Presentation of Thesis for Examination

Humanitarian Helper Wellbeing: A Psychosocial Refugee Care Approach

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Dedicated to V., C., H., & H.

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List of Acronyms and Abbreviations

AAD: Adversity-Activated Development

AC: Affective Commitment

AG: Adversity Grid

APA: American Psychological Association

AWS: Areas of Work Life Scale

CDC: Centers for Disease Control and Prevention (USA)

CF: Compassion Fatigue

CS: Compassion Satisfaction

CSM: Collective Structures of Meaning

CTAR: Centre for Trauma, Asylum and Refugees

CW: CG Jung's Collected Works

DCM: Demand-Control Model

DPR: Distressful Psychological Reactions

DSM: Diagnostic and Statistic Manual on Mental Health Disorders

EAP: Employee Assistance Program

ERI: Effort–Reward Imbalance

EU: European Union

EUPRHA: European Universities on Professionalization on Humanitarian Action

EVASP: Enhancing Vulnerable Asylum Seekers Protection

GBV: Gender-Based Violence

IASC: Inter-Agency Standing Committee

ICD: International Classification of Diseases

ICRC: International Committee of the Red Cross

ICVA: International Council of Voluntary Agencies

IDP: Internally Displaced Person

IFRC: International Federation of Red Cross and Red Crescent Societies

IGO: Intergovernmental Organisation

ILO: International Labour Organisation

IMI: Interactional Matrix of Intervention/Interactional Matrix of Humanitarian Support

IO: International Organisation

IOM: International Organisation for Migration

IRC: International Rescue Committee

JD-R: Job Demand-Resources Model

MAP: Meaning Attribution Process

MHPSS: Mental Health & Psychosocial Support

MSF: Médecins Sans Frontières (Doctors Without Borders)

NCVO: The National Council for Voluntary Organisations (UK)

NGO: Non-Governmental Organisation

NHS: National Health Service (UK)

OCB: Organisational Citizenship Behaviour

OCHA: United Nations Office for the Coordination of Humanitarian Affairs

OED: Oxford English Dictionary

OHS: Ordinary Human Suffering

PD: Psychiatric Disorder

PFA: Psychological First Aid

PM+: Problem Management Plus

POS: Perceived Organisational Support

PTG: Post-Traumatic Growth

PTSD: Post-Traumatic Stress Disorder

R&R: Rest & Relaxation/Rest & Recreation

SDT: Self-Determination Theory

SOC: Sense of Coherence

STS: Secondary Traumatic Stress

SWB: Subjective Wellbeing

TA: Thematic Analysis

THP: The Hague Process on Refugees and Migration

UK: United Kingdom of Great Britain and Northern Ireland

UNESCO: United Nations Educational, Scientific and Cultural Organisation

UNHCR: United Nations High Commissioner for Refugees

US/USA: United States of America

VBC: Value-Based Counselling

Vol.: Volume

VPTG: Vicarious Post-Traumatic Growth

VR: Vicarious Resilience

VT: Vicarious Traumatisation

WHO: World Health Organisation

Abstract

Background: Helpers of refugees may endure various hardships, and, on some occasions, report distress and psychopathological reactions because of their exposure to those adversities. At the same time, they may experience significant resilience or even positive development as a result of those adversities. These newly acquired strengths can be expressed by the concept of *Adversity Activated Development* (e.g., Papadopoulos, 2007). Based on the innovative theories of *Refugee Care* at CTAR (Centre of Trauma, Asylum & Refugees, University of Essex) and on *expanded Jungian theory*, in this thesis I investigate diverse aspects of *humanitarian helper wellbeing.*

Methodology: Eight humanitarian helpers (including workers and volunteers) were interviewed for this study. S*emi-structured* interviews with *open-ended* questions for the collection of qualitative data were conducted. The *Adversity Grid* form (Papadopoulos, 2007), which has been cited and applied in several cases (Gionakis et al., 2022; IOM, 2019; Jasperse, 2021), was completed twice by each participant following the interviews. *Thematic Analysis* (Braun & Clarke, 2006) was implemented for the data analysis.

Results: The empirical results demonstrate a wide range of experienced responses to and consequences of adversities from the participants. Aspects of helper stress including organisational ones, self-care resources and eudemonic wellbeing are identified as main themes.

Discussion: The findings underline the *complexity* of the participants' responses to adversity, which are not only negative and pathological, but also manifest incredible resilience and various gains. They also show that negative reactions are not always pathological and that they are linked to organisational or institutional dynamics issues and not solely to exposure to client's adverse material. This thesis provides a broader

psychosocial approach to helper wellbeing based on a newly developed conceptual framework. Practical recommendations for organisational policies are also provided. Additionally, this project introduces a depth psychological understanding of the helpers' experiences from a Jungian perspective.

Keywords: adversity-activated development, adversity grid, expanded Jungian theory, humanitarian helper wellbeing, refugee care, thematic analysis

Introduction

Humanitarian Helper Wellbeing: A Psychosocial Refugee Care Approach

Prologue

In 2021, according to the UN High Commissioner for Refugees, there were at least 79.5 million refugees (UNHCR, 2021) and, according to the UN Office for the Coordination of Humanitarian Affairs, this number has been rising ever since (OCHA, 2022). To assist these growing numbers of refugees with their multifaceted needs, the role and commitment of helpers either in the humanitarian field or in human services is pivotal. This research is about the helpers of refugees and their wellbeing, from a psychosocial perspective.

Wellbeing, in general, is a topic for which there has been growing interest not only from academic disciplines, such as psychology, but also from mass media and public opinion. With a quick search on the internet, one can find numerous magazines, TV programmes and books about wellbeing in various languages. Meanwhile, the term “wellbeing” can be associated with mental health, physical health, massage practice, coaching practice, spa and wellness, sport activities, healthy lifestyle, feeling good or positively, public health promotion, good nutrition, global happiness, etc.

Wellbeing has also been the subject of research and discussion within various academic fields, such as clinical psychology (Csikszentmihalyi, 1990; Lent, 2004; Ryan & Deci, 2001; Seligman et al., 2005), organisational or occupational psychology (Danna & Griffin, 1999; Dewe & Kompier, 2009; Laine & Rinne, 2015; Panaccio & Vandenberghe, 2009), public health (Carlisle & Hanlon, 2007; Holdsworth, 2019; US Centers for Disease Control and Prevention [CDC], 2018; Zhang, 2010), philosophy (Charles, 1999; Fabjanski & Brymer, 2017; Ransome, 2010; Tesar & Peters, 2020),

interface of religion and psychology (Lee et al., 2017; Nelson & Slife, 2017; Shonin et al., 2014), social sciences (Heins & Deeming, 2015; Kalseth et al., 2022; Keyes, 1998; Sointu, 2005) and psychoanalysis (Fromm, 1976; Jung, 1972a; Leuzinger-Bohleber et al., 2008; Morag, 2017; Rose, 2012).

Over the years, the wellbeing of refugees has increasingly attracted interest from the research community (e.g., Blackwell, 2005; Carta, 2016; El Arab et al., 2023; Hollander, 1998; Jones & Kafetsios, 2005; Mollica, 2001, 2006; Newman et al., 2018; Summerfield, 2000). Nevertheless, the predominant discourse in society and academia favours a *psychotraumatological* approach to the refugee experience and refugee wellbeing (Afuape, 2011; Chondrou, 2019; Pupavac, 2002; Summerfield, 1999, 2000, 2001; Zarowsky & Pedersen, 2000) that tends to neglect any positive elements and gains and focuses almost exclusively on the phase of devastating events that refugees generally have experienced (Papadopoulos, 2002, 2007, 2021a). The effect of this pathologising and victimising narrative and stance (even if one has good intentions) on the wellbeing of refugees can be detrimental, as they may develop a *learned helplessness* and adopt a *victim identity* (Papadopoulos, 2021a).

Since the number of refugees worldwide has reached unprecedented levels (OCHA, 2022), the importance of helpers and humanitarian action is inevitably increasing. Consequently, wellbeing of helpers (either as paid staff or volunteers and either in the humanitarian field or human services) of refugees, which is the topic of this thesis, has increasingly drawn the attention of researchers and humanitarian organisations (Apostolidou, 2016; Barrington & Shakespeare-Finch, 2013; Birck, 2001; Blanchetiere, 2006; Carbonnier, 2015; Jasperse, 2021; Posselt et al., 2019; Posselt et al., 2020; Pross, 2006; UNHCR, 2016; Welton-Mitchell, 2013). For instance, in its roadmap for implementation 2020–2023, the International Federation

of the Red Cross and Red Crescent Societies (IFRC; 2020) prioritises the psychosocial wellbeing of volunteers and paid staff among its goals.

Personal Motivation for Conducting This Study

As a psychiatrist, psychotherapist and newly graduated Jungian psychoanalyst who has worked for refugees and with humanitarians and helpers in human services, my intention through this thesis is to further explain and develop ideas about the wellbeing of helpers of refugees whom I consider to be one of the most progressive, politically active and altruistic parts within our society.

Essentially, this is connected to some biographical elements of mine. I worked at the Outpatient Clinic of Victims of Torture and War of the Swiss Red Cross. There, I had the opportunity to work with some brilliant, committed helpers and humanitarians, to learn from them and to be inspired by them. Earlier, in various positions throughout my training in psychiatry, and, currently, at communal psychiatric services, I worked, and, respectively, I am still working with refugees and asylum-seekers who endured unimaginable calamities and are facing serious postmigration challenges and difficulties. As a result, I continue to collaborate closely with other caregivers of refugees, such as general practitioners, translators and resettlement officers. In all the above contexts, settings and roles, I have noticed and/or witnessed feelings of stress and overwhelmingness in the helpers of refugees. On various occasions, I have also found myself confronted with the painful narratives of the refugees and the complex questions of their psychosocial reality.

Reflecting on all the above, I decided to write my doctoral thesis and conduct empirical research, focusing on the wellbeing of the helpers of refugees. During my psychiatric training, I learned about wellbeing from a clinical/mental health perspective and worked according to the medical model, which, of course, draws attention to symptoms, diagnosis and appropriate treatment of mental disorders.

During my MA studies in Refugee Care at the University of Essex (UK), I was able to deepen my knowledge and understanding in spheres that affect refugees and in the complexity of the refugee experience. In my thesis, I expand these theories from the refugees to their helpers.

Research Questions and Research Purpose

The main research question consists of two parts: (1) whether the helpers show not only negative, including pathological, responses because of their exposure to adversities, but also resilient and positive reactions; and (2) provided that they do, whether the *Adversity Grid* (AG) as a tool assists the researcher to gather a wide range of changes and consequences of exposure to adversities that include negative, positive and resilient reactions. The exposure to adversities this study examines is expected to be overarchingly (but not exclusively) connected to the adverse material and narratives of the refugees while directly working with them. Nevertheless, further crucial aspects (such as organisational issues) should not be neglected.

The predominant approach for most participants and organisations they work for seems to follow the medical paradigm, i.e., it focuses on pathology or symptomatology and views wellbeing as absence or presence of mental health in a clinical sense. From an epistemological perspective, this has limitations: The predominant approach fails to offer an understanding of the wider range of responses and consequences in the aftermath of exposure to adversities.

This main thesis hypothesis is that, for humanitarian helpers, not all stress, or, more generally, not all responses to adversity automatically translate into psychopathology or psychiatric disorder (PD). I assume that helpers experience and understand their wellbeing in a variety of different ways and, clearly, not only from a medical perspective. A further hypothesis is that the AG (e.g., Papadopoulos, 2007,

2021a) is an appropriate tool to be used in a psychosocial approach to investigating humanitarian helper wellbeing.

Guided by the framework of the AG, the *primary* endeavour of this project is to provide empirical evidence and insights into the lived experience of humanitarian helpers and, according to those, to accept or reject the above formulated hypothesis. When applied, the Grid addresses the wide range of outcomes of adversities (negative, resilient/unchanged, positive), due to either direct or indirect exposure. It should be emphasised that, according to the framework of the AG, negative and positive reactions are not mutually exclusive. Clearly, with this project, I seek to give voice to the individual helpers of refugees regarding their wellbeing and experiences. Secondarily, however with strong interest, the aim of this thesis is to develop a conceptual framework that will be applied as an innovative, enriching interpretative lens for the discussion of the findings and the generation of consistent conclusions.

More specifically, the purpose of this thesis is to fill a gap in knowledge by embracing a holistic, psychosocial approach to humanitarian helper wellbeing that encompasses the lived experience of a wide range of responses and consequences due to adversities. Moreover, to my knowledge, it is the first attempt so far in literature to empirically research the wellbeing and reactions of humanitarian helpers using the framework of the AG**.** Further, a specific objective of this study is to reach applicable conclusions and to generate practical recommendations for organisations. On the whole, I suggest that the above-mentioned factors make this thesis topical, innovative and unique. In order to avoid any misapprehension about the essence of this study, I should stress from the very beginning that the aim of this thesis is not to construct a general Jungian wellbeing concept from the ground up. Conversely, Jungian thought is expected to conceptually support my efforts in this study to develop a wider, innovative psychosocial glance at the humanitarian experience.

Theoretical Basis and Conceptual Approach

Working with refugees who have been exposed to adversities implies that humanitarian helpers themselves are exposed to adversity (e.g., Lusk & Terrazas, 2015; Rizkalla & Segal, 2020). Therefore, this project should investigate the after-effects of this "indirect" exposure.

Currently, similarly to refugee wellbeing, the dominant approach to humanitarian staff wellbeing according to both literature and organisations tends to be clinical/psychotraumatological, i.e., focusing on *PTSD, secondary traumatic stress* (STS) and *trauma-related disorders* (Jachens, 2018; Jasperse, 2021; Pupavac, 2004) or, when not plainly medical/psychiatric, it at least includes some clinical connotation, such as *burnout, compassion fatigue* (CF) and *vicarious traumatisation* (VT), and tends to neglect gains, growth and enrichment as a result of adversities (Emmens & Porter, 2009; Guhan & Liebling-Kalifani, 2011). However, there have been attempts to conceptualise these gains, such as *vicarious resilience* (VR; Hernandez et al., 2007) and *adversity-activated development* (AAD; Papadopoulos, 2007, 2013) that could refer to both helper and beneficiary.

Further approaches to the wellbeing of helpers also stem (partially or entirely) from the field of organisational or occupational psychology, which sees to organisational factors and their impact on staff wellbeing, and offers suggestions for how these can be improved so that staff stress and/or distress can be alleviated (e.g., Aldamman, 2020; Aldamman et al., 2019; Ehrenreich & Elliott, 2004; Jachens, 2018; Jachens et al., 2019; Musa & Hamid, 2008; Pross & Schweitzer, 2010; Strohmeier et al., 2019).

While taking into consideration the above-mentioned views, the conceptual approach of this study is alternatively led by the *Refugee Care principles* of CTAR at the University of Essex, including the *epistemological openness* and *vigilance* that led

to the AG tool (Papadopoulos, 2007, 2021a). The framework of Refugee Care, which will be explored in detail in Chapter 2, is fundamental for conducting this study.

A further solid foundation of the conceptual approach of this thesis is composed by relevant elements of *Jungian theory*. Here, the objective is a more comprehensive, psychodynamic understanding of several aspects of the wellbeing of helpers. Succinctly, the main reasons that I opted for Jungian psychology as part of the theoretical backbone of my research are its unique approach to the human psyche and the unconscious for the investigation of individual and collective psychological phenomena, its salient "epistemological openness" that would favour a multi-layered psychosocial approach (Papadopoulos, 2006, p. 43), and its general orientation towards meaning-making and self-actualisation.

For the interpretation of findings, this thesis, with its theoretical "compass" (combining refugee care and expanded Jungian theory), suggests a broader psychosocial, interdisciplinary and blended conceptual approach that integrates facets of organisational psychology, motivational theory, wellbeing theory and group/organisational dynamics. To a great degree, this thesis proves that psychodynamics of groups and institutions, although rather underrepresented in the relevant literature, provide useful insights into the complex psychosocial experience of the humanitarian helper. I apply the term "broader psychosocial" to describe the integrative approach of my thesis, since it does not exclusively rely on a sole psychological, psychoanalytic or psychotherapeutic school of thought.

Empirical Approach

In order to answer the research questions and to test the thesis hypothesis, I conducted empirical research with human subjects.

Eight humanitarian helpers (including workers and volunteers) were recruited and interviewed for this study, with rigorous consideration of ethical aspects. They

worked with refugees on a regular basis in various contexts and in various types of organisations. The qualitative data collection was based on in-depth *semi-structured interviews* with *open-ended* questions and on the AG. Following the interviews, each participant completed the AG twice, which provided me with more raw data. *Thematic Analysis* (Braun & Clarke, 2006) was applied for the analysis of the qualitative data.

The generated themes render numerous and diverse insights into the helpers' understanding of their reactions to adversities and their wellbeing. From the conceptual scope of this study, it can be alleged that the findings go beyond the realm of pathological responses or clinical phenomena and synthesise an innovative, holistic, cross-cutting, broader psychosocial perspective on humanitarian helper wellbeing.

Thesis Structure

This thesis is divided into eight chapters:

In **Chapter 1**, the relevant definitions of refugee, humanitarian and helper, which are repetitively used throughout this study, are laid out and discussed.

In **Chapter 2**, the background framework of this project is set out. This primarily comprises the innovative theories of Refugee Care (including the AG tool) and, secondarily, of principles of expanded Jungian theory, such as Archetypes and Individuation.

Chapter 3 provides a window into the various approaches and conceptualisations of the term "wellbeing" from a philosophical and psychological/psychotherapeutic viewpoint. In this chapter, I also explain why specific aspects of these, such as eudemonia, can be incorporated into the broader conceptual approach of this study.

In **Chapter 4**, I scrutinise the existing policies, guidelines and recommendations on humanitarian helper wellbeing, introduce relevant facets of

organisational/group dynamics (following the well-researched theories of the Tavistock Clinic in London, UK), and outline the most relevant motivations, stressors and sources of dissatisfaction. As in the previous chapter, I expound on why some concrete elements are integrated into the theoretical umbrella of this study.

In **Chapter 5**, I build upon the broad range of psychosocial outcomes for the humanitarian helpers in the aftermath of exposure to adversity regarding their direct work with people from refugee backgrounds. At the level of the helper, I distinguish between the negative/pathological (burnout, STS, CF, VT), the positive (vicarious post-traumatic growth [VPTG], vicarious resilience [VR], AAD), responses and consequences of adversities. Furthermore, I review and critically discuss the concept of PTSD for the refugee and expand the debate from this to the secondary/vicarious trauma of the humanitarian helper. Finally, I compare the different approaches to resilience and outline supportive and protective measures for the helper.

Chapter 6 begins with the main research questions and research objectives, and illustrates the empirical research of this project. Here I draw on the selected methodological approaches to data collection and data analysis. The use of semi-structured interviews, the application of the AG for the collection of a wide range of data and the different steps of Thematic Analysis for the generation of themes are illuminated. Essential ethical considerations within this research methodology are also addressed. Successively, in Chapter 6 I identify and elaborate on the three main themes and subthemes, i.e., the key findings, extracted from the Thematic Analysis.

In **Chapter 7**, the findings from the previous chapter are contrasted with the resource literature and connected to the leading conceptual approach of this study within a critical discussion. The assembling of the conceptual framework is analysed, and a new conceptualisation of helper wellbeing is laid out. Through the discussion of the findings, I endeavour to locate them in their wider context. Moreover, the findings

are being expanded within a psychodynamic and psychosocial context by being interpreted through a Jungian lens, which ascertains a more in-depth and holistic understanding of the helper's lived experience.

In **Chapter 8**, I answer the main research question and draw some general conclusions on humanitarian helper wellbeing as well as making concrete and applicable recommendations for organisations and the individual helper. Essentially, I conclude with topical contributions and main limitations regarding this study. Lastly, I raise emerging ideas that extend this research, which might be explored further.

Pronouns

Please note that in this study I use the pronouns *"s/he"* or *"they"* and *"his/her"* or *"their"* when I refer to a helper or humanitarian in a general way and the gender is unspecified.

Chapter 1: Relevant Definitions

1.1. Defining a Refugee

The term "*refugee*" appeared for the first time in Europe during the 17th century AD, when French Protestants (Huguenots) fled Catholic persecution, seeking shelter elsewhere, including Great Britain (Wennersten & Robbins, 2017).

A *refugee* is "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR, 2010). An *asylum seeker* is "someone who has left their country and is seeking protection from persecution and serious human rights violations in another country, but who hasn't yet been legally recognized as a refugee and is waiting to receive a decision on their asylum claim" (Amnesty International, 2021a). According to the UNHCR, "every year, around one million people seek asylum" (UNHCR, 2021). Besides this,

> At least 79.5 million people around the world have been forced to flee their homes. Among them are nearly 26 million refugees, around half of whom are under the age of 18. There are also millions of stateless people, who have been denied a nationality and lack access to basic rights such as education, health care, employment, and freedom of movement (UNHCR, 2021).

Until the late 1980s, being a refugee as a political state was not equated with "labour" or "economic" migrants and Western public opinion generally adopted a supportive stance towards refugees; however, since the 1990s, the profile of refugees and the issues surrounding them are, increasingly, not being clearly distinguished from those of migrants and, furthermore, people from refugee backgrounds constitute a considerable part of the immigrant population (Ingleby, 2005).

The International Organisation of Migration (IOM) defines *displaced* persons as:

> Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, either across an international border or within a State, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters. (IOM, 2018, p. 55)

The umbrella term “People on the Move”, according to the UN Educational, Scientific and Cultural Organisation (UNESCO) and The Hague Process on Refugees and Migration (THP) network, is used to encompass all relevant groups, including, *inter alia*, refugees, environmental migrants, internally displaced persons (IDPs), asylum seekers, stateless people, seasonal workers and undocumented migrants (UNESCO & THP, 2008). The definition of IDPs is:

> Person(s) or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border. (UN, as cited in UNESCO & THP, 2008, p. 11)

In general, from a legal or socio-political standpoint, the list of terms related to the refugee phenomenon is extensive (e.g., IOM, 2018; UNESCO & THP, 2008).

Papadopoulos (2021a) coined the term “involuntary dislocation”, which, compared to terms such as *forced migration*, *internal displacement* and *climate migration*, does not focus on the reason, the form or the consequences of the dislocation but addresses more accurately the lived human experience of the affected

persons and the fact that the impacted persons would have stayed and continued their lives at their homes if they had been able to choose. More specifically, Papadopoulos refers to two core, distinctive aspects of involuntary dislocation:

> (a) The experience that a person, a family, or a community develops of no longer feeling home as home; this is a specific type of dislocation, of a dislodgement from the experience of "feeling at home" within one's own home.
>
> (b) And then, the actual movement away (mainly physical and geographical but also psychological, cultural, etc.) from the spatial location that has lost the feeling of being home. (Papadopoulos, 2021a, p. 39)

The IOM argues that *forced migration* is, by definition, "a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion" (2018, p. 77) with the additional specification that:

> While not an international legal concept, this term has been used to describe the movements of refugees, displaced persons (including those displaced by disasters or development projects), and, in some instances, victims of trafficking. At the international level, the use of this term is debated because of the widespread recognition that a continuum of agency exists rather than a voluntary/forced dichotomy and that it might undermine the existing legal international protection regime. (IOM, 2018, p. 77)

Papadopoulos (2021a) points out that the term "forced migration" refers only to the process of the actual flight (i.e., the movement), somehow neglecting the lived process of no longer experiencing one's home as a viable, safe space to live in. The term "dislocation" is mostly related to the affected persons themselves and their human experience of the various dimensions of "home" (psychological, social, cultural, linguistic, religious, etc.), whereas "migration" constitutes the geographical movement from one place to another (Papadopoulos, 2021a, pp. 38–39).

Furthermore, although the terms “dislocation” and “displacement” may be synonymous, displacement is linked to *Freudian* psychoanalysis, which may lead to confusion if one applies this within a refugee context, whereas dislocation includes an additional somatic aspect (in medicine/orthopaedics) which, metaphorically, can be compared to the feeling of being dislodged from feeling at home (Papadopoulos, 2021a, pp. 41–42).

In conclusion, involuntary dislocation seems to be a more accurate, more inclusive and *psychosocially* more appropriate term to address the multi-faceted experience of refugees.

For the purposes of this study, unless specified otherwise, the terms “*refugee”*, “*involuntarily dislocated person”*, “*asylum seeker”*, “*displaced person”*, as well as the generic term “*people on the move*” are mostly used interchangeably, since this study is not concerned with the legal or political status of the affected persons who are clients or beneficiaries of humanitarians and human service providers.

1.2. Defining a Helper and a Humanitarian

In this study, I investigate the wellbeing of individuals who work directly with people from refugee backgrounds either within a humanitarian or in a human services context (or a combination of both). This work can be either paid or on a voluntary basis (or, again, a combination of both); for paid staff, it can be part- or full-time. These individuals are affiliated to one or more organisations that are involved in the field of *Refugee Care* (which is explained in Chapter 2).

In this study, I primarily use the very generic term “helper/s*”*, which sufficiently encompasses the above-mentioned definition.[1] For example, the term “helper” has been recently used by the IFRC (2020) and academic researchers (Dawson et al., 2015; Sijbrandi et al., 2016) to describe those who bolster adversity survivors. I will

[1] I decided to use the blanket term “helper” as opposed to “carer” (or “caregiver”), because the latter is often linked to services offered to the elderly and those with disabilities.

often use the term “humanitarian” (which is extensively discussed below), especially when I want to give emphasis to work in the humanitarian field. The terms “helper” and “humanitarian” or “humanitarian helper” are thus used interchangeably in this thesis. In some cases, I distinguish between (a) paid staff or *workers* (also “humanitarian workers”, “aid workers” or “humanitarian aid workers”) or *employees*; and (b) volunteers.

The UK National Council for Voluntary Organisations (NCVO) and others apprise that boundaries between paid and volunteer work are not always clear (e.g., Lindsays, 2023; NCVO, 2022). The main difference between an employee or worker and a volunteer is that the former has signed an employment *contract* with the employer, while the latter has a volunteer agreement (not necessarily in written form) with the organisation (Third Sector Protect, 2023). The lines between paid and unpaid work can become blurred if volunteers have to carry out tasks originally assigned to paid staff. This may also apply to employees who also have a volunteer role within the same organisation, and therefore, paid and unpaid roles should be accurately defined and distinguished from each other (NCVO, 2022). The correct wording when referring to volunteer work is “expectations” and not “duties”, “obligations” or “requirements”, since the latter implies that there could be negative consequences for volunteers if they do not meet the “requirements” (Lindsays, 2023). Finally, Third Sector Protect (2023) advocates that volunteers should be treated with respect by their organisations and should be offered training that is relevant to their defined and agreed roles.

Who is a Humanitarian?

There is no universally acknowledged definition of *humanitarian action* due to the continuous evolution of the term, its high complexity and the changes in insights according to the European Universities on Professionalization on Humanitarian

Action network (EUPRHA, 2013). Borton (2009) raises the problem of defining humanitarian systems by appropriately remarking that “a striking feature of the humanitarian system in 2009 was the continuing lack of clarity as to what the ‘humanitarian system’ actually consists of and where its boundaries lie” (Borton, 2009, p. 4). The Inter-Agency Standing Committee (IASC) defines humanitarian action as “assistance, protection, and advocacy in response to humanitarian needs resulting from natural hazards, armed conflict or other causes, or emergency response preparedness. It aims to save lives and reduce suffering in the short term, and in such a way as to preserve people’s dignity and open the way to recovery and durable solutions to displacement…” (IASC, 2015, pp. 8–9) with its key, universal principles being *neutrality*, *impartiality*, *humanity* and *independence*. Humanitarian action “should be motivated by the sole aim of helping other humans affected by disasters (humanity), exclusively based on people’s needs and without any further discrimination (impartiality), without favouring any side in a conflict or other dispute where aid is deployed (neutrality), and free from any economic, political, or military interests at stake (independence)” (EUPRHA, 2013, p. 8). The definition of a humanitarian, according to commonly accepted dictionaries, is very broad: “a person who works to make other people’s lives better” (Britannica Online Dictionary, 2022); “involved in or connected with improving people’s lives and reducing suffering” (Cambridge Online Dictionary, 2022); or a person “concerned with humanity as a whole” according to the Oxford English Dictionary (OED, 2024).

General examples of areas of humanitarian assistance include, *inter alia,* disaster relief, food security, shelter and protection for refugees, health and mental health/psychosocial support for impacted populations, education, children’s nutrition and human rights. Moyo-Stumptner (2016) argues that *development aid* should be distinguished from humanitarian aid, since this is offered for political purposes by

industrialised Western nations to developing countries during a long time period and under certain conditions, such as political stability, respect of human rights, as well as democratic processes. The number of non-governmental organisations (NGOs) with humanitarian focus has skyrocketed during recent decades (Barnett, 2005) and by 2011 there were an estimated 37,000 humanitarian NGOs (Moyo-Stumptner, 2016, p. 2).

Humanitarianism and *philanthropism* are two intertwined terms that share an interest in alleviating the suffering of *the other*. In a nutshell, the primary focus of philanthropism is the altruistic giving/contributing in a material way (donating), which, naturally, is not a presupposition for humanitarianism; on the other hand, humanitarianism has a more international and cosmopolitan character than philanthropism (Rozakou, 2020). Essentially, the line between philanthropism and humanitarianism is sometimes blurred (Rozakou, 2020, p. 157).

The history of humanitarianism essentially begins with the foundation of the *International Committee of* the *Red Cross* (ICRC) by the Swiss businessman and activist Henri Dunant (1828–1910) in Geneva, Switzerland in 1863.

The UNHCR, as a UN agency for the protection and aid of refugees, was created in 1950 in the aftermath of World War II. In 1971, in the aftermath of the *Biafran famine* in Nigeria, *Médecins Sans Frontières* (MSF) was established by former members of the Red Cross who questioned the policy of neutrality and tolerance, at that time in relation to state violence (Barnett, 2011). A rudimentary categorisation of humanitarian organisations includes: UN agencies (*inter alia* UNHCR, UNICEF, IOM, OCHA); the Red Cross/Crescent Movement (ICRC, IFRC, National Red Cross Societies); humanitarian NGOs that act on an international, national and/or local level (such as World Vision, MSF, Doctors of the World, Caritas, *Action Contre le Faim*, etc.); and other actors, such as private foundations,

philanthropists, local churches, local authorities, donors, diaspora organisations and national/international armed forces (EUPRHA, 2013; Moyo-Stumptner, 2016).

A plethora of humanitarian NGOs (e.g., Greek Refugee Council, Oxfam, Islamic Relief, INTERSOS, ACT Alliance) form the International Council of Voluntary Agencies (ICVA), based in Geneva, which represents them within the IASC.

In this respect, the intention behind Labbe's (2012, p. 7; see Figure 1.1) *Humanitarian Galaxy* is to present a compact, comprehensive and inclusive map of the humanitarian system.

Figure 1.1

Humanitarian Galaxy (Labbe, 2012, p. 7)

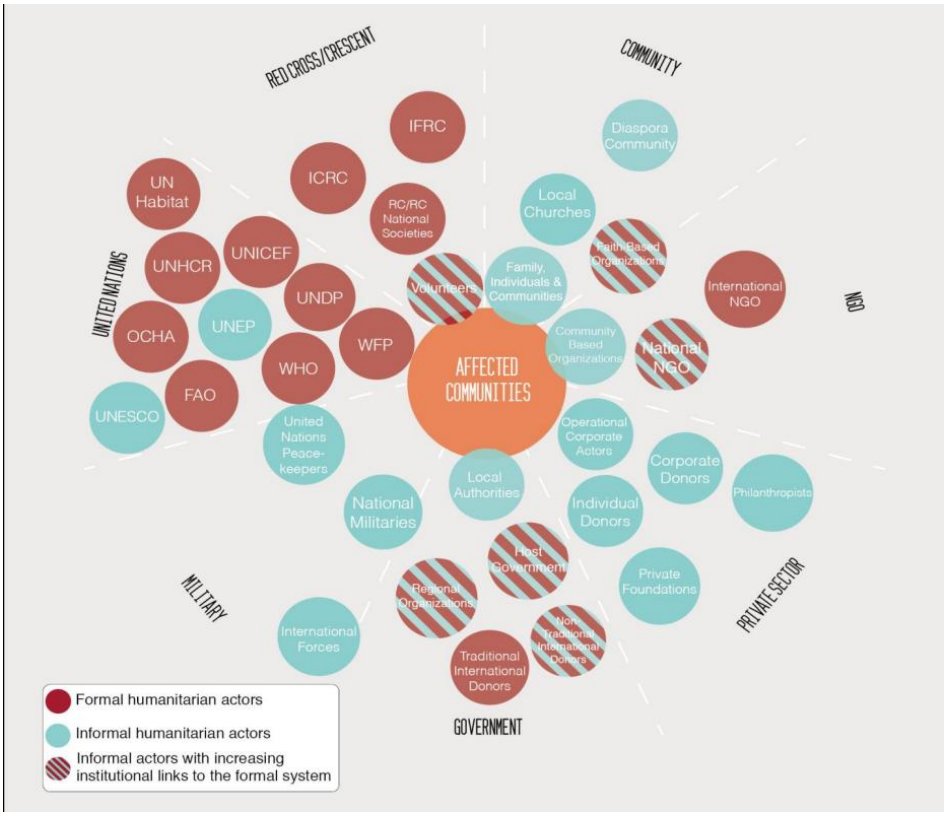


Figure 1.1 distinguishes between *formal* humanitarian actors (such as the ICRC and UNHCR), *informal* humanitarian actors (such as local churches and local authorities) and informal ones that are, though, connected to the formal humanitarian system (e.g., faith-based organisations). Figure 1.1 also identifies six main domains that provide humanitarian assistance and interact with each other: the United

Nations, the Red Cross/Red Crescent Movement, the private sector, national governments, the military and communities.

Further, humanitarian organisations can be divided into *operational* and *non-operational* or *generalist* (Natsios, 1997). Operational NGOs offer direct aid to affected persons in a specialised way, whereas non-operational NGOs financially support local or national NGOs so that they can deliver humanitarian aid (EUPRHA, 2013). To give an example, INTERSOS could be viewed as an operational NGO, while *ActionAid* could be regarded as a more generalist NGO. Moreover, one can distinguish between *faith-based* humanitarian organisations, for example, Action by Churches Together (ACT), Medair, Caritas, Malteser International, Swiss Church Aid (HEKS/EPER), Islamic Relief and secular humanitarian organisations, such as the Red Cross/Crescent Movement or Save the Children (Ferris, 2005). Historically, churches urged the creation of the UN, and faith-based NGOs promoted the establishment of ICVA (Ferris, 2005). Additionally, “many church-based humanitarian organizations have signed on to the NGO/Red Cross and Red Crescent Code of Conduct for Humanitarian Work” (Ferris, 2005, p. 319).

A main distinction between a humanitarian NGO and a humanitarian *charity* or *charitable organisation* is the fact that the latter has a registered charitable status, which is recognised by the government; this requires meeting specific criteria and operating under strict guidelines (Save The Children Australia, 2022). This charitable status is also relevant for the taxation of the organisation. Humanitarian charities and NGOs are non-profit organisations. Moreover, international NGOs (INGOs), such as the *ICRC, MSF* and *Doctors of the World*, should be distinguished from *international organisations or intergovernmental organisations* (IOs/IGOs) such as *UNHCR* and *IOM,* since the former act independently from governments. For the purposes of this

study, I will generally apply the term “NGO”, which is more inclusive and more generic.

Within the humanitarian world, a noteworthy debate is whether humanitarians and their organisations should exclusively focus on relief and aid while maintaining an impartial, neutral, non-political, *Dunantist* stance, or whether they should also promote human rights and democracy when people are affected by the repressive policies of authoritarian governments (Barnett, 2005; Ferris, 2005). Supporters of the former position argue that humanitarianism will be endangered if it becomes highly politicised, whereas followers of the latter view believe that by endorsement of democratic reforms and human rights, affected populations could be facilitated to fight against the root causes of their problems (Barnett, 2005). Furthermore, Barnett aptly notes that “relief was formerly an end in itself, but agencies are increasingly considering its relationship to other goals. For instance, rights-based agencies have demonstrated a greater willingness to exert relief in order to promote basic human rights” (Barnett, 2005, p. 732). Faith-based humanitarian NGOs frequently focus on both human rights or advocacy and relief, and, in general, human rights work and relief work often overlap in today’s humanitarianism (Ferris, 2005).

In 2016, there were over 800,000 humanitarian workers around the world on a national and international level (Stoddard et al., 2017, p. 3); of course, this number does not only refer to those humanitarians engaged in refugee care in any possible form. The number of volunteers in humanitarian organisations is far higher, for example, 13.7 million for the Red Cross Movement only (IFRC, 2019).

This study focuses on the impact that work with refugees has on individual helpers and their organisations. Individual helpers may be employed by these organisations or services, or they may be volunteers. These organisations or services may be explicitly humanitarian (but not necessarily), and they may operate at an

international, national, or even local level. One could argue that, in an expanded sense, the individual who helps refugees in any form or setting performs *humanitarian activity*, even if this person is not directly affiliated to a humanitarian NGO, since s/he contributes to the decrease of human suffering and the improvement of human life (considering also the above-mentioned, generic definitions of the term “humanitarian”). A humanitarian is not necessarily a professional one or a life rescuer, but rather a rescuer of “a possibility of humanity” (Radice, 2019, p. 13). Overall, this study does not aim to define who is a “real” humanitarian and who is not, and, in effect, does not distinguish between humanitarian and non-humanitarian participants. Since all participants perform humanitarian activity and are, in some way, affiliated with a humanitarian NGO or IO/IGO, I finally chose *Humanitarian Helper Wellbeing* as my thesis title, after careful contemplation.

Chapter Synopsis and Thesis Progression

This first chapter provided various reasonable considerations on defining the generic terms “refugee”, “helper” and “humanitarian”, which are relevant for the main course of this study. In this chapter, the approach followed in this thesis regarding these definitions was displayed and clarified; the distinction between paid staff and volunteers was taken into consideration and several differences in the essence of humanitarian actors/organisations were discerned. Also, I explained how the precise title of this project emerged.

In the next chapter, the main theoretical background directing this project will be set out and relevant terms will be outlined and appropriately examined.

Chapter 2: Theoretical Foundations

2.1. Refugee Care

As this project is a study of the wellbeing of those who directly engage in *Refugee Care* from a psychosocial angle, I will endeavour to tentatively define Refugee Care and to chart the domains that this involves. The theoretical background of this thesis relies on the conceptual framework introduced by R. K. Papadopoulos at the Centre of Trauma, Asylum and Refugees (CTAR) at the University of Essex, UK.

2.1.1. Defining Refugee Care

The term “Refugee Care” refers to the specific *academic discipline* at the University of Essex as well as to the extensive *professional (or voluntary) practice* (Papadopoulos, 2020b). The following three points summarise the main framework of Refugee Care:

- Refugee needs are multi-faceted, and thus, the appropriate approach to these needs should be multidisciplinary. “Multidisciplinarity is where two or more academic disciplines collaborate for a specific purpose” (Open University, 2023) and it “draws on knowledge from different disciplines but stays within their boundaries” (Choi & Pak, 2006, p. 351).
- Refugee Care has emerged as a *holistic* synthesis of diverse academic disciplines, such as human rights, philosophy, psychology and social sciences, and professional fields, such as humanitarian aid, legal assistance, psychotherapy, medicine and social work, among others (Papadopoulos, 2020b). A “Refugee Care approach” should consider all the above contexts while examining the refugee phenomenon.
- Refugee Care emphasises the *human experience* of involuntarily dislocated persons and their helpers and conceptualises this experience from a

> *psychosocial* perspective. It focuses on the *complexity*, *uniqueness* and *totality* of the individual who experienced being a refugee or who is exposed as a helper to the narratives and adverse material of the refugees (Papadopoulos, 2019a).

An essential component of Refugee Care is *therapeutic care of refugees* (Papadopoulos, 2002), which should not be confused with psychotherapy. Maintaining a *therapeutic* stance towards refugees ("being therapeutic") does not translate automatically into applying psychotherapeutic techniques that adhere to a concise psychotherapeutic school (Papadopoulos, 2016, p. 14). Consequently, the therapeutic dimension is not an exclusivity for psychotherapists but refers to anyone who supports refugees. Furthermore, traditional psychotherapy may be unavailable or unsuitable for most refugees, who do not have the possibility, motivation, or indicative symptomatology for a specialised form of psychotherapy. Therapeutic care as the application of blended psychotherapeutic ideas and theories outside of the circumscribed framework of a particular psychotherapeutic school of thought could be part of every facet in Refugee Care.

In addition, there are other approaches that are in line with Papadopoulos' framework on Refugee Care. Summerfield (2005) questions the role of traditional psychotherapy for asylum-seekers and advocates a more problem-focused approach. Meanwhile, Latin-American liberation psychology argues that psychology and psychotherapy should shift the focus from the conflicts of the inner world to the psychosocial needs of the disadvantaged (e.g., Burton & Kagan, 2005). Inspired to a certain extent by the theories of liberation psychology, counsellors at the Tavistock Centre in London combine psychotherapeutic ideas with psychosocial, community-based interventions and question the dominant mental health approach (Amias et al., 2014).

2.1.2. Defining "Psychosocial"

The Enhancing Vulnerable Asylum Seekers Protection (EVASP) manual informs that the term "*psychosocial*" was introduced in humanitarian aid "in order to bridge the gap between the social and psychological approaches" (EVASP, 2011, p. 30). A *psychosocial* perspective contains *three inter-related realms*: the *intra-psychic* (one's inner world), the *interpersonal* (interactions with other persons) and the *socio-political* realm (EVASP, 2011, p. 30). More concretely, with focus on Refugee Care:

> The psychosocial approach maintains that assessing needs of asylum seekers should take into consideration the interacting role of psychological and social factors and intervention methods must examine all these factors in total and provide solutions that can deal with more than one problem simultaneously, based on a team approach. In addition, the psychosocial approach examines the relationship between the service providers and the service users because it can influence the efficacy and outcome of the intervention method. In a nutshell, the psychosocial approach maintains that service providers must understand individual, emotional, spiritual, social, cultural, political, economic, familial factors that influence both wellbeing and reactions to adverse events in order to intervene effectively. The emphasis is on the totality of individual experiences rather than focussing solely on physical or psychological aspect of health and wellbeing. (EVASP, 2011, p. 30)

2.1.3. Refugee Care Principles

In this subsection, I will delineate key principles of the psychosocial Refugee Care framework, the aim of which is to capture the human experience of the beneficiaries as well as of helpers and service providers. These principles echo new trends and developments in this field of work and can function as tools for an improved, more profound, multidisciplinary understanding of the subject.

2.1.3.a. Complexity and Synergic Approach. “The first victim of adversity is complexity” (Papadopoulos, 2019a, p. 85). The intense, stressful feelings of pressure, powerlessness and overwhelmingness that helpers may experience in their work with refugees may lead to loss of *complexity* or maintain lack of *complexity* in all psychosocial dimensions (Papadopoulos, 2019a). Within the framework of Refugee Care, complexity means approaching a phenomenon from different angles while considering the wide range of variables that form this phenomenon, and not only the simplest or most obvious ones.

From a Refugee Care perspective and according to the framework of the AG (which will be explored in detail later in this chapter), variables may refer to contrasting qualities, different psychosocial realms and diachrony (Zucca, 2015, p. 32, 204). Loss of complexity may refer, according to setting and context, to the complexity of the refugee phenomenon generally, of refugees as individuals, of the helper’s own work and of the helper as an individual person. Inevitably, loss or lack of complexity results in oversimplification and polarisation of views and solutions, which focus on the vulnerability and the pathology of the clients, neglecting their totality as persons (Papadopoulos, 2020c).

As stated in the introduction, this thesis follows a non-clinical, psychosocial approach according to which not all stress, pain, distress or, in general, response to adversity automatically translates into psychopathology or PD. Thus, the medical/psychotraumatological model cannot sufficiently cover and approach all the psychosocial effects of adversities. In this regard, I agree with the following statement by Papadopoulos:

> In Refugee Care, the concept of complexity is applied to refugees as adversity survivors, but this is expanded to the staff and volunteers working with them who experience adversity either directly or vicariously. Helpers should accept

> that, in many cases, stress either for themselves or their clients is inevitable and there are no simple solutions (or even, sometimes there are no pragmatic solutions at all), but they should also be aware of their own and their clients' complexity, uniqueness and totality as individuals and work with them *synergically* to support their resilience and activation of new strengths and gains. (Papadopoulos, 2020c)

Etymologically, *synergia* could be translated into English as cooperation, collaboration, "working together". A synergic approach does not assume pathologies among refugees but focuses on the connection and the interaction between helper and refugee. In this respect, Papadopoulos proposes the term "*Synergic Therapeutic Complexity*":

> Complexity is a key ingredient of this therapeutic perspective that enables caregivers to connect synergically their own strengths with those of their beneficiaries. This is very different from approaches where caregivers, as experts, impose on their beneficiaries their own theories and their own plans of what they think is good for them. (Papadopoulos, 2022b, pp. 13–14)

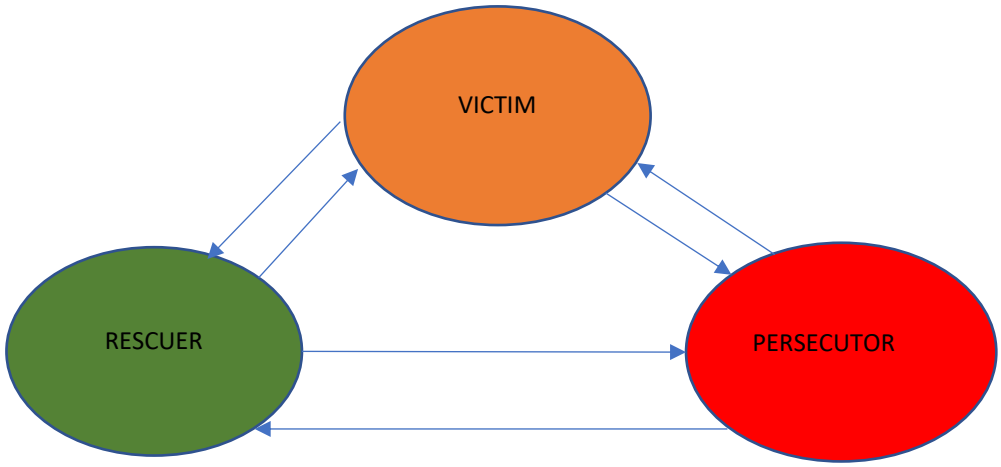
In conclusion, it can be assumed that by being aware of their own complexity, the complexity of the refugees as individuals and the complexity of the setting and the sociopolitical situation, and by identifying their own and their clients' strengths and working on these with constant feedback on a mutual basis, helpers following a synergic approach can possibly relativise their feelings of powerlessness, of being overwhelmed or emotionally charged.

2.1.3.b. Victim Triangle. A complex concept that can crucially affect and shape the synergic therapeutic complexity of humanitarian work with refugees is the *Victim or Drama Triangle*. The term "Victim Triangle" was coined by Karpman (1968)

and includes: (a) the *victim*, (b) the *persecutor* and (c) the *saviour/rescuer* (Figure 2.1). In this subsection, I will describe and discuss the concept of the Victim Triangle.

Figure 2.1

Victim Triangle



According to the Victim Triangle, the victim has been affected by a catastrophe and is, generally, perceived as a “vulnerable”, “innocent”, “helpless” person who needs to be saved, protected and “fostered”. A further, stereotypical view of victims is their *passivity;* hence, people have the propensity to dehumanise and consider them feckless beings (Papadopoulos, 2021a, p. 188). *Victim identity* refers to an enduring state beyond the context of *realistic victimisation*, that dominates every aspect of life of the beneficiary (Papadopoulos, 2021a, pp. 185–186). On the other hand, the *persecutor* is conventionally viewed as “active” and the term can refer to a person or collective entity who victimises and persecutes someone or a group of people directly or indirectly. Depending on the context, the victim in one case and under specific circumstances could be the persecutor in another case under different circumstances. Society and public opinion tend to identify persecutors in order to satisfy their need for the feeling of justice. The *saviour* should ideally support the victim of persecution only during the phase that the victim is vulnerable and urgently requires help, and should not prolong the provided assistance beyond the necessary

time even if the role of saviour offers many advantages and rewards, such as feelings of worthiness and self-fulfilment, social recognition, meaning making, forgetting one's own problems, etc. (Papadopoulos, 2019a).

From a Refugee Care perspective, vigilantly examining the interactions within the Victim Triangle (Figure 2.1) and their *archetypal* character, one could reach the following conclusions (Papadopoulos, 2021a, pp. 187–196):

- The central relationship in the Victim Triangle is the mutual, powerful bond between victim and saviour.
- This dominant bond offers advantages to both sides, victim and saviour.
- Essentially, this bond is sustained and empowered by the existence of the persecutor; therefore, a new persecutor needs to be discovered, if the influence of the previous one has declined.
- In order to maintain his/her role, the saviour can unceasingly emphasise the vulnerability of the victim and unearth endless vulnerable aspects, consequently further victimising the victim and reinforcing the establishment of a dependency and a *victim identity*.
- Because of the benefits from the rescuer's support, the victim may also want to perpetuate his/her role, which leads (in combination with the rescuer's tendencies as described above) to her or his further victimisation and, inevitably, to a chronic victim identity.
- As soon as the Victim Triangle starts to destabilise, the saviours can "become victims" of the increasing and unrealistic demands of the victims; in other words: in this context, the original saviour is the victim of the original victim, who is now the persecutor.

- The original saviour who cannot assist the increasing needs and demands of the victim anymore might now be viewed as a new persecutor by the victim that has adapted a victim identity.
- Regarding its actors, there is a *three-dimensionality* in the Victim Triangle. Any actor can potentially have the role of victim, persecutor or rescuer, depending on the context and circumstances.
- Due to the above, the Victim Triangle should only be active within the appropriate time and context that it is meaningful, functional and controllable, otherwise it can lead to the formation of victim identity.

Awareness of the Victim Triangle can be proved significant for the helper's understanding and response to his/her work with refugees and, consequently, his/her psychosocial wellbeing. The formation of a victim identity should be avoided, as this could not only have severe effects on the refugee but also on the helper.

2.1.3.c. Interactional Matrix of (Humanitarian) Intervention. The complex psychosocial state, in which involuntarily dislocated persons find themselves, is not caused exclusively by the catastrophic events they experienced, and which coerced them to abandon their homes, but constitutes a part of a "wider interactional matrix of reciprocal influences" (Papadopoulos, 2011, p. 1). This includes, apart from the refugees themselves, the wider network of organisations and individuals that offer their assistance to them as the executive part of the "international community", the helpers' families and social contacts, and the extended society with mass media communication, public opinion and all related narratives and debates, in other words, the bystanders and the wider "audience" of the drama triangle. These groups and actors interact with each other directly or indirectly in a reciprocal way and form the *Interactional Matrix of Intervention* (IMI) or *Interactional Matrix of Humanitarian Support* (Papadopoulos, 2011, 2021). For example, within the IMI, humanitarian staff

respond to the needs and expectations of adversity survivors, but also to the expectations of public opinion, which urges the international community to support adversity survivors. If the expectations for assistance and action from both sides (refugees, public opinion) are too elevated, this inevitably leads to a certain pressure, and eventually distress, for the humanitarian staff. From their side, refugees respond to the adversities they have been exposed to, to the reaction of the mass media and public opinion towards them, and to the humanitarian responses that (are expected to) support them.

The helper, inside or outside the humanitarian field, as a member of staff or as an individual, is a major actor in the IMI. If one places the helper in the centre of attention within the IMI, one could argue that helpers may experience the impact of:

- their work with refugees
- refugees as individual persons
- their organisation
- their work colleagues
- other related ones (e.g., family, partners, friends, etc.)
- wider society, mass media and communication, politics

Each of these different interactions described above as part of the IMI have a *psychosocial* impact on the helper. The term “psychosocial”, with its inclusiveness, as outlined in the previous subsection, allows us to grasp the complexity of the impact of these interactions and inter-relationships on helpers as well as helpers’ reactions to this impact on their totality as persons. For example, humanitarians in the field may feel stressed because they think that they cannot meet the expectations of the beneficiaries, the requirements of the organisation or the needs of their families at home. The impact of these multiple interactions does not always have to reflect the detrimental effects of the adverse situations in a negative or pathological or

overwhelming way, but it might as well be an ordinary or positive impact. In other words, the stress that helpers may be exposed to, their reactions to this stress and, in general, their wellbeing, are very dependent on these interactions and the psychosocial impact of these interactions on them.

Essentially, an aspect of the impact of the organisation on its staff has to do with the organisational policies on staff wellbeing. This aspect will be extensively discussed in Chapter 4 and will also be raised in Chapter 7 in light of the study findings.

2.1.3.d. Meaning Attribution Processes (MAPs). Indisputably, a refugee may have experienced some very adverse, painful and upsetting events before, during and/or after flight, as adversities do not necessarily cease to exist in the host or asylum country. Again, indubitably, the refugee helper may be exposed indirectly (vicariously) to these upsetting events through the stories of the refugee and/or through witnessing the refugee's current living conditions and difficulties. Here, the key aspect is that the experience of highly adverse and distressing events either first-hand (refugee) or second-hand (helper) does not correspondingly constitute *per se* PTSD/trauma-related disorder for the refugee or vicarious trauma (or burnout or CF) for the helper. Even though the very first responses to the adverse event can, inescapably, understandably and appropriately, be negative, intense and distressful, the most important facet is the "mediated" response to the event or "*lasting mark* or effect" of the adversity on the refugee (Papadopoulos, 2021a, p. 258). In this context, experience is viewed as the individual, complex (cognitive, emotional, behavioural) processing of a predominantly conscious event (or events) and a crucial part of this processing is the attribution of meaning to this event and to the initial reaction (Papadopoulos, 2021a). This *Meaning Attribution Process* (MAP) encompasses "all the conscious and non-conscious interactions of a wide network of factors that

contribute to the specific way one experiences and responds to adversity and to the initial reactions to adversity" (Papadopoulos, 2021a, p. 258).

MAP should not be simply viewed as the combined effect of several factors on the experiencing of an adverse event, but "rather as a series of interactive processes between (a) the external adverse realities and (b) the contributing factors that affect how these realities are perceived and processed, in the context of (c) the wider societal discourses about these phenomena" (Papadopoulos, 2021a, p. 259). This also means that IMI, as examined in the previous subsection, can contribute to some extent to the shaping of the MAP. From a helper's perspective, the above-mentioned theory on MAPs could be expanded and applied within the approach to vicarious experience and exposure to adversities.

2.1.3.e. Adversity Grid (AG) and Adversity-Activated Development (AAD). The AG, formerly known as *Trauma Grid*, facilitates an overview of the wide range of reactions and consequences to exposure to adversities that adversity survivors experience, including negative, positive and unchanged features in the aftermath of adversities (Papadopoulos, 2007, pp. 309–310). The AG sees to the different levels on which those reactions may take place (personal/individual, family, community, society), thus encompassing all the psychosocial dimensions (intrapsychic, intrapersonal and sociocultural realm) of the individual. It does not solely address the pathological dimensions of adversity and is not restricted to the reactions relevant to the phase of *catastrophic events* but echoes all stages of the refugee experience: *anticipation*, *catastrophic events*, *survival* and *adjustment* (Papadopoulos, 2002, pp. 26–27). The negative responses to adversities are divided into three groups: *ordinary human suffering* (OHS), *distressful psychological reactions* (DPR) and *PD* (Papadopoulos, 2007, pp. 305–306). The unchanged elements include resilience and positive as well as negative characteristics of a refugee's personality that remain

unchanged despite adversities. Positive responses, such as new gains, strengths and growth, refer to *AAD*; these are usually ignored in the dominant trauma discourse. Papadopoulos (2007, 2013) puts forward the concept of AAD as a more inclusive and non-pathologising term that describes the positive changes and growth due to exposure to adverse events or content. AAD can be relevant either to persons who have experienced adverse event(s) or to persons who are exposed to the adverse experiences of adversity survivors through their work with them.

The AG is not a psychometric test or an inventory or a quantifiable assessment tool. Instead, it is a framework that enables both workers and the survivors of catastrophes to differentiate between the wide range of responses to adversity, freeing them from a locked epistemological position that allows them to perceive only one type of effect. Also, it accepts the differentiation between distress and disorder (Papadopoulos, 2021a, p. 280).

The framework of the AG has been discussed and/or used on several occasions (Chondrou, 2019; EVASP, 2011; Gionakis et al., 2022; IOM, 2019; Jasperse, 2021; Kaisar et al., 2012). Although originally designed for the wider understanding and assessment of refugees' responses to adversities, the AG can be applied in different contexts and in numerous ways to address the multi-level impact of exposure to adversities (Papadopoulos, 2021a). The humanitarian worker or psychotherapist usually presents the AG to beneficiaries, administers this to them for thoughts and reflections, following which the beneficiary and worker discuss and complete the Grid together in one or, preferably, more sessions; this can be repeated over a certain time period (Papadopoulos, 2021a). The AG counteracts the overwhelmingness and helplessness of adversity and enables people to deal with their situation in a realistic and non-polarised way by becoming aware of their own resources and enrichment and, consequently, coming up with ways of using them

creatively. Moreover, even if not a clinical tool, the AG “can also be used for assessment or research purposes, in the context of any form of adversity” (Papadopoulos, 2021a, p. 284), for example, health practitioners during the COVID-19 pandemic, survivors of natural catastrophes or persons confronting chronic, severe physical problems. The AG does not adhere to a specific psychotherapeutic school or social theory, is not monopolised by a concrete social science or professional field, is simple, is practical because of its modifiability, does not require long and complex training and, subsequently, can be applied by various types of professionals. The AG could also be applied to groups.

2.2. Central Aspects of Jungian Theory

In the previous section, several innovative theories and ideas covered by the framework of Refugee Care were set out. These, and especially the concept of the AG, compose the overarching theoretical backbone of my research study. For its theoretical construction, this project is additionally based on elements of Jungian theory in an expanded and wider psychosocial, not necessarily clinical, way. C. G. Jung (1857–1961) developed a distinct, pioneering approach to the unconscious individual and collective processes of the human psyche. This depth psychological work encompassed the purposiveness of human experience and life. Both theoretical angles (Refugee Care and Jungian thought) with their epistemological openness and multi-layered psychosocial approach may lead to a more comprehensive understanding of several aspects of the humanitarian helper experience. Next, a summary of relevant principles of Jungian theory is laid out.

2.2.1. Wellbeing and Happiness Through the Lens of Jungian Psychology

In this subsection, I intend to approach wellbeing from a Jungian perspective. It should be noted that in his extensive work, Jung did not provide a complete definition of wellbeing. Nonetheless, I suggest that Jungian theory with its views on

the unconscious and human nature can enhance one's understanding of wellbeing as well as enrich the existing dominant wellbeing theories, which will be presented in the next chapter. In that respect, based on Jung's several germane quotations, I will lay out his multi-dimensional approach to wellbeing and to the individual experience of adversities in life.

In Jungian psychology, illness, healing and life, in general, have a *purposive, teleological* character that empowers enrichment of one's personality and self-actualisation. In his view, Jung addresses that "the end of every process is its goal" (2014, p. 3362) and that "all psychological phenomena have some such sense of purpose inherent in them" (2014, p. 3197). The term "*telos*" originates from Aristotelian philosophy and can be translated into "final cause" or "goal" (e.g., Leunissen, 2021). He also employs the term "*finality*" in order to better describe this sense of purpose (Jung, 2014, p. 3197). From this teleological standpoint, Jung does not pathologise human suffering ("Suffering is not an illness; it is the normal counterpole to happiness" [Jung, 2014, p. 7361]) and the calamities that cause this pain, but he argues that the purpose of dealing with adversities and difficulties in life lies in individual personal growth. In this sense, he holds a view that expands beyond the medical model and approaches these predicaments in a more holistic way.

Personal growth and enlargement and unfolding of the personality within the process of *individuation* (which will be explored in detail later in this chapter) foster the individual's contribution to the collective or societal wellbeing. On this basis, he comments that "individuation is an at-one-ment with oneself and at the same time with humanity, since oneself is a part of humanity. Once the individual is thus secured in himself, there is some guarantee that the organised accumulation of individuals in the State – even in one wielding greater authority – will result in the formation no longer of an anonymous mass but of a conscious community" (Jung,

2014, p. 7391). From the scope of individuation, a further unique aspect of Jung's approach to the human psyche is his focus on the *archetypal-mythical, symbolic* and *spiritual* dimensions that transform and regenerate humane existence; the term "archetype" will be analysed later in the present chapter. These qualities contribute to the accomplishment of the great goal of the individual's true identity and nature which, in Jung's mind, lies beyond illness and adversities and beyond one's successful identification with social roles and social expectations. After all, "individuation is indispensable for certain people, not only as a therapeutic necessity, but as a high ideal, an idea of the best we can do. Nor should I omit to remark that it is at the same time the primitive Christian ideal of the Kingdom of Heaven which 'is within you'" (Jung, 2014, p. 2870). Based on the above, one can extract the conclusion that, for Jung, individuation is the "highest good/goal", not health or happiness.

Furthermore, Jung believes that the human psyche retains a *self-regulating*, compensatory function, which balances purposively any utmost one-sidedness of the conscious attitude and disharmony between the conscious and the unconscious (e.g., Jung, 2014, p. 2359). Essentially, from this perspective, it could also be argued that happiness can also be too one-sided or excessive (e.g., Jung, 2014, pp. 989, 2838).

As I explained earlier, throughout his vast work, Jung did not endeavour to explicitly discuss or define the term "wellbeing". Admittedly, Jung developed his theories approximately 100 years ago and an examination of further, modern prospects of wellbeing is, therefore, requisite (see Chapter 3 of this thesis). Nevertheless, as these quotations above convey, there are core aspects of his unique theory and worldview that could set the foundations of a conceptualisation for wellbeing within a wider, not exclusively medical, psychosocial context. The following

subsections elaborate on more concrete concepts of Jungian psychology that could further corroborate a psychosocial and depth psychological approach for understanding lived human experience and wellbeing.

2.2.2. Archetypal Dimension

Two fundamental, intertwined elements of analytical (or Jungian) psychology are the *collective unconscious* and *archetypes*. I expect that these aspects can be helpful for shaping a wider psychosocial approach to the wellbeing of helpers of refugees. However, I should note that a profound, comprehensive analysis of these two concepts here is obviously not possible considering the main subject and the length of this thesis. On the whole, this thesis follows Papadopoulos' approach to the Jungian model of archetypes.

The collective unconscious could be understood as collectively *shared collective structures* among groups or populations (or, initially, families Jung worked with) or, more precisely, *collective structures of meaning* (CSM) of the human species with the meaning being rather inherent and potential, i.e., not direct (Papadopoulos, 1996, 2006). Based on these CSM, members of groups "structure their perceptions, knowledge, relationships and overall psychological realities" and CSM "contribute to one's creation of sense and the formation of knowledge" (Papadopoulos, 2006, p. 27–28). Generally, the collective unconscious could be described as the fundamental, very primary layer or *prima materia* of the totality of the human psyche. Arguably, the existence of shared, unconscious CSM could be of certain relevance and importance for the relationship between a helper and a beneficiary within a synergic, therapeutic approach or between two helpers.

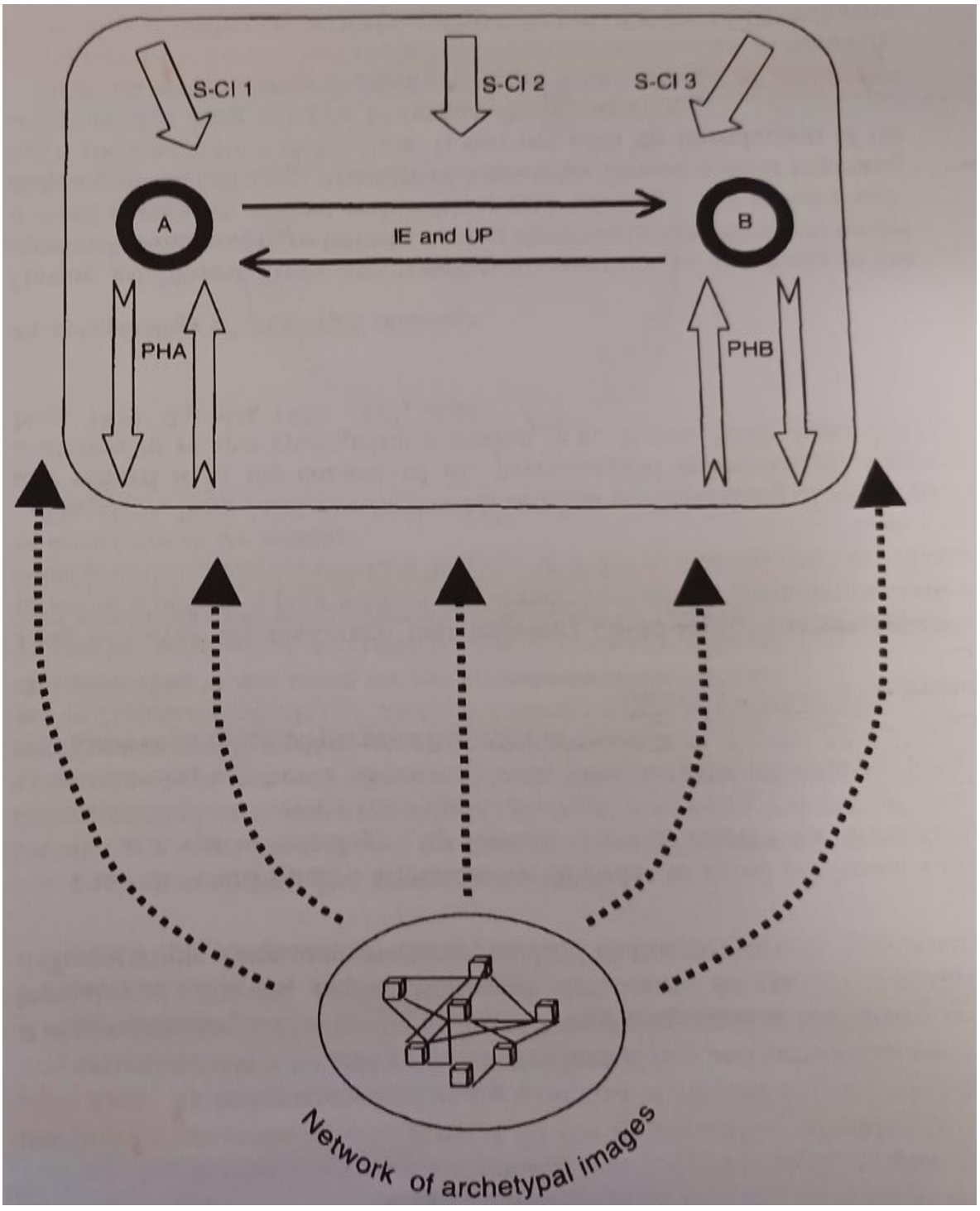
Archetypes constitute a bridge between the personal conscious and shared collective structures, and echo Jung's teleological approach (Papadopoulos, 2006). There is no exact, strict definition of the term "archetype". Additionally, the archetypal

influence in the persons' relationships and interactions with their past, others and society reflects "something much bigger" (Bateson, 1972, p. 468) than the individual person, and Jung was aware of this. Archetypes can be experienced indirectly through images (Jung, 2014, p. 3187), indicate patterns of behaviour and relationships, have a "universal appeal and power despite variations" and encompass "key ingredients of central and typical situations of human nature and life" (Papadopoulos, 2020d, p. 38), constitute archaic forms of *protoexperiences* that are out of the realm of personal consciousness (Papadopoulos, 2019b, p. 103), are characterised by bipolarity (Samuels, 1985), and their manifestation is experienced as numinosity and with fascination.

Papadopoulos (1996, 2006, 2020d) suggests that archetypes or archetypal images (e.g., in Refugee Care polarised motifs such as victim/persecutor or homeness/homelessness) are organised in clusters (*Networks of Archetypal Images*), which means that the activation of one archetype triggers further archetypes of the cluster since they are interconnected. The role of the other triggered archetypes can be of either compensatory or complementary function to the initial constellation. The activation of archetypal networks has an impact not only on individuals but also on their interactions with (a) other individuals, i.e., within a wider socio-cultural and socio-political context and (b) with their own history, which enables a "reframing" of one's past (Papadopoulos, 2006). Papadopoulos (2019) explains the effect of the networks of archetypal images on the relationships between refugees and helpers in the humanitarian field, which is based on the scheme illustrated in Figure 2.2 (below).

Figure 2.2

Network of Archetypal Images (Papadopoulos, 2006, p. 33)



Note: A: person A, e.g., a helper. B: person B, e.g., a beneficiary.
PHA: personal history of person A. PHB: personal history of person B.
IE: interpersonal exchanges. UP: unconscious mutual projections.
S-CI: social-cultural influences.

Looking at Figure 2.2, it is suggested that the contact and (therapeutic) relationship between A (helper) and B (beneficiary or refugee) are summarised within the rectangular box. In this box, one can trace conscious as well as partially unconscious factors, such as personal history, socio-cultural influences and mutual projections. However, in reality, following a Jungian approach, the exchanges and connection between A and B are influenced by the network of archetypal images (located out of the realm of personal consciousness), which may activate a cluster of archetypes, depending on the context.

2.2.2.a. The Wounded Healer Archetype. I will now proceed to a specific archetypal motif, the *Wounded Healer*. From a psychosocial perspective, I suggest that this can be topical for humanitarian helpers with regard to their work. From a Jungian viewpoint, the Wounded Healer originally refers to a psychotherapist or physician, but my intention is to expand this generally to helpers of refugees and humanitarians as highly helping professions. The Wounded Healer describes "healers" (mainly clinical psychotherapists) who have experienced mental illness or severe adversity in their personal lives and, having acknowledged their own "wounds", are open and empathetic to the problems of clients and can enable them to activate their own "inner healer" (Hofmann & Roesler, 2010; Kirmayer, 2003).

I will intentionally avoid the psychoanalytic methodical terms *transference/countertransference*, since some of the study participants are neither psychoanalysts nor psychotherapists and, therefore, there is not always a psychoanalytic/psychotherapeutic setting. On the other hand, I generally use the less technical and less specific term *projection.* In brief, according to the American Psychological Association (APA), projection is an archaic psychodynamic process "by which one attributes one's own individual positive or negative characteristics, affects and impulses to another person or group" (APA Dictionary of Psychology,

2023). Meanwhile, transference and countertransference are considered essential tools of a psychoanalytic/psychotherapeutic relationship and were introduced by Freud (Prasko et al., 2022, p. 2129). Regarding transference, clients project onto the therapist intrapsychic material, such as emotions, beliefs and thoughts, which derive from their experiences with significant individuals, especially from their childhood, such as their mother and father (Gutheil & Gabbard, 1998). Prasko et al. (2022) add that:

> Transference supposes that internal representations of important persons are in memory and could be activated by related signals in any context. Once the transference is activated, the individual looks at the other person through the glasses of the earlier representations of important persons. (p. 2130)

Conversely, the term "countertransference" describes the phenomenon of the psychotherapist reacting to the patient's transference driven by emotions, beliefs and assumptions, which are based on their personal history (the term "countertransference" will be encountered later in the literature review of this thesis, specifically when referring to psychotherapists who work with refugees).

Originally, the Wounded Healer descends from the Ancient Greek myth of the Centaur *Chiron* (or *Cheiron*) who was skilled in medicine but who also suffered from an eternal (as he was immortal), non-healing wound. Chiron is regarded as the archetypal Wounded Healer. Inspired by this myth, Jung introduced the idea of the Wounded Healer in psychology (Hofmann & Roessler, 2010, p. 2).

Generally, it is suggested that choosing a helping profession, such as psychotherapy, is linked with unresolved childhood conflicts (Roberts, 2019, p. 127), struggles and suffering due to unmet needs and existential dilemmas (Gaist, 2010). Gaining some insight into one's own motives and motivations for choosing the profession of psychotherapy is helpful and eye-opening for a person's work with

clients, self-care and self-awareness (Guggenbühl-Craig, 1999; Page, 1999). Moreover, becoming a psychotherapist or psychoanalyst is considered the result of a "calling", vocation (Hollis, 2001), "fateful disposition" (Jung, 2014, p. 7460) or of what feels "right" and "true" to someone (Hollis, 2001). With a visibly teleological intention, Whitmont (2007) states:

> What we suffered as children or adults as the result of disturbed relationships with parents and other close associates may be seen not just as accident or misfortune but as a destined emotional impasse essential for the actualization of our own particular pattern of wholeness. (p. 26)

Moreover, Hollis (2001) stresses that following this sense of truth, rightness and fate, and training and working in the demanding profession of psychotherapy encompasses the idea of *self-sacrifice* for the "good of the world". Exploring Jung's thoughts on fate, self-actualisation and vocation, Gaist (2010, p. 316) aptly adds that "if a man has a sense of vocation, then 'there is no escape, he must obey'. It is what sets a 'chosen' man apart from others".

Discussing and being confronted with the patient's issues activates unconscious material of the psychiatrist, analyst or psychotherapist, which is a "prerequisite to therapy having a positive outcome" (Gaist, 2010, p. 367). According to Jung (2014):

> It is no loss, either, if he [the analyst] feels that the patient is hitting him, or even scoring on him: it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician. (p. 7399)

On this matter, Samuels notes that the concept of "Wounded Healer" is not only about hurt or "damaged" therapists who chose to follow this vocation due to their "invisible" wounds but rather "implies that the therapist must be wounded, recognise

that, and do something constructive stemming from those wounds in relation to the client" (Samuels, 2006, p. 188). As previously stated in this chapter, archetypes, such as that of the Wounded Healer, are characterised by bipolarity; thereupon, in a therapeutic setting, the therapist projects the "damaged" pole ("the woundedness") onto the patient, and the patient projects the "healthy" pole ("inner healer") onto the therapist (Gaist, 2010; Samuels, 1985). Consequently, due to this dynamic, there is the potential for transformation for both therapist and client: The therapist treats an "amalgam" of the client and themselves (Samuels, 1985, p. 333), while, at some point during the therapeutic process, clients can find themselves in the position to recognise and connect with their inner healthy and healer parts.

From the perspective of analytic technique, Groesbeck stresses "the reliving or re-experiencing in small doses of emotionally traumatic experiences whereby psychic integration or healing could take place, and 'blocks in development' could be removed" (Groesbeck, 1975, p. 123). Within the therapeutic relationship and considering the aspect of the Wounded Healer, the above applies not only for the patient but also for the therapist, it changes both, and affects the individuation process of both (Gaist, 2010). In other words, "the therapist comes to see his clients' sufferings as his own, and realises these clients are there also for the purpose of teaching him/her" (Gaist, 2010, p. 385).

Inevitably, and without ignoring the positive effect on therapy of the Wounded Healer archetype, it is inextricably linked to potential risks for the therapist and the therapeutic relationship, including neurosis or trauma "contagion" transmitted from the client to the therapist that could potentially increase the therapist's neuroticism or trigger the therapist's past unprocessed traumas (Gaist, 2010).

In this respect, Groesbeck (1975) reflects:

> The question of how deeply involved the analyst should become in taking upon himself the illness of the patient does not admit of an easy answer. While he must get close enough to be involved, activated and aware of his own wounds to catalyse the process … he must also be aware of the dangers of inflation as well as his limitations, including the possibility of his own death and demise. It is precisely the archetypal image of the wounded healer that can most help him here. (p. 134)

Moreover, self-reflection of the therapist is crucial so that an "inflated" and harmful identification with the "healer" pole with detrimental effects on the therapist (e.g., burnout or mood disorder) and the therapeutic relationship (e.g., victimisation of the client) can be prevented (Sharp, 1991). In this respect, it is suggested that, in the context of the consulting room, self-monitoring and self-reflective, non-neutral abstinence can play a key role for the protection and self-care of psychoanalysts who work with clients that may suffer from trauma-related disorders or have experienced severe adversities, such as refugees (Fischer & Riedesser, 2019, as cited in Horn, 2020, p. 39).

2.2.2.b. Shadow and Victim Triangle. A further relevant archetypal theme that I should delineate is the Jungian concept of the *Shadow*. Inevitably, an extensive analysis of the Shadow is beyond the scope of this thesis**.** In his work, Jung did not deliver an accurate definition of the concept of Shadow (Casement, 2006). Succinctly, the personal Shadow consists of material that is unacceptable, incompatible and repulsive to a person, therefore it is repressed (Casement, 2006). Shadow elements are not exclusively negative, they can also include latent potentialities for growth (Samuels, 1985). One's personal Shadow is commonly linked to personal history and relationships with family members and can become partially conscious through one's projections onto others. Casement asserts that "the

individual who lives through projection is convinced that it is others who have all the bad qualities and who practice all the vices. Therefore, it is they who are wrong, and they who must be fought against" (Casement, 2006, p. 99). Becoming aware of one's own personal Shadow and integrating it is vital for the individuation process or self-realisation in analytical psychology. On a more collective level, human destructiveness, political violence and atrocities are linked with the collective projection and expression of Shadow aspects, but they cannot be solely reduced to a psychological explanation without discerning the complexities of each context (Papadopoulos, 1998).

With attention to the above, I propose that connecting the Shadow to the concept of Victim Triangle (which was presented earlier as a core Refugee Care concept) could enrich one's understanding regarding the interactions within the Victim Triangle. More specifically, from a psychodynamic viewpoint, it could be assumed that the *projected* material from the client's personal Shadow onto the helper and vice versa is critical for the positioning in the three roles of the Victim Triangle (victim, perpetrator, saviour). For example, if a helper constantly feels irritated by the attitude or behaviour of a specific client, one could hypothesise that there might be some projected Shadow aspects of the helper onto the client, of which the helper is not entirely aware. In this example, this contributes to placing the refugee/client in the position of the "perpetrator", from the scope of the helper. In this respect, it could prove problematic or detrimental to the work with clients if helpers project their Shadow material onto the client and "fight" against the client instead of gaining some consciousness of their own intrapsychic, partially concealed aspects. Based on the above, I suggest that the personal Shadow of the helper as well as that of the client with the inevitably related projections could have a considerable effect in the therapeutic care of refugees.

2.2.3. Individuation Process

The idea of *individuation* (or the individuation process or process of individuation), a central element in Jungian thought, was briefly delineated earlier in this section. Individuation can be understood as the potential of a person for wholeness and development (Stein, 2006), which can be bolstered by undergoing psychoanalysis (Samuels, 1985; Stein, 2006). Individuation not only includes "cognitive development, behavioural adjustment, moral attainment" and "the presence or absence of psychopathological features" (Stein, 2006, p. 198) but also goes further than this, constituting a process of becoming who one has the innate potential to be (Stein, 2006). Jung maintains that the urge for individuation is an instinct, a natural law (Jung, 2014, p. 3678). Individuation as a process is, *inter alia,* integrative regarding elements of the unconscious (Jung, 2014, pp. 2509–2510), potentially transformative and renewing even after adversities in one's life. In addition, individuation through its archetypal dimension and symbols encompasses the element of transcendence (e.g., Jung, 2014, p. 3797). Furthermore, individuation holds for every individual and can also be accomplished without psychoanalysis (Samuels, 1985). The social context and collective aspects in the life of the individual may play a pivotal role in their process of individuation (Horn, 2020).

Stein (2006) suggests that individuation can be divided into three stages: nurturance, adjusting and integrating. By the end of the second stage, one is expected to be a self-sufficient, functioning member of society, while during the integrating stage one becomes "a centred and whole individual who is related to the transcendent as well as the immediate concrete realities of human existence" (Stein, 2006, p. 209). From a depth-psychological perspective, the latter is linked to the individual's second half of life and this stage of individuation most likely corresponds

to the majority of participants in this study (and, purportedly, to many other humanitarians and helpers of refugees).

As mentioned earlier, Jung claims that “individuation is at-one-ment with oneself and at the same time with humanity” (2014, p. 7391). In this regard, I concur with Jungian Colacicchi’s suggestions that “individuation appears to be the ethical and healthy tertium between mass-mindedness and individualism: ethical and healthy because it allows both individuals and the society in which they live in to flourish” and that “not only is the individuated subject capable of a better social performance: for Jung, he or she must produce something in favour of society” (Colacicchi, 2021, p. 52). The latter is reminiscent of Erikson’s (1966) psychosocial stage of generativity in his theory on psychosocial life stages, i.e., the stage of one’s contributing to the community and personal involvement in charitable organisations. Furthermore, Hillman (1997) underlines that individuation entails “giving something back” to society. I subtly suggest that Colacicchi’s and Hillman’s remarks on individuation might very well apply for humanitarian helpers: they are neither “mass-minded”, nor individualistic persons and they positively offer their services to humanity and the society/community.

Obviously, an exhaustive examination of the theory on individuation is not feasible within the context of this thesis. Nevertheless, as I have shown above, it is a complex idea that seems to provide valuable, unique insights into comprehending the human life cycle, flourishing and wellbeing. Although individuation as a process essentially puts emphasis on the individual, it is not constricted by this, but it also draws on social/societal content. Summing up, individuation as a concept may possibly improve a broader psychosocial approach to humanitarian helper wellbeing.

Chapter Synopsis and Thesis Progression

In this chapter, I outlined the underlying theoretical background of this project, namely Refugee Care, with the epistemological tool of the AG and core aspects of Jungian theory, such as the individuation process and archetypes. Besides this, I explained and highlighted their overall relevance and weight for the theme of this project, i.e., constructing a broader psychosocial approach regarding the experience and wellbeing of helpers. Nonetheless, guided by an epistemological openness (Papadopoulos, 2006, p. 43), in this thesis I endeavour to integrate further relevant aspects/views into its conceptual approach, which harmonise with the main theoretical background as laid out in this chapter.

Some elements to be further incorporated into the conceptual psychosocial approach of this thesis can be found in the next chapter, which is dedicated to wellbeing. The idea of wellbeing from a multidisciplinary, psychosocial perspective is central to the essence of this project. Thereupon, historical developments and recent advancements in wellbeing research will be laid out and elaborated from the scope of the main theoretical framework, which was set out in this chapter. Later in this thesis, the blended conceptual approach should deepen the understanding and provide additional, valuable insights into the empirical evidence.

Chapter 3: Wellbeing

3.1. State of the Art – Conceptualisations of Wellbeing

3.1.1. Introduction to Wellbeing

According to the US Centres of Disease Control and Prevention (CDC, 2018), there is no accurate, universal definition of wellbeing, and it encompasses various areas of people's lives. The CDC (2018) draws attention to the significance of good living conditions and the connection of wellbeing to public health. The World Health Organisation (WHO; 1997) looks at *wellbeing* as a multidimensional topic by defining quality of life as:

> An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment. (p. 1)

The OED (2024) defines wellbeing as "the state of being healthy, happy, or prosperous; physical, psychological, or moral welfare". Meanwhile, the Merriam-Webster Online Dictionary (2022) proposes as synonyms of wellbeing the words *welfare* and *weal* and as antonym the word *ill-being*. As a concept, wellbeing is more encompassing and more abstract than *welfare*, which is greatly used to describe governmental policies that ensure citizens' wellbeing (*welfare state*; Heins & Deeming, 2015; Kalseth et al., 2022). Furthermore, in comparing wellbeing and *wellness*, Holdsworth (2019, p. 4) suggests that wellness echoes "a state of being in good physical, mental and social health – living well", which is "more than just the absence of sickness", whereas wellbeing is more related to "self-actualization" and "self-fulfilment".

Generally, wellbeing is a complex, multi-faceted construct difficult to define and measure and there has been a growing research interest in this field (Dodge et al., 2012; Fisher, 2014; Pollard & Lee, 2003; Ryff & Keyes, 1995). Tesar & Peters (2020, p. 923) fittingly note that “the idea of wellbeing seems to be part of the zeitgeist. From multiple research projects to organisations and individuals offering the promise of a good life and fulfilling life and positive outcomes”.

In the following sections, I intend to present a multidimensional, comprehensive approach to wellbeing that does not reduce this, as a concept, to happiness or to absence of pathology:

- First, I will critically discuss the main, general debates on the meaning and substance of wellbeing, which are relevant to the essence of this study.
- Second, I will summarise facets and ideas of Ancient Greek philosophy regarding wellbeing and examine their relevance to my study.
- Third, I will refer to various conceptualisations of wellbeing within the broader field of psychology.
- Then, I will discuss how these various, to some extent contrasting but also complementary approaches, relate to the theoretical framework of this thesis.
- Finally, I will highlight aspects of the more specific concept of workplace wellbeing that may provide useful insights into the wellbeing of the humanitarian helper.

3.1.2. Debating the Essence of Wellbeing

According to Ransome (2010, p. 45), “feelings of pleasure and happiness, and the possession of bodily health and other desirable goods” are “popularly identified with wellbeing”. Currently, there are many terms that are used interchangeably (at both colloquial and academic levels) in relation to wellbeing, such as positive mental health, good psychical and mental health, good quality of life, life satisfaction,

happiness, emotional wellness, and positive emotions (APA Dictionary of Psychology, 2022; Bundesamt für Statistik, 2021; Carlisle & Hanlon, 2007; CDC, 2018; Davis, 2019; National Health Service, 2019; OED, 2024). Carlisle and Hanlon (2007) point out that wellbeing, as a popular subject in today's consumerist culture, is generally equated with happiness and that it is a "fashionable" topic for public consumption in the agendas of the mass media and politicians. Meanwhile, Sointu (2005, p. 260) aptly states that "during the late 1980s, wellbeing had come to be conceptualised in relation to pleasant passing of time, involving activities that are pursued for comfort and happiness" while today, the term "wellbeing" is popularly wedded to self-oriented, consumerist practices that focus on beauty, fitness, care of the body and the self.

Interestingly, the extreme valuing or pursuing of happiness and the social pressure not to feel negative emotions may be linked with reduced wellbeing and depression (Dejonckheere et al., 2017; Ford et al., 2014; Ford et al., 2015). Ford et al. (2014, p. 2) describe happiness as "a positive affective state", which should be differentiated from wellbeing and psychological health. Happiness, in general, is beneficial, but, depending on the cultural context, it may also have a negative effect on wellbeing if too much emphasis is given to the personal and hedonic experience of happiness over social harmony, or if happiness leads to a state of *hubristic pride* (Gruber et al., 2011). It is claimed that the importance of cultural factors in relation to wellbeing, such as traditional values and religion as a source of meaning-making, is neglected due to today's dominance of materialistic values (Carlisle & Hanlon, 2007; Eckersley, 2006).

Furthermore, a central debate concerned with modernity is whether the improvements in healthcare and financial development have actually led to a definite increase in psychological wellbeing in contemporary Western societies, which are

characterised by materialism and individualism (Carlisle & Hanlon, 2007; Easterbrook, 2004, as cited in Carlisle & Hanlon, 2007; Eckersley, R., 2006). In his epidemiological research, Eckersley (2006, p. 254) acknowledges that "an important means by which individualism and materialism affect wellbeing is through their influence on values" and that "modern Western culture undermines, even reverses, universal values and time-tested wisdom", as it promotes a materialistic lifestyle that does not correspond to psychological needs and social values and ideals. Additionally, he argues that cultural factors are connected through "psychosocial pathways" to psychological wellbeing, which leads through "behavioural and physiological pathways" to physical health.

Hedonic v. Eudemonic Approach

Taking into account the above-mentioned disagreement over the precise use of the term "wellbeing", one could argue that today emphasis is rather placed on its *hedonic* dimension (Papadopoulos, 2021a, p. 3), which traces its roots to the *hedonism* of Ancient Greek philosophy (Epicureans) and considers pleasure, or, alternatively, avoidance of displeasure, as the central motivation in life (Crisp, 2006; Moore, 2019). Hedonic wellbeing encompasses happiness, pleasure, positive emotions, avoidance of pain and suffering and absence of negative emotions over one's lifespan (Diener, 1984; Fisher, 2014; Ryan & Deci, 2001). Within a psychosocial and Refugee Care perspective, Papadopoulos (2021a, p. 3; 2020) suggests that a comprehensive approach to wellbeing should include the distinction between hedonism and the Aristotelian concept of *eudemonia* and wellbeing should not merely be reduced to its hedonic dimension. In this sense, Werdel and Wicks (2012, p. 11) highlight that to capture the in-depth experience of enduring trauma and adversities as well as the gains deriving from this, one should expand their conceptualisation of wellbeing from the hedonic to the eudemonic approach.

Eudemonic wellbeing or, more accurately, *eudemonia* (or eudaimonia) was first discussed by Aristotle (384–322 BC) in his work *Nicomachean Ethics*, in which he defined it as intellectual contemplation, combined with ethical virtue (Charles, 1999). Eudemonic wellbeing focuses on themes such as personal growth, transformation, functioning at an optimal level, self-actualisation or realising one's true nature, fulfilling one's potential, meaning making and purpose in life (Lent, 2004; Martela & Sheldon, 2019; Ryan & Deci, 2001; Ryff, 1989; Waterman, 2008). It could be said that eudemonic wellbeing is a long-term journey to self-actualisation (Byers, 2020). When compared to hedonic wellbeing, Cooke et al. (2016, p. 732) argue that "in contrast to the focus on affect and life satisfaction in the hedonic models, eudemonic models tend to focus on a larger number of life domains, although they vary significantly regarding the fundamental elements that determine well-being".

In this study, I investigate aspects of the wellbeing of humanitarian helpers of refugees. Essentially, an implication of the one-sided focus on the hedonic, pain-avoiding aspect of wellbeing, for example, in regard to involuntarily dislocated persons, could facilitate a pathologising and victimising attitude towards human suffering, disregard of the complexity, totality and uniqueness of the adversity survivors as human beings and neglect of potential new gains or growth that may result from adversity (Papadopoulos, 2007 & 2020; Pupavac, 2002). This theory may also apply for humanitarians who work with adversity survivors (Papadopoulos, 2021b; Pupavac, 2004). Following the paradigm of the Refugee Care and AG, in this thesis I aim to develop a psychosocial approach to the helpers' experience and wellbeing; therefore, it is mindful of both hedonic and eudemonic aspects.

The following two subsections describe the historical development of the discourse about, and distinction between hedonism and eudemonia, starting with Greek philosophy and expanding to modern psychology and psychotherapy.

Moreover, I explain how this discourse is relevant to the essence of this thesis and why selected philosophical and psychological/psychosocial aspects of this can be integrated by the thesis' conceptual framework.

3.1.3. Historical Fundamentals of Wellbeing

In Ancient Greek philosophy, one can trace some of the very first thoughts and notions on wellbeing. In their worldview, *Presocratic* philosophers of the 6th century BC (Heraclitus, Anaximander) emphasised the balance and harmony between opposites (Rapp, 2007). Later, the ideas of *arete* (moral virtue), *phronesis* (practical wisdom) and *eudemonia* (meaning human flourishing/thriving) were developed by Aristotle and were central for a philosophic approach to wellbeing. According to the Aristotelian view, *living rightly* is necessary for *living well* (Tesar & Peters, 2020, p. 924). A further related notion to eudemonia also introduced by Aristotle is *entelechy* (originating from the Greek word *entelecheia*). Entelechy means "end with itself" (Kells, 2006, p. 263) and can be interpreted as the innate force in every living organism for their potential to be fulfilled (Roumpou, 2018, p. 63) or for their "perfect form to be realized" (Zeng, 2203, p. 8). In this regard, entelechy, i.e., the drive for perfection and self-fulfilment, could be deemed as a motivator for the highest goal, which is "thriving eudemonia", including happiness (Roumpou, 2018, p. 65).

In contrast to Aristotelian thought, the Greek philosopher Epicurus (341–270 BC) and his followers (Epicureans) maintained a more *hedonistic* philosophic stance towards wellbeing by emphasising pleasure (*hedone*) and absence or avoidance of human suffering and distress (Crisp, 2006; Tesar & Peters, 2020). He also believed that hedone is "not the mere absence of pain" and that, to experience this, a person should adopt "a certain attitude", i.e., "take pleasure" in something (Feldman, 2001, p. 665). Nonetheless, Epicureanism stresses that a life of *hedone* should be lived with

justice (Rosenbaum, 1996). *Hedonic* aspects were later incorporated by researchers into the modern study of wellbeing, as reviewed in the next subsection.

The Greco-Roman philosophical school of *Stoicism*, one of whose adherents was the Roman emperor and philosopher himself, Marcus Aurelius Antoninus (121–180 AD), was founded by the Hellenist Cypriot Zeno of Citium in the 3rd century BC. Stoicism originated from Socrates' and Plato's philosophical tradition. According to the Stoics, one's inner reactions to events, rather than the events themselves, determine one's wellbeing. In their understanding of wellbeing and thriving, stoic philosophers focused on the principles of *oikiosis*, *ataraxia* and *conversion* (Fabjanski & Brymer, 2017). Oikiosis means adjusting to the nature of the universe, which includes virtue, and gaining positive emotions and strengths from this (Fabjanski & Brymer, 2017). Ataraxia refers to tranquillity and, according to Marcus Aurelius, one should "acquire the contemplative way of seeing how all things change into one another, and constantly attend to it, and exercise thyself about this part (of philosophy). For nothing is so much adapted to produce magnanimity" (Marcus Aurelius: *Meditations*, as cited in Long, 2007, p. 262). *Magnanimity* is the unselfish state of kindness and generosity, especially against one's enemies (Cambridge Online Dictionary, 2022), and derives from the Greek word *megalopsychia*, which could be translated into "greatness of soul". Conversion is a form of positive transformation, which entails returning to natural balance (Fabjanski & Brymer, 2017). For Stoics, *virtue* is the highest good (Queloz & Van Ackeren, 2024, p. 417), and eudemonia is the supreme goal over one's lifespan (Sharpe, 2013, p. 29), in line with the Aristotelians' beliefs. Furthermore, in Stoicism, one can detect some of the first traces of *cosmopolitanism* in Western philosophy: Virtue applies as the highest value for all human-beings, and one should live in agreement with the *cosmos,* and

serve the other humans as a citizen of the “universal city” or *cosmopolis* (Durand et al., 2023; Kleingeld & Brown, 2019).

Here, I ought to highlight the fact that the Aristotelian concept of eudemonia is captured under the umbrella term of *virtue ethics.* Virtue ethics is one of three principal approaches in the philosophical branch of *normative ethics* and can be generally defined as the one that underlines moral character as opposed to the approach of *deontology*, which focuses on duties and rules, or the one of *consequentialism* or *utilitarianism*, which emphasises the ramifications of one’s actions (Hursthouse & Pettigrove, 2023, p. 1). It should be noted that Stoicism, although distinct from Aristotelian ethics, is considered a part of virtue ethics and generally supports a eudemonic orientation in life (Sharpe, 2013). Moreover, Stoicism could be seen as the linchpin between Western virtue ethics and East Asian philosophy, Buddhism in particular (Fabjanski & Brymer, 2017; Sharpe, 2013, p. 36). On the one hand, based on the above categorisation regarding normative ethics, some scholars argue that Epicureanism is a form of “proto utilitarianism” due to the utilitarian aspect of living in justice, whereas others disregard this view (Rosenbaum, 1996, p. 394).

According to Sharpe (2013), major differences between Stoicism and Aristotelianism with regard to the attainment of eudemonia, are the following: (a) the former supports a detachment of passions and emotions (*pathe*) and emphasises *ataraxia* (absence of worry and tranquillity of soul) and life according to nature, whereas the latter calls for a moderation of those emotions (Sharpe, 2013, p. 29); (b) the former rejects material goods, wealth, and fame, while the latter accepts their significance and supports a right balance in all things; (c) Stoicism commends *episteme*, i.e., intellectual wisdom, in contrast to the Aristotelian praise of *phronesis*, i.e., practical wisdom of life (Sharpe, 2013, p. 34); and (d) Stoics view wellbeing as a

state, while Aristotle regards this as the active process of human flourishing (Sharpe, 2013, p. 30).

I have to underline that a further analysis of the Ancient Greek philosophical concepts related to wellbeing goes beyond the research questions and purposes of this thesis. Nonetheless, in this project I observe the above discussed theories with great interest and recognise the influence of Aristotle, the Stoics and the Epicureans on modern thought regarding approaching and defining wellbeing. More specifically, I focused on eudemonia, since my intention is to incorporate this (as a broader idea within virtue ethics) in the conceptual framework of this thesis, without, though, discounting Epicurean thought on hedonism.

As stated in the introduction of this study, the theoretical backbone of this project relies on Jungian psychology and the framework of the AG and AAD. As discussed in Chapter 2, Jung made an emphasis on the transformative function of human pain and its renewing potential and coined the term "*individuation process*" (e.g., Samuels, 1985), which, in short, could be interpreted as a form of *transformative* and *transcending* self-actualisation (German: *Selbstverwirklichung*). In his work from a Jungian perspective, Hillman (1997) explores the notion of "calling" in one's life, which undoubtedly corresponds with eudemonic and entelechic development. Besides, Colacicchi (2015, pp. 121–122) draws parallels between eudemonia and individuation, from a comparative philosophical scope. Also, as mentioned in Chapter 2, AAD, a key idea in Refugee Care, is a conceptualisation of newly acquired strengths and positive development in the aftermath of adversities. In this respect, I conclude that these aspects of human flourishing, self-actualisation, and growth despite difficulties/adversities or partially as a result of them, generally match a rather eudemonic perspective to life and to wellbeing. Therefore, the integration of eudemonia (and, in the second place, of entelechy as the soul's drive

to perfection and self-fulfilment) should enrich this project's conceptual and broader psychosocial approach.

3.1.4. Psychological/Psychosocial Advancements in Wellbeing Research

In the present subsection, I will succinctly present several approaches to wellbeing based on research developments in the field of psychology. These approaches can be located within the prevailing discourse between eudemonic and hedonic approaches, which was already raised earlier in this chapter.

In early psychoanalysis, one might be reminded of Freud's *reality* and *pleasure* principles, respectively (German: *Realitätsprinzip*, *Lustprinzip*), while comparing eudemonic and hedonic wellbeing. Although a detailed description goes beyond the objectives of this thesis, the reality principle can briefly be summarised as the ability of the mature mind to defer immediate pleasure and to act according to the reality of the external world (Laplanche & Pontalis, 1973, p. 427), as opposed to the pleasure principle, which describes instinctive avoidance of displeasure and seeking of pleasure (Laplanche & Pontalis, 1973, p. 297). In general, it could be said that the reality principle is oriented toward long-term goals and long-lasting life satisfaction, while the pleasure principle is focused on immediate satisfaction of one's needs and desires. In this respect, the reality principle seems to be connected to the Aristotelian eudemonia, while the pleasure principle can be associated with hedonism. This implies that elements of the Freudian reality v. pleasure principle, which was central for psychoanalytic thought, can be perceived as expression and heritage of the question of eudemonia v. hedonism, which dates to the Greek philosophy of the 4th to 3rd century BC.

Further looking at early psychoanalysis, pioneer psychoanalytic theorist Erik H. Erikson (1902–1994) seemed to have a rather eudemonic view of psychological wellbeing. In his *psychosocial life-stages,* he describes that during the stage of

generativity, individuals in their middle adulthood achieve a sense of purpose in life by contributing to the community and developing their connectedness to their partner as well as their social environment (Erikson, 1966). He also concludes that at a later age people digest and adjust to the “triumphs and disappointments” of their lives and can (or cannot) find meaning and, thus, general satisfaction in their life cycle (Erikson, 1966, pp. 118–119). Writing about the human needs for leading a “good life”, Neo-Freudian Erich Fromm emphasises the function of *transcendence,* which he defines as the need of the individual to be productive, creative and to accomplish “a state of purposiveness” (Schultz, 1976, p. 95). Additionally, the German psychoanalyst Erika Fromm (distantly related to Erich Fromm), in her understanding of wellbeing, aptly distinguishes between “the needs (desires) that are only subjectively felt and whose satisfaction leads to momentary pleasure, and those needs that are rooted in human nature and whose realization is conducive to human growth and produces eudaemonia, i.e., ‘well-being’” (Fromm, 1981, p. 26).

From a mixed hedonic-eudemonic perspective to wellbeing, Diener (1984, p. 543) summarises the central areas that constitute *subjective wellbeing* (SWB): happiness in terms of *possessing desirable quality*, life satisfaction based on one’s subjective standards and dominance of positive affects over negative affects in one’s life. Furthermore, Tov and Diener (2013, p. 1) refer to the *tripartite* model for the assessment of SWB, which is comprised of “frequent positive affect, infrequent negative affect, and cognitive evaluations such as life satisfaction”. Additional features of SWB are its subjectivity (it depends on one’s individual experience) and its multi-dimensionality (Diener, 1984). Moreover, SWB also relies on being personally involved in interesting activities, which maintain a reasonable balance between challenge and skill (Csikszentmihalyi, 1990).

In contrast to Diener's combined hedonic-eudemonic view, Ryff & Singer (2008) follow a distinctly eudemonic approach to wellbeing: They attempt to identify the key aspects of *psychological wellbeing*, which they summarise as self-acceptance, purpose in life, environmental mastery, positive relationships with others, autonomy or self-determination and personal growth. Moreover, they draw attention to the concept of *balance* between the aspects listed above as an important factor of wellbeing. Additionally, Ryff (2014) declares that she draws upon Aristotelian philosophy for the development of a eudemonic perspective on psychological wellbeing.

Antonovsky (1923–1994) evidently maintains a eudemonic view of wellbeing with his concept of *the sense of coherence* (SOC), which consisted of the three core factors of *comprehensibility*, *manageability,* and *meaningfulness* (Antonovsky, 1993). In Antonovsky's *salutogenic model* (1987), psychological wellbeing can be achieved despite stress and hardships, i.e., it does not *per se* rule out the presence of stress and adversities. Antonovsky (1987, p. 19) defines SOC as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement". From the above, I conclude that for Antonovsky, wellbeing is located beyond the dichotomic split of pleasure and displeasure, happiness and unhappiness, health and disease, but rather constitutes a continuum on which the individual can predict, comprehend, manage and make meaning of what happens to/around her/him. In this sense, in her chapter on Antonovsky's SOC, Eriksson highlights that: "even the fully robust, energetic, symptom-free, richly functioning individual has the mark of mortality: he or she wears

glasses, has moments of depression, comes down with flu, and may also have as yet non-detectable malignant cells. Even the terminal patient's brain and emotions may be fully functional. The great majority of us are somewhere between the two poles." (Eriksson, 2017, p. 93)

In his model of *Hierarchy of Needs* (1943), which equals an approach to wellbeing, Maslow suggests that a person's highest-level, ultimate need is *self-actualisation* ("becoming who you can be") and, at a later stage of his work, *self-transcendence,* i.e., going beyond oneself in a spiritual sense (Koltko-Rivera, 2006). At very first glance, Maslow's theory seems to be in accordance with Jung's work on self-actualisation and *individuation process* and, furthermore, it evidently distances itself from a predominantly hedonic view on wellbeing. Koltko-Rivera (2006, p. 310) stresses that Maslow's concept of self-transcendence as the ultimate motivation is linked with a "meaning-of-life-worldview" that encompasses altruism, social progression, human wisdom, and spirituality.

Seligman (2018), with his extended research on *positive psychology* and psychological wellbeing, proposes a blended (eudemonic-hedonic) approach concluding that wellbeing consists of five key measurable elements: positive emotions, engagement, relationships, meaning, and accomplishment (PERMA). It could be said that positive psychology "has brought increased focus on eudemonic wellbeing" (Werdel & Wicks, 2012, p. 11). The development of combined eudemonic and hedonic facets is described as *flourishing* (Henderson & Knight, 2012; Seligman, 2011) and this conceptualisation has increasingly drawn attention from researchers (Henderson & Knight, 2012; Huppert & So, 2009; Huta & Ryan, 2010; Keyes, 2007). Huppert and So (2013) distinguished 10 dimensions relevant to flourishing: competence, emotional stability, engagement, meaning, optimism, positive emotion, positive relationship, resilience, self-esteem and vitality. Additionally, Gallagher et al.

(2009) developed a hierarchical model of 14 essential, measurable *first-order* wellbeing factors (positive affect, negative affect, life satisfaction, social acceptance, social actualization, social coherence, social contribution, social integration, autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance), which they then classified according to the three main *second-order* factors, hedonic wellbeing, social wellbeing and eudemonic wellbeing. Nevertheless, positive psychology's approach to wellbeing, which has recently grown in popularity, has also drawn substantial criticism (e.g., Held, 2004; Kristjansson, 2013; Peters & Tesar, 2020; Sundararajan, 2005). Positive psychologists have been criticised for trying to *sell* happiness as a good to today's consumerist society in an overly facile way (Tesar & Peter, 2020) and for discriminating individuals into pessimists and optimists (Miller, 2008), although a person can be optimistic or pessimistic depending on the situation, and pessimists can be successful and happy (Norem, 2001).

Social wellbeing was conceptualised by Keyes (1998), who identified five linked dimensions (social integration, social contribution, social coherence, social actualisation and social acceptance) and supported his proposed model with empirical data. Social wellbeing, as a more socially oriented and collective construct, was described by Keyes as the "appraisal of one's circumstance and functioning in society" (1998, p. 122). It basically refers to the leading of a "healthy social life". The concept of social wellbeing is corroborated by the theoretical work of other psychotherapists, such as Erikson's psychosocial stage of generativity (Erikson, 1966) and Adler's notions of social interest and community sense of belonging (Griffith & Powers, 2007). It can also be connected to Confucius' (c.551–c.479 BC) philosophy that considers wellbeing as moral virtues intertwined with humanity (Sundararajan, 2005). Confucius placed great emphasis on *the Common Good* as he

overarchingly viewed people as members of society and less as atomic individuals (Zhang, 2010); therefore his approach for a “good life” is rather collectivistic than individualistic, underscoring the connection and the harmony between the self and the other (Sundararajan, 2005). A modern development is *psychosocial wellbeing*, a more inclusive term that combines social, collective and psychological wellbeing (Eiroa-Orosa, 2020). The term “psychosocial wellbeing” in the bulk of the current literature covers a wide range of aspects, including emotional, social, physical, economic, political, cultural and spiritual issues and, unavoidably, there is no universally accepted definition for this (Negovan, 2010). A model of psychosocial wellbeing should also accentuate the interconnectedness of the various dimensions of wellbeing (Linley et al., 2009). A related concept, *collective wellbeing,* includes, *inter alia,* collective political action, support for the weak, fighting against injustice and a safe, healthy life for community members (Evans & Prilleltensky, 2007).

From the scope of values research, Maercker (2015) and his associates provide useful insights into the connection of culturally sensitive values and wellbeing. They suggest that *personal value orientation* is related to wellbeing and categorise ten principal value orientations into *traditional* and *modern* (Maercker et al., 2015, p. 9). Benevolence and conformity, which are classified as traditional values, predict social support, while self-direction as a modern value predicts resilience (Maercker et al., 2015, pp. 14–15). Both social support and resilience are generally linked with increased mental wellbeing (Maercker & Heim, 2016, p. 68). Here, it could be claimed that a value-oriented approach to life originated from the Aristotelian idea of “living virtuously”, i.e., living a life of *arete* and *eudemonia*.

I also need to emphasise that the noticeable diversity of modern instruments assessing/measuring wellbeing also reflects the complexity in its conceptualisation. Each of these instruments echoes a concrete approach and epistemological angle to

wellbeing, i.e., some questionnaires are, for example, deficit- or symptom-oriented, others assess hedonic aspects, while some are characterised by a more holistic or eudemonic perspective. Several instruments have been developed and applied for measuring wellbeing, such as the Satisfaction with Life Scale, the Flourishing Scale, the Questionnaire for Eudemonic Well-Being, the WHO-10 Wellbeing Index, the WHO Quality of Life Scale (WHOQOL) and the Oxford Happiness Questionnaire (Cooke et al., 2016). For example, the WHO-5 Wellbeing Index by the WHOQOL Group (1998) assesses one's positive feelings and emotions. Compared to WHO-5, the Australian Red Cross Wellbeing Toolkit (2021) constitutes a basic questionnaire focused on the presence of negative reactions or symptoms, stress and/or distress, which does not, though, refer to psychopathologies and concrete PD. Nonetheless, I should emphasise that this study does not aim to assess the wellbeing of its participants within a quantifiable model but rather investigate the complexity of their experiences and reactions using a qualitative methodology.

3.1.5. Implications/Conclusions with Regard to This Study

In this study's theoretical foundation, I rely on the innovative theories of Refugee Care, including AAD and AG, and Jungian psychology, as explained in Chapter 2. However, in order to synthesise a broader psychosocial conceptual approach on humanitarian helper wellbeing, I endeavour to select and embrace elements from theories of other authors, researchers, and generally, other disciplines. In this regard, in the previous section, I acknowledged that this thesis should generally integrate eudemonic wellbeing from Greek philosophy as a core aspect of its approach, which is in alignment with Jungian theory of individuation and with the framework of Refugee Care.

Nevertheless, it should be elucidated that individuation is *not equal* to eudemonic wellbeing, i.e., the two terms are not identical. First, by definition,

individuation cannot be classified as a form of wellbeing since it is not determined by "being or living well" (wellbeing). Second, conceptualisations of eudemonic wellbeing (Ryan & Deci, 2001; Ryff, 1989; Ryff & Singer, 2008; Waterman, 2008) or other wellbeing concepts with certain eudemonic elements (e.g., Antonovsky, 1993; Henderson & Knight, 2012; Keyes, 2007; Koltko-Rivera, 2006; Seligman, 2018) rather reflect an accomplished state than a process that is lifelong (Samuels, 1985). Third, questionnaires and scales to measure and assess eudemonic wellbeing have been developed and commonly used in wellbeing research, whereas individuation as a lifelong, complex, multidimensional, intrapsychic, and psychosocial, transformative, and transcending process of connecting polarities cannot realistically be objectively assessed and measured. Fourth, again looking at definitions, it is safe to assume that some individuals will not reach the status of *eudemonia* as described by Aristotle (Charles, 1999), but still the same individuals will "individuate" to some degree. In that respect, the Aristotelian notion of *entelechy* seems to echo the psyche's drive for individuation more fittingly than eudemonia. Fifth, even if, indisputably, eudemonic wellbeing is oriented towards meaning, purpose and flourishing in life, this does not necessarily include or insist on the aspect of "social contribution", of "offering something in return to society", which is the basic substance of individuation (Colacicchi, 2021; Hillman, 1997) and is underlined by Keyes (1998) in her definition of social wellbeing and by Erikson (1996) in his proposed psychosocial life-stages.

In the present section, I outlined various approaches and theoretical aspects, some of which, I believe, could enrich and improve the clearly defined theoretical foundations of this thesis in answering the research questions (or controlling the research hypothesis) and meeting its research aim. More concretely, although this thesis inclines towards a wider eudemonic perspective, I agree with Diener (1984) on the subjectivity of wellbeing, even if he generally follows a mixed approach. Keyes'

(1998) proposal for social wellbeing could be viewed as a predecessor of psychosocial wellbeing and is in accordance with the conceptual framework of the AG that explores reactions and experiences not only on the individual level but also on the communal and societal levels. Meanwhile, even if Antonovsky was not a Jungian academic, it seems that his thought around the SOC drifts towards a eudemonic and a Jungian orientation on wellbeing. It could be postulated that Jung's statement that "suffering is not an illness; it is the normal counterpole to happiness" reflects Antonovsky's salutogenic theory (Jung, 2014, p. 7361). Further, Freudian Erikson's psychoanalytic research (1966) on the psychosocial stages over one's lifespan can be associated with Jung's concept of individuation and offers useful insights into the lived human experience according to the life stage, which can be proved pertinent to understanding the humanitarian helper experience. Undoubtedly, Maercker et al.'s (2015) findings and conclusion that personal values (which, to some extent, reminds us of the Aristotelian "virtuous life") intertwined with wellbeing could also constitute a worthy asset in investigating helper wellbeing from a eudemonic angle. Finally, I underline that aspects of Seligman's well-researched positive psychology can be integrated in the approach of this thesis, although his approach draws some criticism and is labelled as "dichotomic", as mentioned earlier. I have to recognise Seligman's pivotal effort in blending elements from eudemonic and hedonic wellbeing while forming his theory on flourishing (e.g., Seligman, 2011, 2018). In this regard, it could also be claimed that flourishing as a concept bears some resemblance to both eudemonia and Jungian individuation.

Overall, in this and in the previous subsection, I discussed philosophical and psychological/psychosocial approaches to wellbeing. Additionally, I explained why selected aspects of these approaches can be fertilely incorporated into this project. Essentially, these aspects are expected to have an effect on the generation and the

interpretation of the findings. In the next section, I focus on a more specialised field of wellbeing, workplace wellbeing, which is topical and relevant for the conceptualisation of humanitarian helper wellbeing.

3.2. Workplace Wellbeing

According to the International Labour Organisation (ILO) in Geneva, *workplace wellbeing* (or wellbeing at work, occupational wellbeing or employee wellbeing) "relates to all aspects of working life, from the quality and safety of the physical environment, to how workers feel about their work, their working environment, the climate at work and work organization" (ILO, 2021) and it is crucial for the productivity of an organisation. Workplace wellbeing is becoming increasingly valued by researchers, organisations (Dewe & Kompier, 2009; ILO, 2021; Panaccio & Vandenberghe, 2009) and major employers at the international level, such as McKinsey (2021), P&G (Business in the Community, 2021) and Informa (2021), who try to secure employee wellbeing. However, there is no agreed-upon definition of the term (Laine & Rinne, 2015).

Burton (2009) in *WHO healthy workplace framework*, focuses on the medical aspects of psychological wellbeing and states that the workplace can be associated with *psychosocial hazards* and mental illnesses for employees. Burton (2009) and Murphy (2009) identify several key factors as potential *work stressors* or *sources of stress* that may lead to declining wellbeing and mental health problems: job content and role (e.g., monotonous tasks), workload, work schedule, organisational culture (e.g., poor leadership), interpersonal relationships at work, career development, participation, and control (for example, low control). As explanatory models for the development of *work-related stress*, Burton (2009) and Murphy (2009) propose the use of the *Demand-Control Model* (DCM) and the *Effort–Reward Imbalance Model* (ERI), respectively, both of which will be discussed in Chapter 5 of this thesis. Dewe

and Kompier (2009) emphasise the transactional nature of stress, particularly the process of *primary and secondary appraisal*, according to which the first (or primary) appraisal refers to the realisation that a demand may constitute a challenge for the employee's wellbeing, while secondary appraisal is concerned with having (or not) the necessary resources to cope with this encounter. Work-related stress can result in various symptoms, such as mental distress, sleep disorder, fatigue, depression, irritability, anxiety and nervousness (Burton, 2009; Murphy, 2009), most of which can have an organisational impact in the form of absenteeism, high turnover, job dissatisfaction, work-family conflicts, alienation and *burnout* of employees (Murphy, 2009).

Considering work-related stress of Refugee Care workers, Papadopoulos (2019) distinguishes between three types of stress: (a) *day-to-day stress*, which is normal, common and manageable, and can even be beneficial; (b) *cumulative stress*, which is a result of daily exposure to distressing factors and may have negative cumulative effects on staff wellbeing; and (c) *critical incident stress*, i.e., stress of very high intensity, as a consequence of extremely painful and distressful events that staff might experience. Cumulative stress and critical incident stress, although two distinctive phenomena, could potentially lead to pathologies, such as burnout, if not properly addressed and dealt with.

From an organisational standpoint, attention is needed for specific areas that are beneficial for the psychosocial wellbeing of workers, and which include supportive leadership, clear roles, good working environment with supportive colleagues and supervisors, acknowledgement of employees' efforts with appropriate rewards, proper work-life balance, personal growth and development, involvement in decision-making, respectful manners and appropriate workload (Burton, 2009).

Regarding workplace wellbeing (e.g., Burton, 2009; Murphy, 2009; UNHCR, 2016) and corresponding to the general debate on the term “wellbeing” discussed in previous sections of this chapter, it could be postulated that the terms “wellbeing” and “mental health” are used interchangeably with emphasis on the relevant medical or pathological aspects (e.g., symptoms, mental diseases) in contrast to a eudemonic *Weltanschauung*. Within an organisational context, Danna and Griffin (1999) suggest that mental health is a medical term and deals with symptomatology, whereas wellbeing is related to life- and job-related experiences in a broader, more holistic sense, thus offering a more eudemonic view on occupational wellbeing. Dewe and Kompier (2009) state that future approaches to work-related stress should not neglect personal growth and positive emotions as results of *positive* coping with stress. Fisher (2014) argues that a eudemonic dimension can be found in some organisational concepts, such as job involvement, work-engagement, thriving at work, as well as meaning in work, with self-actualisation being a central aspect in the latter two.

Taking into consideration hedonic as well as eudemonic dimensions, several researchers put forward a conceptualisation of wellbeing from an organisational angle. Danna and Griffin (1999) state that antecedent factors, which include work settings, factors of occupational stress and personality traits of the employee, can affect the employee’s wellbeing and health. As discussed above, Danna and Griffin (1999) consider wellbeing a more encompassing term than mental and physical health. Decreased wellbeing and health may impact the individual (psychological, physical, and/or behavioural) and the organisation, causing productivity problems and absenteeism. Meanwhile, Fisher (2014) presents her multi-faceted, inclusive concept about wellbeing at work, which consists of three main areas: SWB, social wellbeing and eudemonic wellbeing. From her perspective, SWB encompasses *job*

satisfaction, which is regarded as a core component or, even, as a subcategory of employee wellbeing (Bowling et al., 2010; Fisher, 2014).

Researchers suggest that *leadership* is a further, pivotal factor associated with wellbeing at work (e.g., Alimo-Metcalfe et al., 2008). Several styles of leadership have been charted, including *heroic*, *visionary*, *transformational*, and *transactional* (Alimo-Metcalfe et al., 2008; Mufti et al., 2020). These can be of vital importance for the wellbeing of employees. *Engaging leadership* is concerned with employees' growth and their wellbeing and has an empowering effect on them (Alimo-Metcalfe et al., 2008). Lundqvist et al. (2022) conclude that leadership styles "such as supportive leadership, relationship-oriented leadership and transformational leadership" fuel job satisfaction and workplace wellbeing (2022, p. 2). More specifically, *fair and supportive leadership* is expected to foster *organisational citizenship behaviour* (OCB) as well as *perceived organisational support* (POS) (Meierhans et al., 2008; Panaccio & Vandenberghe, 2009; Rhoades & Eisenberger, 2002). In the literature, POS and OCB are related to occupational wellbeing and both terms are examined in the following paragraphs.

POS is a relevant, well-researched factor regarding wellbeing at work: Panaccio and Vandenberghe (2009) conclude with empirical data that POS can be beneficial for workplace wellbeing. POS as a concept is based on reciprocity between employee and organisation and refers to employees' belief that the *personified* organisation values their efforts, cares about their wellbeing, and offers aid in daunting, stressful situations (Rhoades & Eisenberger, 2002). The proposed mechanism through which POS can enhance wellbeing at work is by contributing positively to *organisational commitment* (Panaccio & Vandenberghe, 2009; Rhoades & Eisenberger, 2002). This concept of organisational commitment is described by researchers (Meyer & Allen, 1991; Meyer & Herscovitch, 2001) as a three-

dimensional construct consisting of *affective*, *normative* and *continuance commitment*. Panaccio and Vandenberghe (2009, p. 225) mention that “affective commitment (AC) reflects an identification with and involvement in the organization, normative commitment (NC) stems from a sense of obligation, and continuance commitment (CC) is based on a perceived necessity to stay with the organization”. Findings show that POS predominantly increases AC (Rhoades et al., 2001).

According to empirical data, OCB may have a positive effect on occupational wellbeing (Kumar et al., 2016; Leon & Finkelstein, 2013) but, controversially, can also be linked with burnout (Emmerik et al., 2005). Organ (1997, p. 91) argues that OCB as a behaviour “contributes to the maintenance and enhancement of the social and psychological context that supports task performance”. Emmerik et al. (2005) describe OCB as a prosocial activity that goes beyond roles and rewards and is associated with *altruism,* thus being more common among groups such as social workers. For instance, OCB may include extra work, volunteerism, or extra-role activities that one does not necessarily get paid for. Leon and Finkelstein (2013) analyse the positive correlation between OCB and wellbeing from the angle of *Self-Determination Theory* (SDT); according to this theory, autonomy in prosocial activity is beneficial to wellbeing as opposed to controlled activity; essentially, for an individual, OCB, with its altruistic self-motivating character, constitutes a predominantly autonomous activity that can be beneficial for workplace wellbeing.

Chapter Synopsis and Thesis Progression

In this chapter, I charted and discussed definitions and approaches to wellbeing from a historical–philosophical as well as psychological perspective. Apart from this, I compared these views to the main theoretical background of this project. I also expounded on why I think that some approaches could be integrated into the conceptual framework of this study. This included the idea of eudemonia, which I

consider a key aspect for the wider psychosocial approach on humanitarian helper wellbeing. Next, central aspects of the concept of workplace wellbeing were summarised in the last section.

Following the examination and critical analysis of wellbeing theories and the presentation of the overarching principles of workplace wellbeing in this chapter, in the next chapter, I will discuss wellbeing, including occupational wellbeing, from the perspective of humanitarian organisations, including, of course, their relevant policies and guidelines. These will also be compared to and contrasted with the theoretical umbrella of this project.

Chapter 4: Policies, Organisational Dynamics, Motivations, Institutional Challenges

In this chapter, the discussion on general ideas and principles regarding wellbeing held in the previous chapter will segue into more specific aspects that are topical for the theme of humanitarian helper wellbeing. Besides this, these facets should be viewed through the lens of the theoretical framework of this study.

This chapter has the following structure: First, it opens with a brief presentation of wellbeing from a humanitarian perspective. Next, it delineates a synopsis of relevant guidelines on humanitarian wellbeing and mental health compiled either by humanitarian organisations or by organisations specialised in humanitarian occupational wellbeing. I also compare these to the theoretical framework of this study. Then, I set out other authors'/researchers' recommendations for policies on humanitarian wellbeing based on evidence-based research. This chapter then proceeds to an investigation of several principles of organisational dynamics, and their potential relevance to humanitarian helper wellbeing is addressed. I discuss these from the scope of the theoretical background of this project. Next, I look at motivations of humanitarian helpers for their work as an integral part of a broad psychosocial approach to their wellbeing, and critically discuss related aspects. Finally, I draw on sources of helper stress and dissatisfaction based on the contemporary literature and distinguish them into organisational and psychosocial.

4.1. Humanitarian Approaches to Wellbeing

The UNHCR places the wellbeing of refugees in the context of Mental Health and Psychosocial Support (MHPSS; UNHCR, 2022). It could be postulated that no clear distinction is made between mental health as part of the "medical model" and wellbeing as a more *holistic* term. A study on humanitarian staff wellbeing launched

by the UNHCR (2016) also equates mental health or absence of psychiatric disorders, such as depression and PTSD, with wellbeing. Particularly on workplace wellbeing, in its workplace wellbeing report, UNHCR (2016) used clinical psychology assessments (e.g., Audit C regarding alcohol abuse and GAD-7 for anxiety) to assess staff mental health and applied the model of ERI to determine the organisational aetiology of psychosocial hazards.

On their website, the *International Rescue Committee* (IRC) draws attention to ensuring the *economic wellbeing* of people in need, meaning assuring "that people in crisis areas have what they need to survive – including food, water, shelter and basic household items – without falling into debt or resorting to desperate measures" (IRC, 2022)**.** In its staff wellbeing guide, *Amnesty International* (2021b) also uses the terms "wellbeing" and "mental health" interchangeably and focuses on practical advice considering stress, anxiety and the clinical–pathological outcomes of burnout and depression.

The IFRC (2022, p. 20) defines wellbeing as being healthy and feeling happy regarding the "material, social, spiritual, cultural, mental, emotional, biological" domains. Furthermore, understanding wellbeing as stress reduction and avoidance of the pathological state of *burnout*, IFRC (2022, p. 4) promotes wellbeing by proposing a concept of self-care for humanitarians "not to burn out and to be effective in their work".

Regarding the wider perspective of humanitarian organisations on issues of wellbeing (such as the examples above), Jachens (2018) argues that the predominant conceptual approach to staff wellbeing and to exposure to adverse material is the clinical one, which overlooks the impact of organisational issues on wellbeing as well as new strengths that emerge from direct engagement with beneficiaries and their suffering. This is corroborated by the employee wellbeing

review conducted by the organisation *KonTerra* (2019, p. 17) on behalf of Amnesty International, according to which, emphasis is notably given to the fact that “there were far more reports related to the working conditions (conflict with managers, poor treatment, “bullying” and the like) than accounts related to viewing distressing footage or other sorts of traumatic material”.

Discussing the clinical approach to wellbeing, Papadopoulos (2021a, p. 25) argues that people tend to “pathologise those they want to help”. Those needing help can be, for example, either refugees or humanitarians. In the relevant literature, there are voices that suggest acknowledging and conceptualising the positive responses and consequences in the aftermath of adversities that helpers experienced (Emmens & Porter, 2009; Guhan & Liebling-Kalifani, 2011; Hernandez et al., 2007; Puvimanasinghe et al., 2015). As a principle, in this thesis I do not favour an arbitrary pathologisation of humanitarian helpers. Informed by an alternative, non-clinical, non-pathologising conceptual framework and based on empirical research findings, in this study I intend to develop new perspectives and insights into the wellbeing of helpers of refugees.

Over the recent decades, humanitarian organisations and NGOs have progressively realised the importance of workplace wellbeing, including organisational aspects mentioned above. As a result, they tried to improve their relevant policies, which I will discuss next in this chapter.

4.1.1. Guidelines on Humanitarian Staff Support and Wellbeing (by Organisations)

Several humanitarian organisations (such as the IFRC) and organisations that serve and support humanitarian staff (e.g., the ANTARES Foundation and KonTerra) have published manuals with guidelines or recommendations on humanitarian staff wellbeing and staff care. Here, I succinctly present a sample of guidelines and policies. These guidelines and policies do not explicitly apply to humanitarian helpers of refugees, but to the majority of the humanitarian world. Nonetheless, I believe they give relevant, useful, and representative insight into the approach of organisations that employ or engage humanitarian helpers of refugees (paid or volunteers) to staff wellbeing and staff care. Table 4.1 (below) summarises the most important facets of these guidelines.

Table 4.1

Guidelines and Recommendations for Policies

Inter-Agency Standing Committee (IASC, 2007), Geneva

- In its definition of the term "staff", IASC includes paid and volunteer, national and international humanitarians.
- Staff should be informed about the sociocultural and historical context of the local populations.
- Staff should be consulted to help identify work-related stress (not essentially traumatic) and should be informed about possible stress management techniques.
- *Rest and Relax* (R&R) policy should be established.
- Communication with family members should be enabled.
- Regular staff meetings, briefings and team building should be facilitated in order to prevent internal team conflicts.
- Culturally sensitive, professional-specific *supervision* is essential.
- Several staff members could be trained to provide *peer support*, stress management and *psychological first aid* (PFA).
- Access to (culturally sensitive) psychosocial support and, if necessary (e.g., due to acute distress), to mental health specialists (for example, psychiatrists) should be enabled and destigmatised.
- PFA should be immediately available to those who experience a critical incident.
- In case of acute, severe distress, a staff member should stop working and consult a psychiatrist.
- Awareness about self-care among staff should be enhanced, for example, through written material.
- A mental health professional should contact all staff involved in an adverse, distressing, painful event up to three months following the incident.
- After a humanitarian mission, staff members should have a *debriefing* and stress assessment.
- A referral list with mental health professionals and psychoeducational information material on stress/stress management should be made available to staff.

Interhealth/People in Aid (Emmens & Porter, 2009), London

- The question of whether policies should differentiate volunteers from full-time paid staff is posed.
- Advantages of in-house staff psychosocial support: In-house psychosocial specialists can offer more consistency to staff, have a better knowledge of the organisational context and staff needs/values, together with more capacity, since staff are their sole clientele.
- Disadvantages of in-house expert: Staff may prefer not to share sensitive information with an in-house specialist within the same organisation. Moreover, an in-house specialist is not necessarily an in-country professional, which means that they may not be available in person or on a 24-hour basis when needed and may not have a sufficient understanding of the conditions the staff live and work in.
- Available mechanisms of psychosocial support for staff can be summarised as follows: (a) *Employment Assistance Programmes* (EAP), which are organisations that offer 24-hour counselling by phone; (b) phone and email support by outsourced mental health professionals; (c) outsourced, independently contracted mental health specialists based, for example, in Europe or

North America, who can go in the field if their presence there is required; (d) psychotherapists within the organisation (in-house) who can counsel staff by phone, online or in the field if needed; (e) in-house, on-site psychosocial support; and (f) referral lists of independent mental health experts.

- Regarding *peer support*: A staff member should be selected according to clearly defined criteria and should be adequately trained and supervised by an in-house mental health specialist in order to function as peer supporter. Peer supporters should act according to concrete protocols after a critical incident. In addition, humanitarian helpers should be made aware of the possibility, advantages, and limitations of peer support.
- The coordination of and collaboration between humanitarian organisations with regard to staff care should be endorsed. Distinct needs between national and international staff should be addressed within staff care frameworks.
- Within a staff care framework, more attention should be drawn toward *resilience* and positive responses such as *adversity-activated development* (AAD), and policies should not solely focus on negative reactions, such as psychiatric pathologies.

Antares Foundation (2012), Amsterdam

- Inclusive guidelines for humanitarians in various roles, including volunteers.
- Work-related stress is mostly unavoidable for humanitarians and might well be a source of growth for some of them, but staff members may also experience negative, pathological effects of stress, which affect the individual and the team.
- Organisations should have a documented, valid, binding policy on stress prevention and stress management of their staff. They should adjust policies to the different needs of different types of staff and encourage a culture of stress awareness among staff.
- The guidelines say that screening and assessment related to stress should take place prior to assignment; this should be conducted according to minimum physical and mental health/*resilience* requirements.
- Attention should be paid to any previous or ongoing treatment because of mental illness, personal characteristics, including coping mechanisms, and prior experience of adversity, either personal or professional, and how this was then managed by the person.
- Pre-assignment stress management training should include identification of stressors as well as reactions, effects and symptoms related to stress, training in skills related to working in a team, and training in coping with stress. Managers should also be in a position to distinguish stressors and reactions to stress and encourage stress-reducing activities and individual staff support.
- Monitoring and evaluation of work-related stress among staff should be ongoing (e.g., through questionnaires) because of constant sources of ordinary stress, difficulty in identifying symptoms among staff and a false sense of toughness that some staff members may convey. Possible indications of stress are scapegoating, conflict in the team, reduced work effectiveness and high staff turnover.
- Ongoing training and support regarding stress management and stress reduction should incorporate stress reduction activities, social support (contact with family), psychological professional support if necessary and supervision.
- Specific and culturally appropriate staff support is crucial and essential in the case of unexpected, adverse events (critical incidents) and this includes PFA and *psychoeducation* regarding effects of adverse, overwhelming events.
- Staff support at the end of the humanitarian mission includes debriefing, stress assessment and possible access to psychosocial services, as difficulties may arise from readjusting to life in one's homeland after assignment.

- Available, ongoing support mechanisms for staff members who experience adversities should include follow-up, peer networks and referrals to relevant services (psychosocial, medical).
- Assignments to roles that are less exposed to stress and adverse psychological effects should then be considered for these staff members. Also, organisations should have a clear, written policy on this.

The IFRC Reference Centre on Psychosocial Support, Copenhagen (2014)

- Guidelines for volunteers.
- Awareness should be raised with regard to prodromal symptoms of burnout.
- With adequate support from their organisations, volunteers should be able to cope with their stress, cooperate efficiently with other team members, recognise when they need help and ask for it, and maintain their wellbeing.
- Managers should guarantee realistic working hours and good working conditions, demonstrate their appreciation for volunteers, offer clear position descriptions, train volunteers for their work in the field, organise regular team meetings, encourage *peer support,* a *buddy system* and working in pairs, offer psychosocial support to volunteers who experience distressing events and reinforce positive coping.
- Supervisors should monitor the wellbeing of volunteers individually and as a team, support them and appreciate their efforts. Meanwhile, supervisors should be supported by senior managers and should be appropriately trained in supporting volunteer psychosocial wellbeing, and their own.
- All volunteers should have a form of psychosocial support when they need it, but the level of support may differ from case to case: for some volunteers, a *generally supportive working environment* with team meetings and, if possible, peer support may be enough, whereas others may require the support of a mental health professional.
- Other psychosocial care measures could include supportive supervision and reflective meetings, especially for those exposed to distress and adversities directly or *vicariously*, and the presence of a psychosocial counsellor in these meetings. Some supportive measures might have to be mandatory to make it easier for volunteers to seek support.
- *Peer support* can be a very effective supportive measure for volunteers. Peer support means *"offering assistance to someone at the same level as the supporter"* (IFRC, 2014). Peer support can help volunteers cope with work-related stress and prevent them from developing severe distress in the short term. Peer supporters can be trained and supervised by mental health professionals, such as psychosocial counsellors, but they cannot replace them.
- A more informal version of peer support is the *buddy system*: two volunteers or one volunteer and one staff member work together, monitor how the other person is coping, suggest to the other person to relax or stop working if there are stress-related signals, etc.

The KonTerra Group, Washington DC (KonTerra, 2017)

- Specific staff subsets such as volunteers, *emergency response teams* and staff on GBV (*gender-based violence*) projects may be more exposed to adverse material, and this must be taken into account.
- Organisations should be committed to staff care. This should be openly communicated to the staff and emphasised and frequently discussed by managers. By doing this, the experience of work-related stress and distress can, to a certain extent, be normalised and destigmatised.
- Policies and procedures should be clearly defined and these should be easily accessible, should be discussed in team meetings to raise awareness of staff care, and should be reviewed and updated regularly. A staff care policy should also be incorporated into budgeting procedures.

- Appropriate screening and assessment of vulnerabilities, strengths, resilience, and coping mechanisms should be an essential part of the recruiting process. Furthermore, during recruitment it should be discussed how a person responded and/or how resilient a person was in relation to experienced adversities in the field. Stressors of the working environment should also be assessed and openly addressed during job interviews.
- New staff members should be informed upon hire about the organisational commitment to staff care.
- Confidential pre-assignment consultations by telephone, videoconference or in person should be offered to staff (especially for those subsets exposed to higher stress) by mental health specialists and should be encouraged by managers. The mental health specialist should in turn have some knowledge about humanitarian work.
- Qualified local counselling services should be employed when possible and counselling should be destigmatised. In terms of location, counselling should be preferably offered on site and, if not possible, remotely. Staff should also be aware of the possibility of accessing staff care and psychosocial services and should be routinely reminded of this possibility.
- Humanitarian organisations should enhance awareness on staff care and resilience through easily accessible printed or electronic psychoeducational material.
- Managers should be adequately trained to assess staff wellbeing.
- Organisations should adopt an R&R policy, which should be communicated to staff and be easily accessible, and participation should be monitored by managers.
- Confidential post-mission counselling sessions should be available to all staff and encouraged by leaders, to support the person's transition and readjustment to life "back home". Support should be available for at least 3 months after the end of the assignment.
- A clear policy in relation to critical incidents should be established and documented. Staff should be adequately informed about the impact of critical incidents, coping strategies and procedures related to crisis management. The staff care specialist should be available for remote or in-person one-to-one support and for on-site group support.
- Direct support to affected family members should also be guaranteed.

Overall, I should stress that guidelines in the table above appropriately emphasise the responsibility of the humanitarian organisations regarding the multi-faceted support and wellbeing of their employees. In summary, I consider the suggested measures to be steps in the right direction, mainly from an organisational perspective. Nonetheless, following the medical model, some of the above-mentioned guidelines and recommendations lay emphasis on the medical aspects of helper stress and distress, such as trauma and burnout (and of treatment/psychotherapy as a possible solution). Without invariably dismissing these

views, I recognise that these tend to pathologise the helpers' reactions in the aftermath of adversities.

However, there are voices, such as Interhealth (Emmens & Porter, 2009), asking for a more holistic perspective that identifies the resilient and positive reactions to adversity. Furthermore, KonTerra (2017) asks for a "destigmatization" and "normalisation" of the experience of workplace distress, which opposes a pathologising and medicalising approach. In addition, peer support is proffered as an adequate, non-clinical and non-pathologising, broader psychosocial measure that could have a beneficial effect on humanitarian helper wellbeing, provided that it is correctly applied to helpers, and not as a substitute for clinical psychotherapy. Further, the Antares Foundation (2012) draws attention to the phenomena of scapegoating and team conflict, which echo a group relational (non-medical) perspective.

In conclusion, I expect that most proposed guidelines (if/when applied) may lead to an enhancement of helpers' wellbeing and an alleviation of their stress and distress. What I was not able to identify in most of these guidelines and policies, though, was a concrete acknowledgement of the complexity of the helper experience and the wide range of responses of the humanitarian helper to adversities, which include not only negative outcomes, but also resilient reactions based on old strengths as well as newly acquired strengths. Moreover, I get an inkling that possible psychosocial (non-clinical) supportive measures, such as support groups, are not being comprehensively covered and scrutinised in the present guidelines. The aim of this thesis is to present an alternative, innovative, psychosocial approach to helper wellbeing that recognises the great complexity in the refugee caregiver experience and that formulates specific proposals for organisations, based on the framework of the AG.

4.1.2. Recommendations on Staff Wellbeing Emerging From Literature Findings

Organisational and Occupational Aspects. From an organisational perspective, humanitarian staff wellbeing and staff psychosocial support has been a matter of growing interest among academic researchers, some of whom refer to insufficiencies, ambiguities, and differences between organisations regarding policies (to name a few: Connorton et al., 2012; Ehrenreich & Elliott, 2004; Jachens, 2018; Pupavac, 2004; Strohmeier & Scholte, 2015; Strohmeier et al., 2019). Moreover, many authors have published their suggestions, from an organisational angle, and proposed measures or guidelines for policymakers based on empirical data (e.g., Ager et al., 2012; Aldamman et al., 2019; Blanchetiere, 2006; Brooks et al., 2015; Curling & Simmons, 2010; De Paul & Bikos, 2015; Guskovitk & Potocky, 2018; Hunt, 2008; Jachens, 2018; McCormack & Joseph, 2013; McCormack et al., 2009; Musa & Hamid, 2008). These may refer to paid staff or volunteers (Aldamman et al., 2019; Phillips & Phillips, 2010; Thormar et al., 2013).

Within a humanitarian context, various authors address the denial or reluctance of organisations to adequately recognise work-related stress, its impact on the humanitarians, and the organisations' role in this (Ehrenreich & Elliott, 2004; Jachens, 2018). However, the consequences of work-related stress – such as absenteeism, high staff turnover, recruitment difficulties and reduced effectiveness – on the organisation as a whole can be detrimental to organisations (Ehrenreich & Elliott, 2004, p. 55).

As a first step of an appropriate, relevant policy, a body of literature emphasises the raising of the level of awareness of staff wellbeing within organisations (Ager et al., 2012; Blanchetiere, 2006; Brooks et al., 2015; Ehrenreich & Elliott, 2004; Van der Veen et al., 2015). Awareness may refer to the resilience factors and the stressors of humanitarian work not only before and during, but also

after the assignment (Blanchetiere, 2006; Brooks et al., 2015; Connorton et al., 2012) and this could be attained, for example, through handbooks (Brooks et al., 2015, p. 393) or open discussions on staff mental health (Blanchetiere, 2006, p. 13).

The importance of a *generally supportive working environment* is addressed by several authors (e.g., Aldamman et al., 2019; Brooks et al., 2015; Curling & Simmons, 2010; Eriksson et al., 2009; Musa & Hamid, 2008). This encompasses social support by colleagues, managers, and leadership and good interpersonal relationships (Brooks et al., 2015; Corey et al., 2021; Eriksson et al., 2009; Jachens, 2018), sufficient team cohesion (Aldamman et al., 2019; Blanchetiere, 2006; Strohmeier et al., 2019, p. 47), good communication within the organisation (De Paul & Bikos, 2015; Nordahl, 2016; Strohmeier et al., 2019, p. 44), connectedness to the organisation endorsed by the team leadership (Thormar et al., 2013, p. 637), reciprocity and tangible or intangible rewards for humanitarian work with involuntarily dislocated people, and placing emphasis on these rewards (Jachens, 2018; Phillips & Phillips, 2010; Puvimanasinghe et al., 2015), financial incentives (Strohmeier et al., 2019), reasonable working hours with breaks (Ager et al., 2012; Brooks et al., 2015; Chatzea et al., 2018), possibilities for recreation (Brooks et al., 2015, p. 392; Curling & Simmons, 2010), positive feedback, recognition and encouragement (Guskovict & Potocky, 2018; Thormar et al., 2013, p. 637), sufficient paid time off (Strohmeier et al., 2019), staff rotation when necessary or beneficial (Korff et al., 2015; Strohmeier et al., 2019), support for ethical decision-making (Hunt, 2008), listening to staff members' humanitarian narratives (McCormack et al., 2009), prioritising staff safety (Aldamman et al., 2019; Brooks et al., 2015, p. 392; McCormack et al., 2009), facilitating the adjustment of staff to the host country from a cultural viewpoint (De Paul & Bikos, 2015; Hunt, 2009; Musa & Hamid, 2008), and clear tasks for volunteers (Aldamman, 2020, p. 296).

A further aspect of social support for humanitarian staff ascertained by several pieces of research is securing and facilitating regular contact to family members and friends, for example, by phone or online (Ager et al., 2012; Blanchetiere, 2006; Cardozo et al., 2005; Nordahl, 2016), with a few authors suggesting that families and partners should accompany the humanitarian aid worker abroad, even though this is in most cases not realistic (Cardozo et al., 2005; Korff et al., 2015).

Moreover, various researchers draw attention to staff selection and recruitment (Hunt, 2008, 2009; Nordahl, 2016). Candidates applying for positions should be able to cope with transitions and adverse life events, should have a stable personal and professional life and should demonstrate sufficient work-life balance (Blanchetiere, 2006, p. 10). According to Hunt, selected candidates should be resilient, modest, introspective and motivated persons with realistic expectations (Hunt, 2009, p. 523).

Psychosocial/Psychological Support for Helpers. Staff psychosocial and psychological support are identified by numerous authors as a core aspect of policies on staff wellbeing (e.g., Brooks et al., 2015; Guskovict & Potocky, 2018; Jones et al., 2006; McCormack & Joseph, 2013; McCormack et al., 2009; Nordahl, 2016; Strohmeier et al., 2019; Thormar et al., 2013). Access to psychosocial support should be facilitated by organisations (Strohmeier et al., 2019). Psychosocial support encompasses multi-faceted interventions. Development of peer support and mentoring programmes is among the most recommended of these interventions (Blanchetiere, 2006; Cardozo et al., 2005; Curling & Simmons, 2010; Nordahl, 2016; Puvimanasinghe et al., 2015).

A well-cited domain is staff counselling, which may refer to outsourced, local counsellors (Curling & Simmons, 2010), in-house staff psychosocial counsellors onsite (Brooks et al., 2015; Jachens, 2018) and phone/online sessions through a

third party, for example, in case of a crisis (Jones et al., 2006; McCormack et al., 2009). In addition, approaches to counselling and therapy may vary: researchers focus on the enablement of meaning-making and sense of belonging (McCormack et al., 2009), strategies for coping with stress, such as relaxation and mindfulness techniques, and cognitive behavioural therapy (Ager et al., 2012; Jachens, 2018), psychotraumatology (Jones et al., 2006), anger and alcohol management, relationships, and post-trauma management (McCormack et al., 2009). Psychoeducation, as part of counselling sessions, provides humanitarians with useful tools for psychological adjustment, awareness about risks and problem-solving and post-assignment empowerment (Brooks et al., 2015; McCormack & Joseph, 2013). In addition, Blanchetiere (2006, p. 13) proposes the promotion of open, non-judgemental discussion regarding emotional reactions on humanitarian problems.

In cases of a *critical incident* with overexposure to adverse material or distress, debriefing, psychological first aid (PFA) and group psychological first aid are proposed as adequate measures (Corey et al., 2021; Hunt, 2008; Nordahl, 2016); the central difference between PFA and debriefing is that PFA does not involve discussions and reflections on the adverse event but provides staff with practical and human support (Corey et al., 2021). Nevertheless, psychological debriefing is viewed with some ambiguity as it is regarded by some researchers as non-evidence-based, ineffective and having a potentially negative mental health effect on staff (Brooks et al., 2005; Corey et al., 2021). McCormack et al. (2009, p. 7) suggest that post-assignment debriefing should not be an isolated supportive measure but the first step of a post-mission psychosocial, psychological and psychoeducational support “package”.

There are proposals for various training programmes that the policymakers should take into account when considering psychosocial support. These suggestions

can refer to different stages of the humanitarian experience. Some authors propose training in stress management and, generally, mental health (Jachens, 2018; Strohmeier et al., 2019), “relaxation” training (Brooks et al., 2005, p. 393), training of managers in protecting the mental health of their staff (Ager et al., 2012), training of peer support staff by a psychosocial counsellor (Curling & Simmons, 2010), training of staff in psychosocial skills, for example, in supporting colleagues (Brooks et al., 2005), training in “conflict resolution” (Blanchetiere, 2006, p. 12), pre-assignment training on psychological “preparedness” (Brooks et al., 2005, p. 393) and on psychotraumatologic elements (Jones et al., 2006), training on aspects of VR (Puvimanasinghe et al., 2015, p. 20), “cultural orientation training” (Hunt, 2008; Puvimanasinghe et al., 2015, p. 9), preservice training with focus on values and ethics (Hunt, 2008), even training of humanitarians’ family members for empathetic listening after their return (McCormack & Joseph, 2013, p. 159). The list of possible training recommendations is extensive.

Regular, technical supervision is regarded a further key aspect related to staff wellbeing and staff psychosocial support by numerous researchers (Curling & Simmons, 2010). Puvimanasinghe et al. (2015, p. 20) underline the importance of ongoing supervision for aid workers in direct contact with adversity survivors. Meanwhile, Jones et al. (2006, p. 98) contend that continuous supervision should be offered online by a person outside of the organisation so that the anonymity of the humanitarian is protected. Effective supervision fosters the resilience of staff (Blanchetiere, 2006, p. 13) and the POS of volunteers (Aldamman, 2020; Aldamman et al., 2019).

Further Discussion. From an organisational standpoint, some authors note the significance of the moral aspects with regard to humanitarian helper wellbeing. Pupavac (2004) calls for the “*re-moralisation*” of the humanitarian mission, which has

been demoralised and viewed with scepticism because of the questionable role of humanitarian organisations during the past decades. The fact that donor governments were funding humanitarian efforts began to worry humanitarian organisations about the politicization of aid and their own role as humanitarians with regard to the ethical and beneficial character of their work. Pupavac (2004) vividly notes that:

> The technologies of aid left many aid workers concerned about the bureaucratisation of aid work as its role expanded … The sense of humanitarianism becoming alienating rather than humanising was heightened by doubts over the efficacy of humanitarian aid work. Soul-searching led to a questioning of the aid worker and recipient relationship too. Empathy for the person in need appeared no longer to be sufficient to guide interventions, and the motives of aid workers themselves came under scrutiny. (p. 496)

Slim (2005) suggests that organisations and their staff should find the right balance between idealism, realism and professionalism in their functions. Meanwhile, Radice (2022) calls for a more political and activistic humanitarianism and criticises humanitarianism's alienation from political voices. According to Blanchetiere (2006, p. 13), humanitarian organisations should protect their staff by conveying to the mass media and to society the positive, moral aspects of humanitarian work. Staff with tasks that include complex ethical dilemmas and triage, such as clinicians, should be supported adequately by organisations regarding ethical aspects, but they should also understand that they are not *immune* to stress related to complicated moral questions (De Waal, 2010; Hunt, 2008, p. 67).

Within the context of Refugee Care, I argue that an approach to staff wellbeing should also include human service providers and helpers (such as therapists or social workers) who work directly with refugees and asylum-seekers in the Western

world. Several researchers have made organisational suggestions on this topic (Apostolidou & Schweitzer, 2017; Barrington & Shakespeare-Finch, 2014; Guhan & Liebling-Kalifani, 2011; Posselt et al., 2020; Pross, 2006), and devised measures showing similarities to those interventions recommended for humanitarian staff. A body of literature continuously considers clinical supervision to be the core, essential aspect for the wellbeing of psychotherapists who work with adversity survivors and involuntarily dislocated persons, and this should be guaranteed by policymakers (Barrington & Shakespeare-Finch, 2014; Pross, 2006). Supervision can help therapists realise the relevance of the political context in relation to their psychotherapeutic work (Apostolidou & Schweitzer, 2017). Peer support, debriefing before and after sessions, recreational activities, relevant training, facilitating work-life balance by, for example, monitoring the number of complex cases, and a generally positive, supportive working environment are viewed as possible organisational interventions for staff support and care (Barrington & Shakespeare-Finch, 2014; Posselt et al., 2020). Moreover, policymakers should endorse collegial support within the organisation (Guhan & Liebling-Kalifani, 2011), personal development of staff members (Eleftheriadou, 1999) and multidisciplinarity (Apostolidou, 2015).

In addition to organisational policies, guidelines and recommendations provided by the findings in the literature, I considered it fruitful to include doctoral studies related to staff and volunteer wellbeing. Table 4.2 (below) provides a summary of the practical implications and recommendations for interventions that emerged from selected, relatively recent PhD research studies on humanitarian helper wellbeing.

Table 4.2

Recommendations for Practice and Organisational Intervention

Burgos Cando (2023, pp. 258–263), regarding **ethnic minority counsellors** working with attempted genocide survivors	Aldamman (2020, pp. 295–297), targeting **humanitarian volunteers**	Manning-Jones (2016, pp. 132–134), referring to **health professionals working with trauma survivors**	Tassell (2019, pp. 190–194), regarding **humanitarian health workers**	Jachens (2018, pp. 206–207) on **humanitarian aid workers** (in general)
Developing counsellor awareness on vicarious resilience, fostering vicarious resilience. Supervision focuses on racial and cultural identity and the development of minority counsellors in training. Psychoeducation in supervision creates more awareness regarding vicarious resilience and helps counsellors recognise the challenges in working with trauma survivors, refugees, genocide survivors and racialised populations. Promoting awareness of the socioecological and political factors that influence a client's life.	Providing opportunities for further development and training. Offering leadership training on psychosocial support. Providing efficient team-building and psychosocial activities. Providing supportive, fair and inclusive work environment.	Promotion of self-care and self-care activities (for example: exercise and spirituality). Offering counselling to workers exposed to vicarious trauma. Support of self-care through healthcare organisations. Offering education on self-care to health professionals. Facilitation of the transition from *vicarious trauma* to *vicarious post-adversary growth* through peer support, peer supervision and peer support groups. Providing training on coping skills after vicarious exposure. Supporting coping strategies at an individual and collective level.	Promoting organisational support (e.g., offering counselling when needed). Promoting social support (e.g., facilitating contact with family and friends). Offering appropriate psychological support and programmes to avoid *overidentification* with clients and *obsessive passion.* Workers should not perform tasks outside their area of expertise. Developing measures to identify motivation and problematic obsessive passion among workers and, therefore, mitigate the risk of burnout. Developing strategies for preventing burnout and recruiting suitable, resilient workers.	Fair distribution of workload, reduction of overtime. Managers should systematically praise their staff to raise their morale. Providing benefits (e.g., regarding vacations and retirement). Promoting self-esteem through vocational training and clarification of steps for promotion. Managers should allow staff more control over their own work, including enabling home-office work. Reducing the "emergency culture". Providing social skills training for leadership/ supervisors. Promoting communication and a supportive attitude. Encouraging workers to seek therapy if required.

In essence, the above table shows that authors effectively value factors such as awareness of negative outcomes and adversities as a part of humanitarian work, promotion of self-care, and psychosocial measures for the wellbeing of staff (e.g., peer support) at the level of institution, and they do not entirely focus on the clinical level of individual psychotherapy. Of course, these PhD researchers approached humanitarian wellbeing from different angles, corresponding to their professional or academic background. However, I generally concur with these authors on the emphasis put on organisational and psychosocial interventions for staff and volunteer wellbeing.

This present section vividly describes the diversity and multidisciplinarity considering proposed measures and ideas within the context of the occupational and psychosocial wellbeing of the helpers. The more “clinical” domain, mostly consisting of staff counselling, clinical supervision and PFA, constitutes only one part of the array of information. This confirms the view of this thesis that the medical/clinical dimension does not capture the whole picture regarding humanitarian helper wellbeing. Nevertheless, even if organisational/occupational aspects are well-represented in the literature cited above, it is challenging to identify voices that call for a discussion and/or awareness of the enrichment, gains, as well as resilience that can become visible within humanitarian work with refugees and exposure to adversities.

Moreover, it could be postulated that a further aspect relatively lacking in the present section is that of group relations/dynamics in the context of work with refugees as team members and as staff members of an organisation. In the next section, the investigation will expand to tacit processes taking place in staff members individually as well as collectively, which explain phenomena at the institutional/team level.

4.2. An Organisational Dynamics Perspective on Helper Wellbeing and Work-Related Stress

In this section, I shall discuss an approach from the scope of theories of organisational/group dynamics and relations. Although these do not exclusively refer to humanitarian organisations and charities working with refugees (this would include, e.g., the NHS), they still may offer useful insight into the multi-layered exploration of staff wellbeing. These theories in group relations have traditionally been developed and well-researched by pioneer psychoanalytic researchers at the Tavistock Clinic in London, UK.

Idealism appears to be the main motive for choosing a helping profession (Roberts, 2019) but according to Tavistock scholars (Bamber, 2006; Bion, 1961; Roberts, 2019), unconsciously, this is linked with the urge to process unresolved childhood issues. This may, of course, be advantageous, but in some cases it can also become challenging if “staff with this expertise rely on it [surviving past issues] as their major form of validation” (Hartley & Kennard, 2009, p. 19). Staff with such past unresolved conflicts might also be more susceptible to work-related stress and distress (Hartley & Kennard, 2009). To what extent one can manage psychological distress is heavily dependent on the support (or lack of it) that a person receives from a very close other (Harris, 1992).

4.2.1. Organisational Defences as Burdens

It can be said that institutional defensive mechanisms, like the personal ones in a psychoanalytic context, may be beneficial for the staff’s coping with stress and anxiety but may also be disadvantageous and disruptive for the realisation of organisational tasks and for the advancement of the organisation (Halton, 2009). Halton (2009, p. 12) argues that “central among these defences is denial, which

involves pushing certain thoughts, feelings and experiences out of conscious awareness because they have become too anxiety-provoking".

A further common institutional defence in carer organisations is the *emotional distance* of the helper regarding the beneficiary as described in Menzies' (1959) highly cited conceptualisation of institutional defences. A similarity between the service providers' adverse, painful past experiences, or early-life situations, and the beneficiary's problems and distressful experiences (Roberts, 2019, p. 127–128) and the recurrent blurring of the line between carer and client, with the carer having similar emotions as the client, especially within a psychotherapeutic context (Hartley & Kennard, 2009), may increase this distance. This distance is established, for example, through bureaucratic procedures, risk management, strict hierarchies, and inflexible timetables (Hartley & Kennard, 2009; Roberts, 2019). Additionally, with regard to humanitarian organisations, Walkup (1997) fittingly comments:

> The perceived dangerous, high-profile nature of relief work leads personnel to develop a heightened sense of group solidarity and protectiveness, which fosters a perception of division between "us" (the aid staff) and "them" (the affected populations). This can be positive for aid workers in that it provides a greater sense of personal security in new, uncertain, and possibly threatening conditions. But this "siege mentality" also can lead to isolationism, reactionary paranoia, and "groupthink". Obviously, these dynamics inhibit good deliberation and communication. (p. 54)

In contrast to Walkup's observations, the prevailing defence may also be the staff's greater *identification* with their beneficiaries "as victims to be overwhelmed by their pain and despair" (Roberts, 2019, p. 135). In both cases (overgrowing distance from/over-identification with clients), there is a problematic relationship between

helper and help recipients, which does not serve the organisational task (Roberts, 2019, pp. 134–135).

In addition, *projective identification* – a psychoanalytic defence mechanism introduced by Melanie Klein and applied within an institutional dynamics context by some of her followers – creates a bridge between individual psychodynamics and interpersonal-organisational processes (Nielsen, 2019). It takes place when an individual unconsciously projects qualities and feelings onto another individual and then that person unconsciously internalises and identifies with those qualities (APA Dictionary of Psychology, 2022). In an organisation, projective identification may refer to individuals or groups and echoes the fact that "it is often easier to ascribe a staff member's behaviour to personal problems than it is to discover the link with institutional dynamics" (Halton, 2019, p. 16). Therefore, a group or an individual within an organisation may function as a "sponge" (Halton, 2019, p. 17) for the staff's collective anger, frustration, disquiet, depression and guilt. More specifically, projective identification is connected with unconsciously "choosing" *a troublemaker* in a group (Obholzer & Roberts, 2019) or, in other words, *scapegoating* regarding an "unchanging individual" (Hinshelwood, 1987, p. 33). Obholzer & Roberts (2019) stress that the "problematic" staff member is viewed:

> As an institutional mouthpiece, into whom all the staff have projected their disquiet. Sitting embarrassedly in the same room, signalling with their eyes that they wish to dissociate themselves from the trouble-maker, they are disowning that part of themselves which, by a process of projective identification, is located in the trouble-maker. (p. 146)

From an organisational dynamics standpoint, Walkup (1997) points out that two main reactions to anxiety and distress in humanitarian organisations are *delusion* and *defensiveness* towards change and innovation. Institutional delusion in

humanitarianism refers to “mediatory myths of success and proficiency” (Walkup, 1997, p. 48), which constitute a form of coping with the distress of failure in a humanitarian organisation. A positive image of the organisation is endorsed through the media of mass communication, although this image does not echo the actual humanitarian situation within the organisation. Far more, it functions as confirmation and justification for the staff’s faith in the organisational omnipotence, virtue and success (Morris, 1991; Walkup, 1997). Meanwhile, organisational defensiveness is expressed through a “conservative, risk-averse tendency” (Walkup, 1997, p. 52) and is a response to criticism (such as claims or accusations of wrongdoing) and other perceived threats to the survival of the organisation. These threats typically reflect a conflict between the beneficiaries’ wellbeing and the requirements for the survival of the humanitarian organisation; also, organisations naturally take a defensive stance towards innovation, for innovation underpins criticism (Walkup, 1997).

4.2.2. Further Difficulties and Sources of Stress

Regarding detrimental dimensions within teamwork, Punter (2007, p. 100) stresses that “there can be rivalry and fear of judgement by peers or managers, and investment in fighting, that gets in the way as a group”. Meanwhile, Nitsun (1996) discusses that, in mental health professions, teams can be responsible for extensive stress. Staff members may be afraid or reluctant to confess to and address their helplessness, their feelings of being overwhelmed, and their distress, and thus may not ask for appropriate support in an atmosphere of rivalry and competition or destructiveness, which they do not consider supportive enough (Hartley & Kennard, 2009). According to Hartley and Kennard (2009, p. 20), “the fear of a negative invalidating response is too great and probably realistic”. Furthermore, in helping and caring professions, staff members may be anxious to admit to their stress and distress because, subsequently, they might be viewed as too “ill” and inadequate to

help people in need and adversity survivors (Hartley & Kennard, 2009), especially if the work environment is not sufficiently caring for staff.

Additionally, Hirschhorn (1993, p. 26) coined the term “normal psychological injuries at work”, implying that it is expected and normal that staff members less “immune” to organisational changes may experience psychological issues resulting from anxiety, uncertainty, helplessness and rejection. Thus, affected staff members may fear that addressing and discussing this stress and distressful psychological reactions within the team may be regarded by others as “making too much of something ordinary, not coping, or as being part of the therapy culture” (Hartley & Kennard, 2009, p. 20).

A further aspect relevant to staff wellbeing and stress is the culture of *perversion* in organisations (Campling, 2015; Long, 1998). Perversion signifies that staff members are exploited and instrumentalised by their superiors, who abuse their position of trust, with this abuse not necessarily being outside of the law in legal terms (Campling, 2015).

Rice (1958) defines a *primary task* as the task the group was originally created for, while Lawrence (1977) distinguishes the primary task into: (a) *normative*, (b) *existential,* and (c) *phenomenal*. The normative primary task is the official task, the existential primary task is what staff believe they do, and the phenomenal primary task is what staff *actually* do, without being necessarily aware of it. The ideal situation for an organisation is when there are no inconsistencies between a normative and existential task (Hoyle, 2004), whereas significant discrepancies may cause turmoil and disintegration of the group (Turquet, 1974).

4.2.3. Suggestions for Support: A Group Dynamics/Relations Perspective

Hinshelwood and Skogstad (2005, p. 166) point out that “the high level of defensiveness that was found in many of the observed institutions appears to be linked with the apparent lack of containment of anxieties within the organisation”. Organisations may often include staff support and counselling in their written policies and recommendations, but this is not always connected to a supportive, open and empathetic workplace environment (Hartley & Kennard, 2009). For managers, it is easier to refer a staff member to mental health services than to effectively question the work climate and the institutional dynamics and reflect in depth on their role and the impact of their work on the staff (Hartley & Kennard, 2009). A system of mutual, social support is the most substantial element regarding staff satisfaction at a workplace in a helping profession (Lederberg, 1998). In conclusion, in theory, bolstering staff solely by referring them to counsellors as a human resources policy or as a form of disciplinary procedure, without looking at and evaluating the social support offered, is when “the solution becomes part of the problem” (Hartley & Kennard, 2009, p. 23).

Staff support groups are formed for staff in caring professions either as a reaction to a challenging situation or as part of the organisation’s support policy (Kennard & Hartley, 2009). Staff support groups could have a place in humanitarian staff wellbeing since “the group can be an effective holding environment in which care givers support and validate each other around the grief, fear and sense of inadequacy that overwhelm them unpredictably” (Lederberg, 1998, p. 290). Hereby, I summarise the central aspects and functions of staff support groups, as outlined by Kennard & Hartley (2009): offering a safe space to staff members, supporting open communication even on painful topics and experiences, discussing burdens within the team and problems between individuals, helping staff to recognise and admit to

their vulnerable positions without being afraid of exclusion or stigmatization, and to become more aware of their emotional reaction without getting emotionally detached, and, consequently, helping staff to cope better with work-related stress and to work better as a team; all these factors can ameliorate staff wellbeing within the organisation. However, differences between staff support groups and, for example, *supervision groups, sensitivity groups* or *reflective practice groups* are vague, and sometimes terms are used interchangeably. Staff support groups are, in general, less structured, less psychoanalytically oriented, more supportive, more flexible and have a less specific focus (Kennard & Hartley, 2009). These elements of staff support groups can be beneficial and applicable within a humanitarian or Refugee Care context.

Campling (2015, p. 2) directs attention to the fact that a *well-functioning* group within an organisation can effectively *contain* stress and feelings of overwhelmingness in staff even if the extended organisation is generally dysfunctional. Furthermore, in the same paper, she calls for a culture of *compassion* or *compassionate care* and *intelligent kindness* among organisations and managers in helping professions (Campling, 2015). Intelligent kindness is a multi-faceted term, as it involves the clinical, managerial, leadership and organisational dimension and the word “intelligent” implies that, within a caring profession, kindness can be applicable in a creative, wise, prudent, realistic, committing, communicative and effective way (Campling, 2015, p. 4). I assume that compassionate care and intelligent kindness could be valuable for a humanitarian or refugee support organisation.

It is recommended that staff in helping professions should be assisted by managers and carer organisations to gain some insight into the motives for choosing their role and to become more conscious of their defensive mechanisms, vulnerable

positions, and individual susceptibility to projective identification (Roberts, 2019, p. 135). Personal therapy may be helpful for identifying and processing past unresolved conflicts, and, even without counselling, developing a more self-monitoring and self-reflective position with regard to one's own emotions and responses can be advantageous for coping with stress and for better interpersonal relationships in the workplace (Obholzer & Roberts, 2019). Furthermore, by identifying the internal task definition, groups may become more conscious of the related defences and anxieties and attempt to redefine this in a more realistic way (Roberts, 2019, p. 135).

Considering the above, it is crucial that managers and staff have knowledge or training in organisational dynamics (Obholzer & Roberts, 2019), and this will contribute to the development and flourishing of a *pro-support organisation* (Hartley & Kennard, 2009, p. 24) that empathises with the staff, is aware of unconscious group dynamics phenomena and proactively supports staff (e.g., through staff support groups), thus making it easier for them to ask for help, whenever needed. To summarise, this is essential for helpers at a workplace, as Roberts (2019) aptly notes that:

> Omnipotent fantasy, obsessional ritual and paranoid blaming can give way to thinking: one can seek to know, to learn from experience and to solve problems. Reparative activities can then become more realistic and practical, allowing workers more solid satisfaction from their very difficult work. (p. 135)

4.2.4. Organisational Dynamics: Conclusion

Extrapolating from the above, I assume that organisational/group dynamics play a central role in humanitarian helper wellbeing. Nevertheless, I admit that these relevant aspects have not always been identified or sufficiently addressed by the guidelines proposed by organisations, as previously outlined in this chapter (see Subsection 4.1.1). Looking at these guidelines, I sense that non-clinical, psychosocial

interventions at a group/team level, such as staff support groups, are outweighed (to say the least, if not neglected) by the suggested clinical measures at the personal level. Moreover, the necessity of a certain basic understanding of group dynamic aspects, for example, by managers, is rarely emphasised. Also, I conclude that there is insufficient reference to organisational defence mechanisms and their impact on humanitarian helper wellbeing (as explored in this section) in the sample of recommendations proposed by the humanitarian organisations. This also seems to be the case for relevant research and literature investigating staff wellbeing, with some exceptions (e.g., Snelling, 2018; Walkup, 1997).

In this respect, Snelling's (2018) observation resonates with the view of this thesis:

> As a clinician, I have also been repeatedly struck by how often my humanitarian clients cite relational difficulties, not exposure to trauma, as a primary source of distress in the field. Even work with those specifically presenting for trauma treatment seems often to link to problematic relationships. Yet while there is a substantial body of research on stress management, resilience and trauma care for aid workers, little specific academic attention has been directed towards their relational worlds. (pp. 1–2)

As aforementioned, this study does not follow a solely medical/clinical approach to humanitarian helper wellbeing. Since the Tavistock perspective on group relations can offer a crucial, non-pathologising understanding of employee stress and wellbeing at the level of the institution, I view the principal aspects of this perspective as an enrichment for my thesis. This thesis is primarily driven by the framework of the AG, which does not focus exclusively on the intrapsychic aspects at the level of the individual but is also concerned with the intrapersonal relations and dynamics at the organisational/workplace level. Therefore, I consider it meaningful to integrate

principal parts of the Tavistock approach in my blended, psychosocial approach to humanitarian helper wellbeing. A group dynamics angle is visible in the findings, conclusions and recommendations that arose from this research.

4.3. Motivations of Helpers

In the literature, several diverse motivations that lead people to humanitarian work and work with involuntarily dislocated persons, either as paid staff or as volunteers, are presented.

Gomez et al. (2020) put forward a basic categorisation of these motivations: *altruistic* (*other-centred*) or *self-centred* (also described as self-directed/selfish/self-serving/egoistic). Additionally, Barnett et al. (1998) view helpers in general as (a) other, or (b) self-oriented. Gomez et al. (2020, p. 7) identify four types of humanitarians with chiefly altruistic motivations, namely Good Samaritan, Do-Gooder, Missionary and Activist, and four with predominantly self-serving motivations, namely Humanitarian Tourist, Martyr, Militant and Crusader. Further categorisation involves the distinction into *faith-based* or *secular* motivations as well as into motivations connected either to *moral virtues* or *deontological rules* (Gomez et al., 2020, p. 1). Meanwhile, Oberholster et al. (2013, p. 7) distinguish between four clusters of humanitarians according to their motivations: Caring Missionary, Focused Worker, Self-Directed Careerist and International Family Custodian. In addition, Yala (as cited in Carbonnier, 2015, p. 201) classifies humanitarian workers into idealists, militants, opportunists, professionals, and adventurers.

Furthermore, a general distinction of psychological motivations, specifically with regard to volunteers, is drawn by Clary et al. (1998): (1) social motivation (having the opportunity to expand one’s social network and gain the admiration of others); (2) learning new skills and acquiring new knowledge; (3) altruistic values; (4) personal

growth and better self-image; (5) career enhancement; and (6) protection from negative emotions, such as guilt and escaping from one's own problems.

4.3.1. Self-Centred Motivations

Self-centred motivations regarding humanitarian work can vaguely be divided into two main groups: *extrinsic* or external (mostly professional and social) and *intrinsic* or internal, i.e., with a psychological function (Ryan & Deci, 2001).

The literature reviewed mentions, *inter alia,* the following as key external motivations: protection from social isolation (Sandri, 2018) by meeting people from other cultures (Hunt, 2009), career development (Albuquerque et al., 2018; Rubin et al., 2016), political career enhancement (Anderfuhren-Biget et al., 2012; Donini, 2010, p. 5231) improvement of social status (Carbonnier, 2015, p. 202; Giauque et al., 2019), recognition from family (Bjerneld et al., 2016), employment (Donini, 2010), group identity (Carbonnier, 2015), such as belonging to a militant religious movement (Carbonnier, 2015, p. 201), better, safer living conditions for one's family (Oberholster et al., 2013), becoming humanitarian "by accident" (Donini, 2010, p. 5321), tangible impact of one's work (Rubin et al., 2016), financial benefits (Oberholster et al., 2013), good working conditions and good retirement plans (Fechter, 2012), *voluntourism* (Mostafanezhad, 2014, p. 114), following fashion (Komenska, 2017) or the footsteps of a popular celebrity who promotes humanitarianism (Mostafanezhad, 2014).

Internal motivations are considered to include: calling (Nordahl, 2016), which can possibly be of religious background (Carbonnier, 2015, p. 201), narcissism (Chouliaraki, 2012; Pross, 2006; Radice, 2019) and satisfaction with oneself (Chouliaraki, 2012), wish for adventure and travelling (Albuquerque et al., 2018; Carbonnier, 2015; Donini, 2010; Rehberg, 2005), feeling of worthiness (Albuquerque et al., 2018), feeling of boredom because of a "conventional" lifestyle (Bjerneld et al., 2006), escapism (Carbonnier, 2015; Meneghini, 2016; Oberholster et al., 2013), work

as a sort of “conscience pacifier” for coming from the rich West and substitute for revolutionary desires (Donini, 2010, p. 5231; Pross, 2006), search for something new and wish to challenge one’s self (Bjerneld et al., 2006; Hunt, 2009), heroic attitude and self-identification as helper (Nordahl, 2016), saving oneself by saving others (Radice, 2019), seeking self-fulfilment/self-actualisation (Bjerneld et al., 2006; Rehberg, 2005, p. 120) and meaning-making (Donini, 2010; Pupavac, 2004).

4.3.2. Altruism, Idealism and Cosmopolitanism

With regard to other-centred or selfless motivations, a core aspect is *altruism* (e.g., Albuquerque et al., 2018; Carbonnier, 2015; Fechter, 2012). Altruism is defined as a “motivational state” that seeks to preserve and enhance the wellbeing of others, and which is opposed to egoism, which tries to improve one’s own wellbeing (Batson, 2010). Batson identifies three further approaches to altruism in the contemporary literature, which are “acting morally”, “helping behaviour” and “helping in order to gain internal rewards”, with the latter implying self-centred motivation (Batson, 2010, pp. 17–18). *Empathy* or *empathetic concern* is an other-centred, emotional reaction consistent with the perceived welfare of another person (Batson et al., 2002), and, for example in a humanitarian setting with people in need and adversity survivors, it contains feelings for the other person, such as “compassion, sympathy, tenderness” (Batson et al., 2002, p. 1656) and is inextricably linked to altruism as it increases the readiness to help the other (Batson, 2010). This *empathy-induced altruism* constitutes a key drive for humanitarian and Refugee Care motivation (Gomez et al., 2020). A very specific form of altruism, relevant within a humanitarian context, is *altruism born on suffering*, which refers to people who have experienced adverse events themselves, with this past exposition motivating them to help people in need (Staub & Vollhardt, 2008). Personal or one’s family’s experiences of involuntary

dislocation or migration can be an altruistic motivation for humanitarian involvement (Carbonnier, 2015, p. 201; Olliff, 2018; Yarris et al., 2020).

A further relevant theme, closely associated to altruism and to humanitarianism, is *idealism* (Scott-Smith, 2016; Slim, 2005; Yala, 2005, as cited in Carbonnier, 2015, p. 201). From a humanitarian and a Refugee Care standpoint, idealism can be understood as the prioritisation of humanitarian ideals, values, and goals over realities (Slim, 2005), with over-idealised motivations and expectations not being a rare phenomenon among humanitarians (Hunt, 2009, p. 520).

Cosmopolitanism is also perceived as a motivation for humanitarian work by researchers (Anderfuhren-Biget et al., 2012; Donini, 2010; Mostafanezhad, 2014; Paulmann, 2013). In summary, cosmopolitanism constitutes the belief that regardless of nationality or other ties, everyone has the right to be treated with the same dignity and respect (Brock, 2015). Etymologically, cosmopolitanism derives from the Greek words *cosmos* (world) and *politis* (citizen). From a humanitarian viewpoint, cosmopolitans are active global citizens, who have a worldwide perspective, could work in most places around the world, are inspired by humanitarian ideals and have the drive to provide help or promote social change and justice for people in need (Anderfuhren-Biget et al., 2012; Barnett, 2005; Carbonnier, 2015; Paulmann, 2013; Slim, 2005).

Additional humanitarian motivations (in the sphere of altruism, idealism and cosmopolitanism) are, *inter alia*, solidarity (Nordahl, 2016), either universality or inclusivity (Scott-Smith, 2016, p. 16-17), family values (Yarris et al., 2020) and moral convictions (Kende et al., 2017), universalism in relation to religious beliefs (Laqua, 2014, p. 176), struggle for democracy and human rights (Albuquerque et al., 2018; Apostolidou, 2015; Donini, 2010; Gomez et al., 2020), emotional connection with the affected communities (Komenska, 2017), compassion (Nordahl, 2016), affective

motivations, such as anger (Yarris et al., 2020), belief in community values (Carbonnier, 2015, p. 201), pro-refugee *opinion-based identity* (Kende et al., 2017, p. 274), *organisational citizenship behaviour* (OCB; Emmerik et al., 2005) and, similarly, *public service motivation* (PSM; Anderfuhren-Biget et al., 2012). Malkki (2015, p. 51) points out that locatedness either within a profession (e.g., medicine) or in a geographical or cultural sense may be significant for the "need to help". For instance, a West-European doctor has the will and the urge or need to help, because s/he is from the rich "Global North" and has a specific professional identity (Malkki, 2015, p. 32).

4.3.3. The Discussion on Motivations

Some researchers have focused on the self-centred motives of humanitarianism (Donini 2010, Mostafanezhad, 2014), whereas others argue that self-directed motives alone cannot sufficiently explain humanitarian involvement. Sandri (2018) suggests that humanitarian action juxtaposes altruistic with self-serving motivations. Previous high-ranking ICRC officials Slim (2005) and Carbonnier (2015) support a meaningful, harmonic relationship between altruistic ideals and professional values. Rehberg (2005, p. 119–120) says that according to empirical data, most international volunteers are "altruistic individualists", driven by a blend of other-centred and egoistic motivations. Similarly, Radice (2019) views other-oriented and narcissistic motivation as inseparable in humanitarianism. Meneghini (2016) discusses how motivations encompass humanitarian, altruistic values and acquiring new knowledge and skills, and believes that only a minority have selfish motives. Fechter (2012, p. 1485) appropriately maintains that "attitudes indicate that many (humanitarians) are driven neither exclusively by altruistic motives nor by self-serving career ambitions. Instead, in many cases, their involvement in aid is driven by both professional and personal interests, some of them directly concerned with helping the

world's poor, others perhaps less so". Additionally, she notices a lack of discourse regarding professional and altruistic motivations of humanitarianism and the overlap of these two dimensions (Fechter, 2012, p. 1396).

A further debate refers to the extent that the motivations of humanitarianism and work with refugees are or should be of a political nature (e.g., Gomez et al., 2020). It has been suggested that political ideology may be an important drive for a therapist's commitment to working with involuntarily dislocated persons, but the therapist should be cognisant of the boundaries between psychotherapy or counselling in the therapy room, and political advocacy for a specific purpose (Apostolidou, 2015). Meanwhile, Slim (2005) and Gomez et al. (2020) assert that there is a link between humanitarian motivations and a liberal, progressive political position. Additionally, Komenska (2017) points out that political ideology can lead a person to humanitarian volunteering. From a self-serving viewpoint, political motivation can also refer to the interest of the humanitarian helper in politics or policy-making (Anderfuhren-Biget et al., 2012; Donini, 2010, p. 5232). This is connected to the fact that, within a rather organisational context, humanitarianism is becoming increasingly political with inevitable consequences for humanitarians' moral principles (Barnett, 2005; Pupavac, 2004). Laqua (2014) understands humanitarianism as being part of domestic and international politics, and it can also be partly interpreted as a form of progressive political activism against neoliberalism (Gomez et al., 2020; Sandri, 2018).

In this project, I do not examine motivational theories as a major focus, but am interested in aspects that are useful for answering the research questions and for the development of a broader psychosocial approach to helper wellbeing. In this regard, based on the literature above, in this thesis I accept and integrate the view that humanitarian helper motives could be altruistic as well as self-centred. In addition, I

agree with the view that humanitarian helper motives are associated either implicitly or manifestly with one's political history or ideology (Apostolidou, 2015; Sandri, 2018; Slim, 2005). I should also emphasise that there is empirical evidence of correlation between motivations and wellbeing, for example, considering motives for democratic participation and life satisfaction (Owen et al., 2008), caregiver motivations and caregiver wellbeing (Quinn et al., 2010) and altruistic motivation and "empathy joy" (Batson et al., 1991). Moreover, there are recent research studies that categorise motives into eudemonic and hedonic, following the discourse between hedonism and eudemonia, as extensively discussed in Chapter 3 of this thesis, and assess their relevance/contribution to wellbeing (e.g., Gentzler et al., 2021; Giuntoli et al., 2019). Heeding this, I expect that the findings of this study may provide valuable insights into the role of motivations in humanitarian helper wellbeing, according to the study participants' individual lived experience.

4.4. Sources of Stress and Dissatisfaction

In the literature, the sources of work-related stress and dissatisfaction for humanitarian and other staff working with involuntarily dislocated persons are either (a) of organisational aetiology, (b) linked to the "actual" work with the beneficiaries, or (c) relate to personal or interpersonal factors of the helpers themselves (Blanchetiere, 2006, p. 4). I will generally divide stress factors into: (a) psychosocial, which encompasses the intrapsychic, interpersonal and sociocultural or sociopolitical realm, following Papadopoulos' definition in the "Enhancing Vulnerable Asylum Seekers Protection" (EVASP) manual (2011, p. 30), with specific focus on the individual person; and (b) organisational, although these categories may in some cases overlap. Some of these factors are more relevant to work in the humanitarian field/refugee camps specifically, while others may be more applicable in other

settings of Refugee Care (e.g., psychotherapy or social work for refugees), but it is not a purpose of this study to make this distinction.

4.4.1. Organisational Sources of Work-Related Stress

Organisational or occupational factors that lead to stress and dissatisfaction may include long working hours and excessive workload (Allard-Buffoni & Jönsson, 2015; Birck, 2001; Curling & Simmons, 2010; Ehrenreich & Elliott, 2004) with a lack of rest or breaks (Rubin et al., 2016, p. 5), issues with the leadership and management, such as lack of role clarity (Rubin et al., 2016, p. 5), lack of guidance and "despotic" tendencies (Albuquerque et al., 2018; Hunt, 2009), security and safety concerns (Bjerneld et al., 2006; Guskovict & Potocky, 2018; Korff et al., 2015; Musa & Hamid, 2008), lack of reciprocity (Jachens et al., 2019) and of recognition from the organisation (Brooks et al., 2015; Curling & Simmons, 2010; Rubin et al., 2016), disproportionately high demands (Soliman & Gillespie, 2011), lack of resources (Ehrenreich & Elliott, 2004; Rubin et al., 2016), especially concerning volunteers (Aldamman et al., 2019), lack of supervision (Schweitzer et al., 2015), boredom (Rubin et al., 2016, p. 4), lack of support by the organisation, including psychosocial support and support by peers (Brooks et al., 2005; Thormar et al., 2013; Vergara & Gardner, 2011), lack of a supportive environment for therapists who work with adversity survivors (Boscarino et al., 2004), a dominant *"macho" culture* that supresses discussion on issues regarding wellbeing and burnout (Blanchetiere, 2006, p. 10), team conflict (Birck, 2001; Ehrenreich & Elliott, 2004), moral conflict due to the triage policy of the organisation (De Waal, 2010, pp. 131–132; Thoresen et al., 2009, p. 363) or due to the policy of political neutrality of the organisation (Ehrenreich & Elliott, 2004, p. 54) or its priorities (Blanchetiere, 2006), even concern and fear that the organisation can unintentionally harm the people in need instead of assisting them (Hunt, 2008, pp. 60–61), "*red tape*" (Giauque et al., 2019, p. 884) as an

administrative phenomenon that encompasses excessive bureaucracy and lack of autonomy for the staff (Allard-Buffoni & Jönsson, 2015; Rubin et al., 2016, p. 5), narrow growth possibilities within the organisation (Allard-Buffoni & Jönsson, 2015) and over-exposure of NGO staff to mass media and communication (Brooks et al., 2015, p. 393).

4.4.2. Psychosocial Dimensions of Helper's Stress

Although research generally highlights that living and working abroad for an organisation (Giauque et al., 2019; Jachens et al., 2019) in an environment of linguistic and cultural barriers (Korff et al., 2015; Rubin et al., 2016) with limited possibilities for socialisation (Curling & Simmons, 2010) and far from one's family or spouse (Ehrenreich & Elliott, 2004, p. 54; Korff et al., 2015) constitute noteworthy sources of stress for staff, attention is also brought to the fact that communication with family during deployment and, mainly, after returning home can possibly be a stress factor due to lack of understanding, validation and recognition by family members and one's social circle (Albuquerque et al., 2018, pp. 5–6; Bjerneld et al., 2006; Brooks et al., 2015, p. 390).

Further, during work with involuntarily dislocated persons (e.g., within a therapeutic context) over-idealised motivations (Guhan & Liebling-Kalifani, 2011; Hunt, 2009) and overidentification (Musa & Hamid, 2008) with adversity survivors may lead to overinvolvement and emotional exhaustion (Pross, 2006; Schweitzer et al., 2015) and to an overly biased attitude on the side of the client (Pross, 2006). Unmet expectations (De Waal, 2010; Jachens et al., 2019) and feelings of uselessness, inadequateness, overwhelmingness, self-doubt and powerlessness (e.g., Apostolidou, 2016; Brooks et al., 2015; Nordahl, 2016) are wedded to the work with beneficiaries. Meanwhile, within a humanitarian work context, Tassell and Flett (2007, p. 17) draw attention to the concept of *obsessive passion*, which they describe

as “internal pressure to obtain contingencies” and which “compels engagement, despite the personal consequences of doing so”. Stress related to the direct work with involuntarily dislocated persons may also be linked to the lack of gratitude from them (Ehrenreich & Elliott, 2004, p. 54), vast differences in the political ideology between service provider and client (Eleftheriadou, 1999) and threat of deportation for beneficiaries (Birck, 2001). Finally, Deighton et al. (2007) state that according to the relevant literature, the level of exposure to adverse content for the helper and the years of experience working with adversity survivors cannot be categorised as stress factors with certainty.

In Chapter 2, I scrutinised the concept/archetype of the Wounded Healer within a Jungian-oriented perspective. Here, I would like to approach this from a different angle. Pross (2006) refers to certain aspects of the depth-psychological concept of the *Wounded Healer* as possible sources of work-related stress in therapeutic work with adversity survivors. However, according to Pross (2006), avoidance of dealing with one’s own profoundly distressing experiences and emotions is, in this case, connected with the need to be therapeutic for others, i.e., the aid recipients. Furthermore, helpers may be inclined to overcome their own feelings of overwhelmingness, helplessness and powerlessness through their multidimensional overinvolvement with the cases of their beneficiaries (Pross, 2006). Generally, therapists with psychiatric or psychotraumatic history of their own, seemingly have a higher possibility of developing work-related symptoms (Price, 1998, as cited in Deighton et al., 2007, p. 65). Also, in humanitarian work, it is known that work-related stress caused by the exposure to adverse content may be amplified if the staff member has a psychiatric or psychotraumatic history (Guskovict & Potocky, 2018; Musa & Hamid, 2008).

In essence, in this project I acknowledge the considerable variety of organisational and psychosocial stressors related to humanitarian work and work with people from refugee backgrounds. Further, as this subsection shows, I have to take into account and to highlight the fact that the vast majority of these sources of helper's stress (with the exceptions of "overidentification" with the adversity survivors and of the "Wounded Healer" dimension) are not directly connected to exposure to the traumatising, distressful narratives of the refugee clients. On the whole, the above points confirm the theoretical framework of the AG and the broader psychosocial approach of this project in their effort to capture the humanitarian helper experience by underscoring complexity, multidimensionality and multidisciplinarity.

Chapter Synopsis and Thesis Progression

In summary, in this chapter I set out key aspects surrounding the topic of humanitarian wellbeing, such as existing guidelines, recommendations for organisational policies, important institutional dynamics and relevant motivations, and critically discussed and compared these subjects to the theoretical background of this thesis. Motivational aspects and elements of group dynamics/relations theory will be integrated into the conceptual framework of this project next to its theoretical backbone, as they can provide valuable insights into the lived experience and wellbeing of humanitarian helpers at different psychosocial levels. Meanwhile, the conceptual approach of this project is informed by current suggestions on organisational policies regarding humanitarian staff wellbeing, and these will be considered during the execution of the interpretational work of this study.

This chapter explored motivational, organisational, group relational and psychosocial dimensions that are not inextricably linked to the exposure to the adverse content of the beneficiaries.

In the next chapter, the focus of the thesis shifts to the wide range of helper reactions and consequences in the aftermath of adversities that are experienced in the immediate contact/work with refugees.

Chapter 5: Negative Consequences, Positive Outcomes and Resilience in Work With Refugees

In this chapter, I endeavour to cover the negative outcomes with a pathologic dimension and the positive changes in staff exposed to adversities through their work with refugees. I will also compare the growth-based concepts of the exposure with the concept of AAD.

First, I approach the phenomenon of burnout from various angles and discuss this from a Jungian perspective, as Jungian psychology is a principal pillar of the theoretical framework of this study. Second, primary trauma with main focus on PTSD as pathological reaction to adversities is laid out and critically discussed and compared to the conceptual approach of this study. Next, I present and analyse secondary traumatic responses to adverse material, which include secondary traumatic stress, compassion fatigue, vicarious traumatisation, and moral injury. Then, the parallels and differences between direct and indirect traumatic phenomena are explained and the expansion of the predominant trauma discourse from the PTSD of the refugee to the vicarious trauma of the helper is critically reviewed through the conceptual lens of this project. Furthermore, I elaborate on the positive psychosocial outcomes for the humanitarian helper in the aftermath of adverse events, which involve vicarious resilience and vicarious posttraumatic growth, and compare these to AAD. Lastly, I define and confer the phenomenon of resilience and coping and expound these on the humanitarian helper's sphere from a psychosocial perspective. In this regard, I also put forward relevant supportive processes.

5.1. Range of Reactions and Consequences in the Aftermath of Adversities

Working with persons who have been exposed to adversities, such as refugees, means, in effect, that humanitarian helpers themselves are exposed to adversity (e.g., Lusk & Terrazas, 2015; Rizkalla & Segal, 2020). Looking at the bulk

of the literature, I agree with Papadopoulos (2021b) that the dominant conceptualisation of this exposure and the relevant work-related stress, and, in some cases, distress, is mostly shaped through a clinical-medical approach, which includes terms popular in the contemporary literature, such as *compassion fatigue* (CF), *vicarious traumatisation* (VT), *secondary traumatisation* or *secondary traumatic stress* (STS) and, of course, *burnout.*

In the literature, the connection between the framework of burnout and humanitarian work is predominant (e.g., Ager et al., 2012; Cardozo et al., 2012; Emmerik et al., 2005; Eriksson et al., 2009; Guhan & Liebling-Kalifani, 2011; Jachens et al., 2019; Strohmeier et al., 2018). Nevertheless, a growing number of authors call for the development of a less (or non-) psychopathological conceptual framework for the helpers of adversity survivors, such as refugees (e.g., Arnold et al., 2015; Barrington & Shakespeare-Finch, 2013; Brooks et al., 2015; Emmens & Porter, 2009; Guhan & Liebling-Kalifani, 2011; Hyatt-Burkhart, 2014; McCormack et al., 2009).

However, it is an *oxymoron* that (relatively) newly emerged concepts, which attempt to approach humanitarian work and work-related stress from a more positive, *salutogenic*, and strength-based perspective, namely *vicarious post-traumatic growth* (VPTG) and *vicarious resilience* (VR), do, in fact, view trauma and/or pathology as their point of departure, even if not directly, but *vicariously* (Hyatt-Burkhart, 2014; Puvimanasinghe et al., 2015). In other words, the VR or VPTG of the helper is made possible only through the exposure to the *trauma-related disorder* of the beneficiary.

I choose to present the phenomenon of burnout in a separate subsection for historical reasons and due to its distinct (from the other phenomena) and more generic nature, as it is not directly associated with the concept of psychological trauma, when compared to the other negative or pathologic outcomes. At this point, it should be noted that, according to the theoretical framework of the AG that guides

this project, burnout and the other negative outcomes are only one dimension of the wide range of responses and consequences as a result of the work with involuntarily dislocated persons. In this sense, they certainly do not grasp the entire psychosocial reality of the humanitarian helper experience.

5.1.1. Burnout

Burnout is a psychological syndrome connected to work-related stress, which encompasses three main dimensions: (a) emotional exhaustion, (b) cynicism (or *depersonalisation*) and (c) reduced personal accomplishment and a sense of ineffectiveness at work (Maslach & Leiter, 2016) with exhaustion being the core component (Bakker et al., 2008; Broeck et al., 2018; Hochstrasser et al., 2016a). Initially, it was assumed that burnout mostly affects workers in helping professions, but later research has shown that it may impact any occupational group (Bakker et al., 2002; Bakker et al., 2008). The concept of burnout comprises clinical as well as organisational aspects (Hochstrasser et al., 2016a, p. 540; Maslach & Leiter, 2016).

Burnout from a Historical Perspective. German American psychologist Herbert Freudenberger (1926–1999) was among the first practitioners to describe the phenomenon of staff burnout based on his work in the *free clinic movement* in New York (1974). He noticed that staff members, including himself, who worked intensively as health services providers with clients, experienced several physical and behavioural symptoms and signs such as exhaustion, headaches, sleeplessness, depression, cynicism, feelings of being overwhelmed, constant negative attitude, irritability, reduced effectiveness and isolation, and suggested that overcommitment and boredom as a result of the routinisation of work are possible risk factors for burnout, and even devised preventive measures, including enhancement of group feeling, avoidance of work overload and routinisation, and physical exercise. He also recommended time off, support groups and open

communication for staff members suffering from burnout but did not suggest any form of psychotherapy as a possible treatment Freudenberger (1974, 1986).

From an occupational-organisational perspective, the concept of burnout was elaborated further by Maslach and Jackson (1981) who identified the three main domains of burnout (exhaustion, depersonalisation, personal accomplishment) by using a questionnaire, the Maslach Burnout Inventory. Emotional exhaustion means loss of energy, fatigue, depletion; cynicism or depersonalisation refer to emotional detachment from clients, emotional withdrawal, and loss of idealism; reduced personal accomplishment is the “inefficacy dimension” of burnout (Maslach & Leiter, 2016). Moreover, Maslach and Leiter distinguished six key areas in which disequilibrium could be a risk factor for a potential burnout: workload, control, reward, community, fairness, and values (Leiter & Maslach, 1999; Maslach & Leiter, 2016).

From a medical/clinical perspective, burnout has not, at least yet, been identified as a distinct psychiatric disorder (PD) according to the WHO ICD-10 (International Classification of Diseases, 10th revision) and ICD-11 classification, but rather as an *occupational phenomenon* that may overlap with pathological entities, such as clinical depression (Bianchi et al., 2015; Hochstrasser et al., 2016a, p. 538; Kaschka et al., 2011; Moss, 2019; WHO, 2019).

Burnout from an Organisational Perspective. Within an organisational context, several models have been devised for the conceptualisation of work-related stress and the burnout experience. These are outlined below. I consider the organisational/occupational perspective vital for the purposes of this study, since it displays an alternative, psychosocial, non-clinical/non-pathological approach to the phenomenon of burnout, and, thus, to humanitarian staff wellbeing.

The Demand-Control Model (DCM) or Job Demand-Control Model (JDC). According to the DCM, greater autonomy at work can mitigate the impact of high job

demands (such as work overload, emotional demands) on job stress, and help workers cope better with stressful conditions (Karasek, 1979 & 1998; Van der Doef & Maes, 1999). In DCM, job demands are defined as the sources of psychological stress in the work environment (e.g., work overload, conflict at work) and job control is defined as the job decision latitude, i.e., the workers' control over the execution of their tasks (Bakker et al., 2005; De Jonge et al., 2000; Karasek, 1979; Karasek & Theorell, 1990). High demands of a job and low worker autonomy predict detrimental health effects, whereas high demands and high autonomy can lead to motivation and growth for the worker (De Jonge et al., 2000). The connection of DCM to the key dimensions (exhaustion, cynicism) of burnout has been well-researched in various studies (e.g., Demerouti et al., 2001; De Rijk et al., 1998; Salanova et al., 2002).

The Effort–Reward Imbalance Model (ERI). The ERI model was developed by Siegrist (1996) and has been linked to the burnout phenomenon (Bakker et al., 2000; Schulz et al., 2009), even within a humanitarian context (Jachens et al., 2019). According to the ERI model, the lack of reciprocity, in terms of high effort and low rewards at work, can lead to adverse health effects such as emotional distress and burnout (Bakker et al., 2000; Siegrist, 1996). Gratification or rewards are divided into three main domains: money, esteem or approval and status control. Meanwhile, efforts are split into *intrinsic*, i.e., the worker's motivations, or *extrinsic*, i.e., the job demands (Siegrist, 1996). The imbalance of efforts v. rewards can be maintained due to various reasons: lack of alternatives in the labour market for employees, strategic thinking (e.g., while anticipating a promotion) and *overcommitment* (Siegrist, 2012). For example, a job with high demands but with lack of job stability and poor promotion prospects creates a "chronic disequilibrium" that may result in work-related stress and burnout (Bakker et al., 2000).

The Job Demands-Resources Model (JD-R). The JD-R model focuses on job demands and resources, their interaction, and their effect on staff wellbeing (Bakker & Demerouti, 2007). Job demands refer to the physical, social, or organizational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs. Job resources refer to the physical, psychological, social, or organizational aspects of the job that (a) are functional in achieving work goals, (b) reduce job demands and the associated physiological and psychological costs (Bakker et al., 2005, p. 170). Within the JD-R context, job demands are not *per se* negative factors, but can potentially turn into stressors (Broeck et al., 2008). JD-R states that job resources can buffer the negative psychological effects of job demands, such as burnout, on staff (Bakker et al., 2003; Bakker et al., 2005). Conversely, a job with high demands and low resources may result due to exhaustion of the limited resources into emotional fatigue, which, consequently, leads to reduced motivation and, eventually, to an emotional detachment from work, i.e., cynicism (Bakker et al., 2005). This reactive detached attitude may be interpreted as a "self-protective" mechanism of the staff members to cope with stress and maintain their resources (Bakker et al., 2008; Maslach & Leiter, 2016) and this assumption has also been supported by the Conservation of Resources (COR) model (Hobfoll, 1989). Moreover, COR suggests that stress is a result of an actual loss of resources or threat of loss or lack of attainment of new resources after investing old resources (Halbesleben et al., 2014). Social support from colleagues and constructive feedback from supervisors are identified as valuable resources that function as protective factors against job stress and burnout (Bakker et al., 2005; Bakker et al., 2008; Van der Doef & Maes, 1999). In contrast with ERI and DCM, JD-R not only focuses on the rather negative job elements

(stressors), but also explores job aspects beneficial to staff wellbeing, i.e., resources (Broeck et al., 2008, p. 278).

The Areas of Worklife (AW) Model. The AW model proposes that imbalances in the six central domains identified by Leiter and Maslach (1999), namely workload, control, reward, community, fairness and values, are linked to the experience of burnout (Leiter & Shaughnessy, 2006; Maslach & Leiter, 2016). AW includes areas discussed in the models above, i.e., workload and control within DCM, reward within ERI and community or social support as stated in JD-R (Masluk et al., 2018). In contrast with DCM, Leiter and Shaughnessy (2006) consider lack of control or autonomy at work as an indirect factor of burnout contributing to distortions in the other five areas of worklife. Based on the AW model, the *Areas of Worklife Scale* (AWS) has been developed and applied as a tool for identifying work-related problems and factors of distress and burnout (Brom et al., 2015; Masluk et al., 2018).

Burnout from a Clinical Perspective. The link between specific personality characteristics and a higher vulnerability for burnout has been discussed by various researchers. These include, for example, unhappy altruists and straightforward pragmatists (Haberthür et al., 2009), the so-called Type D personality (distressed) that is characterised by negative affectivity and social inhibition (Mols & Denollet, 2010; Rössler et al., 2013), lack of self-confidence (Rössler et al., 2013), ambivalent or anxious-preoccupied attachment style, self-sacrificial attitude (Schramm & Berger, 2013), and an avoidance or confrontational conflict resolution style (Montoro-Rodriguez & Small, 2006). Burnout can also be interpreted as an outcome of lack of appropriate self-care (Rothschild, 2022).

From a clinical/psychiatric perspective, several possible symptoms and reactions relevant to burnout as a syndrome have been reported. These can be categorised into four main groups: psychological, physical, cognitive and behavioural

(Hochstrasser et al., 2016b). These include, *inter alia*, irritability, aggression, anxiety and panic attacks, loss of motivation, insecurity, headaches, exhaustion, susceptibility to infections, insomnia, reduced cognitive performance, decision-making difficulty, flattened social life, addictive behaviour and absenteeism (Hochstrasser et al., 2016b; Kaschka et al., 2011). Burnout as a gradual process can be divided into three stages of increasing severity (Hochstrasser et al., 2016b): the first, early stage is characterised by increasing emotional distress, the second includes exhaustion, sleep disorders and physical signs and the third phase is equivalent to clinical depression.

Burnout from a Humanitarian Perspective. Within a humanitarian and refugee support context, Weiseth (as cited in UNHCR, 2001) named several key factors that lead to burnout, including, amongst others, insufficient recognition (see also ERI), insufficient support from managers, lack of control over the situation (see also DCM), too high expectations and scarcity of resources (see also JDR-M), problematic organisational policies, and unwelcome changes. Burnout may affect staff, managers and supervisors.

Apart from physical and emotional signs of burnout, UNHCR points out reactions related to the work setting and the organisation, such as absenteeism, clique formation, scapegoating, conflicts with colleagues, disrespect and cynicism towards colleagues, increased sick leave, which caused loss of meaning in one's work (UNHCR, 2001, p. 13). Considering coping and dealing with burnout, UNHCR (2001) suggests medical care, stress management, and support for work-life balance, equilibrium of efforts and rewards, changing roles, extended leave, and quitting or reconsidering one's career path. In a nutshell, social and organisational support are regarded as the core aspect of adequately addressing and facing staff burnout.

Burnout: Prevention/Protective Factors, Psychodynamics, and Healing.

Maslach and Leiter (2016, p. 109), in their extensive research into burnout, outline several measures for individual coping with work-related stress and preventing burnout, and this without solely focusing on a psychotherapeutic dimension. These include: (a) changing work patterns (for instance, working less, taking more breaks, avoiding overtime work, balancing work with the rest of one's life); (b) developing coping skills (for instance, cognitive restructuring, conflict resolution, time management); (c) obtaining social support (both from colleagues and family); (d) utilising relaxation strategies; (e) promoting good health and fitness; and (f) developing better self-understanding.

These recommendations are, to a certain extent, in agreement with the conclusions of other authors either from a clinical or an occupational-organisational angle (e.g., Bakker et al., 2005; Freudenberger, 1974, 1986; Hochstrasser et al., 2016a; Hochstrasser et al., 2016b; Montoro-Rodriguez & Small, 2006).

A sense of existential significance and religious belief are negatively correlated to burnout (Pines, 2002). The belief that one is making a significant, meaningful contribution in society can act as a protective factor from burnout (Pines, 2000, 2002). A new orientation in life and the reconsidering of values and goals are crucial for the treatment of burnout (Hochstrasser et al., 2016a). Realism instead of perfectionism possibly ameliorates one’s work-life balance (Kaschka et al., 2011). Meanwhile, a sense of *belongingness* and *relatedness* may shield one from work-related stress (Broeck et al., 2008). The experience of burnout can be perceived as a *meaning crisis,* during which affected persons may get to know their own limits, abandon their obsession with professional success and performance, learn to accept and take care of themselves, set new goals in their lives, and connect (or reconnect) with some form of spirituality (Hochstrasser et al., 2016b). Furthermore, the theme of

adjustment in relation to job stress and burnout has also been raised by various authors (Cherniss, 1980, as cited in Hochstrasser et al., 2016a; Silbiger & Pines, 2014; Silbiger et al., 2017).

This thesis relies on Jungian psychology as one of its main theoretical foundations. With regard to the psychodynamic aspects and healing process in burnout, I will now reflect upon Jung's theories, especially those deriving from his concepts of neurosis (German: *Neurosenlehre*) and the *individuation process*. Jung approaches neurosis as a lack of psychological adaptation in one's life (2014, pp. 1400, 1421). This process of adjustment may be inadequate in relation to either "outer or inner conditions" due to the imbalanced adaptation on only one condition and at the expense of the other (Jung, 2014, pp. 8298–8299). "The identification with a social role" and the creation and maintenance of an "artificial personality" constitute, according to Jung (2014, p. 2838), a "very fruitful source of neuroses". As a therapeutic measure for neurosis, he proposes accomplishing "harmony between conscious and unconscious" (2014, p. 3245) and a "re-education and regeneration of personality" (2014, p. 7310). According to Jung (2014, p. 1801), this harmonic state of interaction between conscious and unconscious constitutes an essential element of the individuation process, which he defines as a "an extension of the sphere of consciousness, an enriching of conscious psychological life" (Jung, 2014, pp. 2509–2510). To an affected person, this achievement of a higher level of self-awareness encompasses understanding the *meaning* of neurosis (Jung, 2014, pp. 5214–5215), "what it has to teach" (2014, p. 4474), overcoming "spiritual stagnation" (2014, p. 5215) and integrating new values one has lacked before (2014, pp. 2705–2706). In his *Neurosenlehre*, Jung emphasises the positive and *teleological* aspects of neurosis (Jung, 2014, pp. 2684, 2690, 4471). In conclusion, one could suggest that Jung's theorising on neurosis is consistent with most of the existential approaches on

burnout discussed above. Additionally, the connection of burnout with neuroticism has acted as material for various contemporary studies (e.g., De Hoogh & Den Hartog, 2009; Hursitoglu et al., 2019; Tereszko et al., 2020).

Burnout: Conclusion. In conclusion, the phenomenon termed as burnout is considered multidimensional and historically wedded to helping professions. Inevitably, it is also regarded as a common occupational issue among humanitarians. Following the paradigm of burnout, further phenomena describing negative consequences and responses in the aftermath of exposure to adversities have been termed and conceptualised within the context of helping professions. These terms are presented in the next section of this chapter. In this thesis, I point out that burnout and the other negative or pathologic outcomes only offer a partial, rather clinical, insight into the overall psychosocial experience and wellbeing of the helper. Therefore, a broader psychosocial approach should not exclusively focus on these negative reactions but should also acknowledge and investigate further (not necessarily medical/clinical or undesirable) aspects and changes of the helpers due to their demanding work with refugees.

5.1.2. Further Negative Outcomes of Work With Adversity Survivors

The focus of this project is not on the primary psychological outcomes of man-made calamities or natural disasters that a humanitarian may experience *directly or outside of the workplace* (e.g., an accident in the field, being kidnapped by terrorists, having experienced a severe flood or earthquake), as these are not associated with the direct work with refugees. Moreover, I clearly do not investigate the primary post-traumatic or post-adversity reactions of the refugees. In this thesis, I examine the reactions and the wellbeing of their helpers, including the eventuality of a secondary/indirect traumatic response. Nevertheless, I consider a presentation of the clinical aspects of primary trauma-related disorders vital for the comparison and

distinction between primary/direct and secondary/indirect/vicarious trauma. This assists a better understanding and, therefore, a more in-depth critical discussion of the psychotraumatological framework. Hence, in the present subsection, I will examine direct trauma and secondary negative outcomes of adversities and link them appropriately.

5.1.2.a. Trauma and PTSD: A Psychotraumatological Approach. The word "trauma" etymologically stems from the Greek verb "*titrosko"*, which means "to pierce" (Papadopoulos, 2002, p. 28). Based on this, trauma is the mark left on the skin after an injury, the wound. In this respect, Maercker and Heim (2016, p. 68) refer to trauma as "wounded psyche". However, an alternative etymology of the word suggests that the root verb might be *"tiro"* which means "to rub", more specifically "to rub in" or its opposite, i.e., "to rub off/away". Following this interpretation, "trauma would be the mark left on persons as a result of something being rubbed onto them" (Papadopoulos, 2007, p. 304).

Based on the first etymological connection ("rub on") of trauma, a traumatic experience can be an injury, a wound that can leave an indelible mark, cause pain, suffering and may result in psychopathology (trauma-related mental disorder). Nevertheless, from a psychological perspective, by looking at the second interpretation ("rub away"), one can reach a different conclusion regarding trauma: by "rubbing away" the marks, there is a potential for renewal, for a new beginning in one's life (Papadopoulos, 2002, p. 28).

The psychotraumatological approach, as a clinical approach, works with psychopathologies, i.e., *trauma-related disorders*. Trauma-related disorders are psychiatric conditions defined by the internationally accepted diagnostic manuals. A cardinal conceptualisation of psychological trauma is *post-traumatic stress disorder* (PTSD). On many occasions (e.g., in the press), terms "trauma" and "PTSD" are

used interchangeably, even though this is not always accurate. In 1980, the Diagnostic and Statistical Manual for Mental Disorders, 3rd edition (DSM-III), of the American Psychiatric Association took the plethora of symptoms and labels used with trauma cases and created the diagnosis of PTSD (e.g., Crocq & Crocq, 2000, p. 47). When compared to the majority of PDs, PTSD (like the other trauma-related and adjustment disorders) is distinctive in being a diagnosis focusing not only on intrapsychic/endogenous aetiologies and processes, but also on external events.

From a medical perspective, the criteria for the clinical diagnosis of PTSD are, according to the DSM-V (American Psychiatric Association, 2013), the following: exposure to a distressing event, re-experiencing of the distressing event, avoidance, alterations in cognition or mood, and alterations in arousal and reactivity. The duration of the disorder should be more than one month. Correspondingly, the WHO International Classification of Diseases, 10th edition (ICD-10), proposed four diagnostic criteria for PTSD: exposure to a distressing event; re-experiencing; avoidance; hyperarousal or inability to recall aspects of the event (WHO, 1992). Additionally, the duration of the disturbance should be of at least six months. These criteria were slightly adjusted by WHO ICD-11: re-experiencing; avoidance; heightened sense of threat (WHO, 2022).

A further relevant concept, which is connected to PTSD and that has recently been identified by WHO ICD-11 as a distinct clinical disorder, is *complex post-traumatic stress disorder* (CPTSD). Next to the three core symptom clusters (re-experiencing, avoidance, hyperarousal) of PTSD, three further criteria have been added: disturbances in affect regulation, disturbances in relationships, and negative self-concept (Horn, 2020, pp. 22-23). These constitute the *disturbances of self-organisation* of CPTSD (Møller et al., 2021). Studies suggest that there is a high prevalence of CPTSD among refugees and asylum-seeking persons due to their

exposure to prolonged and/or multiple hardships and turmoil (e.g., Cloitre, 2022; Jowet et al., 2021).

5.1.2.b. Trauma-PTSD: A Critique. Nonetheless, in the literature, there are voices that critically view PTSD and the predominant narrative of psychological trauma, in general. Kushlev (2024) claims that the overuse of the term (psychological) “trauma” makes it lose its original meaning, adding that negative experiences are not necessarily traumatic. Greenberg et al. (2015, p. 2) conclude that “the definition of what constitutes a traumatic event is not clear and is a matter of both scientific and lay debate” and that most may experience some form of potentially traumatic events at some point during their lives. Nevertheless, “it would be wrong to conclude that all stressful events are traumatic for every individual impacted. Not all individuals will react to trauma in the same way…” (Fealy, 2020, p. 63). According to Tehrani (2004, p. 179) “individual and situational factors will influence the effects on individuals”. Similarly, “only a small proportion of those exposed to severe stressors respond with PTSD” (Shalev & Yehuda, 1998, p. 2). Moreover, in the case of traumatic events, only a minority will suffer the devastating and hindering long-term effects of PTSD (Greenberg, 2013, as cited in Fealy, 2020, p. 70). Other researchers showed that post-traumatic stress may be attributed to failure in recovery rather than to the nature of the traumatic exposure (McFarlane & Yehuda, 1996, p. 155). Subsequently, for example in the aftermath of a natural disaster, recovery is assisted when the individual’s perception of the size of the catastrophe and turmoil is balanced by a perceived capability to deal with it (Tehrani, 2004, p. 26). Meanwhile, Seligman (2011, p. 158) pointed out that people who are impacted by previous trauma or have mental health issues are at greater risk of PTSD than those more psychologically fit: “PTSD can often be seen as an exacerbation of pre-existing symptoms of anxiety and depression than as a first case.” Burstow (2005) looks at

the tendency of the predominant model to medicalise and pathologise unpleasant, but still normal, human reactions to adversities. Symptoms such as nightmares may demonstrate adaptive mechanisms of the human psyche to distressing situations (Garbarino, 2008) and should not be hastily classified as psychopathology. As Adshead and Ferris (2007, p. 358) comment, “there is clearly nothing abnormal about feeling bad when bad things happen. It is equally clear that acute psychological stress reactions, however normal, are extremely distressing and uncomfortable.” However, it is claimed that the same external, adverse event can affect individuals who experienced it in varying ways but, generally, most will recover.

From a psychodynamic viewpoint, Kalsched (1996, p. 3) investigated the inner world of dreams of those who have experienced severe trauma through a Jungian lens. He conceptualised trauma and its developmental impact as a self-care system in response to early childhood trauma. However, this self-care system, aimed at shielding the self, can become destructive. Also, Freud (1994, p. 22) stated that “on occasions when the most extreme forms of suffering have to be endured, special protective devices come into operation”.

From the theoretical perspective of Refugee Care, Papadopoulos (2007, p. 303) argues that adversity survivors such as refugees are not “a homogeneous group of people, as if they belonged to a clearly defined psychological or psychiatric diagnostic category”. With this in mind, he adds that “trauma refers to the way one construes and experiences a fact rather than the phenomenon itself” (Papadopoulos, 2007, p. 92). The bulk of the *trauma consensus narrative* (Papadopoulos, 2021a, p. 231) follows a linear causal epistemology, according to which exposure to adversity (direct or vicariously) inevitably leads to trauma and pathology (Papadopoulos, 2002; Pupavac, 2004). If a person develops a pathology in the aftermath of a catastrophic event, this is then the ramification of multiple, complex, interactive variables that

include, *inter alia,* personal factors (e.g., personality characteristics, intellectual level, personal history), relational factors (e.g., support from family, peers), sociodemographic profile, prospects, and relevant systems of meaning (Papadopoulos, 2021a). The discussion on refugee and helper trauma will be expanded in subsection 5.1.3 of this chapter.

As mentioned earlier, in this thesis I do not investigate the wellbeing of refugees that suffer from PTSD. Nevertheless, I should emphasise the fact that the projects that follow the theoretical framework of the AG and Refugee Care (as described in Chapter 2) for the empirical investigation of refugee wellbeing are critical of the dominance or one-sidedness of the medical paradigm, including PTSD, regarding the traditional approach to the complex refugee experience (Chondrou, 2019; Zucca, 2015). This study is also guided by the same theoretical framework (with the difference that the focus is being shifted from the beneficiary to the service provider) and does not follow the medical paradigm.

5.1.2.c. Negative Outcomes for the Helper (STS, VT, CF, Moral Injury). After having looked at primary trauma and PTSD, I will now proceed to further negative/pathologic responses and ramifications as a result of the work with refugees. These can generally be classified under the umbrella term of “secondary” or “indirect trauma” (e.g., Pellegrini et al., 2022). In this project, I examine the wide range of outcomes in the aftermath of the exposure to the adverse material that the beneficiaries carry with them. Consequently, “indirect trauma”, as a possible negative outcome, is a sphere examined in this thesis. However, the focus of this thesis is not exclusively on the negative outcomes and changes due to indirect exposure to adversity. The phenomena that I will discuss in this subsection are secondary traumatisation or STS, CF, VT, and moral injury (separately from the others due to its distinctive nature).

The terms “STS”, “CF” and “VT” are largely used interchangeably in the current literature in relation to work-related stress regarding not only humanitarian staff (e.g., Ehrenreich & Elliott, 2004; Musa & Hamid, 2008; Posselt et al., 2020), but also other helping professions (Ledoux, 2015; Sprang et al., 2019).

The term “STS” was introduced by trauma experts in the early 1990s (Figley, 1995; Stamm, 1995) who tried to conceptualise the manifestation of psychotraumatologic symptoms by people who have not experienced traumatising events directly. Initially, secondary trauma referred to the “contagion” of a primary trauma between family members (Rothschild, 2022), but it later acquired a more inclusive meaning. STS describes the exhibition of PTSD symptoms (such as hyperarousal and avoidance) after the indirect exposure to traumatising events, for example, through exposure to the narratives of a traumatised person. STS as a psychopathological phenomenon shows similarities to PTSD and affects people who assist – either as professionals (e.g., clinicians) or as significant others – persons who suffer from a trauma-related disorder (Figley, 2002; Quinal et al., 2009). Nevertheless, it should also be said that not every psychological stress that a spouse of a traumatised person has, can invariably be attributed to STS (Renshaw et al., 2011). Undoubtedly, humanitarian staff and staff working with refugees belong to these helping professions exposed to STS, including, among others, healthcare professionals, nurses and first responders.

Later, the concept of CF was coined by Figley (1993, 1995) initially describing feelings of “helplessness, confusion, isolation, numbness or avoidance, and persistent arousal in those who interact with traumatised individuals” (Sprang et al., 2019, p. 72). Although CF is a similar concept to STS, it has a less stigmatising and pathologising effect than STS (Sprang et al., 2019). CF can be defined as the “convergence of traumatic stress, STS and cumulative stress/burnout in the lives of

helping professionals and other care providers" (Figley, 2002, p. 124). The term "CF" gained recognition in the field of nursing (Edelkott et al., 2016) and it echoes – in a less clinical-psychopathological approach – "the diminished capacity of a health professional when experiencing the distress at knowing about or witnessing the suffering of their patients and clients" (Nimmo & Huggard, 2013, p. 38). By definition, the essential element of CF is the aid recipient's or client's suffering and distress, but not necessarily PTSD (which conveys a medical-psychiatric dimension).

The term "VT" was coined by Pearlman and Saakvitne (1995) and describes the cumulative exposure to the details of clients' traumatic experiences and, particularly, the negative impact of this exposure on the helper's cognitive schemata (Nimmo & Huggard, 2013; Sprang et al., 2019). In the relevant literature, VT predominantly focuses on psychotherapists and clinicians and tries to conceptualise their experience and reaction while working directly with adversity survivors (Edelkott et al., 2016; Hernandez-Wolfe et al., 2015).

When compared to CF and STS, VT seems to be a more specific concept, and focuses more on the changes of cognitions, such as beliefs about the self, the world, one's work and meaning in life, as a result of direct, repeated, in-depth exposure to the adverse or traumatic material of the clients (Deighton et al., 2007); on the other hand, CF tends to address the emotional pressure and exhaustion of the service provider through the direct work and empathising with people who suffer and are in pain (Barrington & Shakespeare-Finch, 2014; Deighton et al., 2007). In general, the term "VT" reflects a negative, *inner transformation* in the trauma worker as a consequence of the intensive, empathetic engaging with adversity survivors (Pearlman & McIan, 1995). Those affected by VT can demonstrate intense emotional reactions, intrusive symptoms, and disruption to a pre-existing perception of the world (McCann & Pearlman, 1990; McLean et al., 2003; Pearlman & Saakvitne, 1995).

However, according to Canfield (2005, p. 88) “the concept of vicarious traumatization emphasizes the role of meaning and adaptation, rather than symptoms”. VT is considered a normal reaction to intense work with traumatic material and does not imply psychopathology in the helper or the client (Hernandez-Wolfe et al., 2015; Pearlman & McIan, 1995) – although it contains the word *traumatisation* in its compounds – but rather reflects a “transmission of traumatic stress” (Hernandez-Wolfe et al., 2015, p. 157) from the beneficiary to the helper. Wilson and Brwynn (2004) suggest that VT may lead to more intensive countertransference reactions, with the clinicians being less conscious of these reactions, which, subsequently, can result in clinical errors.

Further relevant concepts that refer to comparable phenomena to burnout include secondary victimization, compassion stress, co-victimization, emotional contagion, secondary survivor, secondary wounding, and even countertransference (Canfield, 2005, p. 98). A major difference between burnout and VT, CF and STS is that burnout is currently considered a generic occupational term (Hochstrasser et al., 2016), which, inevitably, is not restricted to the helping professions, such as social worker, counsellor, or clinical psychotherapist. Consequently, as a concept, it is not necessarily linked to the exposure of the distressing narratives and conditions of the client compared to STS, CF and VT (Barrington & Shakespeare-Finch, 2014; Canfield, 2005).

From a psychotherapeutic perspective within a humanitarian and Refugee Care context, there are various studies on CF, VT and STS, although, as mentioned above, these terms are to some extent used interchangeably (Barrington & Shakespeare-Finch, 2014). Apostolidou (2016) describes VT as the internalisation of the client’s adverse narratives, which challenges the vulnerability and the worldview of the service provider. With regard to VT, Pross (2006) argues that an “infection” of

trauma from the beneficiary to the helper may take place, which is characterised by overinvolvement and overidentification with the beneficiary as well as by PTSD and/or burnout symptomatology. The possible impact of negative outcomes on the helpers may vary; some studies show high numbers of CF among therapists of torture survivors (Deighton et al., 2007). CF seems to be higher in some specific professional groups (therapists of refugees) than others (interpreters), which may, however, be mainly linked to the general, challenging psychosocial situation of the asylum seekers, and not necessarily to the exposure to their adverse experiences and narratives (Birck, 2001). Moreover, other findings suggest relatively low levels of STS among humanitarians (Posselt et al., 2019).

Moral Injury

A further concept that may be of relevance for helpers and humanitarians is *moral injury.* Initially, this was used to conceptualise the experiences of various US military veterans. Unlike STS, VT and CP, moral injury does not necessarily assume exposure to the client's adverse or "traumatic" material and narrative. It constitutes a betrayal of one's moral values with a disruption of one's capability to trust (Shay, 2014). Moral injury should not be considered a medical-psychiatric syndrome (Papadopoulos, 2020a). Moreover, it should be examined as a concept in its own right, even if the phenomenon of moral injury contributes to psychopathologies, such as PTSD, explosive anger and depression among adversity survivors (Nickerson et al., 2015).

A working definition for moral injury is "the constellation of inappropriate guilt, shame, anger, self-handicapping behaviours, relational and spiritual/existential problems, and social alienation that emerges after *witnessing and/or participating* in warzone events that challenge one's basic sense of humanity" (Currier et al., 2015, pp. 229–30). From a different perspective, moral injury essentially entails

"perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Meanwhile, Papadopoulos (2020a, p. 16) suggests a differentiation between moral injury and *moral crisis:* Moral injury is primarily connected to the act that transgresses one's moral values, while moral crisis is a more inclusive concept that includes not only the "transgressive" act, but "(i) all the preceding contributing conditions and factors, (ii) the triggering event/s and circumstances, and (iii) the resulting transgressive acts by the perpetrator".

In that respect and within a humanitarian context, moral injury as a part of a wider moral crisis could be experienced, for example, by relief workers who cannot provide assistance for every refugee they would wish to because of lack of resources and/or the triage policy of their organisation; there is a "clash" between one's humanitarian values and moral framework and his/her acts in the reality of the field (De Waal, 2010).

5.1.2.d. Comparing PTSD and Indirect Trauma. In this subsection, I will compare PTSD/direct trauma due to direct exposure and secondary/vicarious trauma because of indirect exposure. Essentially, both direct and indirect trauma are associated with a certain degree of pain and suffering. In the literature, the former is predominantly associated with refugees (Bogic et al., 2012), while the latter is related to their helpers, who are exposed to the painful and distressing refugees' circumstances and narratives through their work with them, and therefore, indirectly exposed to the refugees' experienced predicaments and adversities (Birck, 2001; Musa & Hamid, 2008). Of course, this does not mean that a refugee cannot suffer from secondary trauma and a helper from PTSD. But as the focus of this study is at the helpers' work with refugees, the helper exposure to calamities is expected to be indirect/vicarious and less direct. At the end of this subsection, I refer to the Refugee

Care approach, which this study represents. This approach emphasises that not every refugee suffers from PTSD and not every helper suffers secondary trauma, and that adversities also result in generally positive outcomes for refugees as well as for helpers (Hernandez-Wolfe et al., 2015; Hyatt-Burkhart, 2014; Papadopoulos, 2002, 2007).

A main similarity between PTSD and secondary trauma is, undoubtedly, the symptomatology. For example, typical symptoms of STS could be intrusive images, avoidance, hyperarousal and emotional distress, which mimic the symptoms of PTSD (Bride & Kintzle, 2011, as cited in Pellegrini et al., 2022, p. 371). A further similarity is that both PTSD and indirect trauma can be associated with other psychiatric conditions, such as *somatisation* and *dissociation* (Kianpoor et al., 2017). In brief, somatisation is the expression of psychological distress as organic symptoms, and dissociation refers to various pathological phenomena that are characterised by one's disconnection from one's surroundings, emotions or physical experiences. Relevant examples of dissociation are *dissociative amnesia* and *depersonalisation/derealisation*. Third, both PTSD/CPTSD and secondary trauma can have detrimental effects on one's social and family life (Kianpoor et al., 2017). Moreover, individuals who suffer from either CPTSD or secondary trauma experience negative cognitions considering oneself or the world (Deighton et al., 2007; Kimble et al., 2018).

A main conceptual difference between PTSD and secondary trauma is that the former can be associated with direct exposure to isolated events, while the latter assumes cumulative, indirect exposure, i.e., it reflects a process (Pearlman & Saakvitne, 1995). Another significant difference between PTSD and indirect forms of trauma is that the latter do not *per se* qualify as PDs. This may be attributed to the severity of the symptoms and the level of social functioning in individuals with indirect

trauma. As opposed to PTSD, and similarly to burnout, the WHO International Classification of Diseases (ICD-10, ICD-11) does not identify STS, CF and VT as distinctive PDs. In terms of an ICD-10 classification, further relevant terms, aside from PTSD (F43.1), that describe pathological aspects of these phenomena could be, for example, *adjustment disorder* (F43.2), *enduring personality change after catastrophic experience* (F62.0) or even a *depressive episode* (F32). All these disorders can be diagnosed provided that a specific number of strictly defined criteria are met, and this over a certain, predetermined period of time. Approaching the STS, CF and VT of humanitarian helpers from the constructivist epistemological viewpoint of ICD-10, one would not necessarily locate them within the ICD-10 classification, since VT and CF do not automatically reflect a strictly defined medical-psychiatric pathology (Barrington & Shakespeare-Finch, 2014), but primarily work-related stress (e.g., Cocker & Joss, 2016).

Based on the framework of the AG and regarding the conceptualisation of the negative reactions in the aftermath of adverse, catastrophic events, Papadopoulos (2007, pp. 305–306) outlines three groups of responses and consequences of exposure to adversity: OHS, DPR and PD, all of which were succinctly presented in Chapter 2. OHS refers to normal, common, human response to tragedies and humanitarian crises that many refugees experience and is not pathologic. DPR constitute a more distressing form of OHS that are characterised by discomfort, disturbance, disorientation and other symptoms that do not necessarily need medical intervention; DPR do not fulfil the diagnostic criteria of a PD. PDs, such as PTSD, clinical depression, alcoholism, etc., are defined by internationally recognised classification systems (WHO/ICD, DSM-V) and there is a consensus that they generally require some form of medical or psychiatric treatment and/or clinical psychotherapy. Consequently, considering the above, if one expands these three

degrees of negative effects from adversity survivors to service providers, the CF, VT or STS of an individual could possibly fall into any of these categories (OHS, DPR and PD) depending on the severity of the symptomatic manifestation – and not always into the spectrum of PD, even though CF, VT and STS appear to be connected with a certain symptomatology and pathology. What the theoretical framework of the AG proposes here is that not every negative reaction (in fact, only a subgroup) of the refugee or the humanitarian helper should be viewed as pathological. Plus, negative reactions are only a part of the very wide range of responses and consequences in the aftermath of adversities.

5.1.3. The Continuous Trauma Discourse: From the Beneficiary to the Helper

In the previous subsection, I described the terms “primary trauma/PTSD” and “secondary/vicarious trauma” and discussed their similarities as well as differences. In the literature, PTSD is connected to adversity survivors, such as refugees, while secondary trauma is mainly related to caregivers (and/or family members) of the adversity survivors, such as humanitarian helpers of refugees. In this subsection, my first aim is to draw a parallel between psychopathology (VT, CF, STS and burnout) of staff (mainly due to exposure to clients) and PTSD/trauma-related PDs of the beneficiaries. A general debate on the trauma model was previously presented in Subsection 5.1.2. Now, in this subsection, I will expand the predominant trauma discourse from clients (refugees) to the staff and the volunteers working with/for them. Then, my second aim is to compose a critique of the predominant paradigm. This critique is from a perspective based on the theoretical framework of the AG.

The debate on refugee trauma is extensive, as the predominant narrative tends to pathologise and victimise involuntarily dislocated persons, who have experienced adverse or catastrophic events, as a form of validation for their suffering (Papadopoulos, 2002; Pupavac, 2002). However, by definition, refugeedom

describes a socio-political and not a psychological or medical state (Papadopoulos, 2002).

Refugee populations are usually indiscreetly being labelled as traumatised by humanitarians or human service providers (Eastmond, 1998; Pupavac, 2002) and attention is drawn exclusively to the psychopathology of the involuntarily dislocated (Summerfield, 2000), while resilience and positive changes in the aftermath of adversities are usually neglected (Papadopoulos, 2007, p. 306). In addition, a causal relationship between involuntary dislocation and trauma-related disorder is rather oversimplified and overgeneralised (Summerfield, 2001), and as Pupavac (2002, p. 2) aptly points out: “Automatically constructing refugees as traumatised, the international psycho-social model fails to make a proper distinction between the experience of distressing events and the appearance of a post-traumatic stress *disorder.*”

In effect, only a subgroup of refugees experiences the degree of psychopathology (e.g., PTSD) that requires psychiatric and psychotherapeutic treatment (Chondrou, 2019; Tribe, 2002). Studies show variable rates of prevalence of PTSD in refugees that are too high (Bryant et al., 2023, p. 414). Moreover, the social dimension of loss regarding trauma may sometimes be more detrimental for the survivor than the intrapsychic reality (Horn, 2020, p. 129). Afuape (2011) proposes that several psychological symptoms that refugees demonstrate can be interpreted as adaptive reactions to adversities, such as oppression and political violence. Moreover, on some occasions, refugees who develop PDs are assumed to have suffered from some form of mental illness prior to their exposure to their dislocation adversities (e.g., Cardozo et al., 2004; Hauff & Vaglum, 1993; Mezey, 1960). Summerfield goes even further by referring to PTSD as a “pseudocondition” – always in relation to refugees (Summerfield, 1999, p. 1449).

Furthermore, psychological suffering does not necessarily constitute a PD (e.g., PTSD), as the above discussed terms OHS and DPR (Papadopoulos, 2007, 2013) and, additionally, the concept of *normal acute stress reactions* (Adshead & Ferris, 2007, pp. 358–359) suggest. Customised therapeutic interventions for refugees with a problem-solving, non-trauma-oriented approach, focused on distressing psychosocial domains, such as financial difficulties and social isolation, seem to be successful (Faber & Lee, 2020, pp. 252–254). This is related to the fact that refugees may experience severe adversities in the host country, in some cases of an even more distressing degree than in their country of origin or during the flight (Hollander, 1998; Papadopoulos 2002).

The predominant psychopathological-psychotraumatological model depoliticises the moral, socio-political struggle, and pain of refugees (Blackwell, 2005) and reduces this to a label of mental disorder (Zarowksy & Pedersen, 2000), which neglects their unique and complex features as individuals and their collective socio-political and historical roots (Summerfield, 2001). Jasperse (2021) addresses the lack of cultural responsiveness within the approach and the clinical assessment of refugees (such as cultural formulation interviews), which maintains the inclination towards uncritical pathologising of the involuntarily dislocated by resettlement services.

At present, vulnerability is rewarded and this can be crucial in the protection of adversity survivors: the label of a PD can, in some cases, support an application for asylum or other benefits and be the only possibility to mobilise the established medico-socio-political network in favour of an individual (Summerfield, 2005); this leads, however, to the harmful effects of victim identity, learned helplessness and dependency (Mollica, 2006). I have personally witnessed such situations working as a psychiatrist with refugees at the Swiss Red Cross.

From a humanitarian, collective and psychosocial perspective, the synergic approach (as previously described in Chapter 2) could be representative of a new, more participative, less victimising, less pathologising paradigm in humanitarianism, so-called *resilience humanitarianism* (Hilhorst, 2018), which is based on the reality that refugees and their communities are able to respond, adapt and, recover after catastrophic events, and that refugees and their communities have the resilience and responsibility to organise themselves and find the solutions for their survival and growth (Hilhorst, 2018; Ilcan & Rygiel, 2015). Similarly, the IOM, in its MHPSS handbook (2018) advocates for a non-pathologising, empowering model of a socioecological system. In that respect, the synergic approach is a keystone in a *humanitarian ecosystem* (Hilhorst, 2018, p. 6) that enables local actors and communities to manage crises and calamities.

In expanding this fruitful debate from the involuntarily dislocated persons to the service providers and humanitarians, the following question is posed: How can the dominance of this model in the humanitarian and refugee-supporting world be explained? I will try to summarise some relevant aspects, assumptions and possible elucidations:

- Jachens (2018, p. 4) states that the dominant medical-pathologic model fails to address the role of organisational factors (e.g., workload) in staff wellbeing and, respectively, job stress. Organisational issues should be appropriately discussed, otherwise “refugees cease to be people with problems; refugees become the problem” (Walkup, 1997, p. 46). Attention is exclusively drawn to the traumatised, “mentally ill” refugees with the “infectious wounds” and the “vulnerable” staff who do not take enough care of themselves, and there ends up being an absence of debate about the dysfunctional, not *good-enough* organisation (e.g., with the lack of supportive environment and excessively

long working hours) and its responsibility regarding staff support. One might even go a step further and suggest that a mental health issue (e.g., feeling on the verge of burnout) is one way for humanitarian workers to ask for and take the essential free time (i.e., in the form of sick leave) for their wellbeing and self-care, which would not have been possible otherwise.

- Jasperse's empirical research work in New Zealand (2021) calls for a rethinking and a critical re-evaluation of the prevailing psychopathological presumption of PTSD and VT of refugees and resettlement workers, respectively. She stresses the need for alternative psychological approaches and interventions on beneficiaries and staff. This discussion on PTSD and VT could also be seen as part of a larger debate considering the medicalisation of counselling and the increasing pathologising of societal issues, in general, which several contemporary psychotherapists view with certain scepticism (e.g., Davies, 2022; Loewenthal, 2015; Sanders & Tolan, 2023).
- Pupavac (2004, pp. 495–498) argues that the dominant trauma-related narrative regarding humanitarian workers reflects a modern, collective, rather (self-) pathologising, way of showing empathy to adversity survivors and, additionally, it ignores the deeper crisis of morality and meaning-making in contemporary humanitarianism. In other words, humanitarians are expected to have some type of pathology due to the exposure to the adverse material of the beneficiaries, otherwise they may suffer from feelings of *survivor's guilt* or may be characterised as "indifferent" or "not being sufficiently empathetic" by the wider society (Pupavac, 2004, p. 495), which implies that vulnerability to trauma is indirectly and morally rewarded. In addition, humanitarianism has to some extent lost its earlier moral status and humanitarians are presently not always welcomed by local communities (Hunt, 2008); this moral crisis of the

meaning of humanitarianism can be echoed by staff psychopathology (Pupavac, 2004).

- Humanitarian and other staff working with involuntarily dislocated persons are typically expected to follow the principle of political neutrality (Barnett, 2005) in a politically polarised setting even if this would mean silently tolerating policies or regimes (e.g., Ehrenreich & Elliott, 2004, p. 54) with which they ethically and ideologically disagree, since political neutrality does not necessarily mean emotional neutrality (Malkki, 2015, pp. 184–189). Sometimes, it is expected that humanitarian aid will depoliticise affectively and politically tense situations (Malkki, 2015, pp. 184–9). This “asphyxiation” caused by a depoliticised organisational environment on the politically conscious staff can lead to feelings of powerlessness with regard to the political system and the existing socio-political situation, since “the human stripped of their political subjectivity is stripped of a part of their humanity” (Radice, 2022, p. 147). This inner political conflict of some staff members is then condensed into a clinical supervision topic (Apostolidou & Schweitzer, 2017, pp. 78–79), thus being positioned close to the conceptual framework of for example, VT or CF, since there is no other adequate space for its conceptualisation. Thus, there is a need for a humanitarian discursive space in which political voices should be articulated, heard and discussed (Radice, 2022).
- In the current era of the *politics of pity* and *victim-oriented campaigns* (Chouliaraki, 2010) the dominant narrative of the traumatised, victimised, self-sacrificing, heroic humanitarian who supports the traumatised, victimised refugee can be attractive to the mass media and, consequently, to philanthropists. Papadopoulos (2021a, p. 25) argues that public opinion and specialist professionals tend to pathologise those whom they want to support

properly, emphatically and demonstrably; this applies not only for beneficiaries but for their helpers as well, who represent a progressive, activist and altruist part of contemporary society.

Undeniably, humanitarian work and work with refugees can be stressful and sometimes displeasing (Antares Foundation, 2011). But this does not essentially mean trauma for the helper. Being a psychiatrist, I certainly do not believe that distress and symptomatology or pathology of humanitarian helpers is of little or no (clinical) significance. Some helpers may require medical treatment or psychotherapy for concise symptoms and/or disorders. However, I stress that the manifestation of a pathology, such as burnout or secondary trauma, is only one part within the wider range of possible responses and consequences of adversities and, thus, of helper wellbeing. And, as clearly shown later in this study's empirical investigation, not every participant has experienced symptoms related to their work with refugees.

5.1.4. Positive Psychosocial-Psychological Outcomes

In the previous subsection, I discussed the negative outcomes of adversities for refugees and helpers and included a critique of the predominant medical approach from a Refugee Care perspective. Following the theoretical framework of the AG, I will now proceed to the positive responses and outcomes of adversities that the humanitarian helpers experience, which I will compare to the concept of AAD.

Throughout the bulk of the literature, the way survivors of trauma cope demonstrates control, manageability, understanding, meaningfulness and purpose (Tedeschi & Calhoun, 1995, p. 75). It was proved that there are positive associations between the number of traumatic events experienced and some cognitive and interpersonal character strengths (Peterson et al., 2008, p. 214). Jung also wrote of the potential for development after trauma:

> The inherent tendency of the psyche to split means on the one hand dissociation into multiple structural units, but on the other hand the possibility of change and differentiation. It allows certain parts of the psychic structure to be singled out so that, by concentration of the will, they can be trained and brought to their maximum development. In this way, certain capacities, especially those that promise to be socially useful, can be fostered to the neglect of others. (Jung, 2014, p. 3078)

The above findings and Jung's statement, of course, apply to survivors of direct trauma/PTSD, who experience beneficial effects as a result of adversity or trauma. Nonetheless, the main idea behind these theories, i.e., positive development after trauma, can also be expanded to persons who are indirectly exposed to trauma, such as humanitarian helpers who work with refugees, as this section will show.

Undoubtedly, there are various positive consequences for humanitarian and human services staff working with refugees who are adversity survivors or find themselves in a profoundly distressing psychosocial situation (Puvimanasinghe et al., 2015). This abundance of positive reactions encompasses: admiration for clients and, thus, higher appreciation for therapeutic work, political freedom and human rights, focussing on the positive aspects in life, augmentation of one's professional motivation (Engstrom et al., 2008); personal growth including enhancement of one's spirituality, self-confidence, thoughtfulness and self-assurance (Guhan & Liebling-Kalifani, 2011); becoming more tolerant, more hopeful, more supportive, more effective, more compartmentalising and more politically conscious (Hernandez et al., 2007); increase in one's insight and empathy, improvement in personal relationships, enrichment in personal life, deeper understanding of aspects of human behaviour (Arnold et al., 2005); valuing family and friends more, becoming more open-minded, adaptable and flexible, deeply appreciating human resilience, changing one's life

philosophy (Hyatt-Burkhart, 2014); finding meaningfulness in the humanitarian field that one does not have at the work back home (Albuquerque et al., 2018), and more – the list is extensive.

The conceptualisation of such enrichment, strengths and growth in the relevant literature seems to echo the conceptualisation of negative outcomes like opposites: VR as opposed to VT, *vicarious post-traumatic or post-adversarial growth* (VPTG) instead of STS and/or PTSD, and *compassion satisfaction* (CS) as opposed to CF.

VR, formulated by Hernandez et al. (2007), portrays a positive, but not painless, transforming process and addresses the positive effects, such as growth and empowerment, and resilience building in helpers while they witness the coping and resilience of the survivors of political violence (Engstrom et al., 2008; Hernandez et al., 2007; Puvimanasinghe et al., 2015). Like VT, VR is mainly linked with clinical/psychotherapeutic work with clients. People with VR may also experience (or have experienced) VT, but VT is not a necessary condition for VR (Puvimanasinghe et al., 2015); both VT and VR are natural reactions in work with adversity survivors and they can co-exist (Hernandez et al., 2007). Hernandez-Wolfe et al. (2015, p. 159) suggest that “VR is founded on the assumption that client and therapist influence each other in the therapeutic relationship”. VR demonstrates a positive impact on various domains of the helper’s inner world, such as priorities and goals in life, spirituality, self-care, sociopolitical awareness, feelings of hope, motivation and inspiration, moral values, personal issues, patience, re-evaluation, and new understanding of therapeutic work with adversity survivors (AbiNader et al., 2023; Edelkott et al., 2016; Hernandez-Wolfe et al., 2015). Furthermore, Edelkott et al. (2016) suggest that VR may not always be a conscious process for the clinical

worker. Meanwhile, Scott et al. (2023) propose that there is a positive correlation between *self-care* and VR regarding victim services workers.

VPTG is a concept closely correlated to PTG, which was introduced by Calhoun and Tedeschi (1995) and further discussed by several researchers (e.g., Maercker & Zöllner, 2004; Nolen-Hoeksema & Davis, 2004; Park, 2004). PTG involves post-traumatic or post-adverse positive changes in self-perception, interpersonal relationships and philosophy of life. Maercker and Zöllner (2004, 2006) suggest that PTG as a clinical concept is characterised by a *Janus Face*, i.e., it consists of two contrasting components of coping: (a) the “positive”, transformative, self-transcending or constructive and (b) the illusory component, that expresses “denial, avoidance, wishful thinking, self-consolidation, or palliation” (Maercker & Zöllner, 2004, p. 43). The latter assumes a possible negative effect on one’s post-adverse adjustment if combined with cognitive avoidance.

VPTG was coined by Arnold et al. (2005), who suggested that helpers described a positive impact similar to the one regarding the concept of PTG. VPTG does not involve direct exposure to a catastrophic event, but exposure to catastrophe survivors and to the enormously painful details of this event (Brockhouse et al., 2011). It is defined as the personal growth of the service provider who works with the clients who experience PTG (Hyatt-Burkhart, 2014) and this growth includes a new appreciation of life, better self-awareness, more solid positive relationships, and admiration of human resilience (Cohen & Collens, 2012).

VPTG overlaps with VR and a clear distinction has not been made (Edelkott et al., 2016). Edelkott et al. (2016, p. 720) argue that VR as a concept covers more domains than VPTG, such as the re-evaluation of the therapist’s work with people in pain and gaining a “new confidence in a strengths-based approach” at work. Furthermore, VR in its components addresses resilience as the result of an inner

transformative process for the therapist-trauma worker, while VPTG refers to the growth and the positive changes that a person may experience not only working directly with the adversity survivors as a therapist, but also, for example, being a family member or an interpreter (Hernandez-Wolfe et al., 2015; McCormack et al., 2011; Splevins et al., 2010). As with VR, VPTG and vicarious trauma should not be viewed as two interconnected, mutually excluding states: the presence of VPTG does not rule out synchronous suffering from vicarious trauma in the same person (Manning-Jones, 2016). This implies that appropriate measures for VT should not be disregarded, even in cases of evident VPTG (Manning-Jones, 2016).

CS is relevant to humanitarian work (Birck, 2001; Guhan & Liebling-Kalifani, 2011; Posselt et al., 2019) and, although there is no universally recognised definition in the literature regarding this, it generally reflects the positive working experience and pleasure derived from the direct work with people in need and in pain (Baqeas et al., 2021). From a social work perspective, the term “CS” was introduced by Radey and Figley (2007, p. 207), who described “feelings of fulfilment with clients, rooted in positive psychology and expanded to incorporate the social work perspective”.

From a Refugee Care perspective, Papadopoulos (2007, 2013) introduced the concept of AAD, which suggests that individuals develop new positive qualities, insights, skills, beliefs, etc., which were non-existent prior to adverse events and that appeared as a result of those events. AAD reflects a process of transformation and renewal. Although it may sound irrelevant or disrespectful to expect from a refugee or, generally, an adversity survivor to be able to experience and to express positive gains, these positive effects are realistic and should progressively be differentiated from the emphatically negative “trauma narrative” – here, one can be reminded of Nietzsche’s aphorism “*What doesn’t kill you, makes you stronger”*. AAD as a concept is also applied to staff in order to describe these benefits, enrichment, personal

growth, and new strengths that emerge due to the exposure to the adverse material of refugee/clients that did not exist prior to this work-related exposure. AAD is an attempt to conceptualise those positive responses and changes from a non-medical, non-clinical angle.

Within a staff wellbeing approach and considering the above, comparing AAD with VR and VPTG leads to the following conclusions:

- AAD is not necessarily vicarious, since it may refer to both adversity survivors and their helpers, while VR and VPTG refer only to the helpers. VR and VPTG presuppose the staff's exposure to the adverse narratives of the beneficiaries – with a positive outcome for the staff – whereas a staff member's AAD may result from other types of work-related stress or even from adverse events that do not necessarily relate to the direct work with the beneficiaries. Therefore, AAD appears to be a more generic and more inclusive concept.
- AAD of the helper does not necessarily reflect the AAD of the adversity survivor, but, naturally, both can independently co-exist and even influence each other. VR and VPTG refer to the reaction of the helper to the resilience and post-adverse growth, respectively, of the client.
- AAD does not have psychopathology as its central point of departure, while VPTG is connected to the PTG of the beneficiary, which, subsequently, emerges after the trauma-related disorder (PTSD) of the beneficiary. As Papadopoulos appropriately points out: "PTG assumes that 'growth' occurs after the trauma; the post in PTG echoes the post in PTSD" (Papadopoulos, 2007, p. 307).
- VR appears to apply mostly for psychotherapists who work with refugee clients (Engstrom et al., 2008; Hernandez et al., 2007; Hernandez-Wolfe et

al., 2015), while AAD applies to any humanitarian helper who works directly (or even indirectly) with beneficiaries.

- The conceptual framework within which the term “AAD” was coined clearly distinguishes between growth and the transformation process of AAD and resilience: resilience refers to the positive elements of helpers or adversity survivors that were retained unaffected despite direct or indirect exposure to adversity. In brief, resilient features refer to old and retained strengths, whereas AAD refers to new strengths that did not exist before exposure to adversity. The conceptual framework within which the term “VR” was developed (e.g., Engstrom et al., 2008) does not differentiate between these two types of strengths, i.e., old and newly acquired.

In this section, I described the main positive outcomes as a result of indirect exposure to adversity, which are highly relevant to the investigation of humanitarian helper wellbeing. Then, I compared the discussed terms to the concept of ADD from the perspective of the Refugee Care and AG, which are the conceptual foundations of this thesis. In the next section, I will proceed to the elements of resilience and protective factors that are also vital for developing an integrative, psychosocial approach regarding helper wellbeing.

5.2. Resilience, Coping and Supportive Measures

5.2.1. Defining Resilience

There have been various approaches and definitions of *resilience*. In this thesis, I look at the resilience of humanitarian helpers and other relevant factors of protection from an individual psychosocial as well as organisational standpoint.

According to the OED (2024), resilience is “the quality or fact of being able to recover quickly or easily from, or resist being affected by, a misfortune, shock, illness, etc.; robustness; adaptability” and, according to a more technical definition, “the

power of resuming an original shape or position after compression, bending, etc.". Resilience reflects on the proactive capacity of an organisation to prevent being negatively affected by an event, i.e., its a*gility*, and on the reactive capacity of the organisation to cope with an event and remain stable, i.e., its *robustness* (Wieland & Wallenburg, 2013, p. 301). From a psychotherapeutic perspective, resilience could be defined as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress – such as family and relationship problems, serious health problems, or workplace and financial stressors" (APA, 2022), or as the ability of the human psyche to resist and cope with adversities (Eichenberg & Zimmermann, 2017). From an *Aristotelian-eudemonic* perspective, Ryff (2014, p. 1) views resilience as maintenance of wellbeing in spite of adversities and, consequently, as an essential element for meaning making and self-actualisation in one's life.

Within a psychological or psychosocial context, resilience is linked with *coping*, including *maladaptive* coping strategies (Bonanno, 2004, p. 26), *hardiness* (Kobasa et al., 1983) and *salutogenesis* (Antonovsky, 1987). Bonanno (2004) differentiates between *recovery* and *resilience*, since recovery presupposes the existence of a psychopathology for a certain time period, from which the impacted person then recovers, whereas resilience refers to stress-resistance and preservation of stability. Hardiness, as a form of resistance to stressful and adverse events, is considered a personality trait; hence, an individual may be high or low on hardiness levels (Kobasa et al., 1983). Within his *salutogenic model*, Antonovsky (1979) identifies eight *generalised resistance resources*, including materialistic, emotional, interpersonal, and sociocultural resources, which contribute to successful management of psychosocial stressors. From a culturally oriented psychological perspective,

Maercker et al. (2015, p. 15) proved that *self-direction* as a principal modern value orientation predicts resilience.

At present, coping is a very widely used term and encompasses the individual's responses and efforts in dealing with stress and adversities, with an abundance of diverse coping strategies having been identified so far (Carver & Connor-Smith, 2010, p. 687), including negative or maladaptive coping, such as *dissociation* as a result of *repression* of extremely adverse events (Bonanno, 2004, p. 26) or abuse of alcohol or substances. Cooper et al. (2006, p. 17) distinguish three main coping strategies: (a) *emotion-focused coping*, which includes emotional support, positive reframing, acceptance, religion, and humour, (b) *problem-focused coping*, which encompasses active coping, planning and instrumental support, and (c) *dysfunctional coping*, which involves venting, denial, substance use, behavioural disengagement, self-distraction and self-blame.

A commonly used, relevant term for resilience is *psychological or psychosocial resources* (in general). Hobfoll (2002, p. 307) defines resources as "those entities that either are centrally valued in their own right or act as a means to obtain centrally valued ends". Taylor (2011) understands psychosocial resources as those skills, beliefs, values and personality characteristics that have an effect on how people cope with stressful situations. Fundamental resources are, for example, self-efficacy, mastery, optimism and social support (Hobfoll, 2002; Taylor, 2011).

5.2.2. An Alternative View of Resilience

Compared to other relevant angles, a Refugee Care approach proposes that resilience can be defined as "all the strengths (i.e., characteristics, functions, relationships, etc.) of a person, of a family, of a community or of a society that did not change as a result of the exposure to an adversity" (Papadopoulos, 2021c, p. 17). Individuals are not solely resilient or non-resilient in their totality, but resilience refers

to those specific strengths of the person that remain unchanged in spite of the hardships (Papadopoulos, 2021c). Undeniably, coping and resilience are unique for everyone (Van der Veer, 1998). Moreover, Papadopoulos (2007) explicitly distinguishes between the positive changes, gains and new strengths, which derive from the experience of adversity (AAD), and resilience, which refers to the unchanged, retained positive characteristics, strengths and resources that survived adversity.

Five different psychosocial dimensions synthesising the phenomenon of resilience have been identified by Papadopoulos: *stability*, *recovery*, *tolerance*, *adaptability* and *transformational ability.* More specifically:

> (a) Emphasis on *retaining* existing positive functions, qualities, characteristics, behaviours, relationships, etc., that were present before the exposure to adversity and continue to exist, more or less unchanged: this could be understood as the quality of *stability*.
>
> (b) Emphasis on *returning* speedily to one's previous equilibrium following the disruptive upheavals brought by adversity: this could be understood as the quality of *recovery.*
>
> (c) Emphasis on *tolerating* the various forms of instability created by the adverse changes: this could be understood as the quality of *tolerance*, which also refers to the ability of minimising the harmful effects of this instability, i.e., limiting the damage inflicted by the adversity.
>
> (d) Emphasis on *adapting* to the new changes, contexts, realities, pressures, challenges, and opportunities that adversity activates: this could be understood as the quality of *flexibility* or *adaptability*.

> (e) Emphasis on *developing* new ways of being: this could be understood as the quality of *transformational ability*.
>
> (Papadopoulos, 2021a, p. 274)

In essence, in this study, I generally adopt CTAR's/Papadopoulos' framework of defining resilience (e.g., 2021a), since it clearly distinguishes between retained-resilient features and new positive gains, but also acknowledges and discusses other relevant approaches on this topic.

5.2.3. Protective Elements for Helpers

Protective factors for humanitarians and other helpers of refugees are increasingly investigated by researchers. Within a humanitarian context, I will classify these factors into individual *psychosocial* – which includes the intrapsychic, interpersonal, and socio-political or sociocultural dimension, according to EVASP (2011, p. 30) – and *organisational*.

From an organisational or occupational angle, studies have shown that POS can be protective for the wellbeing of staff, including volunteers (Aldamman et al., 2019; De Paul & Bikos, 2015). Team cohesion is also a significant aspect (Cardozo et al., 2012). Furthermore, support from managers seems to play a crucial role for staff wellbeing (Blanchetiere, 2006, p. 10; Brooks et al., 2015, pp. 392–393). A *transformational* leadership style that motivates and empowers staff (Mufti et al., 2020), protects them from outside pressure (Rubin et al., 2016), provides them with appropriate accommodation and psychosocial and medical care and gives feedback (Thormar et al., 2013), and cares for role clarity (Dubey et al., 2016), is linked with staff satisfaction and resilience. Additionally, *autonomy* at work (Albuquerque et al., 2018, pp. 5–6), especially when there is substantial trust in management (Visser et al., 2016), and active staff involvement in decisions, are viewed as protective elements. Flexible working hours (Visser et al., 2016, p. 1195) and sharing workload

and shift rotations (Brooks et al., 2015, p. 392) can support staff's work-life balance from an organisational perspective. Ultimately, provision of supervision for staff (Barrington & Shakespeare-Finch, 2014; West, 2010) and for further learning, training, career development or research possibilities, for example, sabbaticals (Pross, 2006, p. 1), appears to have a beneficial effect on the protection of staff wellbeing.

Within a psychosocial approach, *social support* is probably one of the most documented protective factors for humanitarian helpers (as delineated by Albuquerque et al., 2018; Blanchetiere, 2006; Cardozo et al., 2012; Eriksson et al., 2009; Guskovict & Potocky, 2019; McAllum, 2018; Posselt et al., 2020; Rubin et al., 2016; Vergara & Gardner, 2011). In a broad sense, social support refers to support from family, spouses, friends, colleagues/peers and supervisors.

Social support can be defined as "the emotional and instrumental social interactions that provide an individual with actual assistance or a belief that such assistance is available" (Skeoch et al., 2017, p. 3).

A further, commonly mentioned factor of resilience and protection for humanitarian and other staff working with refugees, especially for those with a psychotherapeutic function, is *supervision*. Supervision can be one-on-one or in groups; it can be peer-supervision, or it can be provided by an external supervisor (Posselt et al., 2020). Apostolidou & Schweitzer (2017) argue that in the work with refugees, cross-cultural supervision may assist service providers to: (a) identify the impact of the dominant politics on their work and *normalise* their feelings of being overwhelmed, and the uselessness in relation to this; (b) appreciate the importance of bearing witness to the clients' pain; (c) approach the beneficiaries' pain and suffering with a non-pathologising attitude and acknowledge their totality as persons, which offers to them a new perspective as practitioners; and (d) improve their self-

care and self-awareness. The role of supervision in staff wellbeing and resilience is crucial for maintaining a secure inner distance from work and maintaining boundaries (Barrington & Shakespeare-Finch, 2014, p. 1694), processing the adverse content experienced and shared by clients and making meaning of one's work with this (Barrington & Shakespeare-Finch, 2013, pp. 94–95), validating one's difficult emotions (Apostolidou & Schweitzer, 2017, p. 78), increasing one's effectiveness and confidence as a professional and helping in dealing with the uncertainty (Schweitzer et al., 2015, p. 115), and enhancing human connectedness (Posselt et al., 2020, p. 1667).

The frequently cited *work-life balance* of staff members may be preserved through an extensive list of possible coping skills and strategies, which include, *inter alia*, positive thinking, showing flexibility and calmness (Albuquerque et al., 2018, p. 5); healthy diet, exercise, entertainment and limiting caseload, if necessary (Barrington & Shakespeare-Finch, 2014); acceptance of stress, meditation, mindfulness practices, journal writing (Guskovict & Potocky, 2019, p. 969); demonstrating a positive sense of humour and being able to support the other (Blanchetiere, 2006, p. 9); going out, talking to friends and family, drinking alcohol (as a maladaptive mechanism), dedicating enough time for oneself, reading (Guhan & Liebling-Kalifani, 2011, p. 220); openly discussing moral dilemmas in the field (Hunt, 2009); remaining optimistic and realistic in one's expectations and focusing on small, positive changes (Larruina & Gorashi, 2016, p. 234); working in time-limited relationships (McAllum, 2018); support from religious practices, prayer, faith, spirituality, rituals (Barrington & Shakespeare-Finch, 2014; Eriksson et al., 2009; Guhan & Liebling-Kalifani, 2011; Posselt et al., 2020); a wide range of activities, such as dancing, stretching, yoga, swimming, snorkelling, walking, cooking, eating and sleeping well (Posselt et al., 2020); avoiding workaholism and securing time for

hobbies and family (Pross, 2006, p. 8); relaxation and taking breaks (Schweitzer et al., 2015, p. 115).

From a psychosocial viewpoint, further miscellaneous intrapsychic (e.g., traits), interpersonal and sociocultural factors that are identified by authors as sources of resilience are: compassion, to a certain extent (Skeoch et al., 2017); empathy, altruistic interest for clients, patience, gratitude from the beneficiaries as a reward, one's past life experiences and sharing a similar cultural and religious background as the beneficiaries (Guhan & Liebling-Kalifani, 2011, p. 221); openness (Rubin et al., 2016, p. 6); sense of meaningfulness (Albuquerque et al., 2018); a commitment for human rights (Eleftheriadou, 1999); a feeling of belonging (Blanchetiere, 2006, p. 10); being married (Cardozo et al., 2012); years of work experience (Deighton et al., 2007); positive evaluation of one's own work (Eriksson et al., 2009; Larruina & Gorashi, 2016, p. 234); grasping the *complexity* of the humanitarian setting (Blanchetiere, 2006, p. 9); maintaining a sense of calm, of self- and community efficacy, of connectedness, and of hope (Hobfoll et al., 2007).

In her book on self-care for therapists, Rothschild (2022) underlines the importance of *mindfulness*, awareness of one's own history and *structured self-care* that includes a list of tools such as exercises, cleansing and after-work rituals and routines. Indisputably, regarding many of the above-mentioned elements, there is an overlap between the different realms of the psychosocial approach. The APA Dictionary of Psychology (2018) defines mindfulness as "awareness of one's internal states and surroundings" and notes that "the concept has been applied to various therapeutic interventions – for example, mindfulness-based cognitive behavior therapy, mindfulness-based stress reduction, and mindfulness meditation – to help people avoid destructive or automatic habits and responses by learning to observe

their thoughts, emotions, and other present-moment experiences without judging or reacting to them".

5.2.4. Discussing Protection From Stress and Resilience: A Refugee Care Approach

From a non-pathologising stance towards human pain and hardships experienced by humanitarians and helpers of refugees, in this thesis I hold to the beliefs that job stress is to a certain extent unavoidable for staff working with adversity survivors (Antares Foundation, 2012; Guskovict & Potocky, 2019) and that resilience to this stress, as a concept, does not presuppose trauma or psychopathology (Jachens, 2018; Papadopoulos, 2007) as its central point of departure.

From a Refugee Care angle, *expanding one's epistemologies*, *distance,* and *reflection* (Papadopoulos, 2021b) help in looking at things from a different angle and allows a reviewing of the experience within a different context. In addition, taking into consideration the *complexity* of the psychosocial situation is crucial for avoiding *oversimplification* and *polarisation*. I also argue that reserving *routines*, *rituals* and *balance* is beneficial for daily functioning and stress management (Papadopoulos, 2021b). More specifically on rituals at work, these seem to constitute a form of *transition* that acknowledges the fact of working in this world of pain and suffering, i.e., preparation and transition for entering and exiting this world, respectively, and compares these to rituals of traditional celebrations (Papadopoulos, 2022a).

Selection/Examples of Supportive Interventions. Apart from staff support groups and other possibilities explored above, I will now examine the basic elements of two further specific concepts of psychosocial support that could be relevant for helpers without pathologising their stress and distress. I suggest that these are compatible with a broader psychosocial, Refugee Care approach on staff wellbeing

and resilience. A very detailed investigation of these interventions goes beyond the scope of this thesis. Please note that these are only some examples according to the theme-related, contemporary literature.

Problem Management Plus (PM+) has been developed by the WHO and constitutes a brief, transdiagnostic, highly manualised, non-clinician helper-delivered, psychosocial intervention for distress (Dawson et al., 2015) in cases where clinical treatment and psychotherapy are either not possible due to lack of resources (e.g., in the humanitarian field) or not necessary. PM+ is an evidence-based concept that has been implemented with positive outcomes in refugee and other affected populations (e.g., Bryant et al., 2017; De Graaff et al., 2020; Jordans et al., 2021; Sijbrandij et al., 2017; Spaaij et al., 2022) but can also be applied to human subjects in helper professions in an adapted form in the future (Morina, 2021). PM+ consists of five weekly sessions of 90 minutes each, involves relaxation techniques, problem-solving techniques, psychoeducation (if necessary), cognitive-behavioural strategies, enhancement of social support and prevention, and is delivered by trained helpers who are non-clinicians and are supervised by mental health professionals (Dawson et al., 2015; Sijbrandij & De Graaff, 2022; Woodward et al., 2022). More specifically, PM+ encompasses “a relaxation exercise using slow breathing (session 1), a seven-step plan to manage practical problems (session 2), behavioural activation by re-engaging with pleasant and task-oriented activities (session 3) and a strategy to strengthen social support (session 4). Homework is scheduled between sessions and strategies are reviewed in each subsequent session. Session 5 focuses on relapse prevention” (Sijbrandij & De Graaff, 2022, p. 12). PM+ is not exclusively designed for clients who suffer from a mental disorder in strict medical terms; thus, it can be argued that it reflects a less pathologising framework for adversity survivors. PM+ can also be used within a group setting (Akhtar et al., 2021). All the above

considered, I suggest that PM+, either for individuals or for groups, could be a useful, non-medicalising, non-pathologising tool for the psychosocial support of humanitarians and helpers of refugees.

Value-Based Counselling (VBC) has been recently developed by Missmahl and Brugmann (2019) as a brief, culturally sensitive intervention for the psychosocial support of refugees in Afghanistan. The concept of VBC is partially based on a tapestry of theories of, *inter alia,* Jung, Antonovsky, Rogers and Grawe. Similar to PM+, VBC is not a deficit-oriented but rather an empowerment-focused, non-medical intervention that avoids the victimisation and pathologising of adversity survivors, which is particularly suitable in settings where there are restricted resources. VBC employs psychosocial counsellors that work in the mother tongue of the clients, many have a refugee or migrant background, and follow the principle of “do no harm” (Brugmann & Missmahl, 2022). VBC is delivered in three to five sessions, either face-to-face or online, is based on a salutogenic approach, intercultural communication and empathetic validation, and is focused on “guided self-help”, especially in its online form (Brugmann & Missmahl, 2022, p. 26). The application of VBC for refugees in Germany has so far shown positive empirical ramifications (Orang et al., 2022; Orang et al., 2023a, 2023b). In that respect, it could be assumed that an adapted form of VBC tailored to the needs and requirements of humanitarians and helpers could be a helpful psychosocial intervention for their awareness, resilience, protection and eudemonic wellbeing.

Chapter Synopsis and Thesis Progression

Overall, with the focus on the helper, in this chapter I set forth the negative/pathologic and positive results of adversities and several parameters of resilience as predominantly presented by the up-to-date literature, and also critically contrasted several of these to the theoretical basis of this project. On the whole, this

chapter echoes the three different dimensions of the AG (negative, positive, resilient responses) with reference to the humanitarian helper. I should stress that the wide range of outcomes and changes underlines the authority and rationale of the AG.

In the next chapter, in which I scrutinise the empirical research of this study, the key role of the framework of the AG in collating and interpreting a considerable amount of qualitative data is palpable. Epistemological reflections, ethical considerations, and, overall, the overarching methodological strategy are identified and analysed. The empirical findings delivered by the process of thematic analysis (TA) are laid out and unfolded.

Chapter 6: Empirical Research and Findings

In this chapter, the robust methodological background of this project is laid down and expounded. The main epistemological background is also discussed. Next, I cover the study design, which includes the key element of the AG, as well as giving essential explanations on the recruitment and interview procedures. Afterwards, I elaborate on important ethical aspects related to the empirical investigation.

In the second part of this chapter, I draw on the process of identification of themes and subthemes, i.e., the data analysis and generation of the study results, by implementing TA. Furthermore, the research findings are comprehensively outlined, which essentially involves addressing the coded data extracts. Finally, Chapter 6 confirms that the empirical research findings meet the necessary quality criteria. A thorough discussion and interpretation of the results is the subject of Chapter 7.

6.1. Methodology

6.1.1. Research Question, Research Hypotheses, Research Aim

In this research, I investigate the wellbeing of helpers who work directly with refugees in any relevant setting or context, primarily guided by the theoretical framework of the AG and by expanded Jungian theory.

The core research question of this study consists of two parts (as mentioned in the introductory part of this thesis): (a) do humanitarian helpers show a wide range of responses (i.e., not only negative) as a result of the adversities they face in their direct work with refugees; and (b) if yes, does the AG enable the researcher to gather this wide range of changes and consequences of adversities, i.e., negative, positive and resilient reactions?

The main hypothesis is that the reactions of humanitarian helpers to adversities and to the adverse material of refugees are not always negative and are not always combined with distress and/or pathologies. A further hypothesis is that the

framework of the AG is appropriate for guiding a psychosocial approach to humanitarian helper wellbeing.

In order to fully answer the research question, to test/support my research hypothesis and accomplish the research aim, I decided to conduct an empirical study that relies on human subjects and follows a qualitative methodology. As declared in the Introduction, the chief focus of this project is to generate new, valuable information emanating from the study participants' voiced experience by applying the AG. Additionally, a main goal of this project is to synthesise an appropriate, innovative conceptual framework that should provide a holistic psychosocial approach to humanitarian helper wellbeing beyond the clinical sphere. Based on the empirical approach and conceptual framework of this study, I plan to generate applicable conclusions for helpers and, more specifically, practical recommendations for organisations.

The different parts of the empirical investigation are presented, explained and discussed in this chapter.

6.1.2. Methodological Background

Etymologically, the word "*methodology*" contains the words "*methodos*" and "*logos*". Additionally, "methodos" (in Greek: μέθοδος) is a composite of "*meta*" (Greek: μετά) and "*odos*" (Greek: οδός). "Meta" means after, as a part of a process, while "odos" means way, path, or procedure. Consequently, "method" could be described as the "way of doing anything, especially according to a defined and regular plan" (OED, 2024) or the path to be taken to reach an end (Callaos & Callaos, 2014); this final point could be the processing and answering of the researcher's questions (Zucca, 2015). Methodology can be defined as "a body of methods, rules, and postulates employed by a discipline" or as the analysis/study of the methods regarding a specific field (Merriam-Webster Online Dictionary, 2022).

The two main types of research methodology in the social sciences are the *qualitative* and the *quantitative* approaches. According to Amaratunga et al. (2002, p. 19), “[qualitative research] concentrates on words and observations to express reality and attempts to describe people in natural situations. In contrast, the quantitative approach grows out of a strong academic tradition that places considerable trust in numbers that represent opinions or concepts”. Quantitative research is based upon numbers and measurement of data (Barker et al., 2002) and this assists the researcher to maintain an objective and detached understanding of reality, whereas “qualitative researchers seek answers to their questions in the real world. They gather what they see, hear, and read from people and places and from events and activities … their purpose is to learn about some aspect of the social world and to generate new understandings that can be used by that social world” (Rossman & Rallis, 1998, p. 5). Bateson (1997, p. 139) views the dominance of the quantitative approach in the sciences with a critical attitude and highlights the role of qualitative research.

In qualitative research “data is gathered primarily in the form of spoken or written language rather than in the form of numbers. Possible data sources are interviews with participants, observations, documents, and artefacts” (Polkinghorne, 2005, p. 137). A core aspect of qualitative research is the fact that qualitative data collected from interviews is seen as a product of the interaction between researcher and subject (Polkinghorne, 2005). Consequently, qualitative methodology is viewed as a holistic, vivid, real-life approach of social phenomena and human experiences that ascribes an active role to study participants (Ulin et al., 2005). For a proper understanding of a social phenomenon, it is crucial that the historical, socio-political, cultural and organisational contexts are taken into consideration (Ulin et al., 2005). Moreover,

> [Qualitative data] has often been advocated as the best strategy for discovery, exploring a new area, developing hypotheses. In addition, their strong potential for testing hypotheses is underlined on seeing whether specific predictions hold up. Further, qualitative data are useful when one needs to supplement, validate, explain, illuminate, or reinterpret quantitative data gathered from the same setting. (Amaratunga et al., 2002, p. 21)

This study follows a qualitative methodological approach, since it is focused on the participant who provides the researcher with evidence (data) for the experience explored, which the researcher then processes in order to describe this experience as comprehensively as possible to achieve an in-depth understanding of the human condition (Ulin et al., 2005). In this study, I intend to illustrate how the findings connect sufficiently with the evidence gathered in the self-reports/interviews (Polkinghorne, 2005), thus establishing the essential credibility of the results. The gathered data is based on the *self-reflection* of the participants (Polkinghorne, 2005). I expect that the qualitative data will contribute to revealing the meaning that the participants attribute to the experienced events and situations and in recognising how they link this meaning to their psychosocial reality (Amaratunga et al., 2002).

Essentially, in this study I follow an *idiographic* path due to its qualitative approach. The distinction between *nomothetic* and *idiographic* methodology was firstly stated by Wilhelm Wildebrand in 1894 (Thornton, 2008); according to Wildebrand, this methodological distinction reflected the distinction between natural sciences (German: *Naturwissenschaften*) and humanities (German: *Geisteswissenschaften*). The idiographic approach is based upon the heterogeneity of the sample and constitutes a person-specific analysis (Beltz et al., 2016) that enables the researcher to capture – to some extent – the complexity, uniqueness and totality of each participating individual. Unlike the nomothetic approach, which is

mostly applied in natural sciences, the idiographic perspective does not aim to reach *generalised* conclusions and set *lawlike*, general trends related to objective phenomena (Beltz et al., 2016). In other words, the nomothetic approach endeavours to “make general predictions about the population by examining interindividual variation, that is, variation between or across people”, whereas idiographic study tries “to make specific predictions about an individual by examining intraindividual variation, that is, variation within a person over time” (Beltz et al., 2016, p. 447).

Although the findings of this study cannot be generalised, and the selected participants should not be considered a representative sample of the entire population of helpers (Maxwell, 2005), since qualitative research is generally not considered – and is not intended – to be nomothetic, there are in the relevant literature several voices that support its *generalisability* (e.g., Agius, 2018; Leung, 2015). In a nutshell, even if the outcomes are not statistically generalisable to a larger population, “any theory they generate might well be” (Agius, 2018, p. 205). Therefore, I suggest that the results of this study could – apart from approaching and exploring in depth the individual experience – generate an integrative psychosocial approach that could be applied for the wellbeing of a larger group of people working in Refugee Care beyond the immediate sample of participants.

6.1.3. Defining Epistemology, Ontology and Paradigm of this Study

Epistemology. Within an etymological approach, *epistemology* is “the *logos* of *episteme”,* which means the theory about how we know and understand things (OED, 2024). The fundamental question of how researchers get to know what they know with their results at the end of their research reflects the epistemological basis of their study (Kivunja & Kujini, 2017). Slavin (1984) identifies four sources of knowledge in total: *intuitive knowledge, authoritative knowledge, rational or logical knowledge* and *empirical knowledge*. Beliefs and faith are sources of intuitive knowledge, whereas

data collected from books, leaders and experts constitute authoritative knowledge (Kivunja & Kujini, 2017). An approach based on the laws of logic leads to a rational or logical knowledge. If the gathered data derives from experiences, observation and objective facts, then the research can be defined as *empirical*, which also refers to this study. Undeniably, the epistemological position of the researcher plays a central role for the selection of a research methodology (Crotty, 1998).

Three noteworthy types of epistemologies are: *objectivism*, *subjectivism* and *constructivism* (Al-Ababneh, 2020). Objectivism means that meaning and reality exist independently of the human mind (Crotty, 1998). Subjectivism means that truth is not objective but is related to human experience, as with Descartes' famous phrase: *cogito, ergo sum* (translation from Latin: I think, therefore I am). Regarding subjectivism, Saunders et al. (2009, p. 111) state that "social phenomena are created from the perceptions and consequent actions of social actors". Constructivism views meaning as an outcome of the interaction of the human mind with the environment. According to constructivists, the world exists independently of human consciousness, but knowledge of the world constitutes a construction of the human mind and society (Crotty, 1998).

The epistemology of this study leans towards constructivism. In this study, it could be said that the collected data (which eventually lead to the findings) are results (a) of the participants' interaction with their environment and (b) of their interaction with the researcher.

Furthermore, my epistemological position clearly relies on the innovative *Refugee Care* principles, with the AG as the main epistemological tool, and is informed by expanded Jungian theory and Jung's epistemology; the latter was first identified and documented by Papadopoulos (2006). I opted for the AG epistemological tool (the application of which is extensively discussed later in

Subsection 7.1.5), which involves, *inter alia*, the purposive, beneficial function of AAD. The AG echoes Jung's appreciation for a multi-faceted and expanded epistemological approach, as it encompasses the various psychosocial realms, and can be applied by or for both beneficiaries and helpers. By maintaining a position of "Socratic agnosticism" (Papadopoulos, 2006, p. 43), Jung demonstrated his openness to a multi-layered epistemological approach. His view was that a phenomenon should be approached through several lenses due to the diversity of disciplines that investigate and work with this phenomenon. This study approaches humanitarian wellbeing from various angles (not only through a medical lens), thus demonstrating epistemological openness. Furthermore, Jung's epistemology has a teleological orientation, since he attempted to determine the goal, purpose and potential for development, in the symptoms of his clients. In Jung's view, this purpose or teleological function of the symptoms can also shape the personality, which, accordingly, may alter the understanding of one's childhood and past (Papadopoulos, 2006). The teleological perspective does not entirely refer to psychopathology or symptomatology and clinical psychotherapy, but to human existence in general. In this sense, overall, AAD echoes a Jungian finality when approaching human pain and suffering. The research participants are asked if they can identify a new meaning in life or any new insights or simple positive changes as a result of their adverse work with refugees. A further element relevant to this study is Jung's scepticism about the exclusiveness of a linear causal-reductive epistemology (Papadopoulos, 2006). The predominant approach follows a linear causal-reductive epistemology, according to which adversity is expected to cause a pathology or symptomatology (Pupavac, 2002; Summerfield, 2001). Throughout this study, I seek to maintain epistemological vigilance in order to avoid epistemological traps as a result of a linear causal-effect epistemology. In this study, I do not approach work-related stress and pain of

humanitarian staff solely through a clinical/medical lens and make sure not to arbitrarily link stress to trauma-related disorders or other pathological conditions. This is very relevant when considering the various contexts in which humanitarian helper wellbeing is investigated (individual/collective, mental health or medical, psychosocial, organisational).

Ontology. The term "*ontology*" is the "the science or study of being" (OED, 2024). It refers to the philosophical assumptions of the researcher in relation to the nature of the reality of the social phenomenon that is being studied (Kivunja & Kujini, 2017). These underlying assumptions have a central role in the researcher's approach to the research topic or question and in the interpretation and meaning making of the collated evidence (Kivunja & Kujini, 2017). Clough & Nutbrown (as cited in Delgado, 2020, p. 126) state that "for philosophers the twin terms of methodology are ontology and epistemology ... ontology is a theory of what exists and how it exists, and an epistemology is a related theory of how we can come to know those things".

This study follows a *relativist* ontology. The position of a relativist ontology means that the researcher assumes that the phenomenon being investigated has multiple realities, and that those realities can be examined through the interaction between the researcher and the participants (Chalmers et al., 2005).

Paradigm. A research *paradigm* reflects the way of thinking, the worldview, and the theoretical lens of the researcher (Kivunja & Kujini, 2017; Nguyen, 2019; Ulin et al., 2005) and encompasses the ontology, epistemology and methodology of the study.

It could be said that this study follows an *interpretivist* paradigm. Most qualitative studies follow an interpretivist (or constructivist) paradigm (Mason, 1996). The interpretivist paradigm views the world as socially constructed, focuses on the

subjective world of the human subjects, and seeks to understand their perspective and interpretation (Kivunja & Kujini, 2017; Mason, 1996; Ulin et al., 2005). In this case, the methods selected for the collection of data should empower the participants to openly discuss their subjective experiences and meanings of the social phenomena investigated (Ulin et al., 2005). These methods may include self-reports such as *semi-structured interviews*, *diaries* and *reflective sessions*.

6.1.4. Adversity Grid: Epistemological Reflections and Application

The AG is the key epistemological tool for conducting this qualitative research (Figure 6.1). The AG framework was introduced in Chapter 2. This study follows a slightly modified version of the AG as its main epistemological tool, which will be integrated into (a) the data collection and (b) the data analysis (TA).

In this research project, the AG is applied to helpers in order to contribute to a new conceptualisation of staff wellbeing from a combined Refugee Care and expanded Jungian theory perspective. As Papadopoulos (2021) argues, the AG is expressly gainful when used by staff working with people of concern for self-reflection and for the development of self-awareness of one's own reactions to work-related exposure to stress and distress. This aspect of the AG is the key point of departure of this study. Being exposed to adversities and stress within a work context, either vicariously or directly, may lead to the pathologies of VT, CF and burnout, as mentioned in Chapter 5. Essentially, according to the AG's epistemological framework, these pathological elements echo a minor part of the wide spectrum of staff responses to adverse situations and contents. In other words, the partial counteracting of the dominance of the trauma-related, pathologising approach to beneficiaries enabled by the AG can also be effective within a staff wellbeing context. For example, in her doctoral thesis that focused on resettlement practitioners, Jasperse (2021) presented an adapted version of the AG in New Zealand.

The expansion of the staff's epistemologies and self-awareness regarding their diverse reactions to work-related stress without being constrained only to negative or pathological reactions can have an empowering effect, which is supported by the AG. The positive effects, gains, strengths and beneficial changes as result of adversities (AAD), can reflect a new meaning in one's life and a transformed *Weltanschauung* (worldview) but can also refer to something simpler, a more tangible and more specific change or gain in one's daily life (Papadopoulos, 2021a).

In this study, while applying the AG, I classified the negative reactions and consequences into least severe, moderately severe and most severe. I informed the participants that least severe responses could refer to normal human suffering, while most severe may respectively echo pathological conditions (i.e., PDs). But ultimately, participants should decide for themselves according to their lived experience and own interpretation or judgement if a response or consequence is least, moderately, or most severe. I purposely avoided emphasising medical terminology, such as "psychiatric disorders" or "symptoms" while distributing the AG, since my approach in this study is not strictly clinical-medical. Moreover, aside from the individual, the family, and the community-society level, I included a distinctive *organisational/work-setting* level that explores the reactions in the organisation the participants work or volunteer for from the participants' angle, since in this study I seek to explore organisational aspects related to humanitarian wellbeing.

Figure 6.1

Adversity Grid (as applied in the study)

Levels	**Negative**			**Unchanged**		**Positive (AAD)**
	Most severe	Medium severe	Least severe	Negative Unchanged	Positive Unchanged – *Resilient parts*	
Individual						
Family						
Work setting/ Organisation						
Community/ society						

Note. When filling in the AG in this study, the main task of the participants is to monitor as closely as possible the changing effects of the adversities they are facing or faced at four levels: (a) the participant as an individual, (b) the participant's family, (c) the organisation they work in, and (d) the wider community, from their perspective. Participants are asked to regard all conditions, qualities, characteristics, relationships, values, etc., which they consider relevant, and at all four levels, i.e., as individuals (e.g., their own emotional or spiritual world, their creativity, interpersonal and social interactions), then, with regard to their families (e.g., communication), their work setting or any other relevant organisation (e.g., work with clients, relationships with colleagues, physical environment), on their community or society (e.g., whatever type of community they consider of relevance). The category of NEGATIVE effects includes three gradations of severity (i.e., *most severe*, *moderately severe* and *least severe*). The UNCHANGED category has two subcategories (*negative* and *positive).*

6.1.5. Recruitment and Interview Procedure

6.1.5.a. Inclusion and Exclusion Criteria. Eight participants in total were selected and recruited; their ages ranged between 30 and 61 years. Regarding gender, female participants were over-represented in the current study (five females, three males).

The **inclusion** criteria were the following:

- During the period of the interviews the potential participants had a role that includes direct contact with refugees; the study was open to any possible type of work: full-time, part-time, volunteering, paid work, in the field or at headquarters, any role with direct contact with refugees either in a humanitarian or a human services context.
- Potential participants had a working knowledge of English.
- Potential participants had access to an internet connection for the online interviews.
- Potential participants felt mentally stable enough to participate in this study.

The **exclusion** criteria were the following:

- Being underage (<18 years old)
- Being hospitalised at a mental health ward during the period of the interviews

I use the term “selection” since “…sampling carries the connotation that those chosen are a sample of a population and the purpose of their selection is to enable findings to be applied to a population. Sampling implies that the people selected are representative of a population. I think that the term “selection” more closely describes the method for choosing qualitative data” (Polkinghorne, 2005, p. 139).

6.1.5.b. Recruitment and Brief Description of Study Participants. The recruitment was assisted either (a) through my contact with the organisation, and/or with a *gatekeeper*; or (b) directly with the potential participants via phone or email. A gatekeeper is someone who provides the researcher with access to an organisation (Singh & Wassenaar, 2016). Obtaining access to a gatekeeper is an informal process of gaining access to an organisation in order to collect data (Singh & Wassenaar, 2016). Of course, contact with a gatekeeper does not guarantee participant involvement. A gatekeeper should not be coercive in influencing staff members to participate in a study. In two cases, for example, I obtained permission for access

and co-operation from a gatekeeper, as they were persuaded about the "*social value"* (Singh & Wassenaar, 2016, p. 43) and the confidentiality of my study, but recruitment was not possible. Furthermore, in one case, the gatekeeper was one of my study participants, as he fulfilled the selection criteria and showed interest in and availability for my research. In this case, the gatekeeper was somebody who I know on a professional level and, as Singh & Wassenaar (2016, p. 43) very fittingly note: "the informal process involves the researcher's ability to respect the boundaries of the access granted, adopt an objective and formal stance to the research process even if he or she is known to the gatekeepers and research participants".

Participant 1 (P1, female) is a support worker of Italian-German descent who lives in the UK and works with refugees and asylum seekers for British charities in the fields of mental health, complex needs and homelessness. She also volunteers with British humanitarian charities in missions either in the UK or abroad.

Participant 2 (P2, male) is a Jungian Analyst of Italian origin, who was raised in South America. He also has a background in economics. He volunteers as a psychoanalytic counsellor for a relief organisation in Germany.

Participant 3 (P3, female) is a psychologist and humanitarian worker in Turkey who originally comes from an Arab-speaking country. She works in the humanitarian field as an MHPSS expert.

Participant 4 (P4, female) is of mixed Tunisian-Swiss origin and works as (a) an interpreter for refugees at the Swiss society of an international humanitarian organisation and (b) as a volunteer for a Swiss charity that opposes deportations of refugees from Switzerland.

Participant 5 (P5, male) is a German psychiatrist, psychotraumatologist, supervisor, ethnologist and professor of religious studies. He works as a psychiatrist and trauma therapist at an outpatient clinic for the treatment of the involuntarily

dislocated in Switzerland. Moreover, he participates as an MHPSS expert in missions of an international humanitarian organisation.

Participant 6 (P6, female) is a German humanitarian with a background in Human Rights and with a long career at a leading international humanitarian organisation. At the beginning of this study, she was based in the Middle East and supports Afghan refugees having a role in the broader area of protection.

Participant 7 (P7, female) is a Western European humanitarian working as a coordinator for a charity that supports refugees in Athens, Greece. In addition, she is a yoga teacher, offering yoga lessons to refugees, staff members and locals. She started her humanitarian career as a volunteer in Lesbos, Greece, and she also gained field experience.

Participant 8 (P8, male) is a Greek medical doctor (general practitioner) who has a long career in humanitarian aid, including hands-on clinical experience in the field as well as coordinating roles, such as head of mission. Currently, he is the executive director of the Greek department of an international, non-profit, humanitarian aid organisation.

6.1.5.c. Sequential Procedures. In total, I contacted each participant three times. Earlier, *pilot interviews* were conducted, which helped me improve the interview questionnaire by adding questions that explore the family and the workplace dimension (also according to the framework of the AG) from the participants' perspective.

First Research Contact. The first contact was a general interview about how staff understand their work, including elements, such as motivations, sources of stress and satisfaction, coping mechanisms, organisational policies, team relationships, gains and growth.

Raw data were collected during *dyadic* or *one-to-one* (e.g., Polkinghorne, 2005), *semi-structured* and *in-depth* interviews with *open-ended* questions (see Appendix). The duration of the interviews was 60–75 minutes. A semi-structured interview has:

> …a sequence of themes to be covered, as well as suggested questions. Yet at the same time there is an openness to changes of sequence and forms of questions in order to follow up the answers given, and the stories told by the subjects. (Kvale, 1996, p. 124)

The open-ended questions echoed the framework of the AG, and, in my opinion, they would provide me with appropriate and valuable data, which I would then process for generating themes relevant to the research question. The aim of the interview questions of my qualitative study was to approach the research topic from the view of the participant and, subsequently, to comprehend how and why they developed this view (Amaratunga et al., 2002).

As an interviewer and a listener, I tried to maintain an *empathic* stance towards the participants by expressing my interest, understanding and approval of their narratives and listening to them carefully and thoughtfully (Kvale, 1996). At the beginning of the interview, I offered them a *briefing* in which I presented and defined the main purpose of the interview and tried to create a space of openness and comfort in which the participants would be enabled to talk freely (Kvale, 1996). Before ending the interview, I considered a short *debrief* essential for giving feedback to the participants, showing my appreciation and gratitude and, of course, discussing any questions, tensions or negative emotions that may have emerged during the interview.

Second Research Contact. During the second contact, participants were introduced to the AG as a tool for self-reflecting and self-monitoring in relation to their

reactions to work with the involuntarily dislocated. Then, participants completed the AG during the session, and I collected the data via secure email. Some participants chose to reflect on the AG and completed the AG after our online session.

Third Research Contact. After about 6 months, participants were asked to complete the AG for a second and last time and, if possible, note any further comments and reflections on the AG, the interviews, and their work with involuntarily dislocated persons, in general. The rationale behind this was for them to have a second opportunity to look again at the wide range of responses and consequences within the framework of the AG, and possibly to better define their retained and new strengths.

6.1.5.d. Additional Notes on the Interview Procedure. I chose not to wield an audio-recorder when interviewing the participants and preferred to rely on my hand-written notes taken during the interviews. The main reason was that some of the questions may touch on sensitive topics that are connected to unpleasant feelings (such as shame) and I wanted to create a positive environment of trust between the participant and myself and to "minimise any discomfort and support the participant's confidence" (Rutakumwa et al., 2020, p. 577). Some participants expressed their gratitude and approval for the fact they were not recorded and mentioned that this gave them more openness and freedom regarding their answers. Considering this, I believe that facilitating a relationship and an environment in which the participants feel comfortable to express themselves as they want on a specific topic – in other words, establishing a rapport – is more vital than recording with "100% accuracy" what is said during the interview (Oakley, 2016; Rutakumwa et al., 2020). In general, Rutakumwa et al. (2020) suggest that "choosing not to use an audio recorder, because of a likely negative impact … should not be viewed as a weakening of research conduct…" (p. 578) and that "the data quality between audio-

recorded transcripts and interview scripts written directly after the interview were comparable in the detail captured" (p. 566). Moreover, even with the safety provided through the anonymity and confidentiality of the research, it cannot be ruled out that participants will choose not to disclose information that could be harmful to them in any way, for example, in their career (Collins, 1998). Mattimoe and Hayes (2004, p. 20) argue that there is no "right" or "best" approach to data collection and that the decision to record or not should always depend on "its appropriateness in the particular situation".

It should also be noted that I, as a (Jungian) psychoanalyst, cannot rule out that the answers of the participants, especially when referring to other people and including more "expletive" phrases (e.g., "toxic boss"), may contain their own *projection* onto others in a psychoanalytic sense. Nevertheless, my task during data collection was exploring with openness the participants' individual experience; it was definitely not to provide them with a psychodynamic interpretation of their personal material, such as in a therapy session, or question their view on their experience from a psychoanalytic perspective. During data collection, if participants themselves (since some of the participants are psychotherapists) referred to a psychodynamic defence mechanism, this was then acknowledged by me as such, and, of course, was not further investigated or questioned.

6.1.6. Ethical Considerations

Full approval for this study was granted by the Ethics Committee of the University of Essex (see Appendix).

Ethical issues constitute a core aspect for the conduction of a research study and refer to the protection of the research participants (Orb et al., 2001). More specifically, confidentiality, informed consent, protection of privacy or anonymity and wellbeing of the human subjects during a study are fundamental for the research

procedure (Orb et al., 2001). As in comparable projects (e.g., Aldamman, 2020, p. 152), I generally tried to follow the principle of "*doing no harm"*.

Since some of the questions could have hypothetically been perceived as daunting, distressing or uncomfortable by the study participants, they were informed about this potential risk through a Participant Information Sheet (see Appendix). This assured the participants that, in the event of a distressful psychological reaction, the interview would be stopped, and adequate assistance would be provided, if required, to protect the subject and address this eventuality. All participants were given (via secure email) an Informed Consent Form (see Appendix) regarding their voluntary participation in the study, which they were expected to sign and return to me (via email). All participants were adults, and they were not directly recruited from clinical or "vulnerable" populations (such as patients in mental health wards). The participants were made aware that they had the right to withdraw at any stage of the research.

When meeting online with the participants for the interview, and prior to the commencement of data collection, I tried to ensure that they were cognisant of the content of the Information Sheet and that I was available for any questions or if they had doubts, wanted further discussion, or explanation. It is noteworthy that a distinction was made between my role as researcher and my profession as clinician, as potential participants were informed in the Participant Information Sheet that I was not going to explore any pathologies or psychiatric history. Furthermore, they were apprised of the fact that their only, direct (intangible) benefit of participating in my study would be application of the AG and gaining knowledge about its usage, so that they are able to appropriately apply it at work in future. Given the fact that sensitive topics, which potentially could trigger negative reactions, were discussed, the overall process was conducted cautiously. Each participant was attentively listened to and

carefully monitored for any signs of distress that could arise during the interview. Participants were made aware that they had the right to refuse to answer any question or part of a question they did not want to answer, or did not feel comfortable answering, and were advised and motivated to share potential negative emotions or thoughts with me. None of the participants showed signs of distress that would require interruption of the interview and further supportive measures. None of the participants withdrew from the study. For some participants who commented on this, the interview was perceived as *cathartic* rather than discomforting. All participants were given the opportunity to contact me at any time via email (or phone) in case of questions and concerns during and after data collection. Moreover, the availability of the Participant Information Sheet meant all participants were handed the necessary contacts in case of concerns and/or complaints regarding any aspects of this study and their participation in it.

For confidentiality, the letter “P” followed by a unique number was assigned to each participant (e.g., P1 for participant 1) to label their quotations. Data were transcribed onto a password-protected computer and no identifying features such as name, address or employer were recorded, ensuring confidentiality for all participants. Research material (including consent forms, notes, transcripts, reflection diary) are kept securely and are only accessible to the researcher. In some cases, I did not refer to details, such as nationality or current location, that could lead to the participants’ identification. I also respected the participants’ wishes, if stated, regarding which details were allowed to be recorded on paper and which not. Additionally, in this thesis I maintained full anonymity of all international organisations and charities with which the study subjects are or were involved. Ultimately, my goal was to sufficiently ensure that the participants’ relationship to their employers, team

colleagues and organisations, in general, would not be affected in any way by their decision to participate in my study.

6.2. Data Analysis and Findings

6.2.1. Thematic Analysis (TA)

The method selected for the data analysis in this research is *TA*, which focuses on "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). As a result, TA "allows the researcher to see and make sense of collective or shared meanings and experiences" (Braun & Clarke, 2012, p. 57). TA is compatible with the interpretivist paradigm that this research follows (Braun & Clarke, 2006) and, being a flexible method, can be applied either within an *inductive* (*data-driven* or *bottom-up*) or *deductive* (*theory-driven* or *top-down*) approach (Braun & Clarke, 2006). Even in inductive TA, "researchers cannot free themselves of their theoretical and epistemological commitments, data are not coded in an epistemological vacuum" (Braun & Clarke, 2006, p. 84), and "coding and analysis often uses a combination of both approaches. It is impossible to be purely inductive, as we always bring something to the data when we analyse it…" (Braun & Clarke, 2012, p. 58). Regarding inductive TA, the central assumption is the existence of a comprehensible world in which the researcher unearths and explores the different experiences and meanings that emerge from the gathered data (Braun & Clarke, 2012). Deductive TA focuses on the notions, theories and preconceptions that shape the data (Braun & Clarke, 2006). Braun and Clarke (2006, p. 59) point out that "essential for doing good TA are a clear understanding of where the researcher stands in relation to these possible options, a rationale for making the choices they do, and the consistent application of those choices throughout the analysis".

The analysis in this research follows both paths, i.e., inductive (data-driven) and deductive (theory-driven). This means that the generated themes are not only

connected with the collected data, but also, to a certain extent, with the researcher's theoretical background and assumptions. These originate, as discussed in Chapter 2, from the framework of Refugee Care/AG and Jungian psychology but also include further integrated aspects that were declared in the previous chapters of the literature review, such as eudemonic wellbeing and the Tavistock approach on organisational psychodynamics/group relations.

TA is based on *themes*, which can be understood as distinguishable, concrete patterns of meaning in the analysed data (Joffe, 2012). Themes can be of *manifest* or of *latent* content; manifest content is directly noticeable, whereas latent content is implicit and indirectly communicable (Joffe, 2012).

TA is among the most transparent of qualitative methods, and provides a sufficient in-depth analysis of the data by detecting patters of human behaviour, emotions and thinking (Joffe, 2012). One further advantage of TA, apart from its flexibility, is its accessibility, since it introduces the new researcher to coding and analysing qualitative data without demanding previous, complex theoretical or technical knowledge, unlike *Discourse Analysis* (DA), for example (Braun & Clarke, 2012). Additionally, TA is simple to comprehend and learn, may lead to unexpected, but nonetheless insightful results, is a suitable method for a psychosocial approach to the collected data and, finally, generates outcomes easily accessible to the reader (Braun & Clarke, 2006).

Historically, TA evolved from *Content Analysis* (CA), an originally quantitative method (Smith, 2000) that was later applied in the social sciences, and especially mass media studies (Krippendorff, 1989). CA involves identifying specific categories, concepts, even words, and then determining the occurrence of these words in the collected data, such as texts or images (Joffe, 2012). TA is clearly inspired by the systematic character and coding mechanism of CA, but, as Joffe (2012) alludes, a

major difference between TA and CA is the fact that TA succeeds in addressing more implicit and more thematic contents in the qualitative data. Braun and Clarke note that “until recently, TA was a widely used yet poorly defined method of qualitative data analysis” (Braun & Clarke, 2012, p. 57). TA has been extensively applied by researchers but has also been frequently confused with or considered part of other methods, such as DA or *Grounded Theory*, without being identified as a distinctive methodological tool on its own (Braun & Clarke, 2012).

6.2.2. Identifying the Themes

Braun and Clarke (2006, 2012) identify and outline six stages of TA with corresponding guidelines, which I followed in performing the data analysis in this study:

- During the first phase I immersed myself in the collected data, which encompassed repeated reading, thinking and noting down possible ideas related to coding on a more tentative basis (Braun & Clarke, 2006).
- The second phase refers to the process of initial *coding*. According to Ulin et al. (2005, p. 91) coding is “the process of attaching labels to lines of text so that the researcher can group and compare similar or related pieces of information”. These codes are data extracts that constitute “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). I performed coding manually with the support of my supervisors, who are experienced researchers. Codes can be *semantic* or *descriptive* and, therefore, very strongly related to the material that is delivered by the participants, and more superficial, or they can have a more tacit, *latent* character that goes beyond the surface and offers interpretations and insights

into the extracted data (Braun & Clarke, 2012). I identified codes with semantic as well as implicit character.

- During the third stage I classified the initial codes into potential *themes*, which involved my reflection on the interconnectedness between initial codes, initial themes, and different dimensions of themes (Braun & Clarke, 2006). Initial codes can build themes or subthemes, or they can be rejected or transferred into another theme, and, in the end, there are a certain number of potential themes and sub-themes that are formed by the related initial codes (Braun & Clarke, 2006). The number and form of candidate themes should enable an in-depth analysis of the collated data.
- The review of the potential themes that are generated constitutes the fourth phase of TA. I examined whether the themes are coherent and adequately linked to the extracted, coded data. Braun & Clarke summarise the crucial aspects of reviewing the quality of the formed themes:

  > "Is this a theme (it could be just a code)? If it is a theme, what is the quality of this theme (does it tell me something useful about the data set and my research question)? What are the boundaries of this theme (what does it include and exclude)? Is there enough (meaningful) data to support this theme (is the theme thin or thick)? Is the data too diverse and wide ranging (does the theme lack coherence)?" (Braun & Clarke, 2012, p. 65)

- At stage five of TA, I defined and named the individual themes (and subthemes), which were expected to relate to each other but not to overlap, and to effectively deal with the research questions (Braun & Clarke, 2006). I included a comprehensive summary of each formed theme, which is considered essential.

- The last phase of TA consisted of the composition of my final report, which contains the data extracts, the codes, and the themes. I expected that the themes follow a rational order and, ultimately, lead to a robust and persuasive argument in relation to the research question (Braun & Clarke, 2012).

Additionally, I paid attention to potential downsides and methodological "traps" for researchers during the application of TA: TA should be more than just an assemblage of paraphrased extracted data without analytic value, the themes in TA are not supposed to exactly reflect data collection questions, the themes should be sufficiently coherent and should not overlap and, additionally, the conclusions wedded to the themes should be supported by the collected data (Braun & Clarke, 2006).

By immersing myself in the gathered data, searching for, extracting (and re-extracting) codes, and defining and refining themes and subthemes, I determinedly tried to generate themes, which do not constitute "domain summaries" but tendentially echo a "core concept", as Braun and Clarke (2019, p. 593) suggest in their conceptualisation of a "theme". Of course, I acknowledge that some of my findings may inevitably be closer to the collected data, whereas others may be far more "transformative" or "interpretative" in relation to the data, and, eventually, more in accordance with the idea and purpose of qualitative research.

Sandelowski and Barroso (2003, p. 908) differentiate between "qualitative research and research that simply uses qualitative data" suggesting the existence of a spectrum regarding the transformation of collected data into qualitative findings. At one end of the spectrum, qualitative data is identical to the findings, i.e., there is no interpretation of the empirical material; at the other end of the spectrum, the findings are highly qualitative, i.e., highly transformative, and interpretative of the empirical material.

Based on the above observation, in the case of TA (which the data analysis in this study relies on), less “developed” themes that simply contain the raw data as “domain summaries” are at one end of the spectrum, while transformative themes that carry a shared meaning or express a latent pattern in the processed data are at the other end of the spectrum.

Considering the above, I concluded there to be three main themes, and several subthemes (see Table 6.1, below):

Table 6.1

Themes and Subthemes

THEMES	SUBTHEMES
1. Work with refugees can be difficult, stressful, and/or distressing	1.1. Reflections on Stress and Burnout due to Organisational, Workplace-Related and Financial Aspects 1.2. Helper Stress and Dissatisfaction in Working Directly with Refugees 1.3. Various Indications of Pathology 1.4. Negative Influence due to Political Aspects and the Interactional Matrix of Humanitarian Intervention (IMI) 1.5. Negative Effect on Relationships with Family and Friends
2. Self-Care in Refugee Care	2.1. Coping Skills for Resilience 2.2. Awareness of Limitations and of the Complexity of the Conditions 2.3. Therapeutic and Psychosocial Interventions for Helpers 2.4. Quitting a Job Position/Leaving a Role/Changing Careers

3. Eudemonic Wellbeing of the Helper	3.1. Diverse Perceptions of Wellbeing 3.2. AAD of the Helper 3.3. Importance of Family and Friends 3.4. Having an Effect/Impact from an Activistic, Altruistic and Idealistic Standpoint 3.5. Experience of Cosmopolitanism

From Table 6.1, it can be asserted that each major theme is corroborated by at least one category of the AG (i.e., negative responses, unchanged/resilience and positive responses/AAD). The AG was the fundamental epistemological tool for the data collection, either by inspiring the interview questions or by the direct filling out of the AG form distributed to the participants. As explained in the previous section of this chapter, this qualitative data analysis is also theory-driven, which means that the findings, to some extent, may reflect the theoretical background and conceptual approach of this study.

In this regard, I can provide some evident examples of this connection: For example, subtheme “1.1. Reflections on Stress and Burnout due to Organisational, Workplace-Related and Financial Aspects” echoes the discussion around the unfavourable organisational issues and the group dynamics dimensions raised by the scholars of the Tavistock Centre (as examined in Chapter 4). Subtheme “3.3. Eudemonic Wellbeing of the Helper” draws on the concept of eudemonia from Greek philosophy (originally) as well as modern psychology, which was investigated in Chapter 3 and integrated in the conceptual approach of this project. Meanwhile, subthemes “2.2. Awareness of the Complexity and the Limitations” and “3.1. Personal dimension of AAD” are linked to the innovative Refugee Care approach, the theoretical backbone of this thesis, as presented in Chapter 3. Lastly, subtheme “3.4.

Having an Effect or Impact from an Activistic, Altruistic and Idealistic Standpoint" to a degree builds upon the motivational factors regarding work with refugees, as embodied in the wider psychosocial perspective of this thesis.

Besides the above, Table 6.2 (below) is indicative of my work regarding the processes of coding and generating themes and subthemes based on raw data (following the method of TA):

Table 6.2

Sample of Data Extracts for the Generation of Themes

(Based on the Participants' Adversity Grid)

Coded Extracts	**Sub-Subtheme**	**Subtheme**	**Main Theme**
"In summary, I am happy to be able to pursue a meaningful activity at my job in Germany, but also in the assignments in crisis areas, even if I have recurring doubts about sustainability."	Elements of Vicarious Resilience (VR)	Adversity-Activated Development (AAD) of the Helper	**Eudemonic Wellbeing of the Helper**
"My family supports my work when they have the feeling that the meaningfulness of the work makes me feel better."	None	Importance of Family and Friends	**Eudemonic Wellbeing of the Helper**
"I have become modest about the demands on success (especially against the background of environmental conditions in crisis areas)."	None	Awareness of the limitations and the complexity of the conditions	**Self-Care in Refugee Care**
"Today more than ever, refugees are marginalised, isolated and stigmatised in society, including in the host countries, and psychological problems are still not sufficiently recognised…"	None	Negative influence due to Political aspects and the Interactional Matrix of Humanitarian Intervention (IMI)	**Work with refugees can be difficult, stressful and/or distressing**
Perhaps because of restructuring of the organisation, there is a great deal of insecurity, which is not greatly reflected in the work with the clients but in the cooperation with other therapists. It is noticeable that working with severely traumatised people requires full concentration and an optimal working atmosphere in the team; in the absence of the same, difficulties quickly arise in communication and cooperation."	Difficulties and negative relationships with colleagues and managers, including negative team dynamics	Reflections on stress and burnout due to organisational, workplace-related and financial aspects	**Work with refugees can be difficult, stressful, or/and distressing**
"Over the years, the topic of MHPSS has been increasingly recognised and taken seriously by NGOs."	General AAD (not VR)	Adversity-Activated Development (AAD) of the Helper	**Eudemonic Wellbeing of the Helper**

Table 6.2 exemplifies the connection between coded extracts from the data (interviews and completed the AG form) and the emerged sub-subthemes, respectively, subthemes that compose the final themes. Here, I should proclaim that codes could be phrases/whole sentences, as illuminated in the table above, or even single words, mainly extracted from the participants' filling out of the AG.

6.2.3. Theme I: Work With Refugees can be Difficult, Stressful, and/or Distressing

"I feel drained … you can't solve all the problems…" (**P1**)

The first major theme I identified through the TA of the collated data from the interviews and the documentation of the AG comprises the central concepts of stress and distress of the helper. Work with refugees can be difficult, stressful, and potentially distressing either in the humanitarian field on in a human services setting and this reality is in line with the resource literature (e.g., Aldamman, 2020; Apostolidou, 2016; Barrington & Shakespeare-Finch, 2013; Birck, 2001; Eriksson et al., 2013; Guhan & Liebling-Kalifani, 2011; Musa & Hamid, 2008; Posselt et al., 2020; Sifaki-Pistolla et al., 2017; Welton-Mitchell, 2013). This key theme is principally corroborated by the category of negative reactions/consequences of the AG. The findings suggest that stress and/or distress of the humanitarian helper is/are multidimensional and not solely linked to the exposure to the adverse material of the beneficiary. The generated subthemes refer to organisational and psychosocial (including socio-political) aspects.

I add my clarifications of what research participants are referring to in square brackets. These are clarifications and *not* comments.

Participants had a working knowledge of English but are not native speakers, so there might be some insignificant linguistic errors.

6.2.3.a. Reflections on Stress and Burnout due to Organisational, Workplace-Related and Financial Factors. According to their individual, subjective experience, the majority of the participants in this study addressed several organisational and work-related aspects and issues within international organisations, NGOs and charities that engage in Refugee Care, which can cause significant stress to members of staff and volunteers (see, e.g., Aldamman, 2020; Aldamman et al., 2019; Pross & Schweitzer, 2010). For instance, **P8** maintains that "there is more burnout while doing migration management than in war zones…" In addition, **P5**, as a psychiatrist and psychotherapist, states that in his case, organisational matters can undoubtedly be more challenging compared to vicarious exposure to clients with adverse experiences: "My limitations have more to do with the organisational framework than with psychotraumatology" and "work [with refugees] is very satisfying … earlier, I could imagine doing this until retirement … but not anymore because of the [organisational] framework; for example, I cannot determine things such as team meetings…"

1) High workload, lack of staff and lack of satisfactory funding are some of the central problems that organisations face and are identified as sources of work-related stress and dissatisfaction by half the participants:

P1 states in her interview that "we are understaffed" and that in her opinion "the main source of stress is workload … you fight to get things done … you can't do everything otherwise you will get burnout". Furthermore, she suggests that "workload and working hours should be reduced … it should be six hours … the less time you work, the more work you produce…"

P3 argues that "a major source of stress is the lack of stability in the organisations … funds are finished, and projects are terminated…"

Similarly to P3, **P7** comments: “There is more stress because of money and NGO problems than exposure to [refugee] narratives … I am used to this…” She continues: “A big stress is [lack of] money … a lot of NGOs are struggling … due to the war in Ukraine, a lot of international attention has been focused there … NGOs have reduced their operations although the situation has not improved…” In the completed AG, she identifies “lack of funding” on an organisational level and “no money and no safety for the future” on a personal level, respectively, as major negative aspects of the work with refugees. Finally, she remarks that in humanitarian organisations “a lot of people are burned out … people work too much…”

P8 shares a different reason regarding the problem of understaffed NGOs, other than the financial aspect; according to his experience: “You cannot find people interested in working in the field…”

2) Difficulties and negative relationships with colleagues and managers, including *negative team dynamics* and cases of *scapegoating*, as well as difficulties in the collaboration with other teams are viewed by most of the participants as major stressors and sources of dissatisfaction, and these stressors can be of higher severity when compared to the exposure to the adverse material of the clients:

“Partnership between different service providers is extremely difficult, even on paper … a worker has to co-ordinate with too many others … clients are not that difficult…” **(P1)**

“A source of stress [is] the relationships with colleagues; we do not identify team dynamics … those may be problematic … we should be more aware of [team] dynamics…” **(P3)**

“In some cases, there is a ‘blame circle’ … we point out the ‘bad person’ … I do not have [an] explanation for this … the dynamics of the team are affected by what is happening inside and outside of the consulting room…” **(P3)**

“I have experienced scapegoating in 2–3 positions … it is as if there is someone in the organisation who will be the troublemaker – for example, a team leader or a supervisor – no matter if this person is the most devoted … in Arabic we say: the hanger on which you put all the problems…” **(P3)**

“To me, the main sources of dissatisfaction at work are the legal framework and the structural problems in the organisation and with other colleagues…” **(P5)**

“There are toxic people in NGOs … workers in NGOs tend to tolerate toxic people more because you are working for a good cause…” **(P7)**

“HQ is not my most preferred location … I have had a super toxic team there…” **(P6)**

“On the other hand, there have been so many disappointments on how they treat their own staff … there is toxic management … I have been sadly disillusioned…” **(P6)**

“I have been working under a toxic manager in addition to other problems…” **(P6)**

P6 also draws attention to the fact that sometimes it is difficult to maintain a “safe” or “healthy” distance from colleagues and managers:

“[During humanitarian deployments] … you get way too close way too quickly with colleagues…” **(P6)**

“It is often difficult to draw lines … even my toxic manager is fully aware of my private life … everyone discusses my private life…” **(P6)**

P8 argues that “many times, burnout is a result of team conflict, not exposure”, fittingly adding that “as a humanitarian, you do not choose [the] colleagues with whom you live…”

The above-mentioned facets are mentioned by many participants during the completion of the AG, too:

P3 views “negative team dynamics and [team] problems” as a negative, medium severe aspect of the work with refugees. **P5** notices that “perhaps because of restructuring of the organisation, there is a great deal of insecurity, which is not greatly reflected in the work with the clients but in the cooperation with the other therapists. It is noticeable that working with severely traumatised people requires full concentration and an optimal working atmosphere in the team; in the absence of this, difficulties quickly arise in communication and cooperation”. According to **P6,** there is “more disillusionment when it comes to my work, mostly in relation as to how work is managed”. Finally, **P7**’s “former toxic boss” was, to her, the most severe work-related problem documented in the AG.

3) A further matter addressed by at least half of the participants is the fact that existing organisation policies regarding work-life balance, supervision, adequate training and general psychosocial wellbeing of staff are not “good enough”:

“Staff are not prepared to deal with the people coming [i.e., refugees], with legislation, with social aspects … some do not have a clue … there is no training about people on the move … staff are not well informed … it is difficult to work with people unaware [of refugee issues]”. **(P1)**

“Lack of training [on refugee issues] may possibly lead to burnout.” **(P1)**

“There is nothing [no training] about multi-disciplinarity…” **(P1)**

“Work setting/staff/management not prepared to deal with refugees’/asylum seekers’ complex backgrounds and histories” (**P1**, listed in the AG)

“I applied for psychological support within the organisation, but I didn’t get it…” **(P3)**

“Staff support policies are not integrated in the organisational policies … they offer activities but forget about work-life balance … staff support policies do not consider the wider context, the administrative structure … by teaching exercises and

providing staff with activities, they [organisations] place the responsibility onto the helper, but they do not deal with matters such as workload or work-life balance…" **(P3)**

"Organisations provide staff with exercises, activities, workshops on mindfulness and relaxation after staff have been overwhelmed and reached burnout. When there are signs of burnout [among staff], then the organisation provides these…" **(P3)**

"My observation is that prevention [of mental health problems] is limited … organisations have to reconsider how to integrate staff policies…" **(P3)**

"The organisation may have some classic, standardised [staff wellbeing] policies, such as a day of mental health awareness … but one should have an effect on stressors by making changes in the organisation…" **(P5)**

"The rotation policy is a huge cause of stress…" **(P6)**

"Frequent uprooting due to new assignments all over the world" (**P6**, listed in the AG as a less severe, negative element).

Above, P3 and P5 aptly criticise the lack of policies to prevent deterioration of mental health or workplace wellbeing in their organisations. These policies should include the adjustment and improvement of several organisational factors that could potentially act as stressors.

6.2.3.b. Helper Stress and Dissatisfaction in Working Directly With Refugees. All participants – regardless of their background and professional role (i.e., not only psychotherapists) – addressed negative aspects in their actual paid or volunteer work with involuntarily dislocated people, while most confessed individual negative experiences and emotions. Stress is inevitable in work with adversity survivors (Antares Foundation, 2012), and, although some of the reactions and complaints of the participants could hypothetically be compatible with the domain of

VT, these have not been necessarily experienced as severe nor viewed as a possible cause to cease working in the field of Refugee Care.

1) Some participants have experienced feelings of powerlessness and overwhelmingness linked to their own professional limitations or to the limitations due to the setting and the difficult circumstances:

"I feel drained … you can't solve all the problems … it is a vicious circle … for many clients there is no visible way out of the social services … I am tired…" **(P1)**

"It is difficult to get people onto the job market even if they are capable…" **(P1)**

"Frustration about not being able to support refugees/asylum seekers in their struggles upon arrival in the UK such as legal aid, housing, benefits" (**P1**, written in the AG as a negative reaction).

"It [i.e., work with refugees] is valuable but can also be frustrating and in some cases, we can do no more than just be there for the clients…" (**P4**)

"Sometimes sadness, anger because of the injustice, the powerlessness, and the suffering of the affected persons…" (**P4**, taken from the AG)

"I feel overwhelmed by the number of clients that come to us [at the NGO] and have difficulties and then, sometimes I do nothing at all, I feel as if I were paralysed … this has an effect on my active engagement…" (**P4**, additional comment in the AG)

"When does burnout appear? It has mostly to do with powerlessness, not necessarily with the clients' traumatic narratives … it is about not achieving something … for example, take the case of [working with] asylum-seekers who then get rejected…" **(P5)**

With regard to the above excerpts, one could describe these experiences as the participants' reaction to the *daily stressors* of the refugees rather than exposure to severe adversity (Miller et al., 2008; Miller & Rasmussen, 2010).

2) Indisputably, the exposure of the helper and enabler to the adverse material of the adversity survivor can be a source of stress and/or distress. Nevertheless, this is a normal reaction to the painful experiences and stressful conditions of the refugees, and is not necessarily linked with a psychopathology, such as STS or VT. Many participants shared their experience on this exposure and their reactions:

"I really like field work, I prefer field work to administration … But, field work is also heavy, I end up seeing things that I would not expect to, things that are shocking…" **(P3)**

"Work with cases which come too close [to an interpreter] can be discontinued by the interpreters because they [the cases] can remind them [the interpreters] of their own [painful] story…" **(P4)**

"I want to work directly with refugees … this is a double-edged sword … you can make a difference with work … but it can be incredibly tough when interviewing refugees directly … it takes a huge toll on you … the circumstances, the whole stories … there are horrific stories even in the country of asylum … you dig into their story … you get confronted with personal stories of refugees…" **(P6)**

"It [i.e., working directly with clients] used to affect me a lot, I was not being careful … I went too close to the stories of the clients…" **(P7)**

"When you work in crisis, you get emotional, you see suffering you cannot change … I had to put myself into a risk situation…" **(P8)**

"I was quite emotional when I was going to talk to the media … someone told me that I was aggressive…" **(P8)**

"It [i.e., humanitarian work] does touch you emotionally, physically and professionally … you become more cynical…" **(P8)**

3) While being confronted with and reflecting on the clients' needs, the occasionally too high or unrealistic expectations and the clients' learned or

polymorphous helplessness, some participants were aware of the triggering of negative emotions and reactions:

From his experience in volunteer work as a therapist and psychoanalyst, **P2** commented that “you have to be very patient, do more effort for empathy … refugees do not trust somebody immediately … these are difficulties that can cause stress to the therapist … it takes much more sessions for them to feel comfortable and open themselves…” Furthermore, he mentioned that he feels some irritation when “some of the clients think that the state has to provide for them automatically … they do not fight because they think that they have the right to be supported…” Additionally, he noticed that some clients “expect that therapists will manage their practical problems … one or two abandoned therapy as soon as they realised I am no social worker…”

From her experience at an advocacy NGO and as an interpreter for a humanitarian charity, **P4** mentioned that “some clients cannot maintain distance, they always want more…”

In conclusion, one could see here the connection to the interactions inside the Victim Triangle (as described in Chapter 2) according to which the helper becomes the “victim” of the beneficiary who takes, in this context, the role of the “villain”/”persecutor”.

6.2.3.c. Various Indications of Pathology. While completing the AG, some participants documented (under negative reactions) feelings, discomfort or disturbances that were associated with their overall work with refugees and some of which could hypothetically be classified as symptoms of burnout or vicarious trauma. However, from a non-pathologising, non-medicalising perspective, one could claim that these are principally related to normal, human responses to stressful and painful situations. Few of these participants also referred to specific clinical entities or disorders. I acknowledged and respected their individual experience, perception and

interpretation of those manifestations and I did not proceed with further medical exploration, since this is not the purpose or aim of this study.

Filling in the AG form, **P3** mentioned negative reactions at the personal level, including “shame and guilt”, “gaining weight”, “migraines” and “existential crises, difficulty trusting the world. Seeing the world as a radically unfair and awful place”.

P7 referred to the experience of “anxiety” and “secondary trauma” as well as a “gap in the understanding of the world” and “feeling of hopelessness”. Similarly, in his humanitarian missions as a doctor, **P8** has experienced “fear”, “stress”, “anger” and “uncertainty”. He added that “there is burnout because of lack of resources and exposure to adversities”.

In her interview, **P6** voiced that “there are traumatic experiences … some continue, some drop out, some show extreme reactions … there is burnout … there is a whole range of problems such as PTSD … it has taken a quite big toll on people.” In the AG, **P6** emphasised that she has been “very close to burn-out at different times throughout her career” and shared her “most recent experience of having to go on sick leave for several weeks due to impact of security incidents on her mental health”.

From his experience in the field as a psychiatrist, **P5** acknowledged: “[during humanitarian work] I noticed burnout among co-workers and also local aid workers…”

P1 declared: “Sometimes we get support from management … I cannot complain … there is a lot of burnout though…”

Finally, during her first interview, **P4** stated**:** “I have almost experienced burnout … I was very stressed [at that point] and, at the same time, a client of mine was at the hospital … luckily, I had holidays [afterwards]…”

6.2.3.d. Negative Influence due to Political Aspects and the Interactional Matrix of Humanitarian Intervention (IMI). Most participants emphatically highlighted the negative role and effect of the Western political establishments, parts of Western society and, in addition, in a more expansive sense, of the so-called IMI (see Chapter 2) in relation to the care of refugees. This negative influence is viewed and experienced as a source of stress, dissatisfaction, overwhelmingness and powerlessness (e.g., Blanchetiere, 2006):

"In Calais, the situation was affecting … it was cold, wet, rats and mice were everywhere … the French police were nasty and came with dogs to force the refugees to evacuate … it was very moving and tough to see especially all the elderly refugees…" **(P1)**

"The NHS [National Health Service (UK)] is pushing people out of the hospitals too early … two people (i.e., clients of the charity) committed suicide … luckily our team stayed strong … partnership with the NHS was too difficult…" **(P1)**

"Refugees are scared of being deported to Rwanda … there is a lot of trauma and fear because of this…" **(P1)**

In the completed AG, in the dimension of community and society, **P1** addressed the following issues: "Rejection of refugees/asylum seekers", "generalised phobia towards them", "twisted perception of the Other/Unknown", "difficulties engaging the public in the refugees'/asylum seekers' discourse" and "worsening of migrant crisis (overall, not only in the UK)".

From a political standpoint, **P2** stated: "We invest our energy in treating the victims of persecution, but we do not solve the problem. Now, with my work, I can see this more clearly. There are so many refugees and internally displaced people that we are not aware of, that are outside of our optical field". Additionally, he affirms that "because of the Ukrainian crisis, other refugees are now being supported less

than before, also because the number of refugees has grown". Finally, he draws attention to what he understands – in Jungian terminology – as the "Shadow aspects of the helping community": "Fake helpers who promise false advantages and trap refugees, for example, in prostitution".

P3 drew attention to the "split/polarisation in the community and relationships". (**P3** from the AG)

P4 asserted: "A main source of dissatisfaction is the Dublin Regulation, we cannot do much about it, which is very frustrating…" Furthermore, she maintains that "refugees live among us, but they are discriminated [against] … there is no democracy if a part of the population is not democratic … this [work with clients] has changed me totally, the image I now have of Switzerland is very bad…" She notes the "apathy of the people working at the asylum department" and experiences "feelings of hatred when people speak very positively about life or the political system in Switzerland and in the EU".

P5 acknowledges that "refugees were and still are even more today – due to the sheer number – marginally isolated and stigmatised in society, including in the host countries, and psychological problems are still not sufficiently recognised…"

P7 voices: "There is an impression of powerlessness … we cannot make a difference on [the] political level." She also detects a "lack of awareness" about refugees in modern Western society.

P8 expresses his disillusionment regarding EU policies on refugees:

"In Europe I expected it [i.e., care of refugees] to be different [in comparison to developing countries], but it is not … this does not leave you untouched…" **(P8)**

"Here [in Europe] I have to address policies … we [i.e., humanitarians] struggle like Don Quixotes." **(P8)**

"If you don't have a strategy, then you can't do much … we cannot solve the phenomenon of refugees…" He aptly adds: "Vulnerable people live in an environment that doesn't change, for example in Lesbos, Greece. Imagine being a single woman doing shifts in the night [inside the refugee camp] because of the fear of being raped … suddenly everyone there has a mental health issue … and the staff gets frustrated…" **(P8)**

Furthermore, he comments on the stance of parts of local host communities and general society: "Most people look at my work as a humanitarian abroad with admiration … in Greece, though, people want the refugees far away … some say to me: 'take them into your home!'" **(P8)**

6.2.3.e. Negative Effect on Relationships With Family and Friends. "If you are a humanitarian, you must first be humanitarian with your own family." **(P8)**

The majority of participants reported negative effects on their relationship with their family and friendship circle, which are connected to their humanitarian work for the care of refugees. For instance, these, inevitably, include less time or energy for family and friends and unhappy spouses or parents:

"I want to spend more time with my son." **(P1)**

"Limited time to spend with my family due to overwork/studies." (**P1,** from the AG)

"My parents are not supportive at all; they think it is a failure that I am not in my previous career." **(P7)**

"Jeopardizing my marriage because of work conditions, second hand trauma, and distance, of course" and "distance from family". (**P7**, from the AG)

"Relationships with friends back home are difficult." **(P7)**

"Less time with family" and "missing family and social gatherings". (**P3,** from the AG)

"Sometimes I am disappointed by my daughter when she does not show enough empathy or understanding when I am outraged [because of work]." (**P4**, from the AG)

"When I was abroad [for humanitarian work], I mainly had problems with my wife…" **(P5)**

"It [i.e., humanitarian work] affected me emotionally … I forgot my family … I worked too long … I hadn't seen my son for months." **(P8)**

As a humanitarian within an international/intergovernmental organisation and working often in the field abroad, **P6** stresses the difficulties in maintaining social relationships due to the distance and the rotation policy that is inevitable in humanitarian work with refugees:

"For friends, you are not there … sometimes they do not know what to ask … you are not there … sometimes people don't understand…" **(P6)**

"Relationships are a huge challenge!" **(P6)**

"It is difficult, there is a long distance … so much flexibility is required! There is unpredictability … For planning a family, you need more stability…" **(P6)**

"Impact on family: when I find myself in difficult work environments, they worry; at times our relationship can get strained because they don't understand why I pursue this type of work" (**P6,** documented on the AG)

"Having to build new networks, friendships wherever I go next and leaving behind others" and "sadness about having to leave behind people I was very close to". (**P6**, from the AG)

Additionally on her second AG, and from her own recent experience, **P6** stresses that, for a woman, pregnancy/motherhood and work for a humanitarian organisation are, regrettably, not compatible, and this is clearly a source of stress

and disappointment. Apparently, there is a gap in understanding from the side of the organisation:

"[My organisation] is an organisation that relies on absolute flexibility of its staff and availability to move to hardship duty stations from one day to the next. If you have "constraints" like being pregnant or not able/willing to move to hardship/non-family duty stations anymore with a small baby, your career as a woman in [name of organisation] is severely hampered. It is very difficult to find onward employment because the family duty station positions are very limited. I have been through a lot of stress as I was very close to being laid off just before maternity and being unpaid. My future with [name of organisation] after maternity [leave] also remains entirely unclear. These months have had a big impact on me (and my partner) because once again, you feel really sad and disappointed about how things are handled." (**P6**, from the AG)

6.2.4. Theme II: Self-Care in Refugee Care

"I am not there yet [meaning burnout] but I have to take care of myself." **(P1)**

"Wellbeing is the way you take care of yourself." **(P2)**

The second core theme that was generated by the data analysis is self-care and is corroborated by the categories of Unchanged/Resilience (predominantly) and Positive Reactions/AAD (to a lesser extent) of the AG.

While browsing the Internet, one gets the impression that self-care is currently a marketable and fashionable product like wellbeing. According to Scott et al. (2023, p. 368), "self-care emerged in the 1950s as a medical concept for patients to foster more significant health outcomes through personal habits but has often been implemented in the form of individualistic, and sometimes minor, life-style changes". The official definition of the term "self-care" is "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with

illness and disability with or without the support of a health worker" (WHO, 2022). Furthermore, self-care "recognises individuals as active agents in managing their own health care" (WHO, 2022). This approach to self-care appears to be a rather medicalised one. A further, alternative, more colloquial definition is "the practice of doing activities that you enjoy or that are relaxing, especially in order to improve or avoid stress" (Cambridge Online Dictionary, 2022). Self-care is a crucial topic for those who are in helping and caring professions (Bradley, 2013; Rothschild, 2022). Professional self-care includes supervision, peer support, mentor support, raising of awareness (Skovholt et al., 2001). Moreover, self-care should be understood as a life-long process that supports the helper's wellbeing (Venart et al., 2007).

If one approaches the concept of "Self" through a Jungian lens, then this includes the "whole" personality with its unconscious aspects that have the potential to be integrated (e.g., Samuels, 1985). Thus, from this perspective, self-care as care of the "Self" finds a new meaning, a more unfolding and transcending one and closer to self-actualisation and, essentially, the Jungian individuation process.

The identified subthemes under the central concept of self-care include, *inter alia*, (1) coping encompassing skills, routines, activities (Rothschild, 2022) and psychosocial resources; and (2) awareness of the psychosocial complexities and self-reflection; that is to say, the subthemes are generally inclusive and not confined to psychotherapeutic or clinical interventions such as supervision and therapy.

6.2.4.a. Coping Skills for Resilience. Each participant exhibited a variety of coping skills and mechanisms that protect them from stress and distress and preserve their resilience. Coping is a broad concept that describes "the use of cognitive and behavioural strategies to manage the demands of a situation when these [situations] are appraised as taxing or exceeding one's resources or to reduce the negative emotions and conflict caused by stress" (APA Dictionary of Psychology,

2022). In contrast to psychodynamic defence mechanisms, people are, generally, conscious about their coping skills. As previously mentioned in Chapter 5, I consider resilience old retained strengths and characteristics in the aftermath of exposure to adversity.

1) “Sharing is caring” is a commonly used expression indicating that it is important to share things out of care for the other person. Regarding the findings of this study, I will apply this phrase in an alternative way: Some participants view the sharing of their feelings and experiences with team colleagues and managers as a way of coping, self-care, as well as care and protection for the other:

“I will talk to colleagues [about problems], although there is too much mourning … I will talk to managers … I will take time off; there is understanding.” **(P1)**

“Team colleagues share their own burnout experience with us…” **(P1)**

“We share our anxiety and our experiences with colleagues…” **(P1)**

“[As a humanitarian worker] you share about everything, every experience … I am also grateful that there are colleagues in the same situation as me…” **(P6)**

“In our team we share about how we feel, there is open communication…” **(P7)**

As portrayed above, sharing can be a coping skill; on the other hand, sometimes maintaining sufficient inner distance from team colleagues, clients and their narratives, and work, in general, seems to have a protective function for some participants:

“I do not bring things [from work] home…” **(P1)**

According to **P5**, working part-time with refugees is a protection strategy for his self-care: “…I do not work 100% only with refugees…” Furthermore, even during his clinical work with adversity survivors, he manages to keep some distance from their painful stories and problems: “Taking a break, a coffee, having some humour

with clients … it is not only about exposure [narrative exposure therapy] but we can also talk about other, nice things…"

"Now I have better understanding of the situation … I do protect myself … I do not form too close connections [with the clients]…" **(P7)**

Furthermore, for **P7**, a humanitarian working in Greece, it is important that she has her own space (she lives in an apartment alone, with no other humanitarians): "I wanted to have an apartment alone, where I can practice yoga…"

In the AG, **P3** considers positively the fact that she "maintains limited work relationships, which do not develop into a form of friendship", adding that over time she has developed a "better ability to keep personal and work life separated".

2) Boundaries, in general, and specifically in relation to workload and working hours, are viewed by some participants as a considerable means of protection and coping:

"I am good at organising my time … this is a defence mechanism not to get stressed or burned out…" **(P1)**

"I have strictly-defined working hours, this is my policy! There is flexibility from my side, but I do not feel obliged … I have learnt this…" **(P3)**

"If at work someone has too high workload, I support this person … one is not supposed to take too many cases…" **(P4)**

"One should set boundaries, say 'no', step back…" **(P7)**

"There is no work at weekends or during the night … we insist on taking vacations … there is training for volunteers on boundaries and wellbeing…" (**P7)**

This highlights the role of staff training on creating and keeping healthy boundaries.

3) *Routines* are vital for one's daily coping with stress, and *rituals* of transition (for example, transition from workplace to home) show the required respect to the

time, place and the “special weight” of the difficult professional activity with adversity survivors (see also Chapter 5). Routines are defined as regularly repeated processes that keep people healthy, while rituals are considered more purpose-driven and have a symbolic meaning (Denham, 2019; Migliorini et al., 2016; Ruggeri et al., 2023). Rituals can also be beneficial for workplace wellbeing (Griner et al., 2021; Kim et al., 2021). Various activities, including physical ones, hobbies, routines, and personal rituals were identified as forms of management of work-related stress and preserving one’s wellbeing, for example:

“I should do more sport and have more walks…” **(P1)**

“Now I try to do things that I like, that are compliant with myself … I give importance to time for hobbies…” **(P1)**

“Activities outdoors, sports; martial arts after work reduce stress … I do not only do sports, I also try to be aware of myself…” **(P3)**

“Between sessions I have a 5 minute break … especially after a day with difficult cases [clients] I stay half an hour in my room, try to relax, focus on myself and listen to music … I don’t want to take this home with me…” **(P3)**

“I preserve my wellbeing through a compilation of activities: yoga, friends, work-life balance, exchange of ideas with colleagues, debriefing at work … my activities are diversified…” **(P4)**

“I try to exercise three to four times weekly…” **(P5)**

“Sports, nature, being outdoors are a big equaliser…” **(P6)**

“I like eating and preparing good food…” **(P6)**

Apart from practicing yoga, **P7** states: “I meet with friends and take part in outdoor activities as well…”

4) Finally, in the interviews and, particularly, in the completed AG, I was able to identify elements that could be considered possible *psychological or psychosocial*

resources of the participants. As previously mentioned in Chapter 5, under resources, one can classify individual elements of the personality, beliefs, values, etc., that influence a person's resilience (Hobfoll, 2002).

For instance:

- Having "good interaction" with others (**P1**)
- Adaptivity as a personality factor (**P7, P8**)
- Professionalism (**P3**)
- Sensitivity and awareness of one's own feelings (**P3**)
- Having an empathetic personality (**P4, P6**)
- Inner peace, calmness, serenity (**P3, P5**)
- Realism (**P1, P5, P6**)
- Idealism and commitment to humanitarian values and vision (**P6**)
- Smartness (**P5**)
- Independence as a personality trait (**P8**)
- Democratic beliefs and values (**P3, P4**)

6.2.4.b. Awareness of the Limitations and the Complexity of the Conditions. Feeling overwhelmed because of exposure to adverse, stressful or distressing content is responsible for the *loss of complexity*, which results in oversimplified and polarised reactions and solutions, and which can cause further stress and distress. Hence, being conscious (or gaining awareness) of the complexity of the beneficiaries, and of the situation in general, acceptance of the complex psychosocial reality and self-reflection about one's own limitations and reactions are perceived by many participants as essential factors for their self-care:

"I do what I can … if someone is not happy, I accept this … I acknowledge and accept my limitations, capacities, and boundaries, for example, I do not work in management…" **(P1)**

"I am a realist … I do not make promises…" **(P1)**

"My general approach is that sometimes life can be ugly … Serenity means acceptance of this fact … there are some things than one cannot change…" **(P5)**

"Regarding my work with clients, I try to attend further training…as a medical doctor, there is nothing I can do in many cases … what can one achieve? One must accept the situation if one cannot achieve something…" **(P5)**

"Workers must reflect on their work with clients … I am not at all satisfied with that [self-reflection of co-workers] … co-workers and managers show too low self-reflection…" **(P5)**

"I have become modest about the demands on success (especially against the background of the environmental conditions in crisis areas)." (**P5,** from the AG)

"Low expectations, anticipation of multifactorial difficulties in implementing MHPSS, repeated but not unexpected subjectively perceived helplessness in the individual projects." (**P5,** from the AG)

"I have not lost my empathy … I am aware of my capabilities." **(P7)**

"I have acceptance of the things which I do not have power over … things which I have limited impact on…" **(P7)**

P8 presented a multi-dimensional awareness and acceptance of several facts:

First, lack of awareness of the complexity leads to polarisation between humanitarians and local communities and there should be a greater dialogue between NGOs and the rest of society on aspects of humanitarian work:

"Humanitarians do not take the time to explain [to the host communities] … there are challenges … refugees are not angels … they are humans like you and me … they have rights and duties…" **(P8)**

"A father of a teenage daughter in Samos, Greece, once told me: 'I do not have a problem with refugees in general … I have a problem that my life changes

[because of refugees] … my daughter is 16 and young men try to tease her on the street, so I have to leave work one hour earlier to take her to the piano lessons…' I understand that … we cannot say that this is not a problem…" **(P8)**

"Refugees think that they are victims … let's give them then the possibility to organise their lives…" **(P8)**

Second, humanitarians may have their own mental health issues, and, moreover, escapism or past unresolved conflicts could hypothetically be an implicit motivation for some; so, for humanitarians, some degree of self-awareness is required:

"I carry my problems with me … humanitarians carry their problems with them, although they think that they leave problems behind…" **(P8)**

P3 comes to terms with her limitations and powerlessness or lack of effectiveness in some circumstances and recognises feelings of extreme devotion and guilt in her team while trying to safeguard her wellbeing:

"One of my colleagues was too stressed … and this was stressful to me … I cannot solve the problems of my colleague … but I could reflect on how this impacted on me…" **(P3)**

"People are not aware of how stressful humanitarian work is… That's why I have strictly-defined working hours … many people do not pay attention to this and end up working 24 hours a day. We are too devoted to our work, have feelings of guilt towards the community we help and ignore ourselves…" **(P3)**

Furthermore, she confessed "being aware of negative aspects of community, such as sexual and gender-based violence (GBV) within marriage, which resulted in limited trust" and she tries to be "more aware of sub-community" and her larger community "with all its diverse components". **(P3)**

P2, being a Jungian psychoanalyst, seems to come to terms with the complex psychosocial situation and the learned helplessness of clients but acknowledges some improvement, too: “My refugee clients identify themselves as victims and expect everything from the state in a narcissistic attitude but there is an improvement with this as well – also with the fact that they sometimes project the state on me.” Under a Jungian lens, he senses the Shadow aspects of the refugee/client and the helper-therapist.

6.2.4.c. Therapeutic and Psychosocial Interventions for Helpers. Supervision of client cases (especially for those participants in a clinical or psychotherapeutic role), counselling or psychotherapy (whenever indicated and needed) and staff support groups were raised by most participants with regard to helper self-care, protection and resilience:

P1 confessed that she still sees a therapist but her previous career as a carer for people with disabilities was the major stressor, not Refugee Care: “I have been having counselling for many years, also because of work … I have continued seeing her [the therapist] on and off … now, work does not come up as a topic in our sessions often … I now feel more confident…”

P2, as a Jungian Analyst, has the opportunity to bring topics from his work with refugees into his sessions with his personal psychoanalyst, which he regularly does: “In my personal analysis I talk about these matters … this activates a strong countertransference as my analyst is very interested in these cases…”

P3 stated that “in case preventive measures do not work, access to the staff psychologist is good”, but she prioritised work-life balance over psychotherapy. She added: “there is the idea that organisation[s] should look for external staff counsellor[s]…” Furthermore, she conceded: “…I sought support from an external

psychologist for personal matters and relationships and for relationships in the workplace…"

P7 mentioned**:** "When I really needed it, I did not [seek professional support] … I looked for help last year, because I was close to burnout … I did talk to someone, but I would like to do more [about this]…" She added that "when someone [in the organisation] doesn't feel well, he or she takes time off, has access to mental health professionals…" and considered a positive development the fact that "one can access external mental health professionals online…" All in all, staff wellbeing in her organisation "is being assessed, discussed, written down in HR policies … it is not perfect, but it is well done…"

P6 acknowledged the importance of counselling; however, at the same time, she saw some practical burdens and difficulties, including the *fear of stigma*:

"[Speaking about mental health] We have come a long way as an organisation … there is more awareness … there is more material…" **(P6)**

"I wish I had [sought professional support from a counsellor] … I regret that I did not in the past when I was interviewing refugees … there is one staff counsellor for so many people…" **(P6)**

"Regarding staff counsellors, there is now more availability theoretically … but, in practice, this is a different story … you do not know how this can influence if this goes to your manager…" **(P6)**

"I do not feel comfortable to talk to the staff counsellor who is a staff member…" **(P6)**

Notably, she suggests that in her organisation there is more awareness and willingness to deal with cases of sexual harassment compared to concerns about mental health: "I would be more confident to report sexual harassment [compared to mental health issues]…" **(P6)**

P8 admitted that there is fear of stigma among humanitarians, but this is changing presently and, furthermore, he can see the benefits of counselling and supports this as follows:

"I could take the step of talking to a specialist [i.e., mental health professional] … I have never done it … it is not part of our culture in Greece…" **(P8)**

"In the organisation we follow guidelines … we have a medical coordinator for staff health who identifies people with burnout symptoms … we have a mental health support unit … there is a hotline for staff members … we organise a party every week … privacy is respected … there is clear job description … we are close with the staff … we have a protective environment to minimise negative impact and to keep the balance between each other…" **(P8)**

"Many do not want to talk about these problems … they do not want to look weak…" **(P8)**

"There is a collaboration with [an] external psychiatrist and psychologist … Five sessions are paid by the organisation … people make use of this…" **(P8)**

"It is a cultural thing … I did not think that I needed to go see a psychiatrist … this is changing in the organisation…" **(P8)**

"[Regarding staff counselling] It was difficult [for the person to talk] with a psychologist who did not have an idea of the humanitarian setting…" In making this comment, **P8** posed an indirect but legitimate question: Should the counsellors and therapists of humanitarians also have humanitarian experience themselves?

Moreover, P3 and P4 drew attention to the aspect of supervision.

As a psychotherapist and MHPSS professional, **P3** reported: "In an organisation I needed supervision, but this was not provided … so, I sought support from external [supervisors]…" She added: "I have been choosing organisations with policies on supervision and debriefing … others do not prioritise those … they should

be much more focused on supervision and preventive measures [measures for preventing mental health problems/distress]…" In her organisation, there is a "support system with supervision". She elaborated: "Part of the wellbeing policy is to provide debriefing sessions, regardless of the circumstances it needs to be done … there is supervision for staff … there is an attitude [within the organisation] of being helpful and encouraging staff to take leave and express issues … I am not sure if this is a defined written policy … there is an attitude of balancing workload … the supervisor is aware of each case's severity … after a group session with clients I have a debriefing session with the supervisor … after a difficult individual session, I have a debriefing with the supervisor … after all critical incidents, there is a meeting for all staff members…"

P4 conceded: "We have supervision three to four times a year with an external supervisor who is a psychiatrist or a therapist and responsible for us interpreters … there is also the possibility of individual supervision … whoever has a topic or a case, can bring this to the supervision … the group supervision is structured … I am satisfied [with the organisation], but I would like to have more supervision, it is not enough…"

Additionally, **P1** praised the role of staff support groups within organisations: "Support groups are a good thing…" She explained: "Once every month a staff support group is run by an external psychotherapist … we present a case report on a client, but we talk about ourselves [about our reactions on the case], not about the client…" Furthermore, "When a major incident happens, staff gather with managers, and we do what we call reflective practice." Finally, P1 added that staff in her organisation can have psychological phone support for free.

6.2.4.d. Quitting a Job Position/Leaving a Role/Changing Careers.

Leaving a job and an organisation, or changing roles within an organisation, or even

changing one's professional career and orientation is mostly viewed as *ultima ratio* for helpers. There are occasions in which quitting is a realistic and reasonable solution for one's self-care and wellbeing and some of the participants are aware of this. So, I felt like these voices should be heard:

"At some point, I will stop this [i.e., working with refugees] and will move back to Italy…" **(P1)**

"I don't know if I want to work as a psychologist my whole life … and I don't know if this is about psychology in general or about work with refugees…" **(P3)**

"…then, further questions are: is this work appropriate for me? Shall I leave this setting?" **(P5)**

"I often wonder about being in a different profession…" **(P6)**

According to **P8**, although, "if you love it [humanitarian work], you cannot leave it"; he is also aware of the fact that "others started and then stopped…" and that "there are humanitarians who should not work as humanitarians … just like in any other job…"

Finally, it is noteworthy that **P1** and **P7** had previous careers, which they were unsatisfied with and that they left for Refugee Care. To them, this change was experienced as a vital turn in their lives.

6.2.5. Theme III: Eudemonic Wellbeing of the Helper

"My wellbeing is improved through working with people from other cultures…" **(P2)**

The third central theme that emerged from the data analysis was the eudemonic wellbeing of the helper. This theme was principally substantiated by the group of Positive Responses/AAD of the AG. As a concept, eudemonic wellbeing was examined in Chapter 3 of this study. Participants universally drew attention to the multiple, psychosocial dimensions of eudemonic wellbeing that formed the

subthemes. In general, wellbeing in its eudemonic and holistic version seems to have a central role in the individual psychosocial experience of the participants.

7.2.5.a. Diverse Perceptions of Wellbeing. As one might expect, participants did not share a unanimous definition, approach, or understanding of the concept of wellbeing. Nevertheless, there was some common ground among them, and some very remarkable and informative comments emerged. These refer to the holistic, social, physical, occupational, mental health and holistic aspect of wellbeing.

"I have a holistic view on wellbeing … it is about body and mind … wellbeing is many things together…" **(P1)**

"To me, wellbeing is when I wake up content in the morning and I am excited to begin the day … wellbeing is about satisfaction…" **(P5)**

"Wellbeing is a balance of work and personal life … also developing awareness of one's own emotions … also things to do after work: socialising, hobbies…" **(P3)**

"Wellbeing is related to mental wellbeing, assuming that basic material elements are provided … there should be a balance between work and private life…" **(P6)**

"It [understanding of wellbeing] is very individual … to me, physical health, mental health … social circumstances, such as one's friendship circle … to engage in something … one must be active…" **(P4)**

"It [understanding of concept of wellbeing] depends on the person… Wellbeing is mental and physical healthcare … the idea of staff wellbeing is more promoted nowadays…" **(P7)**

Although a considerable number of participants view wellbeing in a *hedonic* or colloquial context, when asked to define it for themselves, *eudemonic* elements (e.g., Ryan & Deci, 2001) are visible in the answers above as well as throughout the entire

interview and completion of the AG, as described later in this chapter. Additionally, **P7** and **P4** point out that wellbeing and its understanding is unique for every person, which is in accordance with the complexity and uniqueness of every person, refugee, or helper.

6.2.5.b. Adversity-Activated Development (AAD) of the Helper. As previously mentioned in Chapter 5, AAD is an inclusive term that describes those gains, strengths, characteristics, values, and skills in the aftermath of adversities. This enrichment and renewal can either be something transformative or something far simpler in one's life. For helpers of adversity survivors, certain adversities they face through their work have to do with exposure to the distressing stories, experiences, and living conditions of their clients. The participants were able to name various aspects of AAD.

1) A considerable part of the AAD reported by all participants could be identified as VR, which is less inclusive than AAD as a concept and mainly refers to workers who get very close to the narratives of the clients, such as psychotherapists (and like many of the participants of this study). VR is a transformative process and echoes the effects on one's own work, values, growth, self-care, *Weltanschauung*, political beliefs, meaning making, etc., through the exposure to the distressing content and the resilience of the beneficiaries.

As a volunteer in Calais, France, **P1** experienced the greatness of solidarity: "I witnessed extreme [in a positive sense] things from humanitarians, such as legal and human rights volunteers … Two French activists went on hunger strike…"

P1 discerned the enrichment through her work with refugees and asylum-seekers:

"It has not been a [professional] growth in my career, but a personal growth … I discovered things that I like … [in life in general, not only professionally]." **(P1)**

"I experienced a positive push thanks to the work with refugees…" **(P1)**

"I love people [i.e., colleagues] I have been working with … and some clients that have shown gratitude to us…" **(P1)**

Elements of VR are also visible in **P3**'s words:

"I witnessed a lot of resilience, a lot of wisdom even if someone is not educated, one can use wisdom … wisdom is a perception of life … two women come to mind: one lost one child and the other five of her six children … to me, this is beyond human capacity … how they dealt with that, this shows a high level of strength … this has touched me greatly…" **(P3)**

"I see that there are not only death and destruction, but there are also hope and resilience … Hope plays a huge role in human life … and dignity as well…" **(P3)**

"Better self-insight, expression of emotions, appreciation of close and important relationships." (**P3**, from the AG)

According to **P4**, working with refugees changes one's world view and priorities:

"I am very grateful, since [at work] I can see how quickly one can lose everything…" **(P4)**

"In general, it [work with refugees] is an enrichment … you are not in [a] bubble with no contact to reality…" **(P4)**

"I now take everything less seriously, I relativise things more, my own problems seem to me less distressing." **(P4)**

Furthermore, working at the advocacy NGO clearly has encouraged her personal and professional development:

"To me, it has been an immense development, since I dared to take the step to work at the charity [i.e., as a volunteer support worker, not only as an interpreter]

… it took me 20 years to take this step … I am prepared to listen to the client's narrative without the presence of a therapist…" **(P4)**

P5, who is a psychiatrist, believes that work with clients who struggle with mental health difficulties can mean their helpers appreciate important things in life in a deeper way: "One reflection [at work] is how good it is for me to be mentally healthy…" To him, work with patients illustrates the importance of mental health.

Additionally, in the AG, he discerns finding meaning and resilience in work with refugees:

"In summary, I am happy to be able to pursue a meaningful activity in my job in Germany, but also in the assignments in crisis areas, even if I have recurring doubts about sustainability." **(P5)**

"The optimal working conditions [with social counselling and interculturally trained interpreters] increases the meaningfulness and success of the treatment of traumatised patients; at the same time I can often learn from their handling of crises." **(P5)**

To **P6**, work with refugees is stressful but also meaningful, compared to a position at the headquarters: "It is easier when somebody is detached at HQ but I do not see the meaning compared to the work in the [humanitarian] field…"

P6's words also convey several gains due to her humanitarian work: "I developed more empathy and understanding … I have had positive experiences … I am now more realistic and less naïve…"

Likewise, **P7** referred to the meaningfulness of the work with refugees and to the aspect of resilience as a gain:

"My life now has more meaning … what I do is small, I am not indispensable, but this is what I can do…" **(P7)**

"Nothing really stresses me now, after my experiences…" **(P7)**

“I am inspired by the people [i.e., helpers and clients], the community and the resilience…” **(P7)**

P7 reported gaining “sense of purpose”, “resilience and capacity to adapt”, “strength” and more “independence”. (Taken from the AG)

P8 self-reflected on the enrichment from his work with people on the move: “I learn more about life … I can understand life better … I can see reality better … it affects me in my way of thinking and how to perceive reality…” He also reported an enhancement of his own “coping mechanisms”.

P2 narrated a transformative experience in his therapeutic work with refugees: “Working with refugees is a kind of spiritual work: With my therapeutic work, I can connect to another soul. For some seconds or short moments, I can feel this transcending experience of connection with the other that gives pleasure and meaning.”

2) Understandably, not all forms of AAD expressed by the participants can be classified as a personal development of VR, since AAD is a more encompassing concept. For example:

“My work [with refugees] gave me a lot of opportunities, for example, academic…I was unsatisfied with my previous career … I was depressed … work was a cause for depression…” **(P1)**

“It [i.e., working with refugees] challenges me in a positive way, for example, I went back to university … it builds up my confidence … me being a person that is bored easily, it offers to me a continuous change of things…” **(P1)**

Above, **P1** refers, among other things, to gaining access to the academic world through her career switch to Refugee Care. Furthermore, in the AG, **P1** expands AAD on the collective level:

"Staff [are] willing to have a better knowledge/understanding about refugees/asylum seekers in the UK accessing mental health services." **(P1)**

"Public engaging [are more engaged] in the refugees/asylum seekers discourse." **(P1)**

"Charities that work with the homeless I'm working for are now more aware of legal policies regarding asylum seekers/refugees." **(P1)**

"Gain of life experience and work experience." **(P2)**

"Work [with refugees] is very satisfying…" **(P5)**

At a collective/societal level according to the AG, **P5** mentioned that "over the years, the topic of MHPSS has been increasingly recognised and taken seriously by NGOs."

"I love my work [with refugees] right now…" **(P7)**

"I have learned so many things … I organised things … I have a lot of responsibilities … I met amazing people … especially young women who take [on] so many responsibilities…" **(P7)**

"Professional growth (responsibilities, team management)", developing a "participative approach" and being "surrounded by amazing passionate people". **(P7,** from the AG)

P4 also noted a collective expression of AAD: "At the NGO where I work, the feelings of belonging, closeness and connectedness among us have increased significantly and this is also very important to me now; an enrichment, for sure."

Equally, **P8** referred to the improvement of "teamwork and morale in MHPSS".

Also from a collective perspective, **P2** stressed that now "the state helps Ukrainian refugees", compared to other previous refugee crises, and that "communities and individuals help Ukrainian refugees by spontaneous mobilisation"**.**

6.2.5.c. Importance of Family and Friends. Findings suggest that connectedness and relationships to one's family and friends, but also, in most cases, acceptance or approval for one's work with refugees by one's family and friendship circle, were an integral part of most participants' wellbeing:

"My family has been very supportive … I come originally from a left-wing family … friends and family members are involved in volunteer work." **(P1)**

"Supported by my family with study/work/volunteering in the field of refugees/asylum seekers" **(P1,** listed as positive, unchanged element on the AG**)**

"My partner is a psychoanalyst and used to work with refugees, too, and she knows and understands the difficulties…" **(P2)**

"My family appreciates my engagement with refugees." **(P2)**

"My social circle has accepted this [work with refugees] and they appreciate this … with others [who do not accept/appreciate this work], I do not have so much to do [share/discuss]…" **(P5)**

"My family supports my work when they have the feeling that the meaningfulness of the work makes me feel better." **(P5)**

To **P3**, continuing to "provide support and care to the family", and increased "appreciation of time with family, appreciation of relationships with family" through work with refugees are two positive elements.

"More understanding for my work compared to when I started this career [in humanitarian aid]" (**P6**, written in the AG)

"Family and friends are supportive, positive…" **(P8)**

"My husband is very supportive…" **(P7)**

P7 also feels "supported by friends back home".

"My family didn't show any specific reaction to my engagement with refugees, they find this normal … with others [who do not approve this] I have no contact…" **(P4)**

"My close friends approve [of my work], are interested [in what I do] and work in the same field … maybe this is a negative aspect … that many of my contacts work in the humanitarian field…" **(P3)**

The social or friendship circle of humanitarian helpers in some cases mostly (or exclusively) consists of people who are themselves helpers, humanitarians, resettlement workers, support workers, activists, advocates, etc. **P3**'s words above show that she views this slightly negatively. In his psychodynamic research with humanitarians, Snelling (2018) suggests the term *(humanitarian)* "*bubble*" to metaphorically describe the way that humanitarian work can be addictive and the fact that field work is the symbolical "refuge" or "haven" in which humanitarian helpers "live" together and which is isolated from "normal" life. This "bubble" corresponds to a defence mechanism (Snelling, 2018) or coping strategy on a personal and collective humanitarian level. In this respect, **P6**'s comment that "colleagues are natural allies" might imply a fostered, defensive mentality of "us against the world" of humanitarian groups (Walkup, 1997).

6.2.5.d. Having an Effect/Impact From an Activistic, Altruistic and Idealistic Standpoint. The feeling of having an altruistic impact and being aware of this fact seems to have a substantial role in the conceptualisation of wellbeing for the study participants.

Altruism and idealism as motivations for their humanitarianism were discussed in Chapter 4. Furthermore, in the relevant literature there is an undeniable correlation between altruism and wellbeing (e.g., Fechter, 2016; Kahana et al., 2013; Morrow-Howell, 2010; Post, 2005).

Activism as “the use of direct and noticeable action to achieve a result, usually a political or social one” (Cambridge Online Dictionary, 2022) is, by definition, of a socio-political nature, and, inevitably, of limited political neutrality and impartiality, whereas humanitarian action as codified by the Red Cross/Red Crescent movement (with this codification being accepted by many other organisations) is expected to be politically neutral and impartial. Some participants in this study work for organisations that officially follow the principles of neutrality and impartiality.

However, this position of depoliticised neutrality faced criticism by contemporary humanitarians (Craze & Luedke, 2022; Slim, 2020, 2021). From the perspective of this criticism, Slim (2020) fittingly comments in *The New Humanitarian*: “Neutral humanitarian action is one version of humanitarianism – not the only version.” Essentially, there is an overlap between civic activism and humanitarianism and the activistic dimension is vital for humanitarian workers and volunteers, otherwise humanitarianism could potentially depoliticise them (Radice, 2022). In order to emphasise this overlap between activism and humanitarianism, Slim (2015) introduces the concept of the *activist humanitarian*.

Christian upbringing, including early exposure to *Liberation* ideology, played a crucial role in **P2**’s decision to work with refugees as a volunteer: “I have had strong motivation to help people in need since I was adolescent … I attended Jesuit Catholic School in Brazil and there they supported Liberation Theology … I grew up with them and have learned to support people…” His altruistic activity offers satisfaction with himself: “It [i.e., working with refugees] is an essential part of my life … it makes me feel good … sometimes I feel I would like to do more…”

P3 looks at her work with survivors of adversity, torture and war, as an expression and empowering of democratic ideology: “I support democratic change in the government of my country of origin and fight against the torture system inside the

country." I think that this is connected to the fact that there is a linkage between democratic values and wellbeing or life satisfaction (Orvinska et al., 2014; Owen et al., 2008).

As far as **P4** is concerned, supporting her political ideology, and having an activistic impact on society appear to be, apart from motivations, a part of her self-actualisation within a eudemonic wellbeing approach:

"I wanted to engage also in a different way, not only as interpreter … there [at the NGO] I can have more impact…" **(P4)**

"We [the NGO] can do something against the system … we 'are annoying' for the system … we have an effect…" **(P4)**

"We have the responsibility to do something about this [i.e., the phenomenon of refugeedom] … or to say that we cannot do anything…" **(P4)**

"I am proud of myself, and I don't have to be ashamed since I do something so that this [i.e., the situation of asylum-seekers] can improve…" **(P4)**

P5 expressed his altruistic motivation: "I see how good my life is, in terms of social conditions, and I want to give something back…"

For **P6**, having an effect at her work with refugees as a humanitarian is a major satisfaction and an expression of her altruism and idealism and, concurrently, meaning making: "I am truly passionate for refugee work … I care about them … I want to make a difference for them … [my organisation] is [a] good employer if you have motivation … Helping refugees keeps me going…"

P6 admitted that she is "still willing to take on new assignments in refugee work despite recent difficult experiences (security incidents)" and is "still committed to the mandate" of her organisation. She added (under positive reactions on the AG) that she is "Hoping to have a positive impact on society with the work that I am doing. Hoping to lead by example/inspire others."

Political drive and ideology as a motivation for humanitarianism and the satisfaction and growth that are linked to this political action and expression were observed by **P7:**

“I don’t consider my role humanitarian, but rather political, I felt responsible about the treatment of the people coming to Europe…” **(P7)**

“My satisfaction is that I do something against something that revolts me … I now like being in a position that includes decision-making … I can make things to be more ethical…” **(P7)**

On the AG, she conceded that through her work in Refugee Care she considers herself now “more engaged in the world”, “more political” and an “activist”.

A hypothesis that arises from **P7**’s statements is that humanitarian work could function as a substitute for inner revolutionary desires or wishes for a political career.

According to **P8**, scientific research is not only an academic motivation but can also give meaning, purpose and insight to humanitarian action, and therefore have a positive impact: “I combine fieldwork and scientific analysis … I started looking more into the scientific part … by documenting and grouping issues with more academic papers, I can advocate better for refugees…”

Furthermore, having a humanitarian impact has been fulfilling and satisfying for him:

“I have stayed long in this career, so I think yes … yes, it gives a meaning in life … I felt I could change lives of other people … even saving one life is enough … I feel my direct impact on many people…”

6.2.5.e. Experience of Cosmopolitanism. The experience, fulfilment and enhancement of the participants’ *cosmopolitanism* as a dimension of their eudemonic wellbeing was an element that I could have classified under the subtheme of AAD, but I preferred to examine this as a separate subtheme in its own right because of its

acknowledged connection to the humanitarian world in the resource literature (e.g., Archibugi, 2004; Barnett, 2005; Donini, 2010; Rozakou, 2020; Slim, 2005).

Cosmopolitanism covers a wide array of views, depending on the context and the intents and purposes of the research, and is not universally defined (Kleingeld & Brown, 2019). Conventionally, “cosmopolitan” means “belonging to all parts of the world; not limited to any one country or its inhabitants” or “having the characteristics which arise from, or are suited to, a range over many different countries; free from national limitations or attachments” (OED, 2024).

From a humanitarian or Refugee Care perspective, cosmopolitanism could be understood as “focusing on the world as a whole rather than on a particular locality or group within it”, as opposed to nationalism, “being at home with diversity” (Calhoun, 2008, p. 428) or “a direct connection between the individual and the world as a whole” (Calhoun, 2008, p. 433).

The findings of this study show elements of cosmopolitanism as motivation, as pre-existing ideology, or worldview, or as AAD and self-fulfilment from the point of view of some participants:

P5 and, especially, **P6**, explained that cosmopolitan aspects are not only a motivation for their work with refugees, but also a considerable enrichment as a result of their professional activity with beneficiaries:

“It is very interesting to meet people from other cultures … I learn a lot from other cultures…” **(P5)**

“I am meeting very nice people, this is the bright side … they are more or less in the same situation [as myself] … it is enriching to meet people from other cultures…” **(P6)**

“I am more open to the world … meeting and working with people from all over the world has been a huge gain…” **(P6)**

"More open to the world, different cultures, people from all backgrounds. I consider this as an enriching experience." (**P6**, listed as positive change in the AG)

P1 addressed, as a part of a more expansive epistemology, the need for a cosmopolitan approach to understanding the psychosocial problems of refugees and asylum-seekers:

"Focus should be more on the society … we only talk about trauma and war … there is a part missing … we need to understand the cultural background, as there are patterns in mental health issues…" **(P1)**

P2, an Italian who has lived in many Latin-American countries and in Europe, is driven by his cosmopolitan motivation to assist refugees and calls for more global, humanistic and ecologic awareness:

"I feel that I can identify with refugees … I am also kind of a 'refugee' … my father left Italy after the end of World War II so I have this in myself…" **(P2)**

"My wellbeing is improved by working with people from other cultures … my pleasure was always to meet with other people from other countries and ask about their lives." **(P2)**

"We or, say capitalism, destroy the planet and nature and this is a greater political problem than a conflict in one country; for example, see the Amazon Rainforest in Brazil. This results in victims of genocide and refugees or internally displaced. We need to reconnect with nature, and the indigenous people there could help us with that." **(P2)**

6.2.6. Trustworthiness of Findings

While the terms "*reliability*" and "*validity*" are indispensable for guaranteeing quality in quantitative research, in qualitative studies the terms "*credibility",* "*confirmability"*, "*dependability"* and "*transferability"* are the essential criteria for ensuring quality (Lincoln & Guba, 1985). Golafshani (2003, p. 601) concludes that

dependability in qualitative paradigms is equivalent to reliability in quantitative paradigms. At any rate, the crucial question to be answered by the researcher considering the trustworthiness of the research findings is the following: “How can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?” (Lincoln & Guba, 1985, p. 290).

During the qualitative research, I was mindful of the above-mentioned four criteria for securing quality of the findings: *credibility*, *dependability*, *confirmability* and *transferability.* Credibility refers to the following questions: “Do the findings show a logical relationship to each other, that is, are they consistent in terms of the explanations they support? Are the findings grounded in, and substantiated by, the narrative data, that is, are the narrative data sufficiently rich to support the specific findings? Do the findings indicate a need for more data?” (Ulin et al., 2005, p. 28). Dependability evaluates whether the research procedure is documented appropriately according to the guidelines and whether an outside researcher can theoretically reach similar findings based upon the same data (Ulin et al., 2005). Confirmability echoes the ability of the researcher to distinguish sufficiently between the researcher’s personal ideas, values, emotions, assumptions and the experiences of the participants. Transferability shows whether the conclusions of the study are applicable to further contexts (Ulin et al., 2005). In addition, *reflexivity* is a result of self-observation and refers to the documentation of the researcher’s reflections, assumptions, doubts, or inner conflicts with regard to the data collection and the conclusions, and contributes significantly to the confirmability of the research (Ulin et al., 2005).

Now, I will explain how the above-mentioned criteria for the trustworthiness of my research were evaluated:

Concerning *credibility* of the findings (themes, subthemes) of this study, the themes are consistent and in logical relationship with the collected data (Ulin et al., 2005). There are no major contradictions and paradoxes between the narrative data and the produced themes. In this respect, the study shows a certain degree of *coherence*, i.e., the fact that it "makes sense as a consistent whole" (Yardley, 2008, p. 248). Additionally, credibility was consolidated by the *richness* of data since these were not only collected through the semi-structured, in-depth interviews, but additionally through two completions of the AG by each participant. The suitability of the selection of the sample of participants regarding the research questions was also explained. Moreover, an extensive literature review of the theoretical and empirical topics that were considered substantial for this study was accomplished, and main, relevant aspects of these topics were presented and discussed previously. The literature review I conducted assisted me in defining and framing the study's main research questions and objectives, in the development of the interview schedule, as well as in selecting the method for data analysis. In brief, the study is embedded in the theoretical and empirical literature "related to the meanings and concepts that are studied" (Yardley, 2008, p. 247).

The research design and procedure were adequately documented and explained, thus ensuring a certain degree of *dependability*. More specifically, I provided a detailed description of the different aspects of the implemented research process, which entailed the comprehensive presentation of the rationale behind the means and process for recruitment and sampling, the method of data collection and the method of data analysis. Furthermore, I presented a sample of extracts from the participants' transcripts that I considered to be relevant and in support of the principal themes identified in the TA. Due to time constraints, I did not proceed to the involvement of an external, professional researcher for conducting an external audit,

since my supervisor and co-supervisor, both experienced researchers, closely monitored the transformation of raw data into findings, which bolstered the dependability of the data.

With regard to *confirmability* of findings, I mainly tried to ensure this by repeatedly reflecting on, checking and refining/correcting/improving the codes, in the first place, and the themes, at a later stage, which were generated from the raw data. Moreover, confirmability was improved by my attentive listening focused on the participants' narratives during data collection, and by constantly reviewing the participants' transcripts in order to apprehend the core meanings they voiced. This decreased the potential for bias based on the researcher's personal feelings, deeply engrained beliefs, preconceptions, background and/or biography.

Transferability of findings was also accomplished, to a certain extent: This study and its findings refer to the psychosocial experience and wellbeing of helpers of refugees that work either in the humanitarian field or in a human services setting. Transferability is ensured when "the findings contribute theoretical insights that advance understanding of the phenomenon and may be useful in subsequent studies" (Stalmeijer et al., 2024, p. 2). For instance, looking at the findings, one could assume that these are transferable into another setting, such as wellbeing of other helping professions or wellbeing research, in general. Moreover, in the Introduction, I thoroughly presented the phenomenon that I am researching, as well as my conceptual and empirical approach towards it, through which I endeavour to devise a new way of looking at this phenomenon. Consequently, the reader can "conceptually situate" my research and "consider its applicability" to other contexts from its very beginning (Stalmeijer et al., 2024, p. 3). Additionally, transferability of this study was augmented by "comparing and contrasting voices of participants, theories, researchers" earlier in the present chapter and by "integrating insights across

different approaches and perspectives" as stated in the introduction and accomplished through the wider psychosocial approach of this thesis (Stalmeijer et al., 2024, p. 3).

Finally, to maintain a degree of *reflexivity*, I decided to attentively keep a reflective journal from the very beginning of my research until the completion of the discussion of the results. Excerpts of my reflective journal are presented later in Chapter 8.

Chapter Synopsis and Thesis Progression

In the first part of this chapter, I defined the key research question and the core research hypothesis. Afterwards, the main epistemological positions of this project were put forward: this thesis inclines towards a constructivist epistemology by relying upon Jung's epistemological positions as well as the framework of the AG. Then, the recruitment procedure of this study was clarified, which included determining the inclusion and exclusion criteria. In terms of data gathering, the process was made up of the conduction of semi-structured interviews with open-ended questions and the completion of the form of the modified version of the AG.

In the second part of Chapter 6, I laid out the TA method, which was selected for the analysis of the collected qualitative data. I outlined the steps followed while processing the data, which led to the generation of the three overarching themes and subthemes of this study. The identified core themes (1. Work with refugees can be difficult, stressful and/or distressing; 2. Self-Care in Refugee Care; 3. Eudemonic Wellbeing of the Helper) are composed of coded data extracts from the participants' answers and echo the various domains and levels provided by the AG. Finally, I expounded on how a reasonable degree of trustworthiness in terms of study results was attained.

Chapter 7: Discussion

The previous chapter comprehensively covered the extracted results of the empirical research, including, of course, the overarching themes and subthemes. In the present chapter, I discuss the results through the lens of the conceptual approach of this thesis and compare this to the existing body of relevant research literature. The last section of this chapter provides a further understanding of the results under the scope of Jungian psychology.

7.1. Synthesising a New Conceptual Approach to Helper Wellbeing

As a transition from the theoretical background and the literature review in the first five chapters, to the discussion of the findings in the present chapter, I need to delineate and explain the essential constituents of the conceptual framework that emerged through the amalgamation of approaches, notions and theories with the original theoretical umbrella of this project (as described in Chapter 2). As declared in the introduction of the thesis, the aim of this project is to set up and outline a conceptual framework as a useful and innovative interpretative lens of the findings. This conceptual framework views humanitarian helper wellbeing in a wider psychosocial, holistic, integrative and multi-disciplinary way.

7.1.1. Participants' and Researchers' Views of Wellbeing

But first, I suggest that one should look at how the helpers themselves, who were the human subjects of this research, spontaneously perceive wellbeing (a) in relation to their work and (b) in their life in general.

The answers generally show some diversity in the participants' personal perception of the concept of wellbeing. As previously mentioned in Chapter 6, none of the participants named eudemonic elements, such as self-actualisation, transformation or meaning and purpose, when specifically asked to define wellbeing,

but these aspects were undeniably evident in other parts of the interviews or during the completion of the AG.

The following facets were predominantly identified by the participants when asked to define wellbeing:

- Physical and mental health (care)
- Satisfaction with one's social life
- Equilibrium or interface between work and personal life

These findings are consistent with the bulk of the literature. Undoubtedly, physical and mental health as components of the concept of wellbeing echo a more medical approach to wellbeing (e.g., APA Dictionary of Psychology, 2022; CDC, 2018; UNHCR, 2016). Moreover, the *social dimension* is integrated into several conceptualisations of wellbeing (e.g., Gallagher et al., 2009; Keyes, 1998; Maslow, 1943; Seligman, 2018).

Indisputably, the term "work-life balance" is commonly cited in academic papers (with some of them referring to humanitarian aid workers, e.g., Blanchetiere, 2006; Burton, 2009; Kaschka et al., 2011; Sirgy & Lee, 2018), in numerous workplace wellbeing guides (Sanfilippo, 2023) and even lifestyle magazines, such as *Men's Health* (Ocampo, 2021).

Of course, the answers of the participants to the question asking for their definition and perception of wellbeing are not "wrong" at all. After all, wellbeing is a subjective matter (Diener, 1984; Jung, 2014, p. 1346) and, furthermore, there is no consensus on its definition (Dodge et al., 2012). Health, social interactions and work-life balance belong to the concept of wellbeing. Nevertheless, I reflect that wellbeing for humanitarian helpers goes beyond these elements. This position is corroborated by the summary of findings of this qualitative study.

Second, how do other researchers generally approach and conceptualise the wellbeing of humanitarians and other facilitators of refugees? Essentially, this depends on the epistemology of each researcher (Kivunja & Kujini, 2017). To name some examples: Tassell (2009), in her research on humanitarian wellbeing, focuses on self-determination theory (SDT) and positive psychology, including the assessment of hedonic and eudemonic wellbeing. Other scholars approach wellbeing from an organisational and managerial angle using models from organisational psychology, such as perceived organisational support (POS) and effort-reward imbalance (ERI) (Aldamman, 2020; Jachens, 2018). Moreover, several researchers view staff wellbeing through the prism of (vicarious) trauma and burnout (Birck, 2001; Cardozo et al., 2012; Posselt et al., 2020; Pross, 2006; Pross & Schweitzer, 2010; Strohmeier & Scholte, 2015), while, through the same prism, some also emphasise the post-adversary positive gains, such as VR and VPTG (Barrington & Shakespeare-Finch, 2013, 2014; Engstrom et al., 2008; Guhan & Liebling-Kalifani, 2011; Manning-Jones, 2016). Additionally, some scholars maintain a rather psychotherapeutic, or, more specifically, psychodynamic approach (Apostolidou & Schweitzer, 2017; Eleftheriadou, 1999; Pross, 2006; Schweitzer et al., 2015), while others may focus more, e.g., on spirituality and religious aspects (Eriksson et al., 2015) in relation to staff wellbeing. Certainly, there is usually an interface of organisational and clinical perspectives.

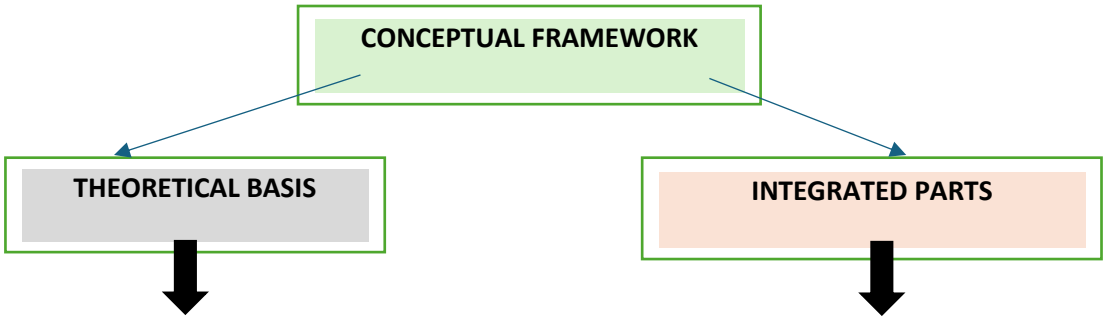
7.1.2. Helper Wellbeing: A Psychosocial Conceptual Approach

Based on its theoretical background and without discarding any of the above views (neither the participants' nor the researchers'), my position in this study is that staff wellbeing is not only a clinical or mental health or occupational theme, but, as the psychosocial framework of the AG also suggests, a multidimensional and complex concept. Accordingly, apart from the theoretical foundations of Refugee

Care and Jungian theory (as extensively discussed in Chapter 2), the conceptual framework of this study regarding humanitarian helper wellbeing is synthesised by various approaches/notions, as depicted in the figure below.

Figure 7.1

Thesis Conceptual Diagram



Refugee Care approach

(e.g., Papadopoulos, 2007, 2021, and other researchers at CTAR)

- Adversity Grid, including AAD and resilience
- Complexity
- MAPs
- IMI
- Victim Triangle
- Attention drawn to victimisation, polymorphous/learned helplessness, victim identity

Expanded Jungian theory

- Individuation process
- Archetypal Theory: Wounded Healer, Shadow

Eudemonia/eudemonic wellbeing

- As a philosophical concept in virtue ethics, Aristotelian and Stoic thought
- Including concepts in modern psychology research, such as: Antonovsky's concepts of sense of coherence and salutogenesis (1987, 1993); Ryff and Singer's concept of psychological wellbeing (2008); Seligman's concept of flourishing in positive psychology (2011)
- Diener's subjective wellbeing (1984)

Social/psychosocial/collective wellbeing

- Keyes' concept of social wellbeing (1998) and further conceptual approaches to psychosocial wellbeing (Eiroa-Orosa, 2020) and collective wellbeing (Evans & Prilleltensky, 2007)
- Confucius' idea of "common good"
- Erikson's psychosocial stages (1966)

Wider organisational aspects regarding humanitarian organisations

- Concept of Perceived Organisational Support (POS)
- Measures of psychosocial support, such as peer support, team meetings
- Generally supportive working environment (Aldamman et al., 2019; Jachens et al., 2019)
- Providing supervision (e.g., Pross, 2006)
- Destigmatisation policy of mental health difficulties supported by organisations

Institutional/group dynamics

- Tavistock approach to overidentification, projective identification, scapegoating, organisational defensiveness (Halton, 2019; Obholzer & Roberts, 2019)
- Staff support groups for the exploration and reflection on group dynamics (Kennard & Hartley, 2019)

Motivational dimension (of humanitarians)

- Altruism, idealism and cosmopolitanism (Carbonnier, 2015; Malkki, 1995; Slim, 2005)
- Political motivations: political history, political ideology (Sandri, 2018; Slim, 2005)
- Blended selfless and self-centred motivations (Sandri, 2018; Radice, 2019)

Concept of vicarious resilience

- (e.g., Hernandez et al., 2007)

Value-based approaches on wellbeing

- Value Based Counselling (Missmahl & Bruggman, 2019)
- Personal value orientation (Maercker et al., 2015)

Examples of "psycho-political" considerations on humanitarian wellbeing

- Pupavac (2004) comments on the moral crisis in humanitarianism
- Apostolidou (2015) discusses emotional reactions of the helper to the overwhelming political material
- Radice (2022) calls for more political and activistic humanitarianism and criticises

humanitarianism's alienation from political voices

Predictably, the above diagram only provides fundamental examples of the perspectives and ideas integrated. Also, judging from the results and later looking at their interpretation, some aspects took up more “room” than others within the integrative/blended conceptual approach of this thesis (e.g., organisational dimension). Nonetheless, I anticipate that this diagram effectively summarises and captures the main components of the conceptual framework that guides this academic inquiry. Relying on this study’s psychosocial conceptual framework, and connecting the findings to the relevant reviewed literature, I am able to identify the following aspects of humanitarian wellbeing:

- **Individual aspects (including rituals/routines).** From the excerpts of the participants one can conclude that experience and perception of wellbeing is a very personal and individual matter that depends on the *complexity, uniqueness* and *totality* of each person and the MAPs in the aftermath of adverse events (Papadopoulos, 2021a). In this regard, one could be reminded of Diener’s well-researched *subjective wellbeing* (SWB; 1984). Two participants, P4 and P7, even acknowledged the fact that the perception of wellbeing is very individual and unique from person to person. To give an example, pre- and after-work rituals of the helper are central and very individual/personal for the daily coping with workplace stress as a means of self-care, as previously mentioned in the findings in Chapter 6 of this thesis.
- **Value-based aspects.** As part of wellbeing, cultural values, either traditional or modern, are an individual/personal matter, too (Maercker et al., 2015). Nonetheless, most participants as individuals seem to share similar values, such as democratic values (P3, P4), cosmopolitan values (P2, P5, P6), and impact values (P4, P6), which would

correspond to the traditional values of “benevolence”, “universalism” and the modern value of “achievement”, respectively (Maercker et al., 2009, as cited in Maercker et al., 2015, p. 9). The framework of Value Based Counselling (VBC), as presented in Chapter 5, also focuses on family and personal values and the conflicts around values, which were also implied by the findings. On some occasions, the subthemes on helper’s stress and negative reactions under Theme I in Chapter 6, infer this clash of values in the helper’s inner world as well as within the organisation.

- **Eudemonic v. hedonic aspects.** Overall, the results suggest that eudemonic elements such as AAD or political engagement as a part of one’s self-actualisation are more central for the conceptualisation of helpers’ wellbeing than hedonic aspects, such as pleasure and absence of negative emotions (or dominance of positive emotions). Nevertheless, working with refugees can also contribute to the helper’s satisfaction and pleasure in work, which could be classified as a hedonic element. This is confirmed by Tassell’s (2009) related study, in which humanitarian workers were found to have high scores in hedonic wellbeing as well as self-actualisation (a core aspect of eudemonic wellbeing).
- **Psychosocial aspects.** Corroborated by the AG, this study proves that a concept of wellbeing echoes all psychosocial realms of the helper (intra-psychic, intrapersonal, socio-political, or sociocultural) that interact with each other (EVASP, 2011). For instance, if one looks at the data extracts as well as the themes and subthemes, awareness of one’s own limitations and of the complexity is an example of an intra-

psychic facet, team dynamics and relationship to family are categorised as interpersonal facets, and influence of the political environment on humanitarians and their organisations speaks for the importance of socio-political aspects.

- **Organisational, workplace aspects and organisational dynamics.** With relation to workplace wellbeing of humanitarian helpers, the organisational dimension undoubtedly plays a key role, based on the findings (as portrayed in Chapter 6). This is emphasised by the relevant literature and, of course, organisations should be constantly made aware and reminded of this. There is an absence (or even if it is present, it is not being scrutinised) of literature on the aspects of organisational dynamics, as these are described and analysed within the Tavistock approach. According to the findings, this is also less discerned by organisations. As a way of illustration, if a colleague or a boss is considered “toxic” by the helper or by the team, a proper reaction could be to identify the dynamics or mechanisms and to foster awareness for these dynamics. In summary, the findings suggest that these aspects are crucial to the wellbeing of the individual and the team or organisation.
- **Ontological aspects.** The data, and subsequently the findings on staff wellbeing, are not based on medical examinations or clinical assessments but mostly on the AG, which is not a test for clinical evaluation but a tool for an epistemological framework. This implies that the findings do not reflect a clinical situation and a symptomatology, but rather refer to aspects that relate to and affect human *existence* (“ontological aspects”) as a whole, not only from a medical perspective.

The term “ontology” describes the totality of our being. Bearing in mind that “usually, terms that refer to the wholeness of a human being include only certain combinations of this totality, e.g., body and mind, personal and social, conscious and unconscious, emotional and intellectual, external and internal” (Papadopoulos, 2015, p. 40), I suggest that a thorough, really holistic concept of wellbeing should embrace ontology as its key constituent. In this respect, for example, it could be said that the findings related to self-care or AAD (in Chapter 6) also have an ontological dimension.

- **Medical-clinical and physical aspects.** Undeniably, even if this study does not have a clinical focus and does not approach wellbeing from a medical perspective, including clinical measurements and assessments, some clinical aspects have emerged in the findings (e.g., secondary, or vicarious trauma, burnout). In addition, when asked about their perception of wellbeing, most participants mentioned the medical dimension. These mostly correspond to the “severely negative” reactions according to the AG (or “psychiatric disorders” in the original AG). After all, one could suggest that mental health *is* wellbeing, but wellbeing is not only mental health, in a restrictive medical sense. If there is a mental health disorder, then, indisputably, appropriate measures (such as clinical psychotherapy or medical intervention) should be taken for its diagnosis and treatment. According to the results, body and physical health are vital parts of helper wellbeing and self-care and their importance should not be ignored or underestimated. This is, generally, in agreement with the relevant literature. Additionally,

when asked about their perception of wellbeing, some participants mentioned the physical dimension (“the body”).

- **Motivational aspects.** Undoubtedly, motivations of humanitarian helpers have been a subject of research (e.g., Barnett, 2005; Carbonnier, 2015; Chouliaraki, 2012; Donini, 2010; Fechter, 2012; Gomez et al., 2020; Malkki, 2015; Meneghini, 2016; Nordahl, 2016; Pross, 2006; Rehberg, 2005; Sandri, 2018 – the list is extensive). Moreover, motivations appear to be an integral part of humanitarian staff and helpers’ eudemonic wellbeing, as this study indicates. Fulfilling one’s political, altruistic or activistic motivation (as described in Chapter 4 and in the findings of Chapter 6) by having an effect and inducing (positive) changes, for example, in the life of a person, population, community or society means fulfilling one’s potential in the *eudemonic* sense of self-actualisation and finding purpose and meaning in life (Ryan & Deci, 2001; Ryff, 1989).
- **Collective aspects.** Various philosophers and scholars have put emphasis on the collective dimension of wellbeing; for example, Confucius advocated the *common good* (as cited in Zhang, 2010). Meanwhile, Jung (2014, p. 2933) commented that “it is sufficient to know that the human psyche is both individual and collective, and that its wellbeing depends on the natural co-operation of these two apparently contradictory sides.” Moreover, social wellbeing, as a more collective concept introduced by Keyes (1998, p. 122), refers to a “socially health life” for the members of the society and encompasses five basic elements*:* social integration (evaluation of the relation with the community), social contribution (the feeling of having an impact on the

community), social coherence (belief that the community is well-organised), social actualisation (society's potential for growth) and social acceptance (positive view about members of the community and humanity, in general). The construct of social wellbeing is bolstered by the work of other psychotherapists, such as Adler's social interest and feeling of belonging (Griffith & Powers, 2007). On numerous occasions, the extracted data indicate that wellbeing of the individual helper is affected by the collective wellbeing of the community or society (Evans & Prilleltensky, 2007). For example, one could think about P3's and her colleagues' feelings of guilt toward refugees, about P1's feelings of tiredness and resignation due to the inability of some of her clients to become financially independent, or about P4's shared enthusiasm that she feels delighted when she can improve the situations of her clients.

All the above considered, I can conclude that the approach to humanitarian helper wellbeing proposed in this project and through its conceptual framework, is a holistic, broader psychosocial one, and not exclusively medical. This does not essentially pathologise human suffering and recognises the purpose and the potential in the experience of adversities. In this section, the leading conceptual framework was outlined and the approach to helper wellbeing according to this framework was set out. In the next section, I specifically discuss themes/findings of the empirical phase through the lens of the introduced conceptual framework and in light of the literature review of the first five chapters.

7.2. Discussing the Findings in Light of the Literature

7.2.1. Organisational and Workplace Detrimental Dimensions

The findings show that organisational and occupational issues and difficulties are dominant sources of stress and adversity for humanitarians, which is consistent

with the resource literature on humanitarian stress and wellbeing (the list is extensive – to name some: Aldamman et al., 2019; Allard-Buffoni & Jönsson, 2015; Birck, 2001; Blanchetiere, 2006; Curling & Simmons, 2010; Ehrenreich & Elliott, 2004; Jachens et al., 2019; Musa & Hamid, 2008; Pross & Schweitzer, 2010; Schweitzer et al., 2015; Yunn Shee Foo et al., 2023).

Notably, the findings suggest that, in many cases, organisational stressors overshadow stress due to exposure regarding their severity, as perceived by the participants (KonTerra, 2019). The organisational or occupational issues most commonly reported by the participants were:

- Lack of funding and financial insecurity
- Too high a workload
- Shortage of staff
- Rotation policy of the organisation
- Lack of organisational support, including lack of prevention, lack of supervision and lack of counselling
- Problems in coordination within the same organisation or with other organisations
- Lack of autonomy at work
- Security issues in the field
- Lack of multidisciplinarity
- Lack of training in refugeedom and relevant cultural issues
- Absence of understanding and support for female humanitarians in pregnancy or motherhood
- “Toxic” managers and “toxic” teams, and negative group dynamics (which is raised in the next subsection)

Overall, these results stand in agreement with the relevant literature. They also disclose some connection with discussed pre-existing models on workplace

wellbeing and burnout, such as JD-R and DCM. Moreover, from an organisational standpoint, the findings validate the well-researched concept of POS and its protective role for helpers (Aldamman et al., 2019; De Paul & Bikos, 2015), although this was not empirically assessed or measured in this study. For the participants in this study, POS could be translated into being a member of supportive or "pro-support" (Hartley & Kennard, 2019) organisations that actively care for the wellbeing of workers by providing *supervision* (e.g., Apostolidou & Schweitzer, 2017; Barrington & Shakespeare-Finch, 2014; West, 2010) *counselling* (e.g., Antares Foundation, 2012; KonTerra, 2017; Manning-Jones, 2016; Tassell, 2019), *staff support or reflective groups* (e.g., Blanchetiere, 2006; IFRC, 2019; Lederberg, 1998) and by dealing with organisational issues.

In contrast to the bulk of the relevant literature (e.g., Ager et al., 2012; Brooks et al., 2015; McCormack & Joseph, 2013; Puvimanasinghe et al., 2015; Strohmeier et al., 2019), the participants do not extensively discuss or highlight (in a positive or negative way) the role and importance of psychosocial or psychological training offered by organisations, with the only exception being training on refugee and intercultural themes. A possible explanation for this could be that most participants are experienced humanitarians, half of them with a solid mental health/psychotherapeutic background and a vast skillset.

Additionally, compared to the existing literature, the participants (at least those for whom this was applicable) do not explore or comment on aspects regarding *mental health screening* prior to staff appointment (e.g., Antares Foundation, 2012) and staff selection and *recruitment* (Hunt, 2008 & 2009; Nordahl, 2016; Tassell, 2019). On the contrary, the participants support *mental health or wellbeing monitoring* of members by organisations during their work assignments (Antares Foundation, 2012; Tassell, 2019; Wellton-Mitchell, 2013).

Finally, t*eam cohesion* and team solidarity (Cardozo et al., 2012) is viewed and experienced by the study participants as an aspect of protection and resilience, but also as a form of collective growth that emerges through the adversities of work.

7.2.2. Organisational and Team Dynamics

The results of this study are largely in conformity with the literature on psychoanalytic theories of organisations. The first finding is that *negative organisational or team dynamics* constitute a key stressor, as perceived by the participants.

Emotional or inner distance from the clients (Menzies, 1959; Roberts, 2019), either as a relatively unconscious defence or as a more conscious coping strategy, is confirmed by the findings. This inner distance is sometimes expressed on an organisational level by bureaucratic procedures and complicated co-ordination (Hartley & Kennard, 2009). Moreover, the findings show that humanitarian helpers as members of groups, teams and organisations learn by time and by experience *not to overly identify* with clients who are adversity survivors. The theme of distance was addressed by P4 and P7 and elicited from the answers of P1 and P5.

The connectedness and solidarity between colleagues are evident in organisations; on the other hand, in this study I also assumed tendencies for a "*siege-mentality"* (Walkup, 1997) or an isolated "bubble" (Snelling, 2018) in the sense of "us against the others". For example, this may be elicited, from P3's, P4's and P6's answers. In this context, The Other is the perpetrator according to the Victim Triangle, who in effect could be, for example, politicians or the army who persecute clients or the clients themselves with their unrealistic expectations and the pressure under which they put helpers.

A further aspect of organisational dynamics validated by the results is the phenomenon of scapegoating (Halton, 2019; Hinshelwood, 1987; Obholzer &

Roberts, 2019) and “toxicity” of managers and/or teams as stated during the data collection. Scapegoating was appropriately summarised in the words of one of the participants (P3) as: “the hanger on which we hang all the problems”.

The findings demonstrate fear or reluctance to admit one’s stress and/or distress and ask for adequate support from the organisation (Nitsun, 1996; Punter, 2007). This is mainly described by the participants, such as P8, as “fear of stigmatisation” or “fear of showing weakness” that presumably could have a negative effect on one’s career as a humanitarian worker. This implies that organisations are not always perceived as “supportive enough” by the participants (such as P3). Nevertheless, participants (such as P6 and P8) notice that nowadays the situation has been changing and organisations seem to have now adopted a more open and supportive policy in that respect.

Moreover, the possibility of a psychotherapeutic intervention, when required, appears to be unanimously appreciated by the participants in terms of coping, self-care, resilience-building, and as a method of treatment, of course. However, I have to underline that the development of a *“therapy culture”* among organisations cannot be a *panacea* to every problem, especially when the issue is of an organisational nature or lies in the domain of institutional dynamics. The findings imply that, even if counselling or therapy of the individual helper/humanitarian seems to be the most effortless or quickest way for the manager or the team to deal with a problem that arises in an organisation, it does not address or solve problems on an occupational or organisational dynamics level. Instead, it rather carelessly shifts the responsibility onto individuals by pathologising them (Hartley & Kennard, 2009).

In other words, organisations follow the medical model that focuses on the individual that should “change” or “heal”, but not on problematic aspects of the organisation that should be discussed and improved (Jachens, 2018). I agree with

the view that a humanitarian organisation that claims to be supportive and "humanitarian" to its own workers is not necessarily the one that simply urges them to seek therapy or refers them to a counsellor or a mental health service. In my view, the results of this study suggest that a genuine pro-support organisation should have the ability of self-reflection and social support for its members and should be cognisant of institutional dynamics phenomena, such as projective identification or over-identification with clients (Hartley & Kennard, 2009).

At this point, I have to comment on the psychodynamic terminology that is used in this subsection. Originally in psychoanalysis, projective identification (and identification in general) describes an individual relational experience that can become evident within a psychoanalytic/psychotherapeutic setting (for example, see: Laplanche & Pontalis, 1973, p. 219, 226–227). However, as stated earlier, in this project I do not wield clinical tools, and I certainly do not aim to clinically evaluate the project participants and collect clinical material. Here, the use of psychodynamic vocabulary follows the Tavistock approach on organisational dynamics and group relations, as described in Chapter 4. In this regard, in this thesis I view projective identification as a manifestation at the level of the institution, as perceived by the participants in their workplace/organisational setting and according to their individual lived experience. If not appropriately taken into consideration (by managers but also by staff members), problematic projective identification at the level of the institution can potentially have detrimental effects on team cohesion due to scapegoating tendencies (Halton, 2019). This reality is also corroborated by the findings of this study.

Finally, looking at the findings, staff support groups, as described in Chapter 4 of the thesis, could be a useful concept for humanitarian organisations in terms of creating an appropriate, holding, empathetic, caring, compassionate and supportive

workplace environment for the workers (Hartley & Kennard, 2009; Lederberg, 1998). Hopefully, participation in these group processes could duly identify personal or interpersonal problems and negative team dynamics.

7.2.3. Motivations for Refugee Care

Generally, the findings imply a blend of chiefly altruistic, idealistic and, to a lesser extent, self-oriented motivations of the humanitarian helpers, as is also suggested by several authors (Carbonnier, 2015; Fechter, 2012; Meneghini, 2016; Rehberg, 2005; Sandri, 2018; Slim, 2005; Vaux, 2001).

More specifically, political motivation, primarily political ideology (Albuquerque et al., 2018; Apostolidou, 2015; Gomez et al., 2020; Komenska, 2017) of the individual or the individual's family, is identified by the participants (such as P1) as chief altruistic motivation for their work with refugees. However, this cannot rule out relevant, self-serving motivations such as interest in a political career or experiencing involvement in Refugee Care and humanitarianism as a substitute for other, more subtle, political, or revolutionary wishes (Anderfuhren-Biget et al., 2012; Donini, 2010; Pross, 2006). For example, one could think of P7's answer that she considered her humanitarian role mainly political, or P4's confession that she tries to resist the system in a political sense.

According to the findings, engagement in Refugee Care and humanitarianism could additionally echo the Western world's *"need to help"* (Malkki, 2015, p. 51) or to "ease" their conscience (Donini, 2010) regarding suffering, calamities, turmoil in other parts of the world or refugee populations. Moreover, the results suggest that this need to help is juxtaposed with a feeling of *anger* (Yarris et al., 2020) and disappointment regarding the reactions of the dominant political forces.

I trust that a further, central motivation for humanitarian work that emerged from the findings is the *cosmopolitan* aspect (for example, as previously mentioned in

Chapter 4): being cognisant of what happens in the world and working with people from all over the world together to help others and to serve the “common good”. This is in consonance with the existing literature (e.g., Anderfuhren-Biget et al., 2012; Barnett, 2005; Carbonnier, 2015; Paulmann, 2013; Slim, 2005).

Other – primarily self-centred – motivations determined by the participants were the following, listed in no particular order:

- Access to academia
- Becoming humanitarian by coincidence
- Having an impact on the community or society
- Feeling of belonging to a group
- Finding of meaning or purpose
- Personal growth or enrichment
- One’s family (or personal) history
- Feeling of satisfaction
- Career development

Notably, *escapism* from one’s own problems and reality as a frequently cited motivation (e.g., Carbonnier, 2015; Meneghini, 2016; Oberholster et al., 2013) is not confirmed by the study results. A more in-depth psychological examination regarding escapism is beyond the scope of this study.

Finally, I should bring to attention the aspects of *variability* and *complexity* of the participants’ motivations. In this respect, each helper can be driven by several co-existing motivations, other-oriented and self-oriented, intrinsic and extrinsic, in their *complexity* and *totality* as persons, which forms a unique, non-homogenous, individual experience. Furthermore, it cannot be ruled out that motivations of the individual change over time (diachronically). Each of these individual experiences was voiced, discussed, and examined in its own right in this qualitative study. This

reflects the epistemological positions of this study, as explained in the previous chapter.

7.2.4. Wide Spectrum of (a) Individual Perception and Experience of Stressors and (b) Responses-Consequences due to Adversities

The findings demonstrate a wide range of responses to staff exposure of stress because of their work with refugees under adverse conditions. These reactions are not solely negative (e.g., Bonanno & Dimminich, 2013; Mancini, 2019; O'Leary, 1998). Furthermore, there is a considerable *variability* regarding what each participant views and individually experiences as a stressor.

By the word "adversity", participants usually understood the generally diachronically adverse nature of their work in Refugee Care and humanitarian aid. However, on some occasions they referred to concretely painful, adverse events (e.g., security incidents; suicide of a client; speaking with a mother whose children have died or have been killed; experiencing scapegoating; intervention of the police to the detriment of refugees).

The application of the AG as a tool is an advantage of this study, as it enables *epistemological vigilance* (e.g., Papadopoulos, 2021a, p. 12), so that epistemological errors due to oversimplification and one-sidedness could potentially be prevented. As stated in Chapter 6, the AG partly inspired the structure of the interviews. The wide range of stressors and reactions to them emerged through the data collection and analysis has been achieved by utilising the AG and echoes the complexity, totality and uniqueness of each participant as a human being.

Corresponding to the structure of the AG, the findings of this study manifest negative and positive reactions to adversities as well as unchanged, resilient elements to adversities and stressors. According to the individual perception and experience of each participant, the responses to adversities may be located on the

personal, family, workplace/organisational and/or communal/societal levels. The results show that stressors, resilience, or coping factors and negative as well as positive reactions refer at least to one of the psychosocial realms as described in the EVASP handbook (2011): intrapsychic, interpersonal, sociocultural, or socio-political. For the intents and purposes of this study, I added here the organisational realm, as a domain in its own right. Finally, it is possible, as the findings suggest, that the same adverse phase or situation in Refugee Care can have contrasting (negative-positive) responses, which the participant experiences and are visible on the AG.

Another noteworthy aspect highlighted by the findings is the *diachrony* (Zucca, 2015) of the adversity, the effects and the related experience, which speaks for its complexity. Within a Refugee Care context, the time frame of the experienced adversities refers to *pre-flight, flight* and *post-flight* (e.g., Kunz, 1981), while Papadopoulos (2002) suggests the stages of *anticipation*, *devastating events*, *survival* and *adjustment*, adding that:

> The “refugee trauma” discourse tends to be restrictive because it emphasizes only one segment of the wide spectrum of the refugee experiences… Unmistakably, the “refugee trauma” discourse privileges the phase of devastating events and blatantly downplays or even ignores the consequences of the adverse nature of the other phases. (Papadopoulos, 2002, pp. 26–27)

Similarly, one could try to contemplate when, or from when until when, for how long, and in how many stages, the adversities take place and affect helpers (in both a negative and positive way). In this respect, considering staff wellbeing, I propose that one should not solely focus on the adversity that a humanitarian has experienced, but also take into account what came before it, and what followed. For example, P1 and P7 admitted that they suffered from adversities and stressors in Refugee Care,

but their change to Refugee Care from their previous careers was “lifesaving” for both. Furthermore, *diachronically,* they can identify benefits, gains and meaning in their work with and for refugees. The fact that they experience stress and pain because of the exposure to clients’ adverse material (and organisational problems) at their work *does not change or erase* the fact that their move to Refugee Care was beneficial to them, and that they also experience growth, enrichment and meaning as a result of their exposure to the adversities of Refugee Care and the humanitarian field. In this context, it would have been an epistemological error to only acknowledge the negative aspects.

Furthermore, I should note that determining the time frame of reference that each participant considered for the individual completion of the AG is a complex matter: most, if not all, of the participants looked at their overall career as helpers of refugees either as staff or as volunteers without exclusively focusing on concrete roles or positions. Nevertheless, it is evident in the findings that, essentially, some of the participants’ answers and self-reflections were significantly influenced by their last or current job positions and roles during the period in which the data was collected, so this material could be viewed as rather *synchronic*. Of course, other answers tend to have a more *diachronic* character. For example, P5’s answers reflected his engagement in a humanitarian organisation, for which he has been working for many years, as well as his work as medical director at a local outpatient clinic, which has been more “short-term”.

Moreover, the findings generally support the proposed theory of MAPs (see Chapter 2). In this respect, trauma could be interpreted as a crisis of meaning (Bracken, 2002; Pupavac, 2004) and calamities that cause distress to the helper as a very first reaction, can – through the complex process of attributing meaning to the experienced adversity and the consequent, inevitable, initial stressful reaction – lead

also to a new positive meaning, a gain (AAD), which is then interpreted as the constructed, mediated, or long-term response to the adversities (Papadopoulos, 2021a). In other words, MAPs do not necessarily follow a linear-causal epistemology, according to which the adversity causes a negative reaction and a negative view of it, but they draw attention to the lasting effect, the mediated reaction that gives a new meaning to the initial adversity. The wide range of AAD among the participants traceable in the results suggests the validity of MAPs.

Even if it is beyond the aims and scope of this study to explore all possible factors involved for each participant and how these factors impact the participants' MAP on each occasion, I have to accentuate that all participants underlined the role of (a) family and (b) relationships outside of family (friends, colleagues, peers) as support systems and the contribution of (c) *set systems of meaning* (such as political ideology, altruism, family values) in experiencing and understanding ("attributing meaning") their prolonged responses to exposure to adversities, predicaments and overall experiences as helpers. In this sense, I conclude that family, relationships and set systems of meaning are considered crucial factors involved in MAP (Papadopoulos, 2021a).

7.2.5. New Strengths and Therapeutic Dimension of the AG

All participants of the study reported numerous gains as a result of their complex and, frequently, profoundly stressful but also rewarding work with refugees. In some cases, the findings suggest that positive reactions to the adverse content of Refugee Care outweigh the negative responses. All participants acknowledged positive responses to adversity, even if the literature tends to neglect these and to focus on the more immediate negative reactions and changes, as previously discussed in Chapters 2 and 5.

The findings corroborate the concept of AAD for helpers, which is visible in many forms. Until now, AAD has been examined in beneficiaries and adversity survivors but not in their helpers (Chondrou, 2019; Senturk, 2017; Zucca, 2015). Additionally, the results support the concept of VR for helpers of refugees. Aspects of VR are contained under the broader umbrella term of AAD.

Looking at the findings, I also tend to agree with Scott et al. (2023) on the connection of self-care with VR, which underlines the correlation between two thematic areas of this study. For example, self-care for participants, such as P3, P5 and P7 (see Chapter 6) increased in the aftermath of exposure to adversities at work. Generally, AAD and VR as manifested in this study are, to a large extent, in agreement with the bulk of the literature considering positive outcomes (including VR) of humanitarian work and work with adversity survivors, for example: more appreciation for political freedom, human rights (Engström et al., 2008), for family and friends (Hyatt-Burkhart, 2014), for one's own life (Welton-Mitchell, 2013), admiration for clients and human resilience (Engström et al., 2008; Hyatt-Burkhart, 2014), finding meaningfulness in the field (Albuquerque et al., 2018), increased self-confidence and self-efficacy (Guhan & Liebling-Kalifani, 2011; Welton-Mitchell, 2013), personal growth and enrichment in personal life (Arnold et al., 2005; Guhan & Liebling-Kalifani, 2011), gains in insight and empathy (Arnold et al., 2005), increased political and global awareness (Edelkott et al., 2016; Hernandez et al., 2007), gaining hope (Hernandez et al., 2007; Hernandez-Wolfe et al., 2015), becoming a more open and flexible person (Hyatt-Burkhart, 2014), better self-care (Edelkott et al., 2016), appreciation of humans in general (Welton-Mitchell, 2013), wisdom (Welton-Mitchell, 2013), and motivation to continue refugee work (Edelkott et al., 2016).

AAD can also refer to simpler, more tangible, more practical, and more quotidian aspects, and not exclusively to transformative, intrapsychic, and meaning-

making components; and this is visible in the findings. These positive developments that are covered by AAD, but not by VR, tend to be less underlined in the bulk of the literature. For instance, participants expressed acquirement of better academic and team-management skills or better awareness of legal procedures. These aspects may sound somewhat “trivial” but are useful tools for one’s professional development (Posselt et al., 2020).

The results show that feeling appreciated by one’s family substantially contributes to helper’s AAD and helper’s wellbeing. Regarding relationships to family members, the findings suggest approval and/or appreciation from family as (a) a motivation for the helper (as previously mentioned in Chapter 6, especially by P1 and P2 in connection with their family’s history and/or ideology) but also as (b) an expression of AAD. Specifically, more appreciation from the helpers for their families is an aspect of VR (as previously seen in Chapter 6, e.g., with P3, P5 and P6), and, therefore, of AAD, which is supported by the findings. In other words, as a “more mediated” outcome of their work with refugees with inevitably adverse content, participants value their families more and, concurrently, experience more appreciation from their families.

Considering the above-mentioned negative reactions and consequences related to adversities and the insufficiency of a linear causal model, it would also be an oversimplification to suggest the same for AAD, i.e., that a very specific adversity has caused a very specific positive outcome. In this study, I propose that AAD of the humanitarian helper is a *lasting* outcome of the overall adverse experience that helpers encounter in their work and this outcome is shaped through the complex MAP, which is unique to any individual.

When compared to VR and the relevant literature, I propose that AAD tends to echo a more *collective* character, as this is perceived and experienced by the person

who fills out the level “community/society” of the AG. The findings show that AAD, as experienced by each participant individually, not only relates to the helpers themselves, their families, and their organisations, but also possibly to a wider societal context (i.e., parts of the IMI); to name some examples from the findings: more openness and more willingness to learn about and understand refugeedom issues in general, better acknowledgement of MHPSS and staff care, more immediate organisation of help for Ukrainian refugees, and more research into the health problems of refugees.

Therapeutic/Self-Care Benefit from the AG. Finally, looking back at the findings regarding AAD and self-care and resilience, I want to emphasise the amount and variety of responses considering old retained strengths and positive elements as well as new strengths, gains and benefits that were mentioned during the first contact (interview based on the framework of AG) and, foremost, during the first or second completion of the AG (second and third contact, respectively). I confirm that the AG helped the participants identify retained positive elements and positive developments in the aftermath of exposure to adversities. In this respect, even if the AG was primarily not exerted for therapeutic purposes in this study (and, clearly, not for measuring a psychotherapeutic effect), but rather as a tool for gathering a wide range of data, I postulate that the fact of being able to acknowledge and self-reflect on their retained strengths, benefits and new gains with the help of the AG carries in itself a beneficial dimension. It can be proposed that a consecutive completion of the AG over time would generally raise the helpers’ discerning awareness of their wider range of responses to adversities and, therefore, could possibly reveal further positive changes (i.e., elements of AAD). This process of constantly becoming aware of one’s old retained positive features and new strengths/gains (and of not only focusing on the negative changes) could be enormously beneficial and empowering

for the helper. In this sense, the AG may be viewed as a tool for practicing and boosting self-care for the helpers.

7.2.6. Negative Reactions and Pathologies

As repeatedly stated, this study does not include a clinical examination or medical assessment and does not focus on symptoms or pathologies but rather explores the psychosocial reality and experience of the participants.

Stress is not necessarily distress and, moreover, distress is not necessarily a psychiatric disorder (e.g., Adshead & Ferris, 2007; Burstow, 2005; Davies, 2022). Nevertheless, many participants, such as P1, P6 and P7, mention concrete pathologies (burnout, secondary trauma) when referring to their own or their co-workers' reactions to adversities in their work with refugees. Burnout, STS, but also less deficit-oriented concepts such as VT, CF and/or moral injury can neither be ruled out nor confirmed by the results, since no medical examination and clinical evaluation (with measurements including evidence-based, diagnostic questionnaires) took place. If a participant made use of a clinical term, I acknowledged this without scrutinising the validity of this term or (self-)diagnosis during the interviews and the completion of the AG.

Moreover, some participants refer to phenomena that could be interpreted as symptoms or mental health difficulties, for example, "shame and guilt" and "migraines" (P3), "hopelessness" (P7), "stress" and "fear" (P8). I admit that the transitional line between functional coping with these difficulties and psychopathology remains blurred. To some extent, this is inevitable due to the nature and essence of this project, in which I did not conduct clinical assessments. Nonetheless, it should be noted that the inclusion criteria for participating in this research project include the human subjects' mental stability as well as current, active, direct engagement with refugees. Of course, this does not rule out a form or level of psychopathology but, to

a certain degree, it ensures that the participants can mostly, at least here and now, successfully cope with their stress, mental health difficulties, symptoms or clinical phenomena they describe.

I should emphasise that, as stated in the research questions and underlying assumptions, in this study I do not seek to prove that helpers do not suffer from symptoms or psychopathologies. I am mostly interested in the assumption that not all negative outcomes for helpers are pathological, i.e., symptoms of a medical disorder. The wide range of negative reactions, consequences and changes that were mentioned by the participants under Theme I in Chapter 6, with the help of the AG, are evidently not at all/not only potentially part of a psychopathology but they expand into the group dynamics, political and social relational realms. For example, financial worries, distance from friends and family, scapegoating within the team, inner political tensions (all described by the participants) could certainly be interpreted as negative developments for the helper, but they are *per se* not of a pathological nature in the medical sense, even if they could, at some point, to some extent, under certain circumstances, potentially harm one's mental health.

Furthermore, it can be suggested that the study participants, and more specifically non-clinicians, tend to medicalise their stress and responses or conceptualise this pain or suffering (and that of their colleagues as well) in a psychopathological way (burnout, trauma-related disorder). P7 confessed that she started psychotherapy because of burnout as a result of her work with refugees and has also suffered from secondary trauma. P3 conceded that she sought professional help (counselling) for, *inter alia*, problems in the relationship with her team colleagues at the organisation, not because of vicarious exposure. P6 has never had counselling but she regretted the fact that she had not, as she had almost suffered from burnout but primarily due to organisational and workplace issues. P4 voiced that she has also

almost suffered from burnout but counselling was not necessary in her case. P1 stated that there are many incidents of burnout in humanitarian organisations.

Once again, I am in no position to confirm as a clinician (and this is here not my role) whether these participants have indeed suffered from burnout or another pathology or not, and if certain criteria for this diagnosis were met. One participant confessed having suffered from depression, but this was because of a previous job, not in Refugee Care. Undeniably, these participants have experienced distress, suffering and pain because of adversities and their stressful work, but their own conceptualisation of this seems to follow the predominant medical/psychotraumatological model.

Moreover, I hypothesise that suffering from burnout or secondary trauma could also be viewed as a form of *validation* of one's painful experience (Papadopoulos, 2021a, p. 222). Additionally, I presume that participating in sessions of counselling (or psychotherapy or psychoanalysis, etc.) is not *per se* an undeniable proof of psychopathology as it is perceived and defined today (APA, 2012; Mayo Clinic, 2023; Sanders & Tolan, 2023). Moreover, at present not everyone needs psychotherapy, even for their trauma (in a broad sense), to heal (Leidenberger, 2023).

A further aspect worth mentioning is, in my understanding, connected with the predominant medicalising, pathologising or victimising narrative that affects refugee populations (e.g., Jasperse, 2021; Pupavac, 2002; Summerfield, 1999), humanitarian helpers (Hyatt-Burkhart, 2014; Jachens, 2018; Jasperse, 2021; Pupavac, 2004) or society in general (Davies, 2022; Hansen, 2014; Wassermann & Wassermann, 2016). This is the overusing of psychiatric terms and/or the labelling of negative normal emotional reactions as symptoms of a psychopathological condition, for which the mass media as well as the diagnostic inflation of psychiatry are responsible. This phenomenon is currently addressed by an abundance of authors in the press and the

academic literature (to name just a few examples: Batstra & Frances, 2012; Der Standard, 2010; Foulkes & Andrews, 2023; Frances, 2013; Geiser, 2023; Kudlow, 2013; Pemberton, 2024; Von Eisenhart, 2019). Frances, former chairman of the American Psychiatric Association (as cited in Guldberg, 2014), rhetorically asks if the diagnostic inflation can still be prevented or if the world has already entered an era of false epidemics. Additionally, in recent decades, the rise of *popular psychology* (or "pop psychology") with controversial effects (Devilly, 2005; Haslam, 2021) could arguably be linked with the above-mentioned tendencies. Looking at the findings, I would hypothesise that these aspects (exaggerated use of "psychiatric" language, rise of popular psychology) could also have affected – to some extent – the conceptual viewpoint of the participants regarding their negative reactions.

Earlier, I discerned and discussed the role of organisational and workplace or group dynamics in relation to stress and distress of staff, as this was demonstrated by the results. As far as the direct work and direct contact with refugees is concerned, the findings suggest that vicarious exposure to adverse material (i.e., repeatedly bearing witness to the beneficiaries' painful narratives and difficult conditions they faced or still face) is not the only way of approaching and understanding negative reactions of the helper, contrary to pre-existing literature on vicarious trauma (Deighton et al., 2007; McCann & Pearlman, 1990; McLean et al., 2003; Musa & Hamid, 2008; Pearlman & McIan, 1995; Wilson & Brwynn, 2004). The findings imply that interactions within the Victim Triangle, and therefore, not solely empathetic exposure to the client's adverse experiences, may also have detrimental impact on helpers and their work.

7.2.7. Helper Wellbeing and the Political[1]

Extrapolating from the findings, I hereby acknowledge that the helpers who participated in this study are highly politicised individuals. For instance, P7 stated that she considers her humanitarian work political. Consequently, they may feel stressed, distressed, or suffer due to political aspects of their work with refugees. More specifically, participants admitted powerlessness and feeling overwhelmed when dealing with the political establishment, the wider political environment and their reactions to refugees. Participants also identified other negative feelings, such as disappointment, frustration, anger and guilt (see Chapter 6). For example, P4 and P8 expressed some intense negative feelings regarding the treatment of refugees by the European governments and the EU, as a whole. Considering this, the findings are generally consistent with the existing literature (Apostolidou, 2015; Birck, 2001; Blanchetiere, 2006; De Waal, 2010; Ehrenreich & Elliot, 2004; Eleftheriadou, 1999; Pross, 2006; Schweitzer et al., 2015; Scott-Smith, 2016).

Apart from being a source of motivation, politics – essentially in a wider sense – is also an integral part of the helper's eudemonic wellbeing, according to the findings. One's political development, the expression of this *political drive* or the realisation of one's *innate political potential* (Samuels, 2016, p. 57) belongs to the helper's and humanitarian's self-actualisation, and hence to the helper's eudemonic wellbeing, as the results suggest.

More specifically, (a) having an effect as an altruistic activist; and (b) developing a cosmopolitan *Weltanschauung* are two central ideas under the main

[1] Here, I prefer the term "political" to "politics" since politics is more connected with state, administration and governance, whereas "the political" could be understood as a broader and more abstract term whose origin can be traced back to the fundamental distinction between "friend" and "foe" according to the German philosopher Carl Schmitt (1996). This distinction emerges from the diversity of ideas, beliefs, cultural practices, ethics, finances, etc. Additionally, Ticktin (2011, p. 251) maintains that "while politics is a set of practices by which order is created and maintained, the political refers to the disruption of an established order".

theme “eudemonic wellbeing” of this study that are, in a broad sense, of a political nature. The connection between wellbeing and altruism generally or *effective altruism* is corroborated by the relevant literature (e.g., Feng et al., 2020; Kahana et al., 2013; Post, 2005; Xiao et al., 2021) as is the linkage between wellbeing and cosmopolitanism (Appiah, 2006; Bauer, 2021; Grinstein & Wathieu, 2012; Malkki, 2015; Yuracko, 2003). More specifically, Yuracko (2003) detects in cosmopolitanism a eudemonic (self-realisation) and a hedonic (pleasure) dimension, while Bauer (2021) refers to a *eudemonic cosmopolitanism* in democratic and free societies. Meanwhile, Beck’s (2003, 2006) approach envisions the expansion of cosmopolitanism in the globalising world and views this as a system of interconnectedness and interdependence in which there is “shared responsibility by everyone for everything and everyone”. Beck’s theory seems to summarise the humanitarian helpers’ cosmopolitan ideology and motivation as expressed in the findings of this study.

Considering the above, the following questions are to be posed: How is the impact – especially the stress, distress, or further negative reactions – of the political on the wellbeing of humanitarian helpers conceptualised? Do the politicised helpers find the necessary open “space” to channel their political voice (and fears) and express their *Weltanschauung* in their organisations and their work with adversity survivors? Then again, on a more collective level, how political can an organisation be in order to sufficiently address political themes and their impact on the helpers, and deal with this impact effectively without pathologising it? I am neither a political scientist nor a political theorist, so my intention is to approach these political dimensions only from the perspective of staff wellbeing, individually and collectively.

First, the discourse on the political (or apolitical) nature of humanitarian organisations (and on its impact on the wellbeing of humanitarians and facilitators) is

a relatively known one. Radice (2022) argues that stripping humanitarianism of its political subjectivity, i.e., its political estrangement, is dehumanising, and he supports the idea that humanitarianism should be an expression of civic activism. Similarly, Slim (2020) advocates a form of activistic humanitarianism that is not apolitical and not neutral. Moreover, Slim voices that humanitarian values "overlap with a certain liberal political ideology" and that essentially "we humanitarians are paradoxically influenced simultaneously by apolitical and political ideals" (Slim, 2015, p. 8). He recognises that neutrality is an "operational" rather than a core humanitarian value (Slim, 2015). De Waal (2010) emphasises that the humanitarian field can be the setting where one's humanitarian values and ideology clash with organisational policies and principles. Sandri (2018) remarks that grassroots volunteer humanitarianism in the Calais refugee camp in France is highly politicised and challenges neoliberalism and traditional "bureaucratic" humanitarianism. On the other hand, and in relation to mainstream Western politics, Barnett (2005) stresses that humanitarian organisations are presently highly politicised and institutionalised at the expense of their autonomy, neutrality and values, while Pupavac (2004) asserts that politicisation (and here I would add "instrumentalisation") of humanitarian aid have led to a demoralisation of humanitarian workers that is reflected by the predominant trauma narrative regarding the helpers themselves and the beneficiaries.

However, from an epistemological point of view, how can this phenomenon of the (negative) impact of political factors on staff be conceptualised in a non-clinical and non-pathologising way, and on an individual as well as collective level?

On a personal level and always depending on the context, if the helper is, according to the interactions of the Victim Triangle, the "rescuer" or the "victim", then a suggested conceptualisation would probably be VT. Nevertheless, even if VT is *a priori* not a PD, the component "trauma" could be associated to trauma-related

disorders. In this context, the AG either in its initial form (with OHS and DPR) or in the adjusted form used in this study (with least, medium, and most severe negative reactions) seems to offer an appropriate framework for approaching the negative impact of political aspects. In contrast to VT, which refers to a reaction on the personal level, and is therefore expected to be examined and "treated" only on this level, the AG can also describe such negative reactions on a more collective level (organisation, workplace, or even community and society), which implies a different way of approaching and dealing with these problems. In this respect, the AG can also be administered to a group of people (for example, an NGO) and can be completed by the group together and used for group self-reflection.

Again, depending on the context, if the helper perceives his/her role as the villain or the persecutor in the Victim Triangle, then maybe the concept of *moral injury* could describe this individual experience. As previously discussed in Chapter 5, Papadopoulos (2020a) introduced the less pathologising (since it is not an "injury") and more encompassing concept of moral crisis. In this respect, moral injury as a reaction and as an experience refers to the individual person (and, consequently, it must be treated in individuals with their personal responsibility) while moral crisis echoes a broader epistemology and not just the individual act of transgression. In this respect, moral crisis could also be used to describe a more collective situation (for example, within an NGO). I suggest that moral crisis also echoes the crisis in purpose and meaning of today's humanitarianism (Pupavac, 2004).

As discussed above, AAD (including VR), on a personal but also on a more collective level according to the AG, constitutes a mediated response to adversities and stressors after an initial negative reaction. The same applies if one of the stressors (or the adversity) is the negative impact of the political environment. Therefore, from an epistemological viewpoint, it can be said that VT and moral injury

only focus on the *inevitable* negative responses and ignore any long-term positive development due to the effect of political aspects.

Finally, from a psychotherapeutic standpoint, even if discussing political material during therapy and counselling (or clinical supervision) can be beneficial, fruitful and supportive (Apostolidou, 2015), political problems generally should not just be reduced to psychological ones and a psychotherapist should not try to be a political theorist but rather provide the client with a safe space, in this case politicised (Samuels, 2016). This also applies for the negative influence of political aspects on humanitarian staff. Maybe contrary to the inclination to *pan-psychism* (Samuels, 2016), clinical treatment and psychotherapy should helpfully be provided, as long as there is a psychopathology that requires this, otherwise other interventions may be more appropriate for dealing with political dimensions that trouble the individual and the group. Samuels draws attention to the person's political development, political history, and current socio-political reality or "political here-and-now" (Samuels, 2016, p. 60). Within a humanitarian context, I suggest that these elements could be the subject of staff psychosocial support, such as staff support groups, role-playing, workshops, or even experimental artistic expression, such as a theatrical play (provided there is the capacity for this) that would enhance a person's or group's political awareness and resilience, stability or protection against negative political influences.

7.2.8. About Social Support

Social support, as the social interactions that offer support or the belief that support is accessible (Skeoch et al., 2017), has been highlighted by numerous authors as a central protection and wellbeing factor for helpers (Albuquerque et al., 2018; Blanchetiere, 2006; Cardozo et al., 2012; Eriksson et al., 2009; Guskovict & Potocky, 2019; Rubin et al., 2016); this may apply to support through family members

and friends (Ager et al., 2012; Blanchetiere, 2006; Cardozo et al., 2005; Nordahl, 2016; Tassell, 2009) or support within the working environment (Aldamman et al., 2019; Barrington & Shakespeare-Finch, 2014; Brooks et al., 2015; Corey et al., 2021; Guhan & Liebling-Kalifani, 2011, IFRC, 2014; Jachens, 2018; McCormack et al., 2009; Posselt et al., 2020; Strohmeier et al., 2019).

Generally, the findings are consistent with the existing literature. All participants referred to some form of social support in relation to their wellbeing and self-care (as presented in Chapter 6). However, on some occasions, participants acknowledged that they either needed to maintain some distance from their colleagues for their self-care, or they confessed that, inevitably, due to the nature of humanitarian work, one may come (to quote P1) “too close, too quickly” to “wrong” or “toxic” people. In this respect, for example, P7 admitted that it has been very important to her to have her own space.

Social interactions could also be harmful for one’s wellbeing and not always a positive social support (Cohen, 2004, as cited in Maercker et al., 2015, p. 9; Hagihara et al., 2003; Lakey et al., 1994; Lincoln, 2000; Palant & Himmel, 2019), although this aspect has not been extensively investigated by researchers (Lincoln, 2000). In their values research, Maercker et al. (2015, p. 15) detect “the notion of a Janus face of social support processes”.

The findings imply that family and friends function supportively for the participants provided that they, at least theoretically and ideologically, sympathise with refugees and support their rights. Based on the above theory (Lincoln, 2000), regular social interactions with family members and friends that have a negative opinion about refugees and Refugee Care could presumably have a negative impact on the helpers. From an epistemological viewpoint, I suggest that this depends on the *complexity* of each helper as a person. Some participants claimed that they do

not (want to) have contact with anyone who is not supportive of refugees, others wished that their families “would understand” their work, whereas one participant, in a more unifying attitude, stressed that humanitarians and helpers should try far more to act as the “linchpin” of the local, host communities and for refugees.

Brief Section Synopsis

Overall, in this section, I approached the findings from the viewpoint of the proposed synthesised conceptual framework and compared/contrasted these to the relevant array of literature. The next section builds more particularly upon the Jungian interpretation of certain findings. I assume that Jungian theory (with its concepts, such as Individuation and the Wounded Healer) provides a substantial, holistic, psychosocial approach so that the lived experience of humanitarian helper wellbeing can be apprehended in greater detail and depth.

7.3. Discussing the Findings in Light of Expanded Jungian Theory

7.3.1. Helper and Archetypal Influences

Archetypal influences unearthed in the results of this study can be traced in the context of the Victim Triangle (with the interactions between the positions of saviour, victim and persecutor subtly nodding to the aspect of Shadow) and in relation to the Wounded Healer. Both concepts were previously reviewed in Chapter 2.

It could be claimed that, on some occasions reported by the participants, the activated cluster of archetypes that influenced them in an intrapsychic way and their interaction with the beneficiary was, for instance, saviour/victim and persecutor, as foreseen by the Victim Triangle. On a different occasion, the cluster of activated archetypes could be defined, for example, as the “Wounded Healer” and “Inner Healer” for the helper and the client, respectively.

In this regard, I would like to discuss in more detail both these archetypal states (the Wounded Healer and the Victim or Drama Triangle) that seem to be of relevance for the work with refugees and, additionally, are corroborated by the findings of this study, by referring to some examples.

7.3.1.a. From the "Wounded Healer" to the "Wounded Humanitarian/Helper". The idea of the Wounded Healer has already been presented not only as a Jungian archetype in Chapter 2 but also briefly under stressors in Chapter 4. I should highlight afresh that not all participants are psychotherapists of refugees, but all of them engage in Refugee Care and in the *therapeutic care of refugees* (as explained in Chapter 2). Reflecting on the findings of the study, which included, *inter alia*, overwork, overidentification with clients, altruistic motivations, challenges in helpers' self-care, and vicarious trauma, I admit that aspects of the Wounded Healer could potentially have a negative effect on humanitarian helper wellbeing. The identification of the helper with the "healer" (or, alternatively, "helper") pole of the archetype due to lack of self-reflection, self-care, supervision, etc., may lead to a problematic over-involvement (Pross, 2006) with lack of awareness of limitations and boundaries. Subsequently, I assume that this could result in CF or burnout. Additionally, based on the above-mentioned findings, I concur, overall, that the identification with the "wounded" pole may augment the pathologising of normal human reactions of the helpers (i.e., observing them solely through the prism of PTSD and/or secondary trauma) and enhance the predominant narrative of the vulnerable-to-trauma humanitarian (Pupavac, 2004).

On the other hand, provided that self-awareness, self-care and social or psychosocial support for the humanitarian are maintained, the Wounded Healer as an archetype could carry with it some valuable potential for positive development for both client and helper (Gaist, 2010). For example, considering the sample of

participants, P4 and P7 were able to clearly identify their enrichment, growth, new strengths and empathy in relation to the adverse work with refugees, but they also highlighted the importance of inner distance from the clients and their narratives. Both reported having felt being on the brink of burnout, which implies "woundedness". This could be interpreted as a hint for the archetypal pattern of Wounded Healer.

In summary, even if the idea of the Wounded Healer primarily refers to mental health professionals who work with patients (psychotherapists, psychoanalysts, psychiatrists), reflecting on the above, I contend that this concept could be expanded also to other helping professions, such as helpers of refugees in humanitarian settings and human services: First, not all refugees (but probably a subset of them) suffer from a psychiatric pathology (Chondrou, 2019; Papadopoulos, 2002); also, the ones without mental health problems usually require a certain amount of psychosocial support. Second, even though some of the participants in this study happen to be both mental health professionals and humanitarians that work with refugees clinically, not all participants work as or are trained as mental health experts in order to support their clients. Nevertheless, even if not all helpers are psychotherapists and even if not all their clients are "clinical patients", a therapeutic approach that enables the synergic work with involuntarily dislocated persons is required in Refugee Care regardless of role and profession.

Therefore, being therapeutic in encounters and work with refugees, even without a background in mental health, could arguably mean one's confrontation with aspects of the Wounded Healer archetype. As an archetype, it is expected to have a universal influence regardless of the concrete setting (Papadopoulos, 2020d). Furthermore, the term "Wounded Healer" has been used in relation to helping professions other than psychotherapists, such as social workers (Golightley &

Holloway, 2017), psychiatric nurses (MacCulloch & Shattell, 2017) and priests or spiritual directors (Gaist, 2010); so I cogitate that it could apply to humanitarian helpers as well.

7.3.1.b. Helper, Victim Triangle and Shadow. I contend that there were visible facets of the archetypal pattern of the Victim Triangle (with the associated polarisation and overwhelmingness) in the findings. In their work in the therapeutic (not necessarily clinical, as previously mentioned) care of refugees, the participants diachronically may have found themselves not only in the position of the rescuer or saviour within the Victim Triangle, but, depending on the context as well as the relationship to the client, also in the position of the victim or, even, the persecutor or perpetrator. The following reported states are exemplary of the three-dimensionality of the Victim Triangle:

- Helpers may have feelings of guilt if they cannot do what is expected by the clients and their personal and professional ethics; in this situation, it is possible that they, to some extent, feel they are in the position of the perpetrator. To illustrate an example, P3 gave an indication of such a situation. She referred to her personal (and her colleagues') feelings of guilt toward the refugees they work with. In this very particular context, it is possible that the refugees/"victims" partly view their helpers, including P3 herself, as "persecutors" or "perpetrators", because, for example, in their opinion, the helpers do not want to help them according to their needs and expectations (and, therefore, they may equate them with the State/"persecutor"). P3 and her colleagues may have sensed this disappointment or disapproval coming from their beneficiaries and reacted with the described feelings of guilt.

- In another example, the helper may also feel themselves being in the position of the victim due to unrealistic expectations, the pressure or even the demanding behaviour of the client. This was hinted by P2, who mentioned sometimes feeling irritated by what he described as the excessive or unrealistic expectations of some refugees. In this particular situation, it could be assumed that in his perception, P2 had the role of the “victim”, who is overwhelmed by the exaggerated expectations/wishes of the refugee/client, who here would “incarnate” the “persecutor” of P2.
- Further, P4 admitted that some of her colleagues “over-identified” with the narratives of their clients and, therefore, were distressed, and, at another point, she reported periodical “feelings of hatred” towards the political establishment and parts of society because of the way they treat and view asylum seekers. It could be assumed that, in the former case, P4’s colleagues were in the position of the “victim” in this specific situation, while, in the latter case, some degree of polarisation is revealed (P4, as “saviour” in alliance with her clients/“victims” against parts of the IMI as “persecutor”, all this in a profoundly polarised environment).
- Meanwhile, P8 emphasised the fact that refugees are human beings and that, like any human being, some of them may cause problems. In addition to this, he stressed that humanitarians should listen more to host communities about the problems and conflicts that they have with refugees and invest more time and effort in explaining the overall situation to them. I trust that P8’s position and reflection could have an

"antidote" effect in case of polarisation, considering the powerful interactions within the Victim Triangle.

- Furthermore, it should not be precluded that all three positions of the Victim Triangle can co-exist synchronically in the same helper, depending on each relation and occasion. I by no means imply that the dynamics within the Victim Triangle presuppose a psychopathology, but rather constitute a natural phenomenon in Refugee Care. Of course, from a depth-psychological viewpoint, the material *projected* from the client onto the helper and vice versa is crucial for the positioning in these three archetypically "loaded" roles (victim, perpetrator, saviour).

Reflecting on the above-mentioned examples, it could be asserted that awareness of the three-dimensional dynamic of the archetypal pattern of the Victim Triangle could offer protection from the detrimental effects of an *archetypal unipolarity* (Papadopoulos, 2006, 2009). One such detrimental relationship would be a helper lured by the unipolar archetype of the "omnipotent" saviour that pathologises and victimises those s/he wants to help and a beneficiary possessed and paralysed by the unipolarity of the "victim" archetype, which translates into polymorphous helplessness and adaptation of a victim identity (as previously seen in Chapter 2). In a highly polarised environment and ignoring the complexities, then saviour and victim feel threatened by the unipolar, archetypal persecutor (e.g., the state) and form an alliance against this at the expense of the therapeutic and synergic relationship. In this respect, realisation of the pattern of the Victim Triangle could be helpful for recognising the archetypal bipolarity dominating a situation like the above.

Drawing on the context of the Victim Triangle and its validation through the findings, I postulate that the relevance of the Shadow as a factor that has a role to play in shaping the interactions between the actors of the Triangle cannot be counted

out. However, this should not be perceived as me advocating counselling or psychoanalysis for all helpers who work with refugees in order for them to become more aware of their personal Shadow, as this is not realistic and not necessary. As the findings showed, improved personal self-reflection and self-awareness that could be acquired or corroborated through supportive measures (such as supervision, support groups, workshops, peer support or, for instance, through sufficient self-care, spirituality, more in-depth discussions with one's own family members and social circle) could help them better grasp their own *complexity*. The Shadow could be seen as part of one's personal complexity and inner world if one is reminded of the "working definitions" of it (as described in Chapter 2). Finally, from a more collective and intrapersonal perspective, I realise that interactions within the Victim Triangle can also be affected by the wider IMI that entails the reciprocal influences of many actors that somehow, directly, or indirectly, have a role in Refugee Care and humanitarian aid, as revealed in Subsection 6.2.3. Reflecting on this, it would probably be an oversimplification to reduce all hinted negative emotions in the interactions between helper and client, such as animosity, solely to the personal Shadow aspects of the helper and the client, respectively.

7.3.2. Helper, Individuation and (Eudemonic) Wellbeing

Judging from the relevant theory in Chapter 2, it could be postulated that individuation, as a concept, delves deep into the human existence and ontology of the individual and that the question of individuation goes substantially beyond health, illness or, even, diverse conceptualisations of wellbeing. I admit that AAD, which was extensively discussed in this thesis, as a concept of transformation, renewal, enrichment and purpose reflects this prospective side of the Jungian individuation process. Aspects of teleology and "finality" have been central for this study, since they are echoed by the AAD of the participants, which was identified among the study

results and can be considered part of the humanitarian helper's individuation process. Considering AAD and VR of the participants (as subthemes in Chapter 6), it can be claimed that there is purpose, goal, growth, or transformation through the challenges, adversities and human pain (which may or may not include psychological symptoms in a clinical sense) that the helper experiences.

Among the findings of this thesis in Chapter 6, AAD emerged as a prime component (i.e., subtheme) of eudemonic wellbeing (main theme). Comparing eudemonic wellbeing to individuation and without overlooking certain differences between them (as outlined in Chapter 3), I suggest that the former, with its holistic approach and the aspects of self-fulfilment, personal development and meaning making, could essentially be viewed as an integral part of the individuation process. In the main, the conceptualisation of helper wellbeing in Section 7.1 can be considered a tapestry of existing wellbeing and psychosocial (in a wider context) theories and elements from innovative Refugee Care concepts and Jungian thought on individuation and wellbeing (as defined in Chapter 2).

As reported in Chapter 6, I used a questionnaire for semi-structured interviews and the AG for the collection of raw data that, naturally, cannot fully capture the complexity and totality of the participants' individuation process. I admit that this would have been practically impossible within the research design of this study. In addition, as I stated in the introduction, devising a conceptualisation of "Jungian wellbeing" was not my goal.

However, the proposed conceptual framework could ideally form a link between wellbeing of the humanitarian helper and the idea of individuation. In the more concrete context of Refugee Care and humanitarian work, a concept of wellbeing tailored to the psychosocial reality and needs of helpers and corroborated by Jungian theory on individuation could ostensibly be practical, applicable, and

comprehensive for humanitarian organisations and humanitarian helpers. After all, I can agree that viewing one's personal "life journey" as an archetypal Hero's journey in the sense of Jungian individuation enhances meaning in life (Rogers et al., 2023) and this applies also for one's "humanitarian journey", considering the participants of this study.

Chapter Synopsis and Thesis Progression

First, in this chapter, I delineated the main conceptual framework of this study with its integral parts; guided by this conceptual approach and based on the results of the previous chapter, I set out a new conceptualisation of humanitarian helper wellbeing.

Second, the main findings of this thesis were discussed from the perspective of the conceptual framework and compared to the reviewed literature of the first chapters. Emphasis was placed on the diversity and complexity of the helpers' reactions to adversities as captured by the AG framework, but further aspects emerged from the results, such as occupational/organisational, group relational, motivational and political, were scrutinised.

Third, this chapter showed that Jungian psychology is appropriate and useful for approaching and grasping a complex psychosocial topic such as humanitarian helper wellbeing. I proposed how the archetypal motif of the Wounded Healer could be adjusted to the humanitarian world (as "Wounded Helper"). Based on the findings, I explained how the connection of the Victim Triangle (even if not originally a Jungian concept) with the archetypal networks and the helper's Shadow might affect the psychosocial reality of the helpers in their work with refugees. Finally, I underscored the relation of helper's AAD and eudemonic wellbeing (as two overarching aspects of the study findings) to Jungian individuation.

The aim of the next and final chapter of this thesis, Chapter 8, is to extract useful and applicable conclusions from the key discussion points of this chapter.

Chapter 8: Conclusions, Contributions, and Reflections

Following the generation of themes and subthemes in Chapter 6 and the discussion of those findings in the previous chapter, in the last chapter of this thesis I endeavour to answer the main research question posed. Moreover, driven by the conceptual framework of this study, I will present and explain the main conclusions of this thesis. Additionally, practicable solutions/recommendations, mainly designated for organisational policies, but also informative for the individual humanitarian helper, are laid out. Lastly, in this chapter I expound on the limitations of this research project as well as on suggestions for further research, and conclude with a sample of my personal reflections during the course of this study.

8.1. Answering the Research Question

Based on the rigorous investigation and discussion of the findings, the core research question is answered.

Question: (a) Do humanitarian helpers show a wide range of responses (i.e., not only negative) as a result of the adversities they face in their direct work with refugees; and (b) if yes, does the AG enable the researcher to gather this wide range of changes and consequences of adversities, i.e., negative, positive and resilient reactions?

Answer: (a) The predominant approach seems to follow the medical paradigm, i.e., it focuses on pathology or symptomatology and does not fully succeed to understand the wider range of responses and consequences in the aftermath of exposure to adversities**.** Participants were able to improve this predominant approach because of their exposure to the framework of AG, i.e., over the three successive contacts with me they were able to also identify several retained strengths (i.e., resilience) and numerous new strengths (i.e., AAD). In summary, this study proves that humanitarian helpers experience and understand the reactions and changes due

to adversity in a variety of different ways and, clearly, not only from within a medical perspective. Moreover, the participants' understanding and experience of wellbeing has been shaped over time, and it needs to be understood dynamically, not statically.

(b) On the whole, this research ascertained that the AG most emphatically does, indeed, provide a very useful and accurate framework for the identification of the wide range of humanitarian helpers' responses to adversity. It also enhances the helpers' ability of not being confined to the predominant medical paradigm of seeing only the negative effects of adversity, as they were able to view their lived experience more holistically.

Relying upon the empirical research and the interpretation of the findings, the two core hypotheses of the thesis that (a) the reactions/changes for humanitarian helpers because of adversities are not always negative and pathologic; and (b) the framework of the AG enables a broader psychosocial comprehension of helper wellbeing, and helpers' lived experience can be accepted. Based on the above, the main aim of this project, i.e., that the voices of humanitarian helpers working in Refugee Care are sufficiently and comprehensively heard, was met. A further, main objective of this project, to synthesise an innovative, psychosocial, conceptual framework on humanitarian helper wellbeing beyond the medical scope, was also fulfilled (see Chapter 7).

8.2. General Conclusions

Following the above answer to the research question, I will now proceed to the main conclusions of this study. These are grouped according to the subject they cover.

Reactions and Consequences because of Adversities (for the Humanitarian Helper)

There are a wide range of responses to the (vicarious) exposure of staff to adversities because of their work with refugees, which are not exclusively negative. More specifically, there are a lot of gains, and enrichment (AAD) as a result of the adverse work with refugees. Furthermore, negative, distressful reactions do not necessarily constitute a pathological condition. Negative, distressful reactions do not necessarily constitute vicarious trauma due to exposure to the refugees' narratives but may have other main causes, such as organisational. Chondrou (2019, p. 323), in her doctoral thesis at CTAR, stresses that "we should make room for the emergence of resilience and AAD in our conceptualisation of refugeedom as well as in our theories and interventions". In this study, I conclude that this also applies for helpers (and their organisations). Like refugees, their helpers are exposed to adversities, and they can suffer, but they also experience resilience and growth as a result of the exposure to these painful events and according to their complexity, uniqueness and totality as individual persons. Refugee resilience and refugee AAD despite, and due to, respectively, the catastrophic events they have experienced also entail transformative potentialities for helpers themselves, an expression of which is VR.

Burnout, Vicarious (or Secondary) Trauma

In this project, I consider burnout and vicarious trauma a possible clinical method to evaluate helpers' reactions to adversities. However, as this study showed, they do not offer full comprehension and description of the changes and consequences for the helper in the aftermath of adversities. Based on the broader psychosocial conceptual approach of this project, I introduce an alternative, innovative, compendious way to investigate these phenomena. Here, I need to underline that in this project, I most certainly do not disdain the predominant clinical approach but call for its expansion in order to capture "the whole picture". On some

occasions, symptoms of burnout and vicarious trauma in the participants of this study cannot be ruled out.

Humanitarian Helper Wellbeing

Wellbeing of helpers of refugees does not only describe a positive mental health state as seen from a clinical perspective, but it is a multifaceted concept that includes organisational/occupational, group relational, psychosocial (intrapsychic, interpersonal, socio-political), motivational, physical, ontological, value-based, individual, as well collective dimensions. Wellbeing is connected to each person's complexity and is based on the individual perception and lived experience of adversity, resilience and AAD. A broader psychosocial approach, as described in Chapter 7, seems to be most appropriate for capturing the various dimensions of humanitarian helper wellbeing.

A Psychosocial View on Wider Workplace and Organisational Aspects

Organisational problems are evidently sources of helper stress and may constitute negative consequences of the work with refugees. On several occasions, stress due to exposure to detrimental organisational issues outshines stress due to exposure to the adverse narratives of the clients/refugees. POS within a "generally supportive environment" (Aldamman et al., 2019; Brooks et al., 2015; Curling & Simmons, 2010; DePaul & Bikos, 2015) and a "pro-support organisation" (Hartley & Kennard, 2019) are very relevant for the workplace wellbeing of the humanitarian helper. Furthermore, issues of institutional and group dynamics should be addressed, e.g., within staff support or/and reflective groups (Kennard & Hartley, 2019) and awareness among staff members about these aspects should be appropriately raised by the organisations. Individual counselling, for example on trauma or burnout, can be helpful on a personal level, but, in effect, it is not a suitable solution for problems of wider group dynamics and for detrimental organisational dimensions.

Adversity Grid

AG proved to be a valuable epistemological tool for both the conceptual and empirical approaches of this project. The AG enabled the investigation of helper wellbeing on different psychosocial levels as well as on an organisational level. It encompassed not only pathological or negative changes, reactions and consequences, but also drastically helped the participants identify resilient elements and positive developments in the aftermath of adversities, thus revealing its therapeutic (in a non-clinical context) dimension. This said, the AG, when regularly completed/applied, can be viewed as a means of self-care for the helper. This study effectively expanded the application of the AG from the refugee to their helper.

Victim Triangle

Even when distress emerges due to direct exposure to refugees and the adverse conditions they face, it is not necessarily a “contagion of trauma” but it could be regarded as a reaction within the Victim Triangle. This study evidenced the relevance of the constellation of the Victim Triangle in regular Refugee Care settings. Moreover, interactions in the Victim Triangle can be stressful for the helper, especially when the political environment is experienced as the persecutor within the Victim Triangle. The depoliticisation of humanitarianism and Refugee Care seems to fuel this stress. This study emphasises that helpers’ (and the organisational) awareness of the Victim Triangle (as an inevitable phenomenon) in Refugee Care is required for self-care in Refugee Care.

Elements of Jungian Theory

This thesis proved that Jung’s concepts and his epistemological lens are appropriate and useful for approaching a complex psychosocial topic such as humanitarian helper wellbeing. More specifically, expanded Jungian theory (with concepts such as Individuation and Wounded Healer) contributes to a more holistic

psychosocial framework for understanding the lived experience of humanitarian helper wellbeing in greater depth. Awareness of Wounded Healer aspects could boost helpers' self-care and policies and measures; individual helpers informed by the notion of individuation may emphasise meaningfulness, growth, as well as positive renewal despite adversities and calamities. Ultimately, Samuels' (2014, p. 101) vision that Jungian psychology "could become a source of support and inspiration to embattled citizens whose experience of their battles is often that they are in it on their own" resonates with my view. In my opinion, these "embattled citizens" can often be helpers of refugees, humanitarians and activists.

Motivational and Political Dimension

Humanitarian helpers are driven by an amalgam of primarily selfless/altruistic and secondarily self-centred motivations. A central altruistic motivation is political ideology/beliefs. A further chief motivation is cosmopolitanism, as shown by this study, which underlines that when political beliefs and values are not appropriately respected and fulfilled within a humanitarian/Refugee Care context, this can prompt stress/dissatisfaction or even distress for the helper. This demonstrates that the political dimension is a substantial factor in humanitarian helper wellbeing. Helper stress or distress linked to political aetiology should not be invariably and indiscriminately medicalised/pathologised. To deal with these cases, appropriate measures that acknowledge the collective and political nature of stress should be carefully planned and implemented.

Eudemonia

Eudemonia (in virtue ethics of Greek philosophy) and eudemonic wellbeing (the equivalent in modern psychological research) can be characterised as key concepts in approaching the wellbeing and the diachronic experience of helpers of refugees, as manifested in this thesis. The concept of eudemonia is

compatible/comparable to Jungian individuation as well as to the framework of AAD. A eudemonic view of a humanitarian's life and wellbeing is a fitting approach to a deeper understanding of the complex psychosocial experiences and the meaning and purpose that arise from them. Even if not identical to the process of individuation, I highlighted that helpers' eudemonia, especially when enriched with another Aristotelian notion, entelechy, could be viewed as an integral part of their life-long, psychosocial (including intrapsychic layers) process of individuation. Nonetheless, when compared to the considerably complex concept of individuation, eudemonic wellbeing can be easier to capture (or even to assess) and therefore it serves the research purposes of studies like the present one.

Thematic Analysis

I conclude that TA proved to be a robust methodological approach for analysing the gathered qualitative data. As this research thesis evinced, in assisting a combined theory-driven and data-driven path, TA brought about themes that represent hidden core meanings of helpers' psychosocial experience in relation to their work and to their endured adversities. This thesis confirms the validity of TA as one of the dominant approaches in psychosocial research data analysis.

Generalisability of the Results

As disclosed in Chapter 6, the results of this study are not statistically significant since this project, as qualitative research, lacks nomic/universal generalisability. Nonetheless, considering the attained *transferability* of the results, as explained in Chapter 6, I should point out that they can be indicative for a large population of helpers (Drisko, 2025; Nikolopoulou, 2023). Subsequently, the psychosocial proposal on wellbeing in Chapter 7, the conclusions drawn in the present section and the recommendations in the following section can provide inferences about humanitarian organisations and helpers, in general. Lastly, one

should not overlook the fact that the discussion on the generalisability of qualitative findings seems to employ a vast body of literature (e.g., Agius, 2018; Carminati, 2018; Delmar, 2010; Hallberg, 2013; Leung, 2015; Nikolopoulou, 2023).

Argumentative Thread

Finally, in order to underscore the clarity and coherence of this thesis and the robustness of its conclusions, I would like to present a sample of the pursued *argumentative thread* that displays the interconnectedness between results, their discussion/interpretation and the general conclusions in Table 8.1 (below). Overall, in this thesis I managed to sufficiently explain the emerged findings and I suggest that each finding (to varying extents) contributed to the final conclusions, and subsequently, to the recommendations laid out in the next section.

Table 8.1

Sample of Argumentative Thread

Findings ⟶	**Discussion** ⟶	**Conclusions**
6.2.3.a. Reflections on Stress and Burnout due to Organisational, Workplace-Related and Financial Factors (subtheme)	**7.2.1**. Detrimental Organisational and Workplace Dimensions AND **7.2.2.** Organisational and Team Dynamics	A Psychosocial View on Wider Workplace and Organisational Aspects
6.2.3.b. Helper Stress and Dissatisfaction in Working Directly with Refugees (subtheme)	**7.3.1.b.** Helper, Victim Triangle and Shadow	Victim Triangle
6.2.3.d. Negative Influence due to Political Aspects and the Interactional Matrix of Humanitarian Intervention (IMI) (subtheme)	**7.2.7.** Helper Wellbeing and the Political	Motivational and Political Dimension
6.2.4.c. Therapeutic and Psychosocial Interventions for Helpers (subtheme)	**7.2.2.** Organisational and Team Dynamics **7.2.7.** Helper Wellbeing and the Political **7.3.1.a.** From the "Wounded Healer" to the "Wounded Humanitarian-Helper" **7.3.1.b.** Helper, Victim Triangle and Shadow	Burnout, Vicarious (or Secondary) Trauma AND A Psychosocial View on Wider Workplace and Organisational Aspects
7.2.5.a. Diverse Perceptions of Wellbeing (subtheme)	**7.1.1.** Participants' and Researchers' Views of Wellbeing AND **7.1.2**. Helper Wellbeing: A Psychosocial Conceptual Approach	Humanitarian Helper Wellbeing AND Eudemonia
6.2.5.e. Experience of Cosmopolitanism (subtheme)	**7.2.3.** Motivations for Refugee Care AND **7.2.7.** Helper Wellbeing and the Political	Motivational and Political Dimension

Note. This table exhibits the argumentative thread followed in this research that resulted in the key, general conclusions of this study. The thread signifies the logical flow between the generated empirical findings, their interpretative discussion according to the proposed conceptual framework and the final conclusions extracted from this discussion. As manifested here, each finding does not necessarily correspond to a sole discussion point/section and might have contributed to more than one main conclusions of the study. Essentially, due to the theoretical and empirical approach of this study, all stages of the argumentative thread (results, discussion, conclusions) resonate, to a certain degree, with the different psychosocial levels and categories of the AG.

8.3. Recommendations for Organisations

Based on the findings, the discussion around the findings, and the conclusions of this thesis, I will finally present practical recommendations for organisational policies:

- Within organisations, an increased awareness of VR and AAD for staff should be acquired through appropriate informative measures.
- Stigmatisation or neglect of mental health disorders as well as pathologising of stress and normal human suffering (which includes exaggerated use of psychiatric terms in an oversimplistic way) should be avoided; increased awareness among managers and staff is therefore needed.
- External psychotherapy could helpfully be provided when and if indicated; the external psychotherapist should ideally have knowledge of humanitarian and Refugee Care issues.
- Organisations should monitor the workload of staff and volunteers (not only the number but also the complexity of client cases).
- Organisations could introduce the AG tool for the strengthening of their staff's self-monitoring and wellbeing due to its beneficial effect. Staff and volunteers should consecutively complete it, and they should not only reflect on the negative changes, but also place emphasis on their old retained and new strengths.

- If possible/applicable, organisations could initiate qualitative research projects to evaluate their staff's/volunteers' wellbeing by combining the framework of the AG with TA as a data analysis method.
- Organisations should make an emphasis on the right balance between two extremes: (a) overidentification with refugees and (b) detachment from them. Staff and volunteers should be made aware of these aspects and, in addition, should be trained in refugee and intercultural issues.
- Social support provided by colleagues as well as by family and friends is a very important protection and wellbeing factor and should be appropriately fostered by organisations. Nevertheless, organisations and staff should be aware of the value of personal time and space and of the fact that social interactions are not always positive and supportive.
- Managers should have some knowledge of organisational dynamics and, correspondingly, be able to reflect on these aspects.
- Open staff support groups for more self- and team awareness without a concise clinical focus should be provided by organisations. On a more individual level, helpers could perhaps benefit from non-pathologising, supportive interventions, such as VBC and PM+ (see Chapter 5).
- More focus could be placed on collective interventions: Groups for reflective case supervision, group meetings, forms of common action (such as a related theatrical play), political clinics and workshops (Samuels, 2016) could raise awareness of political aspects and protect staff, without pathologising their stress or distress, from negative political influence**.**
- More attention should be directed to the cases and issues of humanitarian women who are pregnant or mothers of infants.

Needless to say, these recommendations are general, and it is possible that some organisations already follow them fully or partially.

8.4. Contributions

The major contribution of this study is that it provides new data/empirical insights into the wellbeing and lived experience of those engaged in Refugee Care, based on the epistemological framework of the AG, with its epistemological openness, agility and epistemological scrutiny (Papadopoulos, 2007, 2021). An additional exclusive contribution of this project is the conceptual one, i.e., the fact that it does not only rely upon its defined theoretical backbone but also draws on other relevant theories, such as organisational theories, institutional dynamics and virtue ethics in order to construct an innovative conceptual framework on humanitarian helper wellbeing. A further contribution to be emphasised is that in this project I employ expanded Jungian theory for the better understanding of some generated themes.

Undoubtedly, in the aftermath of calamities, some humanitarian helpers who experience pathologies and symptoms would need professional support through psychiatry, psychotherapy, or counselling. But this study shows that the predominant, clinical/medical approach, which also applies for helper trauma and helper burnout, should probably be revised and expanded. The main contribution of the proposed broader psychosocial approach is that it does not exclusively follow a strict clinical or deficit-oriented model but also emphasises the resilient features and positive elements in the aftermath of exposure to adversities. Also, during the empirical phase, with the instrumental contribution of the AG, I tried to identify AAD and resilient parts of the helpers through the sessions/contacts with them and not focus only on the negative points and pathologic reactions.

To name a further contribution, this study also demonstrates that a qualitative data analysis method such as TA can be effectively combined with a subsequent Jungian “reading” of its results. TA, as my selected method of data analysis, unearthed implicit patterns in humanitarian helper wellbeing and thus facilitated the generation of coherent and comprehensive themes that represent core concepts. Although I come from a Jungian background, I consciously avoided any Jungian or psychodynamic interpretation during the process of data collection and TA, including coding, even latent codes. Therefore, codes and themes have not been direct results of my Jungian analytical “thinking”. Conversely, my intention was to approach certain findings through a Jungian lens. Further, I tried to apply expanded Jungian theory so that the humanitarians’ voices can be better heard and better comprehended.

Last but not least, as described in the previous section, this study provides practical recommendations for organisations that are involved in the field of Refugee Care. Inevitably, these may present similarities to previous attempts but are exclusively embedded in the essence of this research study.

8.5. Limitations and Suggestions for Future Research

A main limitation of this study is that the sample, although diverse, is small, which means that there are inevitably voices in Refugee Care that cannot be heard. As previously mentioned in the conclusions, due to the sample and time constraints, the results cannot be statistically generalised to the entire population of humanitarian helpers. Moreover, the diversity of the sample could be perceived by some readers as a disadvantage, since there was no focus on a concise group of helpers (for example, psychotherapists that work with refugees or humanitarians who only work in the field).

Furthermore, even if each participant completed the AG form twice, the interval between each completion was no longer than 6 months, due to time

limitations. Had this interval been longer, I presume that the second completion of the AG would have demonstrated more changes and additions (and, therefore, more raw data) in relation to the participants' first AG.

Additionally, during the interviews, I tried to maintain an empathic, respectful and attentive stance while listening to the participants. However, I was also very careful to avoid slipping gradually into the role of psychotherapist, which might have had a restricting effect on the size and range of raw data, as participants would have possibly opened up to me even more.

Another limitation is that this study could not sufficiently address the differences regarding the wellbeing of volunteers and paid staff in Refugee Care. Since this is not a clinical or deficit-oriented study, the results do not effectively differentiate between burnout, STS, CF and VT. Furthermore, due to the size of the sample, demographic factors, such as gender, nationality, cultural background, religion, age, marital status, task in the organisation, etc., have not played a significant role for the data analysis and the generation of findings.

A further limitation that should be examined in its own right is my background as researcher. I am a clinician that has some experience in working clinically with involuntarily dislocated persons at the Red Cross. My professional background is not, for example, organisational psychology or organisational dynamics. Due to the epistemological openness of this study, the data echoed aspects from various fields that might have been analysed and discussed in a different way if my professional or academic background had been a different one, even if implementation of this study has undoubtedly led to an enrichment of my knowledge and an expansion of my epistemologies. Furthermore, mostly due to the thesis word limit, several aspects/theories of the developed conceptual framework are not covered as

substantially as I would have wished to; nevertheless, the points most relevant to the essence of the thesis were discussed.

For the data analysis, I chose to use the method of TA, although I am not an experienced academic researcher, and I have not “mastered” qualitative methodology. With hindsight, it is not clear to me whether I could perhaps have used content analysis (CA) instead of TA. It is also possible that to some extent I have conducted CA (without being fully aware of this), since there is an overlap between TA and CA; CA is more objective and more descriptive than TA and focuses on surface meaning, while TA looks at the latent content and finds core concepts, i.e., themes (Vaismoradi et al., 2013). CA would also have been appropriate for my study and for my experience level as researcher, and it might have led to more categories and subcategories than the number of themes and subthemes generated through TA.

Recommendations or suggestions for future research can be summarised as follows:

Future researchers should examine the wellbeing of concise groups of helpers (such as psychotherapists, psychoanalysts, physicians, priests, human rights officers, experts for GBV, etc.) of refugees using the epistemological framework of the AG. In addition to this, differences in the wellbeing between various groups of helpers or between volunteers and paid staff, and while paying attention to demographic factors, could also be explored. CA, possibly in combination with Narrative Analysis (e.g., Edwards, 2015; Polkinghorne, 1988), could also be used for data analysis instead of TA, depending on the researcher and the purpose and design of the research.

Even if AG is admittedly not a clinical tool, randomised clinical trials could be used to examine its therapeutic effect on humanitarians, in which, for example, a

group would receive *Care-As-Usual* (CAU)[1] and would self-monitor their changes and reactions by completing the AG successively for a certain period of time, while a control group would receive only CAU without the AG.

In addition to the suggestions considering the utility and implementation of the AG, future researchers should also investigate the factors that shape MAPs. Further, more focus should be drawn to the organisational and team dynamics of humanitarian organisations, as these aspects seem to drastically influence staff wellbeing. An interesting research project could also be the focused, in-depth examination of helpers' rituals in relation to their work. One could even think of performing qualitative research with close family members of humanitarian helpers.

Another suggestion for further research is the investigation of helper wellbeing by researchers from a different professional and academic background than mine (not necessarily clinicians), such as political scientists, theologians, and anthropologists, since the majority of wellbeing research is conducted by clinicians or organisational psychologists.

Finally, in future, Jungian concepts (such as individuation) could be integrated by academics with Jungian background into modern wellbeing research, even though the question on the "manualisation" of Jungian psychology currently remains an open and controversial topic (Meier, 2021). In qualitative research, data analysis (such as TA) can be efficiently followed by expanded Jungian theory when looking at the findings. From a Jungian perspective, one could think of potentially incorporating material from the helper, such as dreams, imagination, sand play and pictures, into eudemonic wellbeing research. For instance, one could look at Carpani's (2023) doctoral thesis, which presented an analysis and a sequence of dreams to support

[1] CAU is a generic term mostly used in psychotherapy research as control condition that refers to a wide continuum of therapeutic measures, from self-care (no treatment at all) up to highly specialised psychiatric or psychotherapeutic treatment (e.g., Cuijpers et al., 2019).

his proposed Jungian psychosocial model; similarly, one could examine dreams to investigate humanitarian helper wellbeing and individuation. Lastly, conceptual and/or empirical research work could be conducted with specific focus on the impact of the Wounded Healer dimension on humanitarian work.

8.6. Author's Reflections (Instead of Epilogue)

At this point, instead of an epilogue, I would like to share my most important, personal reflections (in no particular order) from my self-reflexive journal between January 2022 (the beginning of raw data collection with the first interviews) and summer 2023 (the discussion and interpretation of the findings).

The reflections are written in *italics*. Following each reflection, I add a brief explanation or comment.

- *"English is not the participant's mother tongue – and neither is it mine, of course."* How could language have affected the data collection through the interviews? Have the non-native speakers always been able to accurately describe, for instance, an emotion very concisely during the interviews? Nevertheless, every participant of the study who is not a native speaker is able to work and communicate in English.
- *"A participant arrived late for the scheduled interview. He was in a hurry but insisted on going ahead with the complete interview and not continue this on another day. He answered all questions, but rather briefly…"; "Another participant is again under time pressure and must leave in 50 minutes; I managed to ask all questions; however, would it have been different for the raw data if we had more time?"; "Completing the AG took some participants 15 to 30 minutes, while others needed a couple of days … how does this affect the reliability of the qualitative data?"* These three reflections are connected to the fact that participants are generally very busy as clinicians, humanitarians in

the field, etc. So, this is the reality, and I had to come to terms with it since I wished to conduct research with them. Admittedly, the fact that the participants would also complete the AG twice at their own pace and convenience made me feel more secure regarding the collection of raw data. Moreover, the interval between the two completions of the AG was 3 to 6 months and I have the feeling that were I to have had more time for my PhD thesis and the time intervals between each contact with the participants were longer, there would have been more changes (and, as a result, more data) between the two completions. And, of course, provided I had more raw data and more time for TA, this would have had an impact on the themes and, probably, the reliability of my research. But ultimately, the time offered for completion and submission of a PhD thesis is 3 years.

- *"Although a clinician, this is not my role while in contact with the participants."* Admittedly, I felt a bit confused, as two participants asked me about my clinical opinion on their situation after the interview. Listening to my inner therapeutic attitude, I carefully responded and offered some recommendations.
- *"I felt a bit worried as one participant confessed that she did not have the capacity to think of negative reactions in the Grid because of a difficult phase she was facing in her personal and professional life…*" The participant asked for more time for the completion of the AG which, of course, I granted her gladly. She did not need or wish to discuss this matter further, although I mentioned that I would be at her disposal at any given time to listen to her and discuss this. After a few weeks, she provided me with her completed AG, with no further comments.
- *"Conducting this research is a transformative experience for me"*. In this respect, I would like to quote AbiNader et al. (2023, p. 238): "In academia,

vicarious resilience may look like a researcher feeling grateful for being trusted with the stories of homicide survivors in their study". My participants are not homicide survivors (their clients, though, possibly are), but they have undeniably witnessed a lot of pain and suffering. I believe that interviewing them, interacting with them, documenting and analysing their psychosocial experience, has had some impact on me, the researcher.

- *"The enthusiasm of the participants makes me happy and motivated…"* The motivation, willingness and availability of helpers to participate in this study surely exceeded my initial expectations. To them, it has been very important that studies like this with a focus on humanitarian helper wellbeing are conducted and that their voices can be heard.
- *"Even if my sample is relatively diverse and inclusive, there are still voices that cannot be heard … how representative for those voices is my sample?"* I have also asked myself the exact opposite question to the previous one. I could have recruited more participants, which then would have led to a demographically richer sample, but I decided against this. Ultimately, one must consider the limited time available to conduct PhD research, and my supervisors were supportive of my decision.
- "*What do I want to achieve with this PhD?*" This is something that I have been asking myself from the moment I began attending the lectures in Refugee Care at the University of Essex, until the completion of my thesis… Do I want to work as a humanitarian or cooperate with NGOs for staff wellbeing? Would I like to do more academic, qualitative research and publish my work? Or do I prefer to co-create an organisation that specialises in staff wellbeing? Or could I just volunteer for a charity in parallel with my clinical professional activities?

- *"I started my research while the severity of the COVID-19 pandemic was lessening and then, during my empirical research, the Ukrainian crisis broke out, and has continued since I finished data collection, analysis and discussion of findings … To what extent have these two major catastrophes affected the findings of my research?"* I suppose that this is a reality that affects many other PhD researchers, too. Although these factors have not substantially affected my research design (most of the interviewing would have been done remotely anyway), some of the participants' answers, and, therefore, the raw data, made reference to these calamities. In this respect, it could be claimed that these are some *synchronic* aspects that influence this study.

Judging from my own experience, I can agree that journal writing is a useful tool in qualitative research (Thorp, 2010), since "reflection can be defined as the interpretation of interpretation and the launching of critical self-exploration of one's own interpretations of empirical material" (Alvesson & Skoldberg, 2000, p. 6). Through a reflexive journal, I was able to better understand my role (Janesick, 1998). Moreover, the journal helped me remember and observe how the process of qualitative data collection and analysis – including my own thinking about this – have evolved (Thorp, 2010). In conclusion, "the clarity of writing down one's thoughts, will allow for stepping into one's inner mind and reaching further into interpretations of the behaviours, beliefs, and words we write." (Janesick, 1998, p. 10).

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APPENDICES

Appendix I: Participant Information Sheet

Participant Information Sheet

DATE:

ERAMS Ref.: ETH2122-0031

My name is Christos Dimitriadis and I am a PhD researcher in the Department of Psychosocial and Psychoanalytic Studies at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

This project is a research project for my doctoral thesis. I wish to add new academic knowledge to the existing literature, and practical ideas about staff wellbeing, thus serving the interests of the staff members of humanitarian aid organisations (INGOs/NGOs), humanitarian charities and public human services. I will look at the diverse aspects of the psychosocial wellbeing of staff who support involuntary dislocated persons in various settings**.** The interviews will cover the following themes: motives/idealism, main sources of stress/distress, main sources of satisfaction, coping mechanisms (e.g., boundaries, rituals, spirituality, hobbies, counselling, etc.), symptoms related to stress at work, gains and personal growth in the context of adversity-activated development, perception of organisational policies and support regarding staff wellbeing. In addition to the theoretical elaboration, interviews with staff who work with refugees will be analysed qualitatively, utilising the Adversity Grid, a tool developed by Prof. Papadopoulos at the University of Essex.

You have been chosen as a potential participant for this research as you work directly with involuntarily dislocated people on a regular basis. The participants who will be recruited will be either members of international humanitarian or local non-profit organisations or public services workers who work directly with adversity survivors either in the field or in their workplace in the staff's country of origin.

I plan on recruiting at least five members of staff (or volunteers), who work with involuntarily dislocated people on a regular basis in various contexts and in various types of organisations. The participants will be interviewed three times each, the interval between each interview will be 3 to 6 months and the duration of each interview will be approximately 45 to 60 minutes. The interviews will be held in languages that the researcher and the participants have advanced or proficient knowledge of. The interviews for the data collection will take place online. The research will be based on strict confidentiality. The data will be collected by notes written down during the interviews, and no audio or video recording is planned. Data will be transcribed onto a password-protected computer and no identifying features such as name, address or employer will be recorded, therefore maintaining confidentiality for all participants. The method of data collection is mainly based on open-ended, in-depth semi-structured interviews. The methodology applied for the collection of data is qualitative. The analysis of the interviews will be based on a method of qualitative

data analysis. Those who will have access to the data will be myself and the University of Essex (University Information Assurance Manager).

It is up to you to decide whether or not you wish to take part in this research study. If you do decide to take part you will be asked to provide oral or written consent. You are free to withdraw at any time, without giving a reason. Withdrawal will have no impact on you.

In the unlikely eventuality of participants experiencing inappropriate distress, the interview will be stopped. In this way, I want to prevent any clinically-related reaction or harm during or due to the interviews. The interview does not constitute or include a medical/psychiatric examination.

During the second interview you will be introduced to the Adversity Grid as a tool for you to conceptualise (a) your work with clients and (b) your own reactions to your work with clients. The third interview will focus on if/how you have applied/reflected on the Adversity Grid and on possible difficulties and benefits relating to the Grid.

There is no undeclared conflict of interest (personal, academic or commercial) in the research work proposed. The results of the research may be published as a journal article, will be used for my doctoral thesis and will be kept in the University of Essex Research Repository. Any results will be anonymised and will not be identifiable. This research has been approved by the University of Essex Ethics Committee.

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project, Christos Dimitriadis, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact Prof. Renos Papadopoulos. If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press – sarahm@essex.ac.uk. Please include the ERAMS reference that can be found at the foot of this page.

Christos Dimitriadis, Doctoral researcher, Department of Psychosocial and Psychoanalytic Studies, University of Essex – cd20818@essex.ac.uk

Renos K. Papadopoulos PhD, Professor in Refugee Care, Department of Psychosocial and Psychoanalytic Studies, University of Essex – renos@essex.ac.uk

Appendix II: Informed Consent

INFORMED CONSENT FORM

(Provisional) Title Of Project: Humanitarian Staff Wellbeing and Burnout: Developing a new psychosocial framework based on Refugee Care principles

Researcher: Christos Dimitriadis, Doctoral researcher, Department of Psychosocial and Psychoanalytic Studies, University of Essex – cd20818@essex.ac.uk

I have read the attached information sheet and have been offered a copy to keep.

I have been given the opportunity to ask any further questions, and have had these questions answered to a satisfactory level.

I fully understand my right to withdraw at any point from the study and for the collected data to be destroyed.

I understand that any information gathered relating to myself will be kept confidential, secure, and not revealed to others.

I am aware that if I have any additional questions I can contact the researcher or university contact named on the information sheet.

I, as the person named below, consent to taking part in this research project.

I give consent for the data collected, and used in the final thesis project to be distributed and potentially published by the researcher, and the University Of Essex.

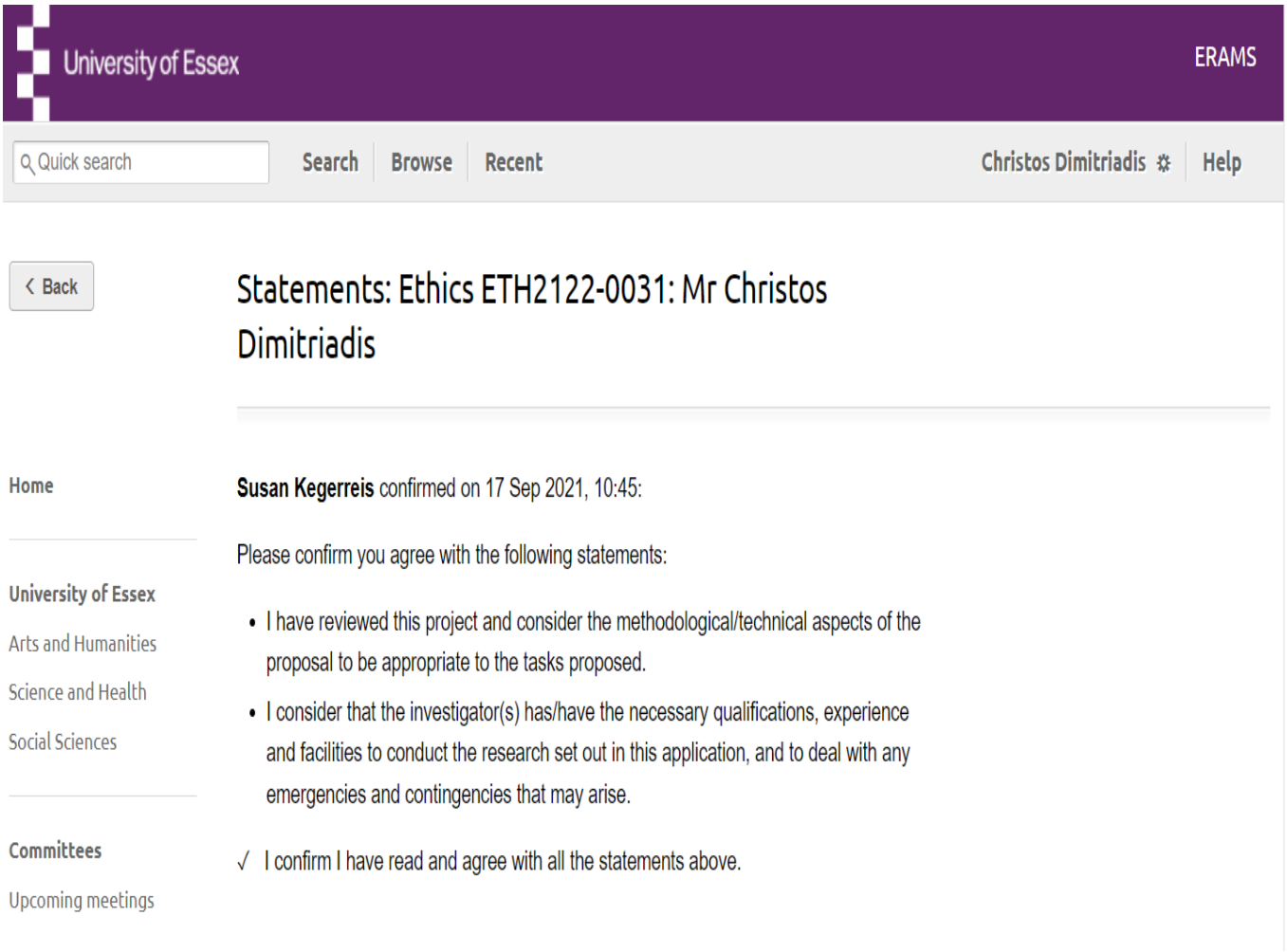
DATE:

PLACE:

NAME:

SIGNATURE:

Appendix III: Ethics Committee Approval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Upcoming meetings
Susan Kegerreis confirmed on 17 Sep 2021, 10:45:
Please confirm you agree with the following statements:
• I have reviewed this project and consider the methodological/technical aspects of the proposal to be appropriate to the tasks proposed.
• I consider that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.
✓ I confirm I have read and agree with all the statements above.

Appendix IV: Interview Questions

DATE

INTERVIEW QUESTIONS

(FOR STAFF AND VOLUNTEERS WORKING WITH INVOLUNTARILY DISLOCATED PERSONS)

Q1: BRIEF BIOGRAPHICAL PRESENTATION

Q2a: CAN YOU DESCRIBE YOUR ROLE IN YOUR ORGANISATION?
Q2b: WHAT LED YOU TO GET THIS ROLE?

Q3: HOW DO YOU FEEL ABOUT YOUR WORK?

Q4: HOW DOES WORK WITH REFUGEES AFFECT/HAS AFFECTED YOU PERSONALLY?

Q5: HOW HAS YOUR FAMILY/SPOUSE/CLOSE FRIENDS REACTED TO YOUR WORK WITH REFUGEES?

Q6: WHAT ARE – TO YOU – THE SOURCES OF SATISFACTION AT WORK?

Q7: WHAT ARE THE SOURCES OF STRESS AND/OR DISSATISFACTION AT WORK IN YOUR OPINION/EXPERIENCE?

Q8: HOW DO YOU USUALLY PROTECT YOURSELF FROM SOURCES OF DISSATISFACTION AND STRESS AT WORK?

Q9a: WHAT DO YOU UNDERSTAND BY THE TERM “WELLBEING”?
Q9b: HOW DO YOU PRESERVE YOUR WELLBEING AT WORK?

Q10: HAVE YOU SOUGHT ANY PROFESSIONAL HELP IN RELATION TO JOB-RELATED STRESS?

Q11a: HOW DOES WORK WITH REFUGEES AFFECT/HAS AFFECTED YOUR WORK COLLEAGUES?
Q11b: HOW HAS IT AFFECTED YOUR RELATIONSHIP WITH YOUR COLLEAGUES?

Q12a: TO YOUR KNOWLEDGE, DOES YOUR ORGANISATION FOLLOW GUIDELINES ON STAFF WELLBEING OR DOES IT HAVE A STAFF SUPPORT OR STAFF WELLBEING POLICY?
Q12b: DOES YOUR ORGANISATION SUPPORT YOU REGARDING WORK-RELATED STRESS?
Q12c: WHAT ELSE CAN/NEEDS TO BE DONE REGARDING STAFF SUPPORT/STAFF WELLBEING IN YOUR ORGANISATION?

Q13a: OVER THE TIME AND IN RELATION TO YOUR WORK, HAVE YOU FOUND A DIFFERENT MEANING IN LIFE?
Q13b: OVER THE TIME AND IN RELATION TO YOUR WORK, HAVE YOU EXPERIENCED ANY POSITIVE CHANGES IN YOURSELF AS A PERSON?

Appendix V: Adversity/Trauma Grid (first version)

The trauma grid

	Negative effects				
	INJURY, WOUND			*Neutral effects*	*Positive effects*
Levels	Psychiatric disorders (PD), PTSD	Distressful psychological reactions (DPR)	Ordinary human suffering (OHS)	RESILIENCE	ADVERSITY-ACTIVATED DEVELOPMENT (AAD)
Individual					
Family					
Community					
Society/culture					

(Papadopoulos, 2007, p. 309)