

DOI: 10.5455/msm.2021.33.94-99

Received: Feb 25 2021; Accepted: Mar 16, 2021

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ORIGINAL PAPER

Mater Sociomed. 2021 Jun; 33(2): 94-99

Professional Quality of Life in Greek Health Professionals Working with Refugees and Migrants

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ABSTRACT

Background: Expatriation and relocation into a new cultural context constitute a psychological journey marked by exposure to potentially traumatic events, the abandonment of the homeland and the effort of seeking safety and a new beginning at all levels. **Objective:** The aim of this study was to investigate the Professional Quality of Life in Greek health professionals working with refugees and migrants. **Methods:** The Professional Quality of Life Scale (ProQOL V) and a demographic and work-related characteristics questionnaire were distributed to 90 health professionals working with migrants and refugees. **Results:** 25.6% of participants reported high CF risk while 75.7% expressed high to moderate potential for CS. Awareness of the factors associated with CF may help health professionals to prevent or offset the development of this condition. **Conclusion:** A compassionate organizational culture, clinical supervision and on-going education may protect health professionals working with migrants and refugees from absorbing or internalizing unmanageable emotions which may lead to compassion fatigue and also help them to gain a deeper understanding of their communication and interactions during the emotionally laden moments of trauma care.

Keywords: Migrants, Refugees, Professional Quality of Life, Trauma, Burnout, Secondary Post-traumatic Stress, Compassion fatigue, Compassion Satisfaction, Emotional work.

foreigner is neither the romantic victim of our clannish indolence nor the intruder responsible for all the evils of the polis... Strangely, the foreigner lives within us: he is the hidden face of our identity. By recognizing him within ourselves, we are spared detesting him in himself. A symptom that precisely turns «we» into a problem, perhaps makes it impossible.» (2).

1. BACKGROUND

Expatriation and relocation into a new cultural context constitute a psychological journey marked by exposure to potentially traumatic events, the abandonment of the homeland and the effort of seeking safety and a new beginning at all levels (2, 3). This journey (3, 4) begins with the decision of expatriation often taken in a state of internal confusion in which personal problems may be intertwined with war, violence, detention, torture, economic and/or political insecurity in the country of origin. Separation from loved ones, places and objects, fear of losing one's support system and social identity, feelings of guilt and separation anxiety begin before migration and may last several years in a context of social disconnection, stigma and persistent hostility (2). Separation and ambiguous loss concern family and social structures, as well as cultural values and personal identity. It is essentially a process of mourning, which takes place in parallel with the immigrant/refugee's effort to invest in the hope of finding safety in the new environment (2). PTSD, depression and ambiguous loss among other post-migration stressors hinder this journey while individuals may have difficulty in remembering traumatic events and thus provide only fragmentary and

«For I am a foreigner residing with You, a temporary resident like all my fathers.» (1).

«The image of hatred and of the Other, a

disorganized biographical narratives. Confronting one's personal journey in non-therapeutic or untimely scenarios might trigger retraumatization and dissociative symptoms (5, 6). Health professionals responsible for the care of migrants and refugees do not remain untouched by their work experiences but have been reported to experience burn-out, secondary traumatic stress, depression and somatic symptoms in the landscape of trauma, workplace and resource limitations (7-9). Therefore, the professional quality of life of health professionals working with migrants and refugees is of particular interest.

Professional quality of life refers to the positive and negative consequences that a professional experiences in relation to his/her work (10). Positive consequences are characterized as Compassion Satisfaction (CS) and are related to employee pleasure and satisfaction, stemming from his/her ability to provide care, meet work requirements and have positive interactions with colleagues during compassionate care. Negative consequences are characterized as Compassion Fatigue (CF) and include two subsets of symptoms: Job burn-out (BO) and secondary traumatic stress (STS) symptoms. Symptoms of BO contain feelings of being trapped, overwhelmed, 'bogged down' and unsatisfied from one's work. By contrast, STS is defined as being 'preoccupied' with thoughts of people one has cared for. Professionals may feel exhausted, trapped, 'on edge' or 'infected' by other's trauma (10). Reported symptoms include fear, sleep difficulties, intrusive images and avoiding listening to other's traumatic narratives. Recently, the British Psychological Society defined CS as "a condition characterized by emotional and physical exhaustion leading to a diminished ability to empathize or feel compassion for others, often described as the negative cost of caring" (11). Nonetheless, instead of developing fatigue due to exposure to suffering and traumatization, professionals may develop high morale and resiliency in adversity while experiencing pleasure and a sense of personal fulfilment and satisfaction (10).

Overall, the impact of working with immigrants and refugees is well recognized by the existing literature. In a recent systematic review of the emotional consequences of trauma work for humanitarian professionals, eight studies focused on professional quality of life (12). However, only two of the studies included a small number of health professionals in their samples. The experience of health professionals working with immigrants was associated with both positive and negative effects but no conclusions can be drawn due to the small numbers of health professionals involved in the studies (8, 9). To the researchers' knowledge, no study has focused on the professional quality of life of health care professionals.

The purpose of the current study was to investigate the professional quality of life of Greek health professionals working with migrants and refugees. A secondary objective was to explore the effect the participants' demographic and work-related characteristics may have on their professional quality of life (CS, CF/STS, and BO). The present research is motivated from the strong international interest in the study of the impact of trauma work on health professionals

working with migrants and refugees and makes a significant contribution to the field as this is the first study to be conducted in Greece.

The Greek Context

Greece has recently transitioned from being an emigration country to an immigration one. The country has been facing a serious humanitarian crisis, as it received almost one million migrants and refugees only in 2015. Since then, this massive migrative wave has continued every year (13). The vast majority of this population comes from the Middle East, Asia and Africa, crossing the sea and land borders of Greece on their way to central and northern Europe (14). Successive arrivals of migrants had a direct impact on society as well as the healthcare sector already burdened by a decade of financial austerity. A large number of health and other professionals and volunteers who work in camps or other related structures are offering constant support and care on a daily basis (7). A study of Greek and international professional and volunteer rescue workers found that Greek professional rescue workers had the highest risk of post-traumatic stress compared to other groups probably because of the exhausting working conditions and lack of regular psychological support. Other risk factors were female gender, age over 38, one or no children, participating in more than 4 missions, and length of employment and frequency of overtime as well as the number of deceased migrants retrieved by the participants per rescue intervention (15).

2. OBJECTIVE

The aim of this study was to investigate the Professional Quality of Life in Greek health professionals working with refugees and migrants.

3. METHODS

Participants

Questionnaires were distributed to 90 health professionals working with migrants and refugees in the greater metropolitan area of Athens, Greece. The inclusion criteria were: age over 18 years, work in organizations for refugees and/or migrants, six (6) month minimum previous experience and good knowledge of the Greek language.

Procedure and ethical considerations

Due to COVID-19 few questionnaires were administered to health professionals working in structures of the Greek Red Cross (after obtaining a written approval of the scientific committee of the organization); the majority of questionnaires were completed by participants on a free online platform. Data collection took place between January 2020 and April 2020. Moreover, informed consent was obtained from participants after providing them with information about the aims of the study and confidentiality issues as well as their right to refuse participation and withdraw from the study at any time they wished.

Measures

The first part of the questionnaire included items on demographic (personal and work-related) characteristics and the second part was the Professional Quality of Life Scale (ProQOL-V) developed by Stamm (10). The ProQOL-V is a 30 item self-report scale with answers varying from 1 (never) to 5 (very often). The questionnaire includes three

subscales: compassion satisfaction (CS), burnout (BO) and compassion fatigue/secondary trauma (CF/STS); each subscale having a different score. In the current study, the Greek version of ProQOL-V was used (16). The Cronbach's α value was satisfactory for each subscale: 0.78 for compassion satisfaction, 0.81 for burnout, and 0.75 for compassion fatigue.

Data analysis

Descriptive statistics were originally generated for sample demographic and work-related characteristics. T-tests were performed to demonstrate significant differences in means, and Pearson and Spearman coefficients of correlations were calculated to determine the strength of linear relationship between variables. Linear regression analysis was performed to examine the relations between the demographic and work related characteristics to each of the three dependent variables: CS, BO and CF/STS. The statistical significance level was defined as $p < 0.05$. Statistical analysis was carried out using the statistical package SPSS v.22.0.

4. RESULTS

Questionnaires were distributed to 90 health professionals who worked with migrants and refugees. The majority of the sample were women (81.1%) and were married (47.8%). The mean age was 37.2 ± 8.5 years and 41.1% had a postgraduate degree (Table 1). The majority of participants (82.2%) reported that most of the time to always, the staff worked as a team. Most of them (68.9%) considered their work environment (relationship with colleagues) as very good to excellent, 60.7% did not desire the same career for their children and 93.4% had experienced a traumatic event in their lives (Table 1).

	Compassion Satisfaction	Burnout	Compassion Fatigue
M \pm SD	37.1 \pm 7.5	22.5 \pm 5.4	21.1 \pm 5.4
High	26 (28.9%)	21 (23.3%)	23 (25.6%)
Moderate	42 (46.7%)	45 (50%)	46 (51.1%)
Low	22 (24.4%)	24 (26.7%)	21 (23.3%)

Table 2. Professional Quality of Life Scores and Frequencies (N = 90)

Scores in the ProQOL were calculated for each dimension using standardised z-scores and t-scores (10). Higher standardised z-scores denoted higher score in the specific subscale, while standardised t-scores were used to categorise scores into low (t-scores ≤ 43.00), average (t-scores between 44.00–56.00) and high (t-scores ≥ 57.00). 25.6% of participants reported high CF risk while 75.7% expressed high to moderate potential for CS (Table 2). The majority

Characteristics	Mean \pm SD/n (%)			
Age	37.2 \pm 8.5			
Sex Male	17 (18.9)			
Female	73 (81.1)			
Position Registered nurse	29 (32.2)			
Nursing assistant	5 (5.6)			
Physician	6 (6.7)			
Midwife	9 (9.5)			
Social worker	19 (21.1)			
Psychologist	12 (13.3)			
Other	10 (10.6)			
Marital status Single	41 (45.5)			
Married	43 (47.8)			
Divorced/Separated	6 (6.7)			
Education High School	9(10%) 40 (44.5%)			
University	37 (41.1%)			
Master	4 (4.4%)			
PhD				
Staff works as a team	Always 33 (36.7%)	Most of the time 41 (45.5%)	Sometimes 16 (17.8%)	Rarely 0 (0.0%)
Desire to leave the unit	Soon 2 (2.2%)	In a year 3 (3.3%)	In few years 22 (24.5%)	Never/indif. 63(70%)
Workplace environment	15 (16.7%) Excellent	47 (52.2%) Very good	18 (20%) Good	2 (2.2%) Poor
Physical health	37 (41.1%)	42 (46.7%)	9 (10%)	2 (2.2%)
			Yes	No
Traumatic experience	87 (93.3 %)	3 (6.7%)		
Personal choice work in unit	57 (63.3%)	33(36.7%)		
Would choose same career pathway for their children	35 (39.3%)	54 (60.7%)		
Would choose same career again	56 (62.2%)	34 (37.8%)		
Experience of a loved one's loss in the last year	41 (46.6%)	49 (53.4%)		

Table 1. Demographic and work-related characteristics (N = 90)

Depended variable	Coefficient b	SE+	P-value
CS			
Desire of the same career for their children	4.17	1.62	0.012
Personal choice of work in unit	-4.10	1.61	0.013
STS			
Traumatic event intensity score	1.25	0.25	<0.001
Staff works as a team	-3.60	1.29	0.007
Total years of working experience	-2.30	0.99	<0.001
BO			
Desire to leave the unit	2.81	1.10	0.013
Choice of the same career again	-2.31	1.01	0.024
Physical health	4.39	1.61	0.008
Traumatic event intensity score	0.62	0.25	0.016

Table 3 Multiple linear regression analyses results. +Standard Error

of the participants (46.7%) reported moderate potential for CS, moderate risk for BO (50%) and moderate risk for CF (51.1%). BO and CF were negatively correlated with CS (BO: $r = -0.69$, $p < 0.001$, CF: $r = -0.17$, $p = 0.105$). Additionally, total number of traumatic life events was positively correlated with CF ($r = -0.32$, $p < 0.002$).

Multiple linear regression analysis revealed that work-related characteristics and traumatic event intensity were related to the participants' score in at least one dimension (CS, STS, BO). Those who desired the same career for their children and those who worked in the unit due to their personal choice had higher CS scores ($p=0.012$ and $p=0.013$ respectively). It was also found that increased rating of a trauma event was related with increased STS score ($p<0,001$). Those who believed that staff worked as a team and increased working time experience had lower STS score ($p=0.007$ and $p<0,001$ respectively). Concerning BO score, those who desired to leave the unit and those who had increased rating of a trauma experience, had higher BO score ($p=0.013$ and $p=0.016$ respectively). Finally, those who had choose of the same career again for their selves and those who had better physical health had lower BO score ($p=0.024$ and $p=0.008$ respectively) (Table 3).

5. DISCUSSION

The main purpose of the study was to investigate the professional quality of life of health professionals working with migrants and refugees. Findings suggest that 25.6% of participants reported high CF risk while 75.7% expressed high to moderate potential for CS. Furthermore, health professionals' perceptions of their working environment and team work dynamics were significantly related with at least one of the dimensions of professional quality of life. Additionally, life history of trauma was related with higher CF scores.

As regards the positive consequences of work with refugees and immigrants, more than three quarters of the participants reported moderate and high compassion satisfaction. These unexpectedly high scores in CS constitute a protective shield against CF since professionals with high CS and moderate BO and CF reflect a 'positive reinforcement profile' (10). Individuals with this profile, despite the moderate scores in CF, carry no significant concerns about being able to accomplish their work. Overall, the results of the present study are similar to those of Lusk al. and Kjellenberg et al. in which caregivers and professionals working with refugees and migrants reported high levels of CS and a lower risk for BO and CF suggesting their competence to manage the impact of work with trauma sufferers (9, 17). Similarly, high levels of CS are reported in other studies (12). Apostolidou found that the positive emotions of professionals working with trauma sufferers were related to the gratitude they received from the sufferers and their improvement, as well as to the personal development resulting from that experience (18). Working with this population appeared to be a source of hope, inspiration and changes in life philosophy, self-perception and social interaction (19).

On the other hand, in the present study, the experience of working with migrants was found to affect negatively the professional quality of life of approximately a quarter of the

participants. A possible explanation could be that the burn-out element of CF is influenced greatly by organizational factors (10). Nonetheless, in the present study, the majority of participants had no desire to leave the unit, described their working environment as very good and thought that the staff most of the times worked as a team. Furthermore, satisfaction with team work was negatively related to CF pointing to the importance of participants' satisfaction with the organizational climate in their working context and a good person-environment fit (20).

Another important result of the present study is that the total number of traumatic life events and the traumatic life event intensity were related positively to compassion fatigue dimensions. Almost all participants had experienced at least one traumatic event in their life, which is consistent with the study by Borho et al (21). Similarly, Akinsulure-Smith et al. found a significant positive association between professionals' history of trauma and post-traumatic stress suggesting that when thoughts, feelings and memories of other people's traumatic experiences were mixed with their own, then professionals may experience high levels of CF(22). On the other hand, Kjellenberg et al. revealed no correlation between history of personal trauma and CF(9). Missouridou stresses that health care professionals' emotional reactions can be partly a result of their own personal history when exposed to the stress and the tensions present in their interactions to traumatized individuals (23). She goes on to suggest that self-awareness, acknowledgement of personal loss history and unresolved issues as well as acceptance of personal limitations constitute necessary equipment of a 'wounded healer' in a genuine encounter with those in need (23).

Other risk factors related to working with immigrants and refugees include years of working experience, physical health and lack of self-motivation. Length of employment was found to be negatively correlated with CF. Posselt et al. revealed a positive correlation between the anxiety levels of health professionals' years of work and their gender (male), years of work and full-time occupation (24) while Kjellenberg et al. reported that long work experience was positively correlated with CF, secondary stress, impairment as well as post traumatic growth (9). An explanation of this noteworthy finding is that maybe participants who kept on working in the field found ways to manage the feeling of fatigue or maybe they "learn" how to use effectively the support they receive from their organizations. Misouridou stresses that through the strenuous journey of learning to provide compassionate care while protecting themselves, health professionals acquire a strong sense of personal and professional identity (23). She also suggests that through the struggles associated with assigning meanings to traumas they are exposed to, professionals may have the opportunity to grow beyond their pre-exposure level of psychological functioning. In this way engaging in an empathic relationship with trauma sufferers may lead to opportunities for growth and a new appreciation of life, spirituality and relationships despite the initial intense emotional impact (23). As regards participants physical health, half of them reported a fairly good level of health while those who were in very good physical health were experiencing lower levels

of CF and BO compared to participants in fairly good health. Similarly, Rizkala & Segal reported a positive correlation between physical health and CS and a negative correlation of the former with CF (25). Additionally, participants who would choose to leave the unit and had not made a personal choice to work in the specific unit presented higher scores in CF and BO, consistent with a similar study by Guhan & Liebling-Kalifani (26). No other demographic factors or participants characteristics were related to any of the professional quality of life dimensions.

Nonetheless, certain limitations of the study should be taken into account. Due to Covid 19 the present study employed a convenience sample while its size was considerably limited. Consequently, there are concerns regarding the generalization of the results to the population of health professionals working with refugees and migrants in Greece or internationally. Furthermore, working during quarantine might have increased health professionals' burn out. On the other hand, the social distance imposed by the COVID-19 pandemic, time spent in direct contact with refugees and the number of clients cared for may have influenced the boundaries of the empathetic encounters with refugees and immigrants.

6. CONCLUSION

Overall, the findings of this study indicate that enhancing resilience and encouraging successful coping strategies could be important targets by the stakeholders in developing efficient and effective prevention and intervention programs to safeguard those at risk and promote their posttraumatic growth while helping careers to cope with the emotions experienced during at work. Screening and targeted interventions to those with high scores on CF and other mental health outcomes may protect both humanitarian professionals and functioning care systems stretched to their limits. Managerial support and a compassionate organizational culture are important to help professionals to express their feelings of frustration especially during the early stages of their career. Regular and long-term provision of mentorship and clinical supervision may facilitate a holding environment supporting professionals to reflect on their clinical work (23). Continuous trauma education may empower humanitarian professionals in understanding trauma dynamics and actualizing their role. The overwhelming moments of trauma care may be a source of anguish, stress and suffering for health professionals but simultaneously an arena of personal maturity and self-actualization. According to Lanara, person-centred care in a complex society constitutes a difficult intellectual and spiritual achievement which requires heroism, passion for social justice and zeal for righteousness in order to overcome internal and external barriers to care and build a strong professional identity in the landscape of serving those in need (27).

• **Author's contribution:** TM, PA and EM made a substantial contribution to the conception and design of the work. TM, TA, EM, and PA had a part in article preparing for drafting or revising it critically for important intellectual content. GF, MM, AM and MD contributed in literature review. All authors approved of the final of the article and agreed to be accountable for all aspects of the work in ensuring that questions related to the ac-

curacy or integrity of any part of the work are appropriately investigated and resolved.

- **Conflicts of interest:** There are no conflicts of interest.
- **Financial support and sponsorship:** Nil.

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