there is an ethical duty to investigate their wellbeing and protect them from harm. This study aims to report the levels of secondary traumatic stress, burnout and compassion satisfaction among Syrian MHWs providing support to Syrian clients, using the ProQOL, and to compare ProQOL scores with other published samples. We also aimed to investigate the psychometric properties of this translated version of the ProQOL.

Methods

Participants and Procedure

We recruited participants for this cross-sectional study using self-completed questionnaires conducted in Gaziantep, a city in South Turkey, 75km from the Syrian border and Istanbul as well as online between April and May 2017. Our inclusion criteria were Syrians with a professional background in psychology who support Syrian clients with any mental health presentations. We recruited through networks of relevant organisations working with Syrian MHWs in Turkey at the time.

The first section of the survey was developed by the research team and forward translated by a bilingual Syrian Arabic speaker, and back translated by another bilingual Arabic speaker. The back-translated version was compared to the original and two contested words were resolved following discussion. This process followed guidelines provided by the WHO (2009).

The ProQOL was translated and validated using a stringent seven-step method suggested by Sousa and Rojjansrirat (2011). We followed all but one non-essential step involving three bilingual (Arabic-English speaking) consultants with a range of professional backgrounds and an additional two monolingual (Syrian Arabic) consultants with a psychology background. The ProQOL was forward translated from English to Arabic by two independent bilingual consultants and any issues were resolved. This was then back-translated (Arabic to English) by two independent bilingual consultants and further discrepancies were resolved. A pre-final version was then piloted by two monolingual Arabic speakers, leading to a final version.

Participants were invited to complete the questionnaire via two announcements during a Syrian Association for Mental Health conference held in Gaziantep in 2017. The questionnaire was also available online, circulated to members of the conference via a mailing list, as well as to members of a Trauma Aid UK mailing list, a charity providing EMDR training and supervision to Syrians in Turkey.

Sixty-seven participants took part. Two participants were excluded as more than half the responses were missing and four were excluded given that they were not Syrian, resulting in a sample of 61 participants (*n* = 32 female; see Table 1).

<Table 1 about here>

Measures

The survey included a set of questions about participants developed for the purpose of this study and shown in Table 1.

The ProQOL-5 scale (Stamm 2010) is a 30-item self-report scale with questions related to three subscales; compassion satisfaction (e.g. “I have happy thoughts and feelings about

those I help and how I could help them"); secondary traumatic stress (e.g. "I avoid certain activities or situations because they remind me of the frightening experiences of the people I help"); and burnout (e.g. "I feel worn out because of my work as a helper").

Convergent and discriminant validity tests have shown that each of these three subscales measure different constructs (Stamm 2010). Reliability ranged from .84 to .90 on the three subscales, and interscale correlations of showed 5% shared variance (r = -.23) with secondary traumatic stress and 2% shared variance (r = -.14) with burnout (Stamm 2010).

Data analysis

We explored the translated ProQOL's psychometric properties through the reliability of each subscale using Cronbach's alpha. We computed mean scores for each subscale to compare with the existing literature. Data were analysed using SPSS V.22.0. A boxplot flagged one significant outlier on all subscales; closer examination showed that this outlier was not due to error and this was kept in the analyses.

Results

This translated Arabic version of the ProQOL showed good psychometric properties. Internal consistency estimates of reliability were good for compassion satisfaction (Cronbach's α = .84), and acceptable for secondary traumatic stress (Cronbach's α = .78) and burnout (Cronbach's α =.73).

Participants reported a mean secondary traumatic stress score of 20.9 (*SD* = 5.5). Using cut-off scores recommended in the manual, 26.2% of participants (n = 16) reported high levels of secondary traumatic stress in this sample compared to only 5% reporting high levels in a sample of 532 self-identified US trauma specialists (Craig and Sprang 2009) and 0% in a sample of 506 Norwegian child protection personnel (Baugerud et al. 2017). Mean secondary traumatic stress levels were 10.3 (*SD* = 6) in a sample of 506 US counsellors (Lawson and Myers 2011), 11 (*SD* = 6.1) in US trauma counsellors (McKim and Smith-Adcock 2014), 10.03 (*SD* = 6.16) in US psychologists (Sprang et al. 2007) and 11.83 (*SD* = 6.74) in 169 frontline mental health care professionals in the US (Ray et al. 2013).

A mean compassion satisfaction score of 42.7 (*SD* = 5.4) was seen in this study, higher than population norms of 36.5 (Stamm, 2010). This sample's mean compassion satisfaction score was also slightly higher than in other samples of US counsellors (40.53, *SD* = 5.57; Lawson and Myers 2011), US trauma counsellors (40.9, *SD* = 5.6; McKim and Smith-Adcock 2014), US psychologists (38.56, *SD* = 6.36; Sprang et al. 2007) and frontline mental health care professionals (36.92, *SD* = 6.25; Ray et al. 2013).

Participants reported a mean burnout score of 21 (*SD* = 5.1), similar to population norms of the ProQOL reported as 20 and to a sample of US counsellors reported as 19.9 (*SD* = 6.0; Lawson and Myers 2011) and lower than in a sample of US psychologists, 25.7 (*SD* = 3.6; Sprang et al. 2007).

Exploratory follow-on analyses to examine whether any participant demographics (gender, profession, importance of religion, supervision regularity, cases per week, percentage of Syrian clients on caseload, percentage of clients with trauma on caseload and years of experience) were related to professional quality of life. All but two analyses were non-significant. A significant regression equation was found for burnout; $F(1,57) = 5.44$, $p = .023$, with an R^2 of 0.087, indicating that more years of experience was associated with lower

burnout scores. Analysis of variance showed a main effect of profession on all three subscales; compassion satisfaction, $F(3, 57) = 3.19$, $p = .03$; burnout, $F(3, 57) = 3.52$, $p = .021$ and secondary traumatic stress, $F(3,57) = 3.50$, $p = .021$. Data inspection showed that the four participants with no prior educational training in a psychology-related discipline scored higher on secondary traumatic stress and burnout and lower on compassion satisfaction, relative to trainee and qualified psychologists and psychiatrists. Given unequal sample sizes across professional groups, we conducted a non-parametric equivalent. A Kruskal-Wallis test showed that there was a statistically significant difference between all three subscales by profession: compassion satisfaction, $p = .003$, burnout, $p = .021$ and secondary traumatic stress, $p = .043$.

Discussion

While mean burnout scores in this sample of Syrian MHWs were similar to population norms for the ProQOL in US samples working in routine mental health care services and other samples in the existing ProQOL literature, mean secondary traumatic stress scores were much higher. Mean compassion satisfaction scores were also higher than ProQOL norms and slightly higher than other samples of MHWs in the literature.

We expected a high level of secondary traumatic stress in this sample than in existing samples given multiple factors such as daily stressors due to the ongoing nature of the Syrian conflict, past trauma and reduced opportunities for training and education (Dutton and Rubinstein 1995). Specific pathways leading to high secondary traumatic stress scores are unclear. Heightened levels may occur where MHWs have experienced past trauma, although this link is unclear and inconclusive (Baird and Kracen 2006); a shared traumatic reality may increase risk of secondary traumatic stress (Argentero and Setti 2011; Naturale 2007). The provision of ongoing supervision is crucial in this context, and self-care should be incorporated as part of additional training as well as a standalone component, such as the self-care training sessions delivered to Lebanese field workers working with Syrian refugees (Chemali et al. 2017). An educational intervention programme developed to reduce secondary traumatic stress, the Accelerated Recovery Programme (Gentry et al. 2013), incorporates self-care as well as grounding, containment, self-soothing and boundary setting. Such additional programmes can increase the support mechanisms in place for this population.

The same factors that likely led to secondary traumatic stress may have contributed to greater compassion satisfaction in this sample of Syrian MHWs, such as identification with clients with similar backgrounds and experiences, possibly leading to increased confidence in understanding their clients' needs and heightened motivation and investment in providing care and relief to clients (Hamid et al., in press). This may also contribute to the finding of a level of burnout among this sample similar to that of interpreters working with traumatised clients from a similar background; they also reported high levels of compassion satisfaction (Mehus and Becher 2016).

The fact that burnout scores were similar to counsellors and psychologists in the US (Lawson and Myers 2011; Sprang et al. 2007**)** was a surprising finding given the high workloads and reduced supervision opportunities that Syrian MHWs face in this context, as well as the reported high secondary traumatic stress. It may be that Syrian MHWs are somewhat protected from burn out as a result of the high levels of compassion satisfaction they experience. Syrian MHWs all reported feeling a strong sense of fulfilment and meaningfulness as a result of providing relief to other Syrians experiencing a collective conflict (Hamid et al., in press) and job reward, whether financial, institutional or social, may

protect individuals from burnout (Maslanka, 1996). Years of experience were negatively associated with burnout, as with social workers (Boscarino et al. 2004) and trauma specialists (Craig and Sprang 2009) in the US. It could be that MHWs experiencing burnout leave the profession, so that those with more years of experience represent the survivors. A cross-sectional study cannot distinguish between these explanations.

Although small in number, Syrian MHWs without an academic psychology background showed significantly higher secondary traumatic stress and burnout scores and lower compassion scores. These MHWs may be more likely to struggle because they lack the specific psychological tools and insight to carry out therapy. Specialist trauma training significantly predicted lower secondary traumatic stress and burnout, and higher compassion satisfaction (Craig and Sprang 2009; Sprang et al. 2007). Given the rise of task-shifting in poorly resourced settings, where tasks originally performed by a highly qualified specialist are transferred to a less specialised and qualified worker (Sijbrandij et al. 2017), this raises issues of selection and training of workers.

There is an increasing need for trained Arab MHWs given the historical shortages within the context of ongoing conflicts and post-conflict settings in the Middle East (Bruckner et al. 2011). Data was gathered using a questionnaire from a relatively small sample of Syrian MHWs, limiting the generalisability of the findings. Given the lack of literature on Syrian MHWs, the usefulness of this research is validated. Soon after this research took place, Heritage and colleagues (2018) presented a shorter 21-item version of the ProQOL which demonstrated excellent psychometric properties. Further dissemination of this Arabic version of the ProQOL, shortened as suggested by Heritage and colleagues (2018), to non-Syrian Arab MHWs to determine its suitability for wider use would be helpful.

While the use of established measures helps to compare with the existing literature, comparing this sample to other samples with the majority being of White ethnicity and living in stable conditions may introduce the notion of category fallacy (Kleinman 1977). Secondary traumatic stress does not arise from working with trauma per se, but rather is a consequence of the interaction of working with survivors of trauma within an individualised post-modern Judeo-Christian Western culture (Satkunanayagam et al. 2011). There also seems to be a lack of conceptual clarity in the literature pertaining to professional quality of life (Baird and Kracen 2006).

Training displaced Syrian MHWs provides a sustainable model of provision of mental health care, in line with the United Nations' 2030 Agenda for Sustainable Development and the Sustainable Development Goals (United Nations 2015; Izutsu et al. 2015). It enables Syrian MHWs to gain enough experience to become supervisors and increases access to psychology within displaced, conflict-affected communities. This would reduce caseloads and provide more opportunities for specialist supervision and training; a movement in this direction would likely contribute to an overall increase in the professional quality of life of Syrian MHWs in the longer term.

This study was the first to examine Syrian MHWs' professional quality of life. Syrian MHWs providing care to forcibly displaced Syrians in Turkey showed elevated levels of secondary traumatic stress relative to other samples pointing to a need for increased availability of specialist supervision and support such as self-care training. Despite this, levels of burnout were similar to other populations and compassion satisfaction was similar, if not slightly elevated. Training displaced Syrian MHWs within conflict-affected communities is an

acceptable, sustainable solution to increase resources relative to demand. Poor levels of professional quality of life in Syrian MHWs who did not have an educational background in psychology suggest the need for increased academic, not only vocational, training in this population. This Arabic version of the ProQOL showed acceptable psychometric properties and is suitable for use amongst Syrian MHWs. Future research is important to elicit richer descriptions of Syrian mental health workers' experience of providing mental health care in the context of displacement and a shared reality.

Declarations

These results were originally written between March and June 2018 as part of a larger doctoral thesis. This paper was written between April and August 2019 for the purpose of publication. This study met the University College London Research Ethics Committee approved criteria (0163/001). All participants gave informed consent and all data was de-identified. The datasets used and analysed during the current study are available from the corresponding author on reasonable request. The authors declare that they have no competing interests. This work was supported by the University College London Doctorate in Clinical Psychology, funded by Camden & Islington NHS Foundation Trust and the University College London Grand Challenges doctoral students' small grants scheme.

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