

PSYCHOTHERAPISTS' READINESS AND PROFESSIONAL QUALITY OF LIFE IN TREATING TRAUMATIZED REFUGEES: DETERMINANTS AND CORRELATES

A Cumulative Work on the Impact of Patient Origin,
Expected Treatment Outcome and Therapists Work Experience

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LIST OF ABBREVIATION

AYR	Accompanied Young Refugees	<i>Begleitete junge Geflüchtete</i>
CBT	Cognitive Behavioral Therapy	<i>Kognitive Verhaltenstherapie</i>
EMDR	Eye Movement Desensitization and Reprocessing	<i>Eye Movement Desensitization and Reprocessing</i>
KIDNET	Narrative Exposure Therapy for Children	<i>Narrative Expositionstherapie für Kinder</i>
NET	Narrative Exposure Therapy	<i>Narrative Expositionstherapie</i>
ProQOL	Professional Quality Of Life	<i>Professionelle Lebensqualität</i>
PTSD	Posttraumatic Stress Disorder	<i>Posttraumatische Belastungsstörung</i>
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy	<i>Traumafokussierte kognitive Verhaltenstherapie</i>
UNHCR	United Nations High Commissioner for Refugees	<i>Hoher Flüchtlingskommissar der Vereinten Nationen</i>
UYR	Unaccompanied Young Refugees	<i>Unbegleitete junge Geflüchtete</i>

Note. The German term for the abbreviation is written in *italics*.

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PART 1

MENTAL HEALTHCARE FOR REFUGEES IN GERMANY: BETWEEN SYSTEMIC BARRIERS AND PROFESSIONAL CHARACTERISTICS

1 · Abstract

Approximately 123.2 million people are currently forcibly displaced worldwide, with many seeking protection in Germany. Traumatic experiences, displacement, and post-migratory stressors often lead to psychological distress and mental health disorders among this vulnerable population. Psychotherapeutic approaches, such as cognitive behavioral therapy and trauma-specific interventions, have proven effective in reducing symptoms of psychological distress among refugees. However, despite high need, few receive adequate care. This is in part due to structural and political barriers, limited access to Germany's healthcare system, and psychotherapists' attitudes toward treating refugees. The present dissertation consists of three publications exploring the latter factor, focusing on therapists' treatment readiness, expected therapeutic outcomes, previous work experience, and professional quality of life as potential obstacles to care. By examining these potential obstacles, this dissertation aims to identify opportunities for enhancing awareness of personal reservations and doubts concerning the treatment of refugee patients among mental health professionals, and to offer a revised perspective on the demands associated with this work.

The first publication analyzed the readiness of German psychotherapists to treat refugees, focusing on how patients' countries of origin affect therapists' readiness to offer treatment as well as therapists' expectations of treatment success. The study employed six case vignettes that varied by patients' gender and country of origin (Syria, Ukraine, Germany). One of these vignettes was randomly presented to a total of $n = 623$ licensed psychotherapists and $n = 218$ psychotherapists in training. The participants rated their readiness to treat the presented patient and the anticipated treatment outcome. The results indicate significantly lower readiness to treat refugees than non-refugees. No significant differences were found between Syrian and Ukrainian patients. Regarding expected treatment outcome, therapists anticipated lower success rates for refugees. The vignettes with the Syrian patients received the lowest ratings.

The second publication examined whether professional quality of life (ProQOL) and prior experience working with refugees affect therapists' readiness to provide treatment to this group. ProQOL includes the following three aspects: Burnout, compassion satisfaction, and secondary traumatic stress. Among the 821 licensed psychotherapists and psychotherapists in training surveyed, moderate levels of compassion satisfaction and low levels of burnout and secondary traumatic stress were reported, indicating low overall strain. Compassion satisfaction was positively and secondary traumatic stress negatively correlated with readiness to treat. Incorporating the variable of patients' refugee background into the analysis negated the effect of secondary traumatic stress on treatment readiness, while the influence of compassion satisfaction remained unchanged. Therapists with prior experience in treating refugees reported higher compassion satisfaction, lower burnout scores, and greater readiness to provide care than those without such experience. However, ProQOL was not significantly correlated with readiness to treat refugees.

The third publication examined the ProQOL of psychotherapists and child welfare workers who worked with unaccompanied young refugees (UYR), as well as potential influencing factors. The comparison revealed that child welfare workers experience significantly higher levels of strain than psychotherapists. Psychotherapists with prior experience of treating refugees reported greater compassion satisfaction. Regression analysis showed that a high number of PTSD cases in treatment was associated with increased secondary traumatic stress among psychotherapists. Additionally, trauma-specific training was linked to higher secondary traumatic stress levels in this group. No significant predictors of ProQOL were identified for child welfare workers.

This dissertation contributes to the current state of research, as it addresses key barriers in the psychotherapeutic care of refugees. By examining psychotherapists' treatment readiness, expected treatment success, and professional quality of life, it reveals psychological factors that may impede refugees' access to care. The findings emphasize the critical need for trauma-specific training, both prior to and following licensure, highlighting its importance for access to qualified care for refugees independent of their countries of origin. Furthermore, the dissertation advocates for early exposure to refugee populations during clinical training. Having prior

experience in this area enhances treatment readiness and compassion satisfaction, suggesting that early engagement may foster professional confidence and reduces therapeutic resistance. Adding further depth to this analysis, including child welfare workers working with UYR enriches the understanding of occupational stress and compassion satisfaction in the context of child welfare. By comparing psychotherapists and child welfare workers, this body of work identifies notable disparities in stress levels, thereby calling for more consistent and structured support across professional domains.

In sum, this dissertation contributes to the academic discourse on refugees' mental health and offers practical recommendations for improving mental healthcare utilization by addressing therapists' characteristics such as ProQOL. To improve these characteristics one may discuss supervision, education or systemic reforms as implications of this dissertation.

2 · Background

2.1 Official Numbers

A refugee, according to the Convention, 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.

(United Nations High Commissioner for Refugees [UNHCR], n.d., p. 3)

Recent UNHCR statistics place the global forcibly displaced population at approximately 117.3 million individuals (UNHCR, 2025a). More than half of these (73.5 million) are internally displaced, 36.4 million are refugees, 8.4 million are asylum seekers, 6.1 million are in need of international protection. More than one third of forcibly displaced people (49 million) are children under the age of 18. The UNHCR (2025a) indicates that 67% of the world's refugee population derives predominantly from five countries: Venezuela (6.5 million), Syria (5.5 million), Ukraine (5.3 million), Afghanistan (4.8 million), and Sudan (2.5 million). Germany has hosted around 2.7 million refugees so far (UNHCR, 2025a). In 2024, a total of 213,499 asylum seekers were registered in Germany, representing a decline of approximately 34.2% compared to the previous year (Bundesamt für Migration und Flüchtlinge, 2025b). As of September 2025, a total of 87,787 initial asylum applications had been submitted (Bundesamt für Migration und Flüchtlinge, 2025a). In 2024 the nationalities with the highest number of initial asylum applications were Syria (33.5%), Afghanistan (14.9%), and Turkey (11.2%) (Bundesamt für Migration und Flüchtlinge, 2025b). With regard to unaccompanied minor refugees, a total of 13,344 initial asylum applications were submitted in 2024 (92.4% were male), primarily by children fleeing from Syria (42.6%), Afghanistan (25.4%), and Somalia (8.2%).

2.2 Refugees' Mental Health

Due to cumulative trauma, arising from persecution, war, or other crises in their home countries, as well as from dangerous flight routes during displacement, the refugee population is exposed to an increased risk of mental disorders (Blackmore et al., 2020; Emmelkamp, 2023; Schlaudt et al., 2020; Schmidt et al., 2023). In an Australian study on potentially traumatic events, it was reported that 44.2% of the participating refugees experienced a lack of food or water, 43% reported life-threatening situations, 39.3% had no access to medical care, 28.6% witnessed combat, and 22.2% experienced torture (Nickerson et al., 2021). Gender-based differences in trauma history were highlighted by Mundy et al. (2020), with 42% of women reporting domestic violence and 21% sexual violence, while 81% of men reported imprisonment and 65% torture. Living in war zones and experiencing persecution were mentioned equally frequently by refugees of both genders. On average, men reported 5.9 traumatic experiences, compared to 4.2 among women. Approximately two-thirds of refugees arriving in Germany from the countries with the highest migration rates (Syria, Afghanistan, Turkey) are male (Bundesamt für Migration und Flüchtlinge, 2025b). Among Syrian refugees, this may reflect the perception that young men have better prospects for successfully arriving in their host country, including hopes of finding employment or reuniting with their families through safer migration channels (Damir-Geilsdorf & Sabra, 2018).

After arriving in the host country, many refugees report clinical psychological symptoms resulting from experiences prior to and during their flight. Common mental health disorders among Syrian refugees in high-income Western countries include anxiety (40%), depressive disorders (31%), and post-traumatic stress disorder (PTSD, 40%) (Nguyen et al., 2022). Von Haumeder et al. (2019) reported a 46.5% prevalence of PTSD among Syrian refugees in Germany. Furthermore, Buchcik et al. (2023) found that 51% of Ukrainian refugees surveyed in Germany reported anxiety symptoms, while 44.7% reported depressive symptoms, notably 77.3% were female. In a Portuguese study 44.16% of Ukrainian refugees (81.8% female) reported PTSD symptoms (Figueiredo et al., 2024). Refugees from Ukraine were predominantly female, as conscription for men was still in effect at the onset of the war (Federal Ministry of

the Interior, 2022). Female refugees demonstrate a markedly elevated vulnerability to mental health disorders (Blackmore et al., 2020; Buchcik et al., 2023), a vulnerability strongly associated with systematic sexual assault and violence, which is closely linked to the onset of PTSD (Blackmore et al., 2020; Vallejo-Martín et al., 2021). Mundy et al. (2020) further documented elevated levels of depression, anxiety, and somatization among refugee women when compared to men. This pattern extends to younger populations. In a German study, UYR and accompanied young refugees (AYR) also reported high prevalence rates for PTSD (UYR 64.7%; AYR 36.7%), depression (UYR 42.6%; AYR 30%) and anxiety (UYR 38.2%; AYR 23.3%) (Müller et al., 2019).

2.3 Postmigration Factors

In addition, post-migration factors in the host country appear to have an impact on refugees' mental health. Insecure asylum status, poor living conditions (Schilz et al., 2023), lack of work or schooling, separation from the family, and experiences of discrimination have been shown to have a negative impact on refugees' mental health (Grabo & Leavey, 2023; Hajak et al., 2021; von Haumeder et al., 2019). In addition to discrimination, refugees may experience a conflict of cultural identity, which can also negatively impact their mental health (Rahim et al., 2023). At the same time, higher levels of psychological distress are associated with lower levels of integration (Hajak et al., 2021). Insufficient integration may lead to post-migratory barriers, which in turn contribute to psychological distress. Factors like fair treatment in the community, stable housing situation, sufficient food and financial funds for daily living, and access to healthcare, education, and employment programs appear to be associated with a significantly lower risk of PTSD (von Haumeder et al., 2019). A significant relationship was identified between quality of life, including personal growth, leisure, relationships, and well-being, and mental health among Syrian refugees (Gokkaya et al., 2025).

The quality of post-migration factors in Germany depends on the refugee's country of origin. Since the beginning of the Russian invasion, Ukrainian refugees have received a direct residence permit until March 2027 (Bundesamt für Migration und Flüchtlinge, 2024b). Ukrainian refugees are encouraged to forego asylum procedures, since applying for asylum may restrict their autonomy regarding location, living arrangements and employment, as these are regulated by government assignment policies. It is important to note that some refugees from other countries, such as Syria and Afghanistan, may require additional documentation to obtain a secure residence status, including an asylum application. After submitting their application, they are initially only allowed to stay in the area specified in their residence permit (Bundesamt für Migration und Flüchtlinge, 2019). In most cases, asylum seekers are assigned to reception centers (shared housing) throughout Germany after submitting their application. They must remain there until a final decision is made on their asylum application. Type and location of accommodation are therefore subject to the consideration of the federal and local bodies of government in charge, with little to no input by the refugees themselves. In 2022, the overall average duration of the asylum procedure to a final legal decision was about 24 months (Deutscher Bundestag, 2023). Asylum seekers in reception centers are barred from finding work or further education for six months. Employment bans apply to individuals from safe countries of origin, those with rejected asylum claims, and those who have misrepresented their identity (Bundesministerium für Arbeit und Soziales, n.d.). In comparison, Ukrainian refugees have immediate access to the labor market and training/education under § 24 Section 1 of the Residence Act, except for stateless individuals or non-Ukrainian nationals who fled from Ukraine (Bundesministerium für Arbeit und Soziales, 2025). According to Brücker et al. (2022), the majority of Ukrainian refugees have settled in private housing (75%), with only a small fraction (9%) residing in shared accommodations. Nevertheless, Boiko et al. (2024) demonstrated that Ukrainian refugees who were forced to leave their homeland were at a higher risk of anxiety, depression and stress than those who remained in Ukraine. Contributing stressors included job loss, dissatisfaction with health, and experiencing hostility. Overall, post-migration factors such as education, employment, and housing vary considerably among refugee subgroups in Germany. These factors may substantially influence their experiences and well-being once they are settled.

2.4 Effectiveness of Psychotherapy with Refugees

It becomes evident that the prevalence of mental disorders among refugees is shaped by the burdens encountered prior to, during, and after displacement. Furthermore, the reported high prevalence of mental health disorders among refugees highlights the need for effective psychological treatment for this population. Various psychotherapeutic manuals have demonstrated efficacy in addressing these disorders. Furthermore, there are currently several therapeutic interventions developed specifically for refugees (Molendijk et al., 2024). Among these, cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET) have received considerable empirical attention (Turrini et al., 2021). In the treatment of adult refugees, studies have demonstrated the efficacy of symptom reduction for depression (Uhr et al., 2025) and PTSD (Kip et al., 2020; Turrini et al., 2019). Follow-up assessments indicate that the benefits of treatment may persist for up to six months after therapy (Kip et al., 2020). A significant reduction in anxiety symptoms was also demonstrated (Turrini et al., 2019). While Molendijk et al. (2024) concluded in their review that various treatment interventions generally improve mental health outcomes in refugee populations, other studies suggest a more cautious interpretation. For instance, Antuña-Camblor and Hernández (2025) found no evidence supporting the efficacy of EMDR for refugee populations. Similarly, Turrini et al. (2025) demonstrated in their review that while various interventions have been shown to be superior to treatment as usual in the treatment of PTSD, depression, and anxiety, only small effect sizes and the risk of bias were noted.

Psychotherapeutic treatments have also proven effective for refugee children and adolescents like UYR and AYR (Chipalo, 2021; Genç, 2022). A substantial body of research has demonstrated the efficacy of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT; Chipalo, 2021; Cohen et al., 2017) and KIDNET (Schauer et al., 2024) in reducing symptoms associated with PTSD (Genç, 2022). Another promising group-based program tailored for young refugees is Mein Weg ("My Way"), which has been supported by several studies (Pfeiffer & Goldbeck, 2017; Pfeiffer et al., 2018; Pfeiffer et al., 2019). The results indicated a reduction in self-reported PTSD and depressive symptoms (Pfeiffer et al., 2018; Pfeiffer et al., 2019).

While not all studies indicate such differences, some suggest that female refugees have higher success rates in psychotherapy than men (Opaas et al., 2022; Stenmark et al., 2014). In a longitudinal study by Opaas et al. (2022), 35 male and 19 female refugees from 15 different countries of origin, 31% of whom were from Iraq, were followed over a period of ten years. Female refugees reported a significant reduction in PTSD, anxiety and depression symptoms. One potential explanation for this disparity is that refugee men are more likely to experience torture, a form of trauma considered especially severe due to its externally imposed passivity, compared to refugee women (Opaas et al., 2022).

In addition to the proven effectiveness of evidence-based therapy, treatment within a different cultural context is generally challenging, as both the absence of and differences in understanding mental illness among refugees can significantly impact the therapeutic process (Peñuela-O'Brien et al., 2023). These factors complicate the establishment of a psychotherapeutic relationship. Refugees' attitudes toward psychotherapy often reflect tensions between cultural expectations and clinical practices. For some, discussing personal difficulties in a therapeutic setting may challenge traditional norms, while others find it helpful and constructive (Duden, 2020). Concerns related to stigma and mistrust toward practitioners were reported. These concerns may stem from experiences of persecution and inhumane treatment during the flight and prior to it, as well as from discrimination and a lack of transparency in the host country's authorities. Confronting trauma was described by refugees as both meaningful and helpful in processing, as well as stressful and hindering in terms of forgetting. In some cases, the uncertainty surrounding resettlement has caused both patients and practitioners to question the perceived value of psychological treatment. A distinction between countries of origin and attitudes toward psychotherapy among refugees was not made. However, a qualitative study by Ziyachi and Castellani (2024) demonstrated that migrants and refugees should not be treated as a homogeneous group in therapeutic settings. Even individuals with similar cultural backgrounds and countries of origin remain distinct people with different needs, belief systems, and life circumstances. The study provided clear evidence that focusing solely on cultural and national origin leads to the reinforcement of stereotypes and inappropriate therapeutic interventions.

2.5 Between Needs and Barriers: Obstacles to Mental Health Service Utilization in Germany

Despite experiencing heightened stress levels, a critical need for psychotherapeutic care, and the existence of evidence-based effective treatment for this population, refugees in Germany face significant structural and systemic barriers in accessing the healthcare system (Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer [BAfF], 2024; Dumke et al., 2024b). These obstacles are rooted in institutional limitations within the healthcare system (BAfF, 2024), restrictive refugee policies, and challenges related to intercultural communication and professional engagement between refugees and German psychotherapists (Dumke et al., 2024b). Additionally, refugees remain an underrepresented demographic in clinical research, which creates gaps in evidence-based approaches tailored to their specific needs (Hinchey et al., 2023; Panter-Brick et al., 2020).

Due to a new regulation in §§4 and 6 of the Asylum Seekers Benefits Act (§§4 und 6 des Asylbewerberleistungsgesetz (AsylbLG)), asylum seekers are no longer allowed to claim benefits in accordance with statutory health insurance after 18 months, but only after 36 months (BAfF, 2024). During this initial three-year period following arrival in Germany, medical care for asylum seekers is limited to acute conditions and pain management, with expenses typically borne by the social welfare authorities. Psychotherapeutic care is only permitted in exceptional cases and after a thorough evaluation and professional assessment. In comparison, Ukrainian refugees in Germany have access to the full scope of benefits of statutory health insurance (Bundesamt für Migration und Flüchtlinge, 2024a). In the context of gender-specific differences, it is important to note that factors such as childcare responsibilities, gender hierarchies, social expectations, ideals, and discrimination can pose significant barriers to accessing healthcare for refugee women (Coumans & Wark, 2024; DeSa et al., 2022; Zivot et al., 2020). These barriers may increase the risk of physical and mental health problems for refugee women. According to Hahn et al. (2020), access is complicated by several factors. These include, besides the aforementioned legal and statutory aspects (Sections 4 and 6 AsylbLG), socio-cultural

aspects such as intercultural openness, navigating a foreign healthcare system, communication aspects such as language barriers, and environmental aspects such as the availability of therapy places. While psychotherapists frequently cite limited capacity as a barrier to refugee treatment, studies found no evidence of a direct link (Dumke et al., 2023; Kiselev et al., 2020). Whereas some studies have shown different therapists' characteristics to be relevant: Kiselev et al. (2020) observed that therapists with limited or no experience working with refugees tend to report shorter waitlists and fewer treatment refusals – indicating that capacity exists, yet treatment remains inaccessible for refugees. Moreover, additional barriers that may arise in the psychotherapeutic setting include organizational or bureaucratic difficulties (Potter et al., 2023). In this context, there is often uncertainty regarding the funding of treatment and interpreter services (Duden et al., 2020; Kiselev et al., 2020). Organizational issues, such as appointment cancellation (Duden et al., 2020; Potter et al., 2023), alongside the occasionally ambivalent treatment motivation among refugees (Potter et al., 2023), are described by psychotherapists as significant barriers within the therapeutic context.

A study by Schoenberger et al. (2024) found that 48.9% of surveyed Syrian refugees in Leipzig reported experiencing mental health challenges. However, only 7.6% of them sought professional counseling. Instead, many first turned to family, friends, or religious support. This uncertainty about where to seek help suggests limited awareness and the persistence of stigma around mental health. Fear of being misunderstood due to language barriers was also a key concern that emerged. In this context, the authors highlighted the importance of language and cultural mediators. The study further revealed that 53.7% of respondents experienced discrimination by public authorities and 31% within the healthcare system. Furthermore, in a study conducted by Boettcher et al. (2021) in North Rhine-Westphalia, it was found that despite an evident need and contact to mental healthcare services, none of the surveyed refugees from Syria, Afghanistan and Iraq received evidence-based psychotherapy in accordance with the German S3 guidelines. Dumke et al. (2024a) demonstrated that the objective need for treatment remained relatively stable over a 12-month period (82.4% at 12 months), yet only 16.7% had access to mental healthcare services after 6 months, and 26.1% after 12 months. After the six-month follow-up, only 2.8% of surveyed refugees in need of treatment had received care that

met the minimum adequacy standards. Minimally adequate treatment was defined as either eight sessions of psychotherapy or medication with four follow-up visits. After twelve months, 17.4% had accessed treatment. Regarding minimally adequate psychotherapy specifically, only 4.3% received care within that timeframe. Furthermore, the Dumke et al. (2023) study found that psychotherapists provided 20% fewer sessions to refugee patients than to non-refugee patients, citing language barriers and limited contact with the refugee population as contributing factors. It thus becomes evident that, even when psychotherapy is accessed, it often proves to be insufficient.

2.6 The Impact of Therapists' Characteristics on the Efficiency of Refugee Mental Healthcare

In addition to the previously mentioned barriers, psychotherapists' attitudes toward refugees play a crucial role in refugee treatment: Bansak et al. (2016, 2023) suggest that host populations in Europe tend to favor individuals who align with their socio-economic and cultural expectations with a significant anti-Muslim bias. Factors such as professional background, religious affiliation, and gender shape public attitudes, often resulting in greater support for Christian, female, and skilled refugees. Refugees from Ukraine are generally more welcome in Europe than those from countries such as Syria, Afghanistan, or Eritrea (Bansak et al., 2023). Moise et al. (2024) found that Europeans largely support Ukrainian refugees because they feel directly involved in the war. Backing Ukraine politically and morally makes them more sympathetic towards this group of displaced people, especially since the war feels close and unjust. Changes in views on the war shift attitudes toward refugees (Moise et al., 2024).

A study by Dumke and Neuner (2022) indicates a noticeable bias among therapists when treating refugees, with expectations of increased emotional toll and therapeutic difficulty. Therapists expressed more therapy-inhibiting attitudes toward refugee patients than toward non-refugees. These attitudes (cognitive, affective, and behavioral in nature) influenced clinical decisions,

resulting in fewer referrals for psychotherapy. Concerns were particularly prevalent in cases involving refugee women, where stigma surrounding trauma treatment further complicated access to care. Meanwhile, male refugees were less frequently referred for psychotherapy and more often directed toward psychiatric medication. Professional experience with refugee populations, as well as personal exposure and openness, enhanced therapists' readiness to engage in treatment (Schlechter et al., 2020). However, language limitations and discomfort in working with interpreters presented major challenges. Therapists' readiness to treat was diminished by self-doubt and the assumption of irrationality – the belief that behavior is shaped by uncontrollable processes. This perspective led to low expectations of therapeutic success.

Recent research increasingly highlighted the influential role of therapists' expectations in shaping psychotherapy process and outcomes, an effect that aligns with the concept of the interpersonal self-fulfilling prophecy (Dragioti et al., 2015; Rosenthal & Rubin, 1978; Shaw, 1999; Swift et al., 2018; Wampold, 2001). Swift et al. (2018) demonstrated that trainee therapists' expectations significantly influenced patient progress, highlighting the need for clinicians to reflect on and manage their assumptions to prevent unintended consequences. Moreover, according to Constantino et al. (2020), not only therapists' expectations but also those of the patients played a pivotal role in shaping the therapeutic dyad and process. Therapists reported a stronger therapeutic alliance in the subsequent session when patients held higher expectations regarding treatment outcomes. These shared optimistic expectations were associated with an improved therapeutic relationship and a reduction in patient distress. In addition to expectations, the therapist's personal sense of hope has proven to exert a beneficial influence on therapy outcomes, particularly when working with individuals experiencing deep hopelessness (Bartholomew et al., 2019). However, despite growing awareness of these psychological dynamics, there is a notable gap in the literature regarding therapists' expectations in contexts involving refugee populations. Most available studies emphasized refugee clients' perspectives and beliefs (Asfaw et al., 2020; Schlechter et al., 2023), while the expectations of psychotherapists treating them remain under-explored.

2.7 Occupational Stressors and Protective Factors in Psychosocial Work with Refugees

In general, it can be said that working with a population that has experienced significant trauma like refugees poses considerable challenges. It is therefore important to consider the mental well-being of practitioners, for example by examining their ProQOL. ProQOL refers to how helpers feel about their work, balancing the positive (compassion satisfaction) and negative (compassion fatigue) effects of caregiving (Stamm, 2010). Compassion satisfaction refers to the positive emotional experience derived from being able to help others. Compassion Fatigue includes burnout and secondary traumatic stress, referring to feelings of exhaustion, frustration, and depression, as well as passive exposure to the trauma experienced by others.

Psychotherapists, social workers and other professionals, including interpreters, may experience symptoms of secondary traumatic stress and burnout due to the emotional strain involved (Denkinger et al., 2018; Živanović & Marković, 2020). Roberts et al. (2021) highlighted a concerning prevalence of psychological strain among professional and volunteer workers engaged in refugee support work. Their meta-analysis revealed that nearly one-third of participants (29.7%) exhibited severe burnout levels, while close to half (45.7%) experienced moderate to high levels of secondary traumatic stress. Denkinger et al.'s (2018) research also identified secondary traumatic stress in 22.9% of participants, with severe symptoms observed in 8.6%. The sample consisted of German social workers, psychotherapists, and interpreters who were engaged in supporting women and children exposed to violence perpetrated by the jihadist terrorist organization Islamic State (IS). The research highlighted several contributing factors to elevated secondary traumatic stress levels, including prior trauma or flight experience, frequent and prolonged direct engagement with beneficiaries, a tendency toward preoccupied attachment, and working specifically with children. In contrast, the study by Živanović and Marković (2020) did not identify any significant association between the amount of direct contact with beneficiaries, or the duration of involvement in refugee protection, with the severity of second-

ary traumatic stress symptoms. However, it was found that both the number of reported traumatic experiences and their specific content were correlated with higher levels of secondary traumatic stress.

Beyond indirect trauma exposure, occupational stressors play a critical role in contributing to burnout. Ghafoori et al. (2024) reported increased strain resulting from long working hours, demanding workloads, and a lack of adequate training and supervision. These conditions were associated with reported feelings of helplessness and exhaustion. Petravičiūtė et al. (2025) reported a correlation between burnout and elevated levels of secondary traumatic stress among professionals and volunteers working with refugee populations. Here too, a personal history of trauma emerged as a risk factor for burnout (Mavratza et al., 2021). Conversely, social support and compassion satisfaction were found to be associated with lower levels of secondary traumatic stress mediated by lower levels of burnout (Petravičiūtė et al., 2025). Mavratza et al. (2021) investigated compassion satisfaction among health professionals working with refugee populations, including social workers and psychologists. The findings indicate that 75.7% of participants exhibited moderate to high levels of compassion satisfaction (Mavratza et al., 2021), a factor that has been shown to exert a protective influence against stress (Posselt et al., 2020). Furthermore, it has been shown that supervision which fosters a strong alliance and addresses emotional, educational, and professional needs is essential for the well-being of professionals providing therapeutic support to refugees (Posselt et al., 2020). Equally essential are trauma-specific training providing a high sense of self-efficacy (Isawi & Post, 2020). As previously mentioned, Denkinger et al. (2018) found that the burden was higher when working with refugee children than with refugee adults. Unfortunately, there is currently little to no research on the professional quality of life of healthcare professionals working with unaccompanied young refugees. Furthermore, there appears to be limited evidence on the extent to which the ProQOL influences mental health care utilization among refugees and the treatment readiness of licensed psychotherapists and psychotherapists in training in Germany.

3 · Description of the Dissertation Project

The following section aims to highlight the gaps in the current research landscape more clearly, considering the above-presented theoretical framework. To this end, it outlines the dissertation project's objectives and presents its underlying research questions.

3.1 Relevance and Derivation of the Research Questions

Based on the aspects described in Part I, we conclude that the elevated demand for psychotherapy among refugees is in stark contrast to the inadequate access and implementation of effective treatment. Recent studies have examined psychotherapists' attitudes toward working with refugees and have shown that the readiness to treat refugees is generally low (Dumke & Neuner, 2022). Since refugees in Germany and Europe are treated differently depending on their demographic characteristics and are assigned to varying levels of societal value (Bansak et al., 2016, 2023), the question arises whether this is also reflected in the access to therapeutic services. So far, to the best of our knowledge no research has examined whether refugees' country of origin influences psychotherapists' readiness to provide treatment or their expectations regarding therapy outcomes. Moreover, several studies describe work with refugees as burdensome, often referring to professional quality of life (Roberts et al., 2021). Therefore, the readiness to treat refugees may depend not only on the patient population but also on therapist variables such as previous experiences and existing strain in the form of burnout and secondary traumatic stress. This dissertation addresses aspects of therapists' treatment readiness and expected therapy outcomes based on refugee country of origin and previous experiences in working with refugees and the professional quality of life of psychotherapists in Germany.

The first objective of this dissertation is to assess the readiness to treat refugees among German licensed psychotherapists and psychotherapists in training. The focus lies on the influence of the refugee patient's country of origin as well as the expected therapy outcome. To gain a more

nuanced understanding, case vignettes involving Syrian and Ukrainian refugees, as well as German patients, are presented. The selection of countries reflects the previously reported anti-Muslim bias and the bureaucratic advantages granted to Ukrainian refugees in Germany. By evaluating expected therapy outcomes based on country of origin, we aim to determine whether the risk of a self-fulfilling prophecy occurs more frequently among certain patient populations.

Refugee Background	Gender	Traumatic Experience	Post-traumatic stress symptoms
No flight experience	Female	Sarah is 19 years old and went on vacation with her mother in 2021. During the trip, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Sarah has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Sarah withdraws more and more and is often sad.
	Male	Daniel 19 years old and went on vacation with his mother in 2021. During the trip, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Daniel has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Daniel withdraws more and more and is often sad.
Syria	Female	Nadjiba is 19 years old and fled Syria together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Nadjiba has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Nadjiba withdraws more and more and is often sad.
	Male	Ibrar is 19 years old and fled Syria with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Ibrar has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Ibrar withdraws more and more and is often sad.
Ukraine	Female	Natalia is 19 years old and fled Ukraine together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Natalia has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Natalia withdraws more and more and is often sad.
	Male	Dmytro is 19 years old and fled Ukraine together with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Dmytro has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Dmytro withdraws more and more and is often sad.

Figure 1 Case vignettes from the study I and II (Schwegler et al., 2025a; Schwegler et al., 2025b)

Building on this, the next step is to explore whether psychotherapists' readiness to treat refugees is influenced by their previous experiences working with refugees and their professional quality of life. The aim is to determine if low readiness to treat refugees is primarily due to therapist-related variables, such as previous experiences, burnout and secondary traumatic stress, rather than patient-related variables.

As Denkinger et al. (2018) demonstrated, working with refugee children may be an additional risk factor for secondary traumatic stress. In order to gain a broader understanding of the burden experienced by caregivers and practitioners, professional quality of life among psychotherapists and child welfare workers was assessed as part of the BETTER CARE project between 2020 and 2022 (Rosner et al., 2020). BETTER CARE was a project which aimed to implement and evaluate a stepped-care model for UYRs living in child and youth welfare facilities using evidence-based treatments (Rosner et al., 2020). It included an initial screening and indication phase, followed by either the group intervention My Way (“Mein Weg”) led by trained child welfare workers, or TF-CBT delivered by trained psychotherapists. Child welfare workers played a key role in implementing the preventive group program, while psychotherapists were responsible for providing individualized TF-CBT to participants with greater clinical needs. The objective was to ensure that the improved care model remains sustainable beyond the duration of the project. The psychotherapists in question are practitioners who work with children and adolescents. Based on the data, the aim of our study is to determine whether the strain occurs not only in the treatment of adults but also with UYR, reflected in reduced professional quality of life, and whether this strain has a potential impact on readiness to treat. To address a gap in current research, the professional groups of psychotherapists and child welfare workers will also be compared.

3.2 Research Questions of the Dissertation Project

The following questions arise for the dissertation project based on the current state of research.

1. Are licensed psychotherapists and those in training less ready to treat refugee patients compared to non-refugee patients? Does the country of origin of the refugee patient influence the therapists' readiness to provide treatment? Do licensed psychotherapists and those in training anticipate lower treatment success for refugee patients compared to non-refugee patients? Does the patient's country of origin influence the therapist's expected treatment success? (publication 1)
2. How do previous experiences in working with refugees affect the ProQOL (burnout, secondary traumatic stress and compassion satisfaction) among German psychotherapists? How does the ProQOL (burnout, secondary traumatic stress and compassion satisfaction) of German psychotherapists influence their readiness to treat refugees presenting with PTSD symptoms? How does prior experience in treating refugee patients predict psychotherapists' readiness to treat refugee populations? (publication 2)
3. What are the levels of compassion satisfaction, burnout, and secondary traumatic stress among German child welfare workers and licensed psychotherapists? Are there significant differences in compassion satisfaction, burnout, and secondary traumatic stress between German child welfare workers and licensed psychotherapists? How do demographic variables (e.g., age, gender, years of experience) influence compassion satisfaction, burnout, and secondary traumatic stress in both professional groups? How do work-related variables (e.g., caseload, professional role, trauma exposure) impact the levels of compassion satisfaction, burnout, and secondary traumatic stress among German child welfare workers and psychotherapists? (publication 3)

4 · Synopsis of the Publications

4.1 Publication 1 – Psychotherapists’ readiness to treat PTSD: the influence of refugees’ country of origin

Schwegler, P. M., Gossmann, K., Neumann, T., Moser, A., Speth, T., & Rosner, R. (2025).

Psychotherapists’ readiness to treat PTSD: the influence of refugees’ country of origin.

European Journal of Psychotraumatology, 16(1),

<https://doi.org/10.1080/20008066.2025.2456381>

Background: Refugees are often exposed to traumatic events, which can lead to psychological disorders such as post-traumatic stress disorder, depression and anxiety. Despite the high demand for mental health support, refugees face significant restrictions in accessing the healthcare system and psychotherapeutic services. In addition to bureaucratic obstacles, the reluctance of German psychotherapists to treat refugees further exacerbates these access difficulties. Previous research has demonstrated that psychotherapists are significantly less willing to treat refugees than non-refugee patients. However, that study did not differentiate between refugees' countries of origin. Furthermore, therapists' expectations regarding treatment success in refugee populations appear to be largely unexplored. This study aims to investigate the refugee background and the country of origin of the vignette patient, as potential influences on psychotherapists' readiness to provide care and their expectations of treatment outcomes.

Methods: An anonymous, cross-sectional online survey was conducted among licensed psychotherapists and psychotherapists in training across Germany between October 2022 and August 2023. Recruitment involved outreach via professional associations and training institutions. Participants provided demographic and professional data and were randomly presented with one of six PTSD-related case vignettes that varied in terms of gender, refugee status and

country of origin (Ukraine versus Syria). The traumatic event, as well as the resulting symptomatology, remained unchanged. Treatment readiness and expected treatment success were assessed using visual analogue scales (0 – 100).

Results: The final sample comprised 871 participants (623 licensed psychotherapists and 218 psychotherapists in training). The mean age was 45.5 years, and 83.7% of participants identified as cisgender women. Around 12.2% of participants reported having a migration background, 0.9% had personal experience of flight, and almost half had prior experience of working with refugees. Overall treatment readiness had a mean score of 80 ($SD = 23$), and expected treatment success averaged 67 ($SD = 16.6$). Therapists reported significantly lower readiness to treat patients with refugee backgrounds ($F(1, 867) = 30.88, p < .001, partial \eta^2 = .034$), regardless of gender or country of origin (Figure 2). They also reported significantly lower expected treatment success for refugee patients ($F(1, 840) = 11.61, p < .001, partial \eta^2 = .014$), with the lowest ratings given to Syrian patients ($M = 63.88, SD = 16.89$) compared to those from Germany ($M = 69.81, SD = 15.97, p < .001$) and Ukraine ($M = 67.17, SD = 16.28, p = .048$) (Figure 3).

Discussion: Patients' refugee background negatively influenced both psychotherapists' treatment readiness and expected therapy success. Syrian refugees were perceived as being less likely to have a positive treatment outcome than Ukrainian patients. Licensed psychotherapists and psychotherapists in training did not differ in their readiness to treat refugee patients. Therefore, it might be practical to integrate training in trauma-focused approaches for working with refugees into the education of psychotherapists from the outset, to enhance their readiness to provide treatment. Ongoing supervision may help address personal doubts, fears, and stereotypes. The results support expanding vignette studies to include factors such as trauma complexity, family status, and differentiating between migrants and refugees. Due to the allegiance effect, therapists' belief in success may impact actual therapy outcomes, particularly for Syrian patients. Therefore, training must emphasize that trauma-specific interventions are effective across diverse groups. Limitations include self-selection bias, single-item measures, and generalizability. Therapist characteristics were under-explored. Refugee background influences therapists' readiness and expectations. Addressing this bias through targeted training and supervision could reduce PTSD undertreatment among refugees.

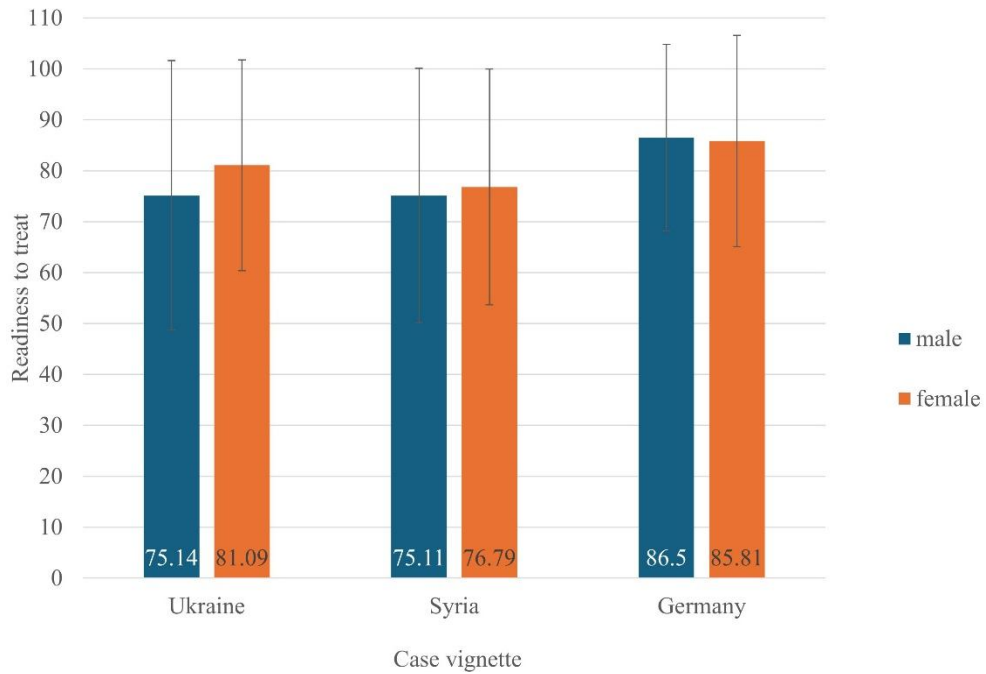


Figure 2 Mean values and standard deviation of readiness to provide treatment (Schwegler et al., 2025a)

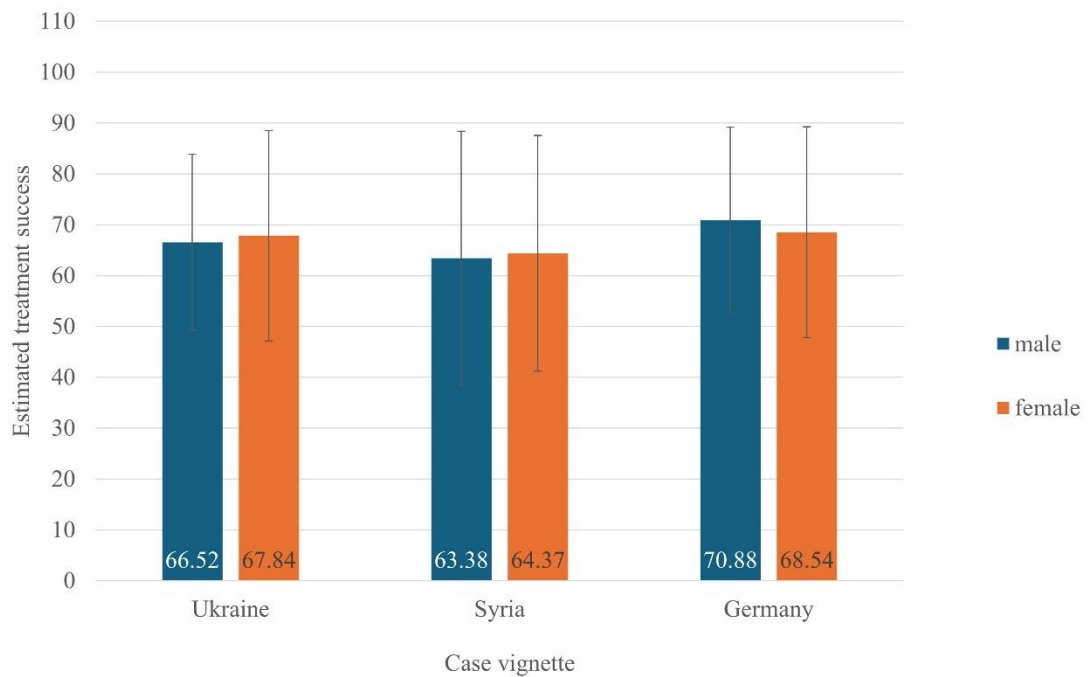


Figure 3 Mean values and standard deviation of the estimated treatment success (Schwegler et al., 2025a)

4.2 Publication 2 – Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A Cross-Sectional Vignette Study

Schwegler, P. M., Neumann, T., Rosner, R., & Gossmann, K. (2025). Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A Cross-Sectional Vignette Study. *Clinical Psychology and Psychotherapy*, 32(3), <https://doi.org/10.1002/cpp.70076>

Background: In 2024, nearly 38 million refugees were reported globally, and Germany was one of the largest host countries in Europe. Due to traumatic displacement and post-migration stressors, refugees face heightened risks of PTSD, depression, and anxiety. Although psychotherapy has proven effective, access remains limited. Barriers include legal restrictions, language barriers, stigma, and therapists' reluctance to treat refugees. High emotional strain and professional quality of life (ProQOL) may influence therapists' readiness to treat refugee patients. This study examines the impact of ProQOL and previous experience on psychotherapists' readiness to treat refugees in Germany.

Method: The study was approved by the university's ethics board and was conducted via an anonymous online survey among licensed psychotherapists and psychotherapists in training across Germany. After providing informed consent, participants were randomly shown one of six PTSD case vignettes that varied by gender and refugee demographics. The survey collected demographic data, professional experience, and professional quality of life data on compassion satisfaction, burnout, and secondary traumatic stress. Therapists rated their treatment readiness using a visual scale (0 – 100).

Results: The final sample included 821 psychotherapists (590 licensed psychotherapists, 203 psychotherapists in training). The average age was 45.44 years, and 83.7% were female. Nearly

half (48.6%) had prior experience of treating refugees. Participants showed moderate compassion satisfaction and low levels of burnout and secondary traumatic stress (Figure 4). Those with experience treating refugees had higher compassion satisfaction ($M_{\text{difference}} = 0.76$, 95% CI [0.131, 1.387], $t(818.97) = 2.37$, $p = 0.009$, $d = 0.17$) and lower burnout scores ($M_{\text{difference}} = -0.60$, 95% CI [-1.147, -0.60], $t(819) = -2.18$, $p = 0.015$, $d = -0.15$), though there was no difference in secondary traumatic stress. The mean readiness score was 80.3. Higher compassion satisfaction was correlated with greater readiness ($\beta = 0.21$, $p < 0.001$), secondary traumatic stress with slightly lower readiness ($\beta = -0.08$, $p = 0.047$). Including the refugee background in the analysis negated the effect of secondary traumatic stress on readiness, while compassion satisfaction remained unaffected. Having prior experience working with refugees increased readiness to treat refugees in the future significantly ($\beta = 0.17$, $p < 0.001$). None of the ProQOL scales were significantly correlated with readiness to treat refugees.

Discussion: Overall, psychotherapists reported a positive ProQOL, with higher compassion satisfaction when treating refugees. Those deeply committed to treating refugees may feel a stronger sense of compassion toward them. Alternatively, therapists with a naturally higher level of compassion satisfaction may be more inclined to engage in the treatment of refugee patients. Since ProQOL did not influence treatment readiness, resistance may stem from language barriers, self-doubt, and general concerns. Prior experience improves future readiness to treat, so targeted training and early exposure to refugee therapy, especially during education, may build confidence and reduce feelings of helplessness. Another practical implication could be establishing support networks and providing expert supervision, which could positively influence the treatment readiness and well-being of psychotherapists.

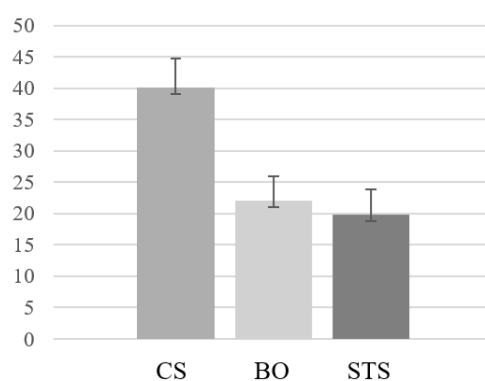


Figure 4 Mean values and standard deviation of the ProQOL-Scores (CS, compassion satisfaction; BO, burnout; STS secondary traumatic stress) (Schwegler et al., 2025b)

4.3 Publication 3 – Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study

Schwegler, P. M., Kasparik, B., Thielemann, J., Eilers, R., Pfeiffer, E., Sachser, C., & Rosner, R. (2025). Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study. *Child and Adolescent Psychiatry and Mental Health, 19*(77), <https://doi.org/10.1186/s13034-025-00942-0>

Background: Child welfare workers and psychotherapists who work with UYR in Germany experience significant emotional stress and an increased risk of burnout, secondary traumatic stress, and reduced compassion satisfaction. Although various risk and protective factors, such as work experience, number of patients, and trauma history, have been identified, the influence of these factors remains inconclusive. This study compares the levels of compassion satisfaction, burnout, and secondary traumatic stress between German child welfare workers and licensed psychotherapists working with UYR. It also examines how demographic and work-related variables impact these outcomes.

Method: Data collection occurred between 2020 and 2022 within the BETTER CARE trial comparing stepped care to treatment-as-usual for UYR. Participants were recruited through professional networks and CYWS facilities. Baseline assessments were conducted before any clinical intervention. $N = 198$ child welfare workers and $N = 97$ psychotherapists completed the Professional Quality of Life Scale (ProQOL) measuring compassion satisfaction, burnout, and secondary traumatic stress. Demographic data were gathered via standardized questionnaires. Statistical analyses included descriptive statistics, partial correlations, t-tests, Mann-Whitney U-tests, and hierarchical regressions.

Results: Compared to child welfare workers (Burnout: $M = 21.94$, $SD = 4.18$; Secondary traumatic stress: $M = 21.17$, $SD = 4.12$), psychotherapists reported significantly lower levels of burnout ($M = 19.10$, $SD = 3.55$; $p < .001$) and secondary traumatic stress ($M = 18.12$, $SD = 3.43$; $p < .001$). Compassion satisfaction was comparable between the groups overall. However, psychotherapists who had prior experience treating refugees had higher compassion satisfaction scores, whereas child welfare workers with similar experience showed lower scores. Regression analyses revealed no significant predictors of burnout. For psychotherapists, previous work with UYR significantly predicted higher compassion satisfaction ($M_{\text{difference}} = -3.32$, 95% CI $[-4.93, -1.7]$, $t(103) = -4.07$, $p < .001$, $d = -0.83$). Lower secondary traumatic stress was associated with more weekly therapy sessions, while higher secondary traumatic stress was linked to treating more PTSD cases and having received trauma-specific training. Secondary traumatic stress was lower among those with a migration background. No significant predictors were found for child welfare workers' outcomes.

Discussion: Differences in ProQOL scores between the two professional groups may result from increased occupational stress among child welfare workers or disparities in educational backgrounds. Prior work experience with refugees may enhance compassion satisfaction, indicating that working with UYR can be fulfilling. Elevated secondary traumatic stress scores have been linked to treating a higher number of PTSD cases, suggesting that trauma-related content has a stronger impact on practitioners. Consistent and adequate training is essential across professional groups. Future research could explore whether supervision and peer consultation serve as protective factors against burnout and secondary traumatic stress in refugee-focused clinical practice.

5 · Discussion and Conclusion

This dissertation aimed to examine different characteristics of German psychotherapists on their potential influence on their therapeutical work with refugees. Emphasis is placed on treatment readiness, which serves as the primary outcome of this work. Refugee background, the patient's country of origin, prior professional experience with refugees, and ProQOL were examined as potential predictors of readiness. Expected treatment success was analyzed in relation to refugee background and country of origin. These themes are explored across the three publications included in this work.

5.1 Discussion of Key Findings Across Publications 1 – 3

The first publication addressed the research questions concerning psychotherapists' readiness to treat refugees and their expectations regarding treatment success, depending on the patient's country of origin. To the best of the author's knowledge, this was the first study to explicitly differentiate between Ukrainian and Syrian backgrounds. The study found a generally high readiness to treat patients with PTSD. However, a significantly lower readiness to treat refugee patients was observed when distinguishing between refugee and non-refugee patients. These findings are consistent with those reported by Dumke and Neuner (2022). It is possible that uncertainty, fear, and concern when working with traumatized refugees are more pronounced. The reduced readiness to provide treatment may be due to concerns about bureaucratic and organizational challenges, as well as opaque funding structures (Duden et al., 2020; Kiselev et al., 2020; Potter et al., 2023). Additionally, 18% of the participants were child and adolescent psychotherapists. Given the upper age limit of 21, the vignette case involving a 19-year-old might have been perceived as borderline. This age factor could further decrease treatment readiness, considering the previously described challenges. Future research may distinguish

more clearly between adult psychotherapists and those specializing in child and adolescent psychotherapy. Furthermore, early education in academic training and trauma-specific programs tailored to working with refugee populations may influence treatment readiness. Independent of the patient's refugee status, trauma-specific training in general has already been shown to influence fears, concerns, and treatment readiness (Gossmann et al., 2021). Regular supervision and transparent information networks might be an option for supporting clinicians in this context. Differentiating between the countries of origin (Ukraine versus Syria) and gender (male versus female) did not yield any significant differences in treatment readiness. As demonstrated in Part I of this dissertation, the legal status and the extent of bureaucratic obstacles differ between Ukrainian and Syrian refugees. However, these disparities do not seem to impact the therapeutic readiness. There was no evidence for the previously mentioned Muslim-bias (Bansak et al., 2016, 2023). Rather, the refugee background itself appears to exert a stronger influence than the patient's specific country of origin. To strengthen this finding, future research should include additional countries of origin, such as Afghanistan or Nigeria. Moreover, employing diverse vignettes that vary in legal status and include more detailed accounts of refugees' flight experiences could help determine whether bureaucratic obstacles or the nature and severity of trauma influence therapists' readiness to engage in treatment.

In addition to lower treatment readiness, German licensed psychotherapists and psychotherapists in training expected less treatment success for refugee patients compared to German patients. Notably, PTSD symptoms and traumatic events were the same across all vignettes. Reduced expectations may be explained by anticipated barriers such as language difficulties (Schlechter et al., 2020), cultural differences (Peñuela-O'Brien et al., 2023), and organizational or bureaucratic concerns (Potter et al., 2023). These findings may also be interpreted considering potential stigma. As previously discussed, therapists' expectations regarding the therapeutic process and outcomes may have a substantial impact on both progress and treatment success (Dragioti et al., 2015; Rosenthal & Rubin, 1978; Shaw, 1999; Swift et al., 2018; Wampold, 2001). Our study revealed that expectations for Syrian refugees were lower than those for Ukrainian or German patients. A potential explanation for this finding could be the anticipated severity of traumatic experiences in the country of origin or during the displacement. In this

context, the anticipated differences in the flight routes taken by Syrian and Ukrainian refugees, along with their respective risk levels, might be considered (International Organization for Migration [IOM], 2024; UNHCR, 2025b). Further insights may be obtained by examining objective knowledge of flight causes, routes, and trauma impact on therapeutic outcomes. Additionally, the results can be interpreted in light of potential stereotypes that licensed psychotherapists and those in training may hold. These explanations could be examined in further research by adding vignettes on these topics. Nevertheless, this result suggests that Syrian refugees may face diminished prospects for treatment success from the outset, owing to the lower expectations held by licensed psychotherapists and psychotherapists in training. In this context, training and continuing education might be essential, especially given the scientific evidence that therapy and in particular trauma therapy is effective across diverse backgrounds and nationalities (Kip et al., 2020; Molendijk et al., 2024; Turrini et al., 2021; Uhr et al., 2025). In addition, providing therapists with evidence-based trauma manuals specifically designed for refugees could help increase their treatment readiness and minimize any doubts about the success of treatment. Furthermore, future research could examine whether access to professional interpreters or administrative support, particularly regarding transparency in funding and assistance with bureaucratic procedures, moderates the relationship between patients' refugee background and psychotherapists' readiness to provide treatment. Research could also examine whether these forms of support influence the relationship between refugee status and expectations of treatment success. To sum up, treatment readiness among licensed psychotherapists and those in training is lower toward refugee patients compared to non-refugee patients. In this context, the refugee background appears to play a more significant role than the patients' specific country of origin. In contrast, a different pattern emerges regarding expected therapeutic outcomes: Licensed psychotherapists and psychotherapists in training anticipate the lowest treatment success in cases involving Syrian refugees. Answering the research question aims to shed light on the reasons why psychotherapy with refugees often fails to materialize. In doing so, the focus should not only be on political and structural barriers but also on the challenges faced and provided by practicing psychotherapists themselves.

The second publication was built upon the first by examining whether ProQOL may influence the readiness to provide treatment to refugees. This inquiry is based on the hypothesis that increased strain on psychotherapists may reduce their readiness to treat refugees with anticipated PTSD symptoms. The study also explores prior experience in working with refugee populations as a potential predictor: It aims to determine whether experience affects ProQOL and influences the readiness to engage in treatment. The results of the analyses indicated that ProQOL did not have a significant impact on the readiness to treat refugees. However, compassion satisfaction was found to be positively associated, and secondary traumatic stress negatively associated, with general readiness to treat individuals with PTSD. When refugee status was included in the analysis, the effect of secondary traumatic stress disappeared, while the association with compassion satisfaction remained stable. The findings are consistent with those of Duden et al. (2020), who, based on their survey of therapists, described working with refugees as fulfilling and associated with positive effects. Similar to the findings reported by Posselt et al. (2020), our sample also exhibited relatively high levels of compassion satisfaction, low levels of burnout and secondary traumatic stress. As demonstrated in the study by Petravičiūtė et al. (2025) higher compassion satisfaction levels mediated by lower burnout levels can predict lower secondary traumatic stress symptoms and may function as a protective factor. This could contribute to a lower baseline level of strain among licensed psychotherapists and psychotherapists in training. Consequently, no negative effect on treatment readiness was observed.

Several studies have highlighted the potential negative effects of working with refugee populations, with a particular focus on the risks of secondary and vicarious traumatization among mental health professionals (Brooks et al., 2022; Ghafoori et al., 2024; Kizilhan, 2020; Roberts et al., 2021). By contrast, Posselt et al. (2020) reported high levels of compassion satisfaction and found that compassion satisfaction was correlated with lower levels of anxiety, stress and depression. The participants in their study described working with refugees as fulfilling and satisfying. Similarly, Puvimanasinghe et al. (2015) found that working with refugees can foster mutual empowerment, with clinicians perceiving patient progress as rewarding. Both Puvimanasinghe et al. (2015) and Duden et al. (2020) also highlighted shared learning as a meaningful

and positive aspect of therapeutic engagement with refugees. Our study also found no significant negative effect of prior experience working with refugees on ProQOL. Greater clinical exposure was not associated with increased levels of burnout or secondary traumatic stress. In fact, compassion satisfaction increased with more extensive experience in refugee therapy. Therefore, it is possible that participants in our sample with extensive experience working with refugees attribute greater value to this work and benefit from it in terms of their mental well-being.

Our study demonstrates that working with refugees cannot be viewed solely as negative or harmful. Studies, including the present one, have shown that therapists can also derive positive experiences from this work (Duden et al., 2020; Posselt et al., 2020; Puvimanasinghe et al., 2015). This might need to be shared with psychotherapists in the field to enhance treatment readiness toward refugees. Supervisors, as well as other psychotherapeutic colleagues involved in supervision and intervision networks, who highlight this potentially positive experience could serve as multipliers. Nonetheless, secondary traumatic stress and burnout are recognized risks associated with clinical work involving traumatized refugees (Brooks et al., 2022; Ghafoori et al., 2024; Kizilhan, 2020; Roberts et al., 2021). It is important to consider both dimensions of the research landscape.

The influence of previous experience working with refugees on treatment readiness was further examined in the second publication. Licensed psychotherapists and psychotherapists in training who had prior experience reported a greater readiness to work with refugees again. These findings are consistent with those reported by Schlechter et al. (2020). Mutual empowerment and the fulfilling nature of refugee work may also be explanatory factors (Duden et al., 2020; Puvimanasinghe et al., 2015). The findings suggest that overcoming initial stigma and concerns is essential for positive experiences and a greater readiness to treat this patient group in the future. Therefore, it might be an option to incorporate refugee-related clinical work into academic study programs and psychotherapy training to enhance first positive treatment experiences. A practical implication could be fostering an exchange between psychotherapists in training and experienced therapists, who, as previously outlined, could serve as mentors and motivators when working with refugees. In the sense of model learning (Bandura, 1977) this might lead to

motivation in treating refugees for the first time. At the research level, therapeutic readiness among psychotherapists in training could be further examined by assessing it in a longitudinal study: Prior to a trauma-specific training for treating refugees, immediately after the training, and one year after graduation. The aim is to develop evidence-based recommendations for incorporating refugee-specific content into psychotherapy training programs.

In summary, with regard to the research questions of the second publication, current levels of strain do not significantly impact psychotherapists' readiness to treat refugees. Prior experience working with refugees does not affect burnout or secondary traumatic stress levels but is associated with higher compassion satisfaction. Moreover, such work experience increases future readiness to treat refugee patients. Addressing these questions contributes to greater transparency regarding the strain involved in refugee-related clinical work. The decision not to treat traumatized refugees cannot be attributed solely to the psychotherapist's ProQOL.

The third publication extends the second by further examining ProQOL among psychotherapists treating UYR. It also seeks to differentiate between psychotherapists and social workers, and to explore potential influencing factors of ProQOL. Even among participants who primarily worked with children and adolescents, compassion satisfaction scores ranged from average to above average, while burnout and secondary traumatic stress levels were low to moderate. These results contrast with those of previous studies examining professionals working with refugees (Denkinger et al., 2018; Ebren et al., 2022; Roberts et al., 2021; Živanović & Marković, 2020), suggesting that the work setting and patient group may play a decisive role. For example, the professionals surveyed by Živanović and Marković (2020) worked in transit centers, while our sample worked in youth residential groups. It is also possible that it is more stressful to work with adults versus children, as the aforementioned studies sampled professionals working with adults. However, Denkinger et al. (2018) reported that working with refugee children is more psychologically demanding than working with refugee adults. Moreover, the sample consists of a motivated group of participants who voluntarily joined the overarching BETTER CARE project (Rosner et al., 2020). Those experiencing high levels of burnout and secondary traumatic stress may have opted not to participate in the survey.

There are small, yet statistically significant, differences between the two groups of professionals, with child welfare workers experiencing higher levels of burnout and secondary traumatic stress than psychotherapists. One possible explanation might be that child welfare workers may experience greater strain, potentially due to higher workloads caused by overtime, staff shortages, or heavier caseloads (Poulsen, 2017; Wilke et al., 2020). Furthermore, child welfare workers usually spend extended periods with emotionally distressed children throughout the day, whereas psychotherapists generally engage with clients in structured, time-limited sessions – typically 50 minutes once per week. These differences in daily exposure may contribute to varying levels of occupational stress. Differences in professional training may also have an effect. Psychotherapists receive extensive education on treating PTSD and benefit from regular supervision throughout their clinical training, which is not necessarily true for child welfare workers. However, we did not examine these work-related factors in the present study. A promising direction for future research involves analyzing the structural barriers that make social work with UYR particularly demanding for child welfare workers. Furthermore, one-third of the participating psychotherapists had no prior experience working with refugees. However, secondary analyses revealed that psychotherapists with relevant experience reported higher levels of compassion satisfaction than child welfare workers with comparable experience. These findings suggest that the nature of refugee-related work may not be the primary factor influencing ProQOL. Rather, other work-related variables appear to play a more substantial role. Building on this, the comparison of psychotherapists with and without experience working with refugees again demonstrates the significant positive effect of this factor on compassion satisfaction. Levels of burnout and secondary traumatic stress remained unchanged, providing further evidence, alongside previous studies (Duden et al., 2020; Puvimanasinghe et al., 2015), of the fulfilling nature of refugee-related work. Future research could delve deeper into the underlying mechanisms of compassion satisfaction, such as professional identity, coping strategies, and perceived feedback from clients. Targeted support and development may not only strengthen therapists' well-being, but also ultimately benefit the UYR they treat.

Additional findings from the third publication indicated that a high number of PTSD cases treated, as well as advanced training focused on trauma therapy, correlate with elevated levels

of secondary traumatic stress among psychotherapists. Hensel et al. (2015) found that a greater proportion of time spent working with trauma survivors is associated with increased psychological strain among psychotherapists, whereas engagement with clients without trauma histories may exert a regulating effect. It can be assumed that this is also the case here since more weekly therapy sessions are associated with lower secondary traumatic stress levels. However, these sessions did not exclusively involve PTSD cases. The observed association between additional training focusing on trauma therapy and elevated secondary traumatic stress scores contradicts the previously mentioned argument regarding differences between professional groups. We interpret this relationship as being driven by an increase in treated PTSD cases and hypothesize a mediating effect. Therapists who demonstrate an interest in treating PTSD by pursuing specific training may subsequently treat a greater number of PTSD cases. However, this could lead to elevated levels of secondary traumatic stress. Finally, psychotherapists with a migration background reported lower secondary traumatic stress levels than those without, seemingly contradicting prior research suggesting that personal experiences of displacement or trauma increase stress when working with refugees (Denkinger et al., 2018). However, our study assessed migration background, which is not necessarily linked to trauma or flight. It is likely that a shared cultural and linguistic understanding contributed to more effective and fulfilling therapeutic work. Further research projects could explore whether psychotherapists with a refugee background or migration experience achieve more favorable therapeutic outcomes when working with refugee clients or report lower levels of secondary traumatic stress compared to therapists without such backgrounds. Cultural and linguistic congruence may enhance therapeutic efficacy and compassion satisfaction, potentially exerting a protective effect against secondary traumatic stress. In addition, future qualitative analyses could offer deeper insights into cultural schemas and the subjective significance of cultural proximity in therapeutic relationships. More broadly, it is essential to increase the inclusion of psychotherapists with refugee or migration backgrounds in scientific research.

In summary, the research questions from the third publication can be answered as follows: German child welfare workers and licensed psychotherapists who work with UYR report lower levels of strain than previously suggested by the literature reporting on refugee work. To date,

no known study has specifically examined the ProQOL of German child welfare workers and psychotherapists who treat and support UYR. On average, child welfare workers experience higher stress levels than licensed psychotherapists, potentially due to differences in work environments. Among psychotherapists, it is important to account for the diversity of cases encountered in daily clinical practice, as a high prevalence of PTSD may contribute to increased professional strain. Overall, the study enhances transparency regarding ProQOL across professional groups working with UYR and emphasizes the positive aspects of this work.

5.2 Strengths and Limitations

This dissertation encompasses certain strengths and limitations. First, it should be noted that the participant cohort in the first two publications consisted of licensed psychotherapists and those in training. In Germany, a variety of professionals are involved in psychotherapeutic care, and outpatient services are primarily provided by licensed psychotherapists. Psychotherapists in training also work in outpatient settings, but they are still undergoing professional training. Despite their substantial involvement in patient care, this group is often overlooked in research. Therefore, it is a key strength of the first two publications to include both licensed psychotherapists and psychotherapists in training. Future studies should aim to differentiate more precisely within these professional groups, for example between different therapy approaches. To the best of our knowledge, no studies have examined psychotherapists' attitudes toward refugees based on their ethnic origin. Although this may be considered a provocative research question, issues of discrimination based on origin, religion, or skin color should not be excluded from scientific inquiry. We believe our study offers a small but meaningful contribution to this important area of research. The concepts of self-fulfilling prophecies and adherence in the therapeutic process are well-established in existing research. However, this area remains largely unexplored in the context of psychotherapy with refugees. A key strength of the present study is raising therapists' awareness that their initial attitudes toward refugees may affect the effectiveness of their work. Furthermore, using vignettes was a methodological strength of this study. We employed vignettes to reduce social desirability bias in responses related to the treatment of refugees. Each participant received a different vignette, which obscured the underlying research question to a certain extent.

UYRs are markedly underrepresented in the current research landscape. Consequently, there is limited empirical data on professionals who treat and support this population. Distinguishing between professional groups, such as child welfare workers and psychotherapists, may provide valuable insights into context-specific challenges and structural deficits. These distinctions can inform targeted interventions, improve professional support systems, and ultimately enhance the quality of care provided to UYR.

In addition to its strengths, this dissertation project has certain limitations. It is possible that self-selection bias influenced the composition of the study cohort. The survey conducting publication one and two may have attracted psychotherapists with a heightened interest in the clinical presentation of PTSD, as well as those experiencing lower levels of occupational strain who had the capacity to participate in a research study. Consequently, treatment readiness and compassion satisfaction may be disproportionately high, while symptoms of burnout and secondary traumatic stress may be comparatively low. These factors should be considered when interpreting the findings. Additionally, the potential influence of social desirability bias cannot be entirely excluded. The study addresses a topic that is frequently subject to public and political debate in Germany, which may have affected the sincerity of responses, particularly regarding treatment readiness, even with the use of vignettes. Another relevant contextual factor is the extensive media coverage of the war in Ukraine during the data collection period. This may have shaped participants' attitudes toward the patients' country of origin in the vignette (Moise et al., 2024). Previous research has demonstrated that media representations significantly influence public attitudes toward refugees (Kosho, 2016; Tsai et al., 2023). Moreover, the study is based solely on the German healthcare system, which restricts the generalizability of the findings to other countries. This should be considered when interpreting the results. Future research should examine psychotherapists' treatment readiness in international contexts to enable broader comparisons. Regarding the data collection in the first two publications, it should be noted that while visual analogue scales are a useful tool, they provide only limited explanatory power. Future research should use multi-item scales to assess treatment readiness and obtain more valid data. Additionally, the small effect sizes limit the practical applicability of the findings. Furthermore, the therapeutic approach (e.g. psychodynamic approach, behavioral therapy or systemic therapy) was not examined. It might be possible that certain approaches are incompatible with interpreters or language barriers in general. For example, an interpreter might interfere with the transference process in depth-psychological approaches. This should be considered when interpreting the results regarding therapists' readiness to treat.

In the third publication, nearly one-third of the participating psychotherapists had not yet worked with UYR when the data was collected. This should be considered when interpreting

the primary findings. To address this limitation, secondary analyses were conducted. However, these analyses are based on a reduced sample size, which could have affected the findings. Additionally, key variables such as therapists' own refugee or trauma backgrounds, supervision and intervision use, overtime, staff shortages, and shift work may have influenced ProQOL outcomes, yet they were not captured in the study. Finally, it should be noted that potential selection bias may have affected the third publication. The overarching BETTER CARE project offered benefits to participants that likely attracted highly motivated therapists and child welfare workers to support UYR (Rosner et al., 2020). This may have affected the composition of the sample, resulting in higher levels of compassion satisfaction and a lower burden. Conversely, this cohort may inherently show greater motivation and compassion satisfaction, which is why they engage with this patient group. Thus, the findings provide valuable insights into the well-being of professional practitioners working with UYR.

5.3 Implications and Future Directions

The dissertation aims to advance research into discrimination and stigmatization within the German psychotherapeutic care system, with a particular focus on refugee populations. The findings indicate that psychotherapists are less inclined to treat refugee patients with traumatic experiences compared to German patients with the same experience. Furthermore, they tend to anticipate lower treatment success in these cases. Notably, Syrian refugees were assigned the lowest expected treatment outcomes, despite the case vignettes being controlled for type of traumatic event, PTSD symptoms, and age. The current level of strain among psychotherapists, as measured by burnout and secondary traumatic stress, does not seem to affect their readiness to treat refugee patients. One might have assumed that therapists under significant strain would avoid working with refugees. However, the findings propose that therapists who work with refugees and UYR report significantly higher levels of compassion satisfaction and are more ready to provide treatment. The following section aims to highlight both practical and research-based implications that could be derived from the dissertation's findings.

To begin with the practical implications, educational and training interventions for psychotherapists might be a helpful way to promote the treatment for refugees at high risk for mental disorders. The mental health of refugees, as well as clinical work with this population and its success, could be integrated into the curriculum of clinical psychology studies. Additionally, subsequent licensure training might incorporate trauma-specific treatment approaches for refugees. The training period could be used to facilitate contact with refugee patients, in order to proactively counteract potential prejudices and concerns. This phase is particularly suitable, as close supervision is typically available.

To further support practitioners, it may be beneficial to implement specialized supervision and establish professional networks after licensure. Potential burden, challenges and barriers could be addressed and resolved within specialized peer groups. Another helpful way to support initial contact with refugees might be the implementation of a mentoring program. Therapists with

extensive experience of working with refugees might serve as points of contact and support for newly licensed psychotherapists. Therapists could increase their readiness through greater knowledge of refugees' specific circumstances and by learning from trainers who serve as therapeutic role models. However, further investigation may be needed to explore whether and how these options could potentially influence treatment readiness.

Given the anticipated treatment success, it might be helpful to continue implementing and expanding manualized evidence-based trauma therapy specialized for refugees. Psychotherapists may expect improved treatment success and greater confidence when they can rely on an effective, scientific proven manual. Facilitating access to interpreters and increasing transparency in bureaucratic and funding-related matters may influence the readiness to engage in therapy and the anticipated treatment success. A practical approach might be to establish direct connections between interpreters and psychotherapists to bypass long processing times by social welfare authorities.

Building on the research-based implications, future studies might focus on identifying additional factors that influence psychotherapists' readiness to provide treatment. Potential mediators could include personal fears and concerns, as well as openness toward other cultures. To investigate these dynamics more deeply, future inquiry might employ diverse vignettes. Vignettes that vary by characteristics such as the patient's country of origin, religion, skin color, educational background, or asylum status may offer valuable insights into underlying biases among psychotherapists. In addition to conventional barriers such as language difficulties and bureaucratic obstacles, it might be helpful to examine how the attitudes of practicing psychotherapists are influenced by the media and current political trends in Germany. Societal narratives and stereotypes associated with specific nationalities, and their impact on therapeutic decision-making, could be systematically investigated. Distinguishing between conscious rejection, implicit biases, limited cultural competence and structural barriers might provide valuable insight into the mechanisms underlying unequal treatment in German psychotherapeutic care. Another important aspect is the generalizability of this dissertation's findings. As previously mentioned, the influence of the respective country's refugee policy may play a role and could

be worth considering. This might involve differences in healthcare systems, bureaucratic challenges in accessing psychotherapy, and potential administrative burdens for psychotherapists. Accordingly, this research could be replicated in other national contexts to explore whether similar patterns emerge under different political and institutional conditions.

Furthermore, future research could assess the impact of integrating evidence-based manuals into academic studies and clinical training on treatment readiness. As previously discussed, a longitudinal study examining treatment readiness and anticipated treatment success before, immediately after, and at follow-up intervals following the manual's implementation might offer further insights. Moreover, the role of psychotherapists who have personal experiences with forced migration or a migration background in working with refugees might be examined more closely. Their unique insights and expertise could significantly improve refugee care. However, they are underrepresented in literature and should be more systematically integrated into research efforts.

Furthermore, a longitudinal study might be beneficial for future insights, allowing for more precise monitoring of whether working with refugees leads to long-term changes in ProQOL and expected treatment success. As noted in the limitations, the burden experienced by child welfare workers in their work with UYR also warrants closer examination. In particular, work-related stressors such as overtime and shift work should be investigated as potential mediators. Additionally, potential protective factors such as supervision, interprofessional support, and collegial assistance could be systematically considered. Moreover, future research could delve deeper into compassion satisfaction in this context. As previously noted, scholarly exploration of topics such as professional identity and the management of positive and negative patient feedback could be of particular interest. Professional identity could be examined through qualitative research and in relation to perceived compassion satisfaction. Patient feedback might also be investigated to determine whether positive or negative feedback influences the degree of compassion satisfaction experienced by psychotherapists. Insights from such research might have practical implications for clinical settings. In outpatient care, fostering compassion satisfaction among practitioners and promoting a resource-oriented work environment that enhances

the perceived meaningfulness of working with refugee populations may be essential. Supporting psychotherapists could help to improve the quality and availability of psychotherapeutic care for refugee populations.

To conclude it is worth emphasizing that working with refugees should not be viewed solely through the lens of challenges and negative aspects. Highlighting the effectiveness and positive aspects of this work is equally important. Doing so might enhance psychotherapists' expectations regarding therapeutic efficacy, reduce stereotypes and stigma, and foster greater motivation to engage with this population.

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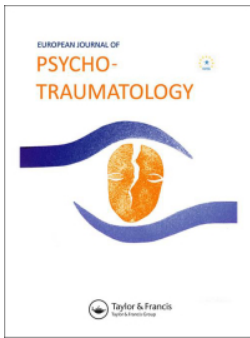
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PART 2

PUBLICATIONS

Publication 1

Title	Psychotherapists' readiness to treat PTSD: the influence of refugees' country of origin
Authors	Pia Maria Schwegler ¹ Katharina Gossmann ¹ Theresa Neumann Anne Moser Theresa Speth Rita Rosner ¹ shared first author
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Psychotherapists' readiness to treat PTSD: the influence of refugees' country of origin

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ABSTRACT

Background: Previous research suggests that psychotherapists' readiness to treat traumatized patients varies according to patient and therapist characteristics, including the patient's refugee background.

Objective: This study aims to examine the relationship between psychotherapists' readiness to treat patients with symptoms of post-traumatic stress disorder and various patient and therapist characteristics, including refugee background and country of origin.

Method: In our vignette study with a nationwide online survey in Germany ($N = 871$), we assessed the readiness of licensed psychotherapists (LPTs) and therapists in training (PiTs) to treat patients with PTSD. Vignettes described patients with PTSD who differed in gender, refugee background, and country of origin (Syria vs. Ukraine). Participants rated treatment readiness and expected treatment success based on the vignette they received.

Results: Treatment readiness and expected success were significantly lower for refugee patients. There was no difference in treatment readiness between refugees from Syria and Ukraine, but therapists expected less therapeutic success for Syrian patients compared to Ukrainian patients. Gender did not influence the results.

Conclusions: The study shows that refugee background and country of origin influence psychotherapists' readiness to treat PTSD and their expectations of treatment success. These findings highlight potential reasons for the undertreatment of refugees and suggest opportunities for intervention and training, such as informing therapists about effective treatments for refugee patients.

Disposición al tratamiento de los psicoterapeutas en Alemania: la influencia de los antecedentes y el país de origen de los refugiados

Antecedentes: Investigaciones anteriores sugieren que la disposición de los psicoterapeutas para tratar a pacientes traumatizados varía según las características del paciente y del terapeuta, incluyendo el origen del paciente refugiado.

Objetivo: Este estudio pretende examinar la relación entre la disposición de los psicoterapeutas para tratar a pacientes con síntomas de trastorno de estrés postraumático y diversas características de los pacientes y los terapeutas, incluyendo los antecedentes y el país de origen de los refugiados.

Método: En nuestro estudio de viñetas con una encuesta en línea a nivel nacional en Alemania ($N = 871$), evaluamos la disposición de los psicoterapeutas licenciados (LPTs, por sus siglas en inglés) y los terapeutas en formación (PiTs, por sus siglas en inglés) para tratar a pacientes con TEPT. Las viñetas describían a pacientes con TEPT que diferían según el género, los antecedentes de los refugiados y el país de origen (Siria o Ucrania). Los participantes calificaron la disposición para el tratamiento y el éxito esperado del tratamiento en función de la viñeta que recibieron.

Resultados: La disposición al tratamiento y el éxito esperado fueron significativamente menores en el caso de los pacientes refugiados. No hubo diferencias en la disposición al tratamiento entre los refugiados de Siria y Ucrania, pero los terapeutas esperaban un menor éxito terapéutico en el caso de los pacientes sirios en comparación con los pacientes ucranianos. El género no influyó en los resultados.

Conclusiones: El estudio muestra que los antecedentes y el país de origen de los refugiados influyen en la disposición de los psicoterapeutas a tratar el TEPT y en sus expectativas del éxito del tratamiento. Estos hallazgos destacan posibles razones para el tratamiento insuficiente de los refugiados y sugieren oportunidades de intervención y capacitación, como informar a los terapeutas sobre los tratamientos eficaces para los pacientes refugiados.

Abbreviations: LPT: Licensed Psychotherapist; PiT: Psychotherapist in Training

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Treatment readiness; expected therapeutic success; PTSD, patients' characteristics; migration; flight; country of origin

PALABRAS CLAVE

Disposición al tratamiento; éxito terapéutico esperado; TEPT; características del paciente; migración; huida; país de origen

HIGHLIGHTS

- Online study based on randomized PTSD case vignettes.
- Therapists reported less treatment readiness for refugee patients with PTSD symptoms and expected less therapy success for Syrian refugees with PTSD symptoms compared to Ukrainian.
- Results can be used to improve training for therapy in an intercultural setting.

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1. Introduction

In June 2024, the UNHCR estimated 117.3 million forcibly displaced people worldwide, of whom 37.6 million were refugees (UNHCR, 2024a). In January 2024, a total of 26,376 asylum applications were submitted in Germany, with the most prevalent nationalities being Syria, Afghanistan, and Turkey (BAMF, 2024a). Since Russia's invasion of Ukraine in February 2022, about 6.73 million Ukrainians have been forced to flee their homes (UNHCR, 2024b). By the end of 2023, 977,000 Ukrainians had sought refuge in Germany (Statistisches Bundesamt, 2024).

Refugees are exposed to significant stress and traumatic events, leading to an increased prevalence of mental disorders such as PTSD, depression, and anxiety (Figueiredo et al., 2024; Hajak et al., 2021; Müller et al., 2019; Nguyen et al., 2022). Recent studies have shown a pooled prevalence of 40% for anxiety, 31% for depression, and 31% for PTSD among Syrian refugees resettled in high-income Western countries, indicating that prevalence is higher than in the respective host countries (Nguyen et al., 2022). 44% of Ukrainian refugees surveyed in Portugal met the criteria for PTSD (Figueiredo et al., 2024). In a sample of Ukrainian refugees in Germany 44.7% reported depressive symptoms, and 51.0% exhibited anxiety symptoms (Buchcik et al., 2023). Longitudinal studies show that these symptoms often persist for years in refugee populations (Hinchey et al., 2024; Opaas et al., 2020). Refugee women are at greater risk of mental illness (Blackmore et al., 2020; Buchcik et al., 2023), particularly PTSD due to an increased risk of sexual violence (Blackmore et al., 2020; Schlaudt et al., 2020).

In addition to the stress and traumatic experiences they endured during flight, Syrian refugees in Germany face significant post-migration challenges in their host country (von Haumeder et al., 2019). Language barriers, socio-economic hardships, family concerns, and the complexities of the asylum process have a significant impact on their overall well-being. Moreover, unemployment, housing problems, lack of medical care, and exposure to stereotypes and discrimination contribute to psychological distress and increased traumatic stress. The post-migration situation of refugees from Ukraine in Germany may differ due to the granting of a direct residence permit until 2025 (BAMF, 2024b). Ukrainian refugees are advised to consider whether applying for asylum is the best option for them, as this may affect their choice of residence, accommodation and employment (BAMF, 2024b). According to Bruecker et al. (2022), 18% of Ukrainian refugees of working age are employed 6 months after their arrival, 75% live in private accommodation, 9% in shared accommodation. Regardless of country of origin and host country,

research suggests that post-migration stressors can increase overall psychological distress (Hajak et al., 2021; Li et al., 2016) and the risk of PTSD (von Haumeder et al., 2019).

The high level of psychological distress among refugees highlights the need for psychological support in host countries. Research has shown that refugees can benefit significantly from psychotherapy (Kip et al., 2020; Turrini et al., 2019). Trauma-focused cognitive behavioural therapy for child and adolescent refugees (TF-CBT) (Chipalo, 2021; Genç, 2022) and Cognitive Behavioural Therapy (CBT), Narrative Exposure Therapy (NET) and Eye Movement Desensitization and Reprocessing (EMDR) for adult refugees (Turrini et al., 2019) have been shown to significantly reduce symptoms of PTSD, depression, and anxiety. Stenmark et al. (2014) observed a gender difference in the efficacy of therapy, with refugee women showing greater benefit, although research on gender differences remains limited.

Despite the high need for psychotherapy and the proven therapeutic success, refugees are an underrepresented population in clinical research (Hinchey et al., 2023; Panter-Brick et al., 2020) and often face significant challenges in accessing the German health care system (BAfF e.V., 2023). These difficulties are due to bureaucratic aspects, the opacity of the health care system in a foreign country, and language barriers (Hahn et al., 2020). In general, there appear to be gender disparities in access to health care, with refugee women facing more barriers, such as lack of cultural awareness of gender norms and discrimination (Coumans & Wark, 2024; Zivot et al., 2020). In the first 18 months after their arrival, refugees in Germany are only entitled to medical treatment for acute illness or pain, with the costs covered by the Social Welfare Office (BAfF e.V., 2023). Ukrainian refugees have had full access to statutory health insurance since 2022 (BAMF, 2024c). However, health care capacity is limited and waiting lists are long, especially for psychotherapy (BAfF e.V., 2023). Patients with standard health insurance wait an average of 4.7 months to begin treatment (Funke-Kaiser, 2022), while refugees in psychosocial centers wait an average of 7.2 months (BAfF e.V., 2023). Even though capacity is often mentioned by psychotherapists, no connection could be found between capacity and refugee treatment (Dumke et al., 2023). Kiselev et al. (2020) also reported that therapists with the shortest wait times and lowest rejection rates did not treat refugees. Dumke et al. (2023) examined further barriers such as limited contact with psychotherapists, language barriers, and the availability and cost of trained interpreters. Refugees are an underrepresented population in psychotherapy, receiving 20% shorter treatment than other patients.

Additionally, to the described objective barriers to access the German health care system, reservations

about psychotherapy with refugees were expressed by therapists. Attitudes towards refugees in Europe often depend on the refugees' socio-demographic characteristics, with a notable anti-Muslim bias and a preference for skilled professionals over the unemployed and for refugee women over men (Bansak et al., 2016; Bansak et al., 2023). A German study conducted by Dumke and Neuner (2022), found that psychotherapists' attitudes toward refugee patients differed significantly from those toward non-refugee patients. Psychotherapists showed significantly higher psychotherapy-hindering attitudes towards refugees. They expected greater difficulty and more negative emotions in therapy, which was associated with less provision of psychotherapy for refugees. Where outpatient psychotherapy was recommended for refugee women, medication or inpatient treatment was recommended for refugee men. These findings indicate that psychotherapists' attitudes may contribute to refugees' lack of access to psychotherapy and, consequently, to evidence-based treatments. According to Schlechter et al. (2021), German psychotherapists' readiness to work with refugees was influenced by self-doubt, neutrality, comfort in working with interpreters, previous experience of working with refugees, and language barriers. Additionally, a qualitative survey identified specific bureaucratic effort, organizational difficulties, and client motivation as key factors affecting psychotherapists' willingness to treat refugees, although therapy was generally perceived as enriching (Potter et al., 2023). Peñuela-O'Brien et al., (2023), also addressed challenges, including migrant status, emotional responses, and cultural differences. Psychotherapists therefore expect certain barriers when working with refugees.

In the past, research has repeatedly shown that psychotherapists' expectations have a decisive impact on treatment outcome and progress (Dragiotti et al., 2015; Rosenthal & Rubin, 1978; Shaw, 1999; Swift et al., 2018; Wampold, 2001). Swift et al. (2018) was able to predict treatment outcome based on trainee therapists' outcome expectations, explaining 11% of the variance in patient change. Bartholomew et al. (2019) highlighted the importance of therapist hope in influencing treatment outcome. Additionally, the expected outcome of the therapeutic process appears to influence the patient-therapist relationship, with stronger alliances formed when patients expect positive outcomes (Constantino et al., 2020). However, there is limited research on psychotherapists' expectations of therapy outcome when working with refugees.

As shown, refugees experience significant psychological distress, but face challenges in receiving adequate psychotherapeutic support due to both objective barriers, such as language difficulties, and subjective barriers such as psychotherapists' attitudes

toward treating refugees (Dumke & Neuner, 2022). These attitudes may influence the therapeutic outcomes. However, there is limited research on how a refugee's country of origin affects the attitudes and expectations of LPT and PiT in Germany. The research question of this study is whether the country of origin of the refugee patient influences the therapists' readiness to treat and the expected treatment success. Due to the differences between Syrian and Ukrainian refugees in the German health care system (BAfF e.V., 2023; BAMF, 2024c) and the attitude towards refugees depending on their socio-demographics (Bansak et al., 2016; Bansak et al., 2023), these two countries of origin were included in the analysis. The following four hypotheses were proposed: (1) Therapists perceive a lower readiness to treat refugees than non-refugees; (2) Therapists perceive a lower readiness to treat Syrian refugees than Ukrainian refugees; (3) Therapists expect a lower treatment success with refugees than non-refugees; (4) Therapists expect a lower treatment success with Syrian refugees than Ukrainian refugees. In both research questions, the gender of the patient is considered as a potential influencing factor.

2. Methods

2.1. Ethics

The study was approved by the university's ethics board (approval number: 121-2022). All participants were informed about the aims of the study and gave their informed consent before participating in the survey. Furthermore, they were informed about applicable data protection regulations.

2.2. Recruitment and participants

The cross-sectional study was designed as a nationwide anonymous online survey among LPTs and PiTs in Germany. The survey was distributed among psychotherapists (including PiTs and LPTs) in Germany by cooperating with regional and national psychotherapist associations as well as training institutions for psychotherapy. These associations and institutions informed their members about the survey via newsletters, journals, separate emails, or internal cloud servers. Some federal associations for LPTs referred us to the publicly available psychotherapist search options on their homepages. According to these referrals, we searched the directories of these associations for publicly available email addresses and contacted all listed LPTs. For recruiting the PiTs, we compiled an exhaustive list of all psychotherapeutic training institutions in Germany by federal state and therapeutic approach. Then, we randomly selected an institution for each therapeutic approach in each federal state if available and contacted

these institutions by phone and by email. If this institution agreed in distributing our survey to their trainees, it received the study information as well as the study invitation. If this institution did not agree or answer, we randomly selected the next one with the same therapeutic approach for this federal state. A total of 51 institutions were contacted, with a response rate of 68.63% (35 acceptances). All trainees in a participating training institution received the study information.

The study consent included information on the duration and aim of the anonymous survey, the data protection regulations, as well as the requirement that only psychotherapeutic practitioners can participate. As the survey aimed to assess treatment readiness regarding different migration and refugee backgrounds of patients with PTSD using an experimental design with randomly presented case vignettes, we did not include information about the case vignettes in the study invitation. The duration of the online survey was about 15 minutes and at the end, a total of $N = 1032$ LPTs and PiTs participated. Of these, $n = 161$ data sets were excluded from the statistical analysis because they dropped out before they were assigned a case vignette or because they had not answered the items related to the presented case vignette. Further analysis (chi-squared test) did not reveal any differences in whether early dropout was associated with being already licensed or still in training. The odds of dropping out were increased by 0.59 for women [$X^2(1) = 5.42, p = .02$]. The final sample consisted of $N = 871$ LPTs and PiTs.

2.3. Procedure

The survey was presented in German, and data was collected anonymously with Qualtrics (Qualtrics, Provo, UT, 2023) during October 2022 to August 2023. After giving their informed consent, the participating therapists provided demographic information like age and gender as well as professional information like therapeutic approach. In this demographical section, we also assessed the migration and refugee background as well as native tongue and experiences with PTSD treatment. After the demographical section, the participants were presented with one of six case vignettes, portraying a patient with PTSD symptoms, see [Figure 1](#). Based on the case vignette, the participants rated their personal readiness to conduct psychotherapy with the described patient. The psychotherapists did not receive any incentives for voluntary participation in the survey.

2.4. Material

2.4.1. Measures

Participating LPTs and PiTs provided the following sociodemographic and professional information: age, gender, university degree program completed, own migration and refugee background, native tongue, further language skills, licensure information (LPT vs.

PiT), patient focus (adults vs. children/adolescents), therapeutic approach (cognitive behavioural therapy: CBT; psychodynamic therapy, including psychoanalysis and depth therapy: PDT; systemic therapy: ST), number of therapy sessions per week, number of patients treated for PTSD, therapeutic experience with refugees, and additional trauma-specific training.

Participants were randomly presented with one of six case vignettes (see below) and rated their level of readiness to psychotherapeutically treat as well as the expected treatment success on a single item visual analogue scale (VAS) ranging from 0 (low) to 100 (high). The two items were as follows: For treatment readiness ‘How willing are you to treat the described person psychotherapeutically?’ and for self-expected therapy success ‘How successful do you expect the therapeutic treatment to be?’

2.4.2. Case vignettes

For assessing treatment readiness, we developed six mostly parallel vignettes (65–66 words each) and varied the patient’s gender (woman vs. man). Additionally, we varied the refugee background (refugee vs. no-refugee), and for the two flight vignette types also the country of origin (Ukraine vs. Syria). All vignette characteristics were randomized among the participating therapists. To parallelize the Ukraine vs. Syria vignettes, the flight vignettes for Ukraine and Syria were identical except the names of the described persons as well as the country of origin. To enhance a maximum parallelization between the refugee vs. no-refugee vignettes, we developed a no-refugee vignette with the same traumatic experience as the refugee vignette during a travel. All six vignettes are shown in [Figure 1](#).

2.5. Statistical analyses

To analyze the hypothesis regarding the treatment readiness based on the manipulated variables of the case vignettes, we conducted two 2×2 ANOVAs. The first 2×2 ANOVA included readiness to treat the described patient as the dependent variable and the manipulated factors patients’ gender (woman vs. man) and patients’ refugee background (refugee vs. no-refugee). The second 2×2 ANOVA then distinguished between different countries of origin among the two refugee vignettes (Syria vs. Ukraine). Accordingly, patients’ country of origin and gender were included as independent variables.

The second hypothesis was also tested by two 2×2 ANOVAs with expected therapy success as dependent variable and again manipulated patients’ characteristics gender (woman vs. man) and patients’ refugee background (refugee vs. no-refugee) as independent variables for the first ANOVA. The second 2×2 ANOVA again distinguished between different countries of origin among the two refugee vignettes

Refugee Background	Gender	Traumatic Experience	Post-traumatic stress symptoms
No flight experience	Female	Sarah is 19 years old and went on vacation with her mother in 2021. During the trip, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Sarah has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Sarah withdraws more and more and is often sad.
	Male	Daniel 19 years old and went on vacation with his mother in 2021. During the trip, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Daniel has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Daniel withdraws more and more and is often sad.
Syria	Female	Nadjiba is 19 years old and fled Syria together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Nadjiba has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Nadjiba withdraws more and more and is often sad.
	Male	Ibrar is 19 years old and fled Syria with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Ibrar has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Ibrar withdraws more and more and is often sad.
Ukraine	Female	Natalia is 19 years old and fled Ukraine together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Natalia has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Natalia withdraws more and more and is often sad.
	Male	Dmytro is 19 years old and fled Ukraine together with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Dmytro has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Dmytro withdraws more and more and is often sad.

Figure 1. Randomized vignettes.

(Syria vs. Ukraine) by including those together with patients' gender as independent variables.

All predictors utilized in all analyses consisted of sufficiently large sample sizes for the analyses. Demographic factors that were less pronounced, such as the therapists' own migration background, were only used for descriptive purposes and are considered in the discussion. These factors were not included in the analyses to avoid introducing bias.

3. Results

3.1. Descriptive statistics

The final data set ($N = 871$) consisted of $n = 623$ LTPs, $n = 218$ PiTs, and $n = 26$ psychologists with a master's

Table 1. Demographic information about the participating psychotherapists (LPTs and PiTs).

Variable	$N = 871$					
	n	M	SD	Mdn	Min	Max
Age (years)	871	45.49	12.30	44	24	80
Licensed for (years)	594	12.48	8.44	10	0	42
Own practice for (years)	483	11.11	9.15	8	0	50
Employed by a clinic/hospital since (years)	98	8.89	7.82	7	1	32
Therapy sessions per week	871	18.62	9.12	20	0	50
Number of patients treated for PTSD	843	47.24	213.16	15	0	5400
Number therapy with refugees	420	12.15	27.14	5	0	250
Number therapy with refugees treating PTSD	421	8.50	18.27	3	0	150

or diploma degree without licensure plans; $n = 4$ indicated another qualification. The mean age of the sample was 45.49 years ($SD = 12.3$, $Mdn = 44$). 83.7% of the participants identified as cisgender women ($n = 729$) and five reported diverse gender. 103 participants (12.2%) reported a migration background, $n = 8$ (0.9%) reported flight experiences themselves, and $n = 425$ participants (48.8%) had already worked with refugees. Further participant characteristics can be found in Table 1 and Table 2.

The distribution of the vignettes can be found in Table 3. Readiness to treat ($N = 871$) had a mean value of 79.98 ($SD = 23.00$; $Mdn = 87$; $Min = 0$; $Max = 100$), 59.4% of the participants scored above the mean value. Expected treatment success ($N = 844$) had a mean value of 66.89 ($SD = 16.55$; $Mdn = 70$, $Min = 3$; $Max = 100$), 53.8% scored above the mean value. Readiness to treat and expected treatment success for each vignette are shown in Figure 2 and Figure 3.

3.2. Results of the 2×2 ANOVAs regarding treatment readiness

For our first hypothesis about therapists' lower readiness to treat patients with refugee experience, the two-way ANOVA was significant: $F(1, 867) = 30.88$, $p < .001$, partial $\eta^2 = .034$. There were no significant differences in readiness to treat based on the gender

Table 2. Demographic information about the participating LPTs and PiTs.

Variable	N = 871		Variable	N = 871	
	n	%		n	%
Training status			Gender		
Completed training	623	71.5	Female	729	83.7
Currently in training	218	25.0	Male	137	15.7
Diploma or Master's degree without training	26	3.0	Diverse	5	0.6
Other	4	0.5	Working with refugee	425	48.8
Type of license	162	18.6	Yes	40	4.6
Psychotherapist for children and adolescents	370	42.5	Migration background	63	7.2
Psychological psychotherapist	66	7.6	Yes, myself	8	0.9
Psychological psychotherapist also licensed for treating children and adolescents	21	2.4	Yes, my parents		
Medical psychotherapist	6	0.7	Flight experience		
Other			Yes		
Employed by a clinic/hospital	98	11.6	Therapeutic approach		
Own practice	497	59.0	Behavioural Therapy	657	75.4
			Psychodynamic Approach	229	26.3
			Systemic		
Approved for public health care insurance	495	58.8	Other	49	5.6
Specific trauma training				33	3.8
EMDR	336	38.6			
TF-CBT	339	38.9			
NET	251	28.8			
Imaginary Rescripting	243	27.9			
Hypnotherapy	149	17.1			
CPT	91	10.4			
Play therapy	86	9.9			
Somatic Experiencing	39	4.5			
Other	178	20.4			
None	139	16.0			

Note. LPT – Licensed psychotherapist, PiT – Psychotherapist in Training, EMDR – Eye Movement Desensitization and Reprocessing, TF-CBT – Trauma-Focused Cognitive Behavioural Therapy, NET – Narrative Exposition Therapy, CPT – Cognitive Processing Therapy.

of the patient presented in the vignette, $F(1, 867) = 0.91$, $p = .34$, partial $\eta^2 = .001$. There were no significant interactions between gender and flight experience, $F(1, 867) = 1.87$, $p = .17$, partial $\eta^2 = .002$.

For our second hypothesis about therapists' lower readiness to treat patients with refugee experience from Syria, the two-way ANOVA was not significant: $F(1, 587) = 1.21$, $p = .27$, partial $\eta^2 = .002$. There were no significant differences in readiness to treat based on the gender of the patient presented in the vignette, $F(1, 587) = 3.76$, $p = .053$, partial $\eta^2 = .006$. However, a trend can be observed for the gender variable. Therapists' readiness to treat refugee women tends to be higher than their readiness to treat refugee men. Apparently, the effect is greater for the variable Ukraine, but it cannot be interpreted as the effect disappears as soon as the country of origin is added as a variable. There were no significant interactions

between gender and country of origin, $F(1, 587) = 1.18$, $p = .28$, partial $\eta^2 = .002$.

3.3. Results of the 2 × 2 ANOVAs regarding expected treatment success

For our third hypothesis about therapists' lower expected treatment success for patients with refugee experience, the two-way ANOVA was significant: $F(1, 840) = 11.61$, $p < .001$, partial $\eta^2 = .014$. There were no significant differences in expected treatment success based on the gender of the patient presented in the vignette, $F(1, 840) = 0.25$, $p = .62$, partial $\eta^2 = .000$. There were no significant interactions between gender and flight experience, $F(1, 840) = 2.01$, $p = .157$, partial $\eta^2 = .002$.

For our fourth hypothesis about therapists' lower expected treatment success for patients from Syria, the two-way ANOVA was significant: $F(1, 575) = 5.73$, $p = .017$, partial $\eta^2 = .010$. Regarding the country of origin the observed effect proved also significant: $F(2, 838) = 8.76$, $p < .001$, partial $\eta^2 = .02$. The expected treatment success is significantly lower for Syrian patients compared to German and Ukrainian patients. Bonferroni post hoc tests also revealed that the expected treatment success was significantly lower for Syrian patients than for German ($p < .001$) and Ukrainian ($p = .048$) patients. There were no significant differences in expected treatment success based on the gender of the patient presented in the

Table 3. Distribution of the vignettes.

Vignettes	N = 871		N = 844	
	n	%	n	%
Flight – Ukraine – Male	152	17.45	147	17.42
Flight – Ukraine – Female	149	17.11	146	17.30
Flight – Syria – Male	141	16.19	140	16.59
Flight – Syria – Female	149	17.11	146	17.30
No Flight – Germany – Male	151	17.34	144	17.06
No Flight – Germany – Female	129	14.81	121	14.34

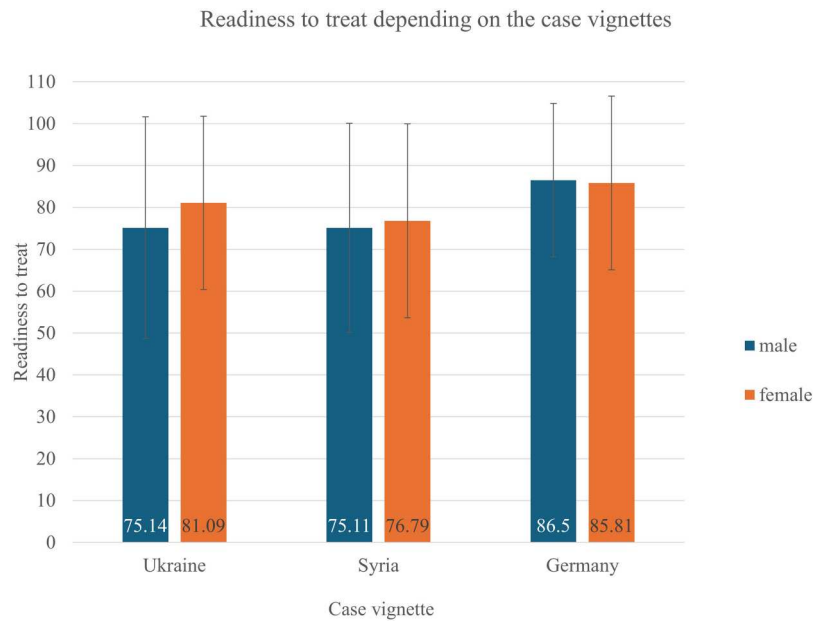


Figure 2. Readiness to treat depending on presented vignettes (the figure shows mean values and standard deviations).

vignette, $F(1, 575) = 0.7$, $p = .403$, partial $\eta^2 = .001$. There were no significant interactions between gender and country of origin, $F(1, 575) = 0.01$, $p = .906$, partial $\eta^2 = .000$.

If the two-way ANOVA is calculated separately for the respective group of PiTs [$F(1, 214) = 7.66$, $p = .006$, partial $\eta^2 = .35$] and LPTs [$F(1, 619) = 21.77$, $p < .001$, partial $\eta^2 = .034$], the results for lower readiness to treat refugees were replicated. The patients' country of origin had no impact on the PiTs' [$F(1, 140) = 0.35$, $p = .556$, partial $\eta^2 = .002$] and LPTs' [$F(1, 420) = 2.58$, $p = .109$, partial $\eta^2 = .006$] readiness to treat the described vignette patients. The results could also be replicated for the expected treatment success. Even though the results for the LPTs [refugee background: $F(1, 599) = 13.46$, $p < .001$, partial $\eta^2 = .022$; country of origin: $F(1, 410) = 7.25$, $p = .007$, partial $\eta^2 = .017$] became clearer, additional information was obtained from the PiTs: The patient's refugee background [$F(1, 207) = 0.21$, $p = .650$, partial $\eta^2 = .001$] and country of origin [$F(1, 138) = 1.18$, $p = .279$, partial $\eta^2 = .008$] had no influence on the expected treatment success in this cohort.

4. Discussion

Previous research demonstrated that refugees suffering from PTSD due to their flight experiences have less access to psychotherapy in the German health care system (BAfF e.V., 2023; Nguyen et al., 2022). However, there is no data distinguishing between different countries of origin among refugees. We conducted a nationwide online survey among LPTs and PiTs to assess their readiness to treat as well as the expected therapeutic success as potential reasons for this undertreatment. To account for possible differences

between countries of origin (Syria vs. Ukraine), we designed an experimental study to examine patients' characteristics like country of origin, refugee background, and gender regarding their impact on the treatment readiness and self-expected therapeutic success among psychotherapists in Germany. The patients' characteristics were combined in six different case vignettes and one of these vignettes was randomly presented to each participant who then rated their readiness to treat and their expectation on therapeutic success for this vignette patient. For the $N = 871$ LPTs and PiTs in our study, we found that the readiness to treat as well as the expected therapeutic success for the vignette patients with a refugee background were significantly lower than for the vignette patients without refugee background. There was no difference between the countries of origin of the refugee vignettes (Syria vs. Ukraine) regarding the treatment readiness. However, there was a significant difference for the expected therapeutic success: Psychotherapists expected less therapy success for the Syrian vignette patients in comparison to the Ukrainian ones. All results were independent from patients' gender and showed only small effect sizes.

Our study has shown that the readiness to treat a specific patient with PTSD was generally high in our sample. However, the treatment readiness was influenced by the refugee background of this person, among others. This needs to be considered when the psychotherapeutic undertreatment of refugees is discussed and interventions are planned. As previous research demonstrated, trauma-specific training can have an impact on treatment readiness and related concepts like fears and doubts about the treatment (Borah et al., 2017; Cook et al., 2020; Gossmann et al., 2021; Schnell et al., 2015; Sundborg, 2019).

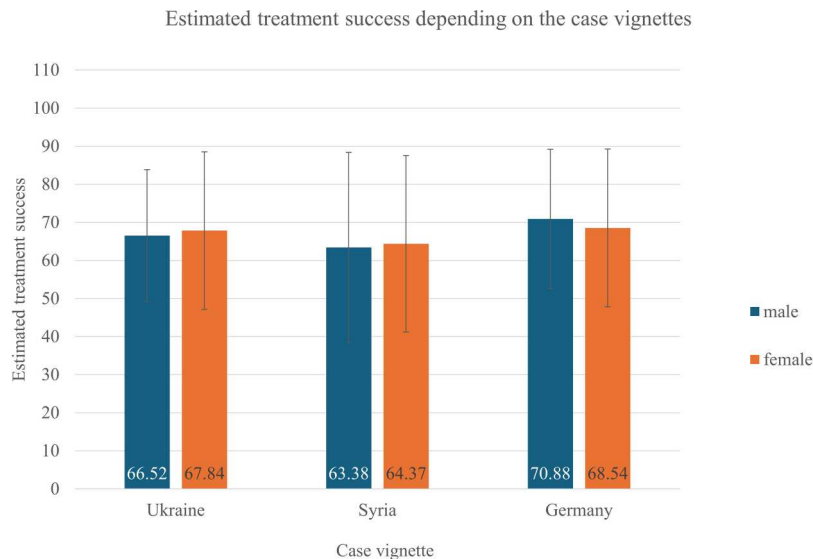


Figure 3. Estimated treatment success depending on presented vignettes (the figure shows mean values and standard deviations).

Therefore, training especially for treating patients with a refugee background should be provided after and during licensure. This applies equally to PiTs and LPTs, as no differences in readiness were found between these groups. Furthermore, the role of supervision needs to be explored. It might foster the treatment readiness when ongoing supervision is provided. Treatment readiness might not only depend on a lack of training but also on personal fears and doubts (Gossmann et al., 2021; Schlechter et al., 2021), which can be addressed during training and above all during supervision. Future research should examine the influence of supervision on treatment readiness and personal doubts with a control-group-design. Additionally, further experimental research could include other relevant patients' factors to a randomized vignette design such as the complexity of the trauma (e.g. PTSD vs. complex PTSD), age (children vs. adults), or the family status at time of migration or flight (unaccompanied vs. accompanied). As we did not find differences between the countries of origin (Syria vs. Ukraine) but only for the refugee background (refugee vs. no-refugee), future studies could also include other countries of origin like Afghanistan or Nigeria in a vignette study to prove the effect that the country of origin is less important than the refugee background itself when discussing treatment readiness of psychotherapists in Germany. Furthermore, future vignette studies could also distinguish between migrants in general and refugees to demonstrate if a refugee background increases the influence of migration regarding the attitudes of psychotherapists.

For the expected therapeutic success, we also found a small influence of refugee background: Psychotherapists expected less therapy success for PTSD-patients with than without a refugee background. Additionally, a lower therapy success was expected for Syrian

refugees in comparison to Ukrainian ones. So, we found no influence of the country of origin on the treatment readiness but on the expected therapeutic success. This might be a hinderance in achieving therapy success as previous research demonstrated that due to the allegiance effect a psychotherapist's personal conviction of therapeutic success has a relevant impact on the actual therapeutic success (Dragioti et al., 2015; Rosenthal & Rubin, 1978; Shaw, 1999; Swift et al., 2018; Wampold, 2001). So, one might hypothesize that even if a refugee patient suffering from PTSD receives psychotherapy, his or her country of origin might influence the therapy outcome – even when the nature of the traumatic experience is controlled like in our study. Although it is important to note that the effect was rather small, the results highlight the relevance of education on the success of treatments for PTSD for all countries of origin as previous research demonstrated that trauma-focused interventions like TF-CBT are successful among different ethnic groups as well as for refugees (Chipalo, 2021; Turrini et al., 2021). So, existing trainings for PTSD treatments as well as the standard psychotherapy training in Germany should highlight more the suitability of trauma-specific therapy for all ethnic groups and countries of origin and inform about expectable therapy outcomes. When considering the cohort of PiTs alone, the expected treatment success was not influenced by refugee background or country of origin. Perspectives may shift after licensure as barriers to refugee therapy become more apparent, or the differences may be generational. PiTs may have grown up with the issue differently or received more specific training. Further research should explore these differences in depth by replicating this study in a new cohort in a few decades to consider generational effects.

Based on our results, gender had neither a significant influence on the treatment readiness nor on the expected therapeutic success. However, we found a tendency regarding a higher treatment readiness towards Ukrainian women compared to men. These findings are relevant as the demographical characteristics of refugees from Ukraine and Syria in Germany distinguish: From Syria mainly (unaccompanied) men arrive in Germany, while from Ukraine more families or women with children arrive. Therefore, regarding the demographics we find less Syrian women and less Ukrainian men in Germany. Still our results show no difference for gender, but as already mentioned for the country of origin (Syria vs. Ukraine) in relationship with the expected therapeutic success. Thus, it is possible, that the beliefs and stereotypes about the country of origin overweight the ones about gender. Future studies could use a survey-like design to assess stereotypes, cultural openness, and fears or doubts in general and in relation to specific countries of origin. Additionally, these studies could consider the gender of the therapists to see if the matching of therapist and patient genders might be relevant. We also found that women were 0.59 more likely to prematurely drop out of the survey. It remains unclear whether this is due to vignette patient assignment and gender or statistical bias, as 83% of our group were women. Thus, the results regarding drop-out due to gender should be interpreted with caution.

4.1. Limitations

The recruitment strategy involved randomly selecting psychotherapeutic associations and training institutions, offering all members the opportunity to participate. As participation was voluntary, self-selection bias is likely, with psychotherapists interested in PTSD treatment more inclined to participate. This may explain the high reported treatment readiness and potential overestimation due to self-selection bias. Social desirability may also have influenced the results, although the anonymous design of the study and random vignette presentation help to reduce this effect.

The two outcome variables were measured with a single-item VAS, which is prone to measurement error. Future research could improve reliability of the variables using a multi-item scale. The VAS was chosen for the overall efficiency of the questionnaire. It is important to exercise caution when interpreting the results, due to the possibility of a Type I error by not including Bonferroni correction for all analyses and the small effect sizes. In a post-hoc test, the gender variable trend may not have appeared. Modest effect sizes suggest that the practical applications of these findings are limited. Furthermore, the error bars

show a high heterogeneity in the two outcome variables. This represents the different attitudes regarding treatment readiness and therapeutic success among psychotherapists. This heterogeneity needs to be considered in interpreting the results. Further research should also focus on therapist characteristics like previous experiences with refugees or intercultural competence or openness and their influence on treatment readiness and therapeutic success.

Given the international variability in health care systems, the results may not be fully generalizable to therapists in other countries. Although we assessed therapists' refugee backgrounds to explore potential correlations with treatment readiness, the small number of therapists with such backgrounds ($n = 8$; 0.9%) limited reliable analysis, affecting the generalizability of the findings. In this study, the impact of therapist characteristics was given less consideration, as the primary focus was on the characteristics of the vignettes. It is important to acknowledge that the therapist's work experience, for instance, may influence factors such as readiness and the expected treatment success.

5. Conclusions

This study was the first to experimentally assess the influence of country of origin, refugee background, and gender of patients suffering from PTSD after a traumatic experience regarding treatment readiness and expected therapeutic success among PiTs and LPTs in Germany. Our results demonstrated that the experimentally assessed patients' characteristic of refugee background does have an impact on treatment readiness and the expected therapy success among psychotherapists. Additionally, for Syrian refugees the expected therapeutic success was lower than for Ukrainian ones. Future research could include other potential mediators like personal fears and doubts, openness towards new cultures, or own migration background of psychotherapists. This inclusion of therapists' characteristics next to patients' characteristics could help to put the impact size of therapists' vs. patients' characteristics into relation. Our results based on treatment readiness and expected therapeutic success should be considered when discussing undertreatment of refugees suffering from PTSD and for interventions to close this treatment gap by e.g. focusing on these aspects in training. Therefore, trauma-specific training could focus more on the treatment of refugees and the suitability of an intervention for different ethnic groups and refugee backgrounds. That might increase the expectation of therapeutic success among LPTs and PiTs and so decrease undertreatment of refugees with PTSD by fostering treatment readiness.

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Ethics approval statement

The institutional review board of the Catholic University Eichstätt-Ingolstadt approved the study in December 2022 (ethics approval number: 121-2022). All participants gave their written informed consent to participate in the study.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The generated and analyzed data as well as the statistical code of the analyses are available from the corresponding author on request as they are not publicly available due to privacy reasons and ongoing analyses.

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Publication 2

Title	Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A cross-sectional vignette study
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My contribution	I co-designed the study, conceptualized the research question, coordinated, and supervised both data collection and participant recruitment, and contributed to the data acquisition. I performed, interpreted the statistical analyses, and drafted the manuscript. I initiated and finalized the submission process and integrated the reviewers' feedback.
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Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A Cross-Sectional Vignette Study

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Keywords: professional quality of life | psychotherapy with refugees | refugee background | treatment readiness

ABSTRACT

Background: Previous research has shown that psychotherapists' characteristics influence their readiness to treat refugee patients. The impact of therapists' professional quality of life (ProQOL) regarding their treatment readiness for refugee patients is unknown.

Objective: This study aims to evaluate the ProQOL among psychotherapists in Germany. It examines how these factors and previous experience working with refugees affect psychotherapists' treatment readiness for refugee patients with symptoms of post-traumatic stress disorder (PTSD).

Method: In our study, we assessed the treatment readiness of licensed psychotherapists (LPTs) and psychotherapists in training (PiTs) using randomized refugee versus nonrefugee vignettes. Participants ($N = 821$) rated their treatment readiness for the presented case, reported their professional quality of life on the ProQOL questionnaire as well as prior experience with psychotherapy for refugees.

Results: The ProQOL differed significantly between therapists with and without experience treating refugees: Compassion satisfaction was higher, and burnout lower for those who had already treated refugees. Overall, treatment readiness was lower for refugee than for nonrefugee patients. Therapists with prior experience of working with refugees reported a significantly higher treatment readiness for the refugee vignette. Treatment readiness was not affected by the reported ProQOL.

Conclusions: Treatment experience with refugees did not negatively impact therapists' ProQOL but fostered their further treatment readiness for this specific patient group. Psychotherapists should be encouraged to gain initial treatment experience with refugees to improve long-term health care for refugees. Encouragement could be achieved by providing supervision or specialist training.

Abbreviations: BO, burnout; CS, compassion satisfaction; LPT, licensed psychotherapist; PiT, psychotherapist in training; ProQOL, professional quality of life; STS, secondary traumatic stress.

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Summary

- Access to psychotherapy is particularly difficult for refugees in Germany, due to political, structural and individual factors, including psychotherapists' reservations.
- Psychotherapists' previous experience with refugees leads to higher compassion satisfaction, lower burn-out and greater readiness to work with refugees again.
- Professional quality of life does not influence the readiness of psychotherapists to treat refugees with PTSD.
- However, it appears that psychotherapists in general are less willing to treat refugees than nonrefugees.
- In order to provide better psychotherapeutic care for refugees, it is important to address structural and bureaucratic barriers as well as individual barriers such as lack of supervision, self-doubt and lack of knowledge.

1 | Introduction

In October 2024, the United Nations High Commissioner for Refugees reported 37.9 million refugees worldwide (UNHCR 2024). Of these, 65% originated from four countries: Syria, Venezuela, Ukraine and Afghanistan. A refugee is a person who has fled his or her home country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion and is unable or unwilling, owing to such fear, to return (UNHCR 1951). So far in 2024, 179,212 asylum applications have been submitted in Germany (Bundesamt für Migration und Flüchtlinge 2024). Refugees have shown to be at higher risk to mental disorders due to the cumulative traumatic experiences associated with their displacement (Emmelkamp 2023; Blackmore et al. 2020; Schlaudt et al. 2020; Schmidt et al. 2023). According to the study by Nickerson et al. (2021), the most commonly reported experiences of refugees who fled to Australia were lack of food or water (44.2%), being close to death (43%) and experiencing torture (22.2%). Among Syrian refugees in high-income Western countries, 40% reported symptoms of anxiety, 31% of depression and 31% of post-traumatic stress disorder (PTSD) (Nguyen et al. 2022). Ukrainian refugees reported similar rates, with 51% experiencing anxiety symptoms and 44.7% experiencing depressive symptoms in Germany (Buchcik et al. 2023); 44.16% reported PTSD symptoms in a study from Portugal (Figueiredo et al. 2024).

Even after arriving in the host country, refugees often face multiple stressors (Emmelkamp 2023). Post-migration stressors, such as discrimination in the host country, have been shown to negatively affect refugees' mental health (Grabo and Leavey 2023). Poor living conditions and limited social support increased PTSD and depression symptoms among refugees in Germany (Schilz et al. 2023). Language barriers, family concerns and anxiety about the asylum process also had a negative impact on mental health, whereas being treated fairly in the community, having enough food, financial support and

access to health care and education had a positive impact (von Haumeder et al. 2019).

Given the potential high need for psychological support in the refugee population, it is important to note that psychosocial interventions were shown to significantly reduce PTSD, depression and anxiety symptoms in refugees (Molendijk et al. 2024; Turrini et al. 2019). The results of the meta-analysis by Molendijk et al. (2024) supported the effectiveness of psychological treatments for adults, adolescents and refugee children. Positive effects are maintained over follow-up periods of at least 1 month (Turrini et al. 2019) and up to 6 months (Kip et al. 2020). In particular, cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing therapy (EMDR) were shown to be effective in reducing symptoms of PTSD in refugees (Turrini et al. 2021). While Antuña-Cambor and Hernandez (2025) reported no significant effects of EMDR on PTSD, Molendijk et al. (2024) found no differences in the methods studied but reported an overall effectiveness. Reports from refugee patients vary. Duden et al. (2020) found distrust of psychotherapy and concerns about stigma. Talking about problems was seen as both helpful and inappropriate. Trauma exposure in therapy gave meaning to experiences but was also stressful and worsening for some. While some found psychotherapy beneficial, others saw no improvement and preferred physical therapy or medication.

Although the need for and effectiveness of psychotherapy for refugees is high, accessing health care remains especially difficult for this population (BAfF e. V. 2024; Dumke, Wilker, et al. 2024). During the asylum process, health care costs are covered by the social welfare office (BAfF e. V. 2024). Within the first 18 months after arrival in Germany, it is difficult for refugees to get psychotherapy, as they are only entitled to medical care for acute illnesses or pain. Applications for psychotherapy and coverage are considered time-consuming and unlikely to be successful. After 18 months, refugees are entitled to the same benefits as those with statutory health insurance. In addition, due to limited treatment capacity in Germany, there are long waiting lists for psychotherapeutic treatment (BAfF e.V. 2024). Other barriers include uncertain asylum status (Duden et al. 2020) and difficulties navigating a foreign health care system (Hahn et al. 2020). For refugee patients, a different understanding of mental health, fear of stigmatization and lack of awareness of available services can be a hindrance (Dumke, Wilker, et al. 2024). For psychotherapy in particular, language barriers, lack of trained translators and lack of clarity about funding are prominent barriers among psychotherapists (Duden et al. 2020; Dumke et al. 2023; Kiselev et al. 2020). When treatment was available, it was on average 20% shorter than for nonrefugee patients (Dumke et al. 2023). Only 26.1% of the refugees in need of treatment had access to mental health services 1 year after their arrival in Germany, with only 17.4% receiving minimally adequate treatment, and 4.3% receiving minimally adequate psychotherapy (Dumke, Schmidt, et al. 2024).

Furthermore, psychotherapists in Germany showed more therapy-hindering attitudes and expected more negative emotions for themselves when treating refugees compared to non-refugees (Dumke and Neuner 2022). As a result, they were

generally less inclined to accept refugees as clients (Dumke and Neuner 2022; Schwegler et al. 2025). Factors perceived to influence therapists' treatment readiness include bureaucratic hurdles, organizational challenges, client motivation (Potter et al. 2023) and cultural differences, such as differing views on mental disorders and their treatment (Dumke, Wilker, et al. 2024; Peñuela-O'Brien et al. 2023). Self-doubt and comfort working with interpreters were identified as significant predictors for therapists' treatment readiness towards refugee patients (Schlechter et al. 2020). Prior experience with refugees, both private contact and in therapy, was shown to not only increase therapists' treatment readiness (Schlechter et al. 2020) but also reduce their therapy-hindering attitudes towards refugee patients (Dumke and Neuner 2022).

The professional quality of life (ProQOL) of psychotherapists is another aspect to be considered in relation to their readiness to treat refugees. In general, working as a psychotherapist can involve a high level of responsibility, emotional strain, but also openness and tolerance (Răbu et al. 2016). Given the higher prevalence of PTSD among refugees (Nguyen et al. 2022; Figueiredo et al. 2024), there is evidence that working with forcibly displaced people can lead to increased emotional distress in the form of burnout (BO) and secondary traumatic stress (STS) among mental health care providers from different countries like Turkey, Greece or Iraq (Brooks et al. 2022; Ghafoori et al. 2024; Kizilhan 2020; Roberts et al. 2021). In addition to exposure to trauma reports, post-migration factors such as resettlement difficulties and political and social barriers lead to frustration and disappointment among Australian caregivers (Puvimanasinghe et al. 2015). This had a cumulative effect on symptoms of secondary traumatization. Conversely, research has also shown that working with refugees is associated with an increase in compassion satisfaction (Posselt et al. 2019) and can have a positive and empowering impact on service providers in Australia (Posselt et al. 2019; Puvimanasinghe et al. 2015). In the interview study conducted by Puvimanasinghe et al. (2015), the majority of participants indicated that their motivation to engage with refugees was derived from their prior experience in this field. They reported that through their appreciation and awareness of the refugees' strengths and resilience, caregivers internalized these as positive experiences.

To summarize, various barriers exist in the psychotherapeutic treatment of refugees. In addition to bureaucratic aspects (BAfF e. V 2024), cultural differences (Potter et al. 2023; Peñuela-O'Brien et al. 2023) and reservations among psychotherapists (Dumke and Neuner 2022; Schwegler et al. 2025), it is possible that the ProQOL of German psychotherapists has an influence on their readiness to treat refugees. Increased stress among psychotherapists could lead to a decreased readiness to treat refugees. However, there is a lack of research on the relationship between ProQOL, experience of treating refugees and readiness to treat refugees among German psychotherapists working in outpatient settings, including licensed therapists and those still in training. Therefore, the main aim of this study was to find out whether the ProQOL of German psychotherapists influenced their readiness to treat refugees. Furthermore, this study aimed to reflect the situation of outpatient psychotherapeutic care in Germany as realistically as

possible. The survey was designed to be as broad as possible and included both experienced psychotherapists and psychotherapists in training (PiTs), different specializations (e.g., treating adults or children and adolescents, working with behavioural therapy or depth psychology) and different working contexts (self-employed or employed in a clinic). In addition, we aimed to replicate the results of Schlechter et al. (2020) using patients' vignettes on a larger sample. A further aim was to find out whether the readiness to treat refugees was influenced by previous treatment of refugees. In summary, the following hypotheses were proposed: (1) Previous experiences in working with refugees has an impact on the ProQOL (BO, STS and CS) of German psychotherapists; (2) the ProQOL (BO, STS and CS) of German psychotherapists influences their readiness to treat refugees with PTSD symptoms; (3) previous experience in treating refugees will lead to a higher readiness to treat refugees.

2 | Methods

2.1 | Ethics

The university's ethics board approved the study (approval number: 121-2022). Before participating in the online survey, all participants were informed about the aims and duration of the study, the anonymous design, the applicable data protection regulations and the participation requirements. We did not include information about the case vignettes in the study invitation as the survey was designed as an experimental study with randomly presented case vignettes. To participate, interested psychotherapists had to give their informed consent.

2.2 | Recruitment and Participants

The study design corresponds to a nationwide anonymous online survey with experimental aspects using randomly presented case vignettes. According to the participation requirements, only psychotherapists—either licensed (LPTs) or in training (PiTs)—could participate. Psychotherapists were informed about the survey by different regional and national psychotherapist associations as well as psychotherapeutic training institutes who distributed the survey among their members via newsletters, journals, separate emails or internal cloud servers. Additionally, in accordance with the referrals of some federal associations for LPTs, we searched the publicly available directories of these associations for email addresses of LPTs to inform them about the survey. For the recruitment of PiTs, we compiled a directory of all training institutes for psychotherapy in Germany by federal state and therapeutic approach. From this directory, we randomly selected one institute in each federal state for each therapeutic approach, if available. After contacting the selected institutes and obtaining their agreement, the institutions distributed the survey to all their trainees. If an institute did not agree or answer, the next institute with the same therapeutic approach for the respective federal state was contacted.

The online survey took about 15 min and a total of $N=1032$ LPTs and PiTs participated. Of these, we excluded $n=211$ data

sets from the statistical analysis due to dropping out before the case vignettes were presented or missing data related to demographics or ProQOL. The final sample included in the statistical analysis comprised $N=821$ psychotherapists.

2.3 | Procedure

The study data were collected anonymously with Qualtrics (Provo, UT, 2020) between October 2022 and August 2023. After providing informed consent, the psychotherapists shared demographic details such as their age, along with professional information, including their prior experience in providing psychotherapy to refugee patients. After the demographic section, the participants reported their ProQOL on the ProQOL questionnaire (Stamm 2010). Afterwards, one of six case vignettes was randomly presented: Each of them described a patient with PTSD symptoms with or without a refugee background (see Figure 1). The psychotherapists then rated their readiness to treat the portrayed patient. The survey was conducted entirely in German, and the psychotherapists participated voluntarily without receiving any incentives.

2.4 | Material

2.4.1 | Measures

Participants provided sociodemographic and professional information during the survey, which can be found in Tables 1 and 2.

Therapists were randomly assigned one of six case vignettes (see below) and asked to rate their treatment readiness for the patient described in the vignette using a single-item visual analogue scale (VAS) ranging from 0 (*Low*) to 100 (*High*): ‘How willing are you to treat the described person psychotherapeutically?’

2.4.2 | Case Vignettes

According to the experimental study design, we developed six parallel vignettes (65 to 66 words each), varying the patient's gender (female vs. male), refugee background (refugee vs. non-refugee) and, for the two flight vignettes, their country of origin (Ukraine vs. Syria). The Ukraine versus Syria vignettes were

Refugee Background	Gender	Traumatic Experience	Post-traumatic Stress Symptoms
No flight experience	Female	Sarah is 19 years old and went on vacation with her mother. During the trip, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Sarah has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Sarah withdraws more and more and is often sad.
	Male	Daniel is 19 years old and went on vacation with his mother. During the trip, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Daniel has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Daniel withdraws more and more and is often sad.
Syria	Female	Nadjiba is 19 years old and fled Syria together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Nadjiba has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Nadjiba withdraws more and more and is often sad.
	Male	Ibrar is 19 years old and fled Syria with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Ibrar has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Ibrar withdraws more and more and is often sad.
Ukraine	Female	Natalia is 19 years old and fled Ukraine together with her mother. While fleeing, they were picked up by a group of armed men. They beat her up, harassed her and shot her mother. Since then, Natalia has had a lot of difficulties.	She is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Natalia withdraws more and more and is often sad.
	Male	Dmytro is 19 years old and fled Ukraine together with his mother. While fleeing, they were picked up by a group of armed men. They beat him up, harassed him and shot his mother. Since then, Dmytro has had a lot of difficulties.	He is often confronted with intrusive memories, is unable to concentrate and has problems falling asleep and staying asleep. Dmytro withdraws more and more and is often sad.

FIGURE 1 | Randomized vignettes.

TABLE 1 | Demographic information about participating LPTs and PiTs.

Variable	N = 821					
	n	M	SD	Mdn	Min	Max
Age (years)	821	45.44	12.21	44	24	80
Licensed for (years)	562	12.20	8.29	10	0	42
Own practice for (years)	460	10.95	9.11	8	0	50
Employed by a clinic/hospital for (years)	93	8.90	7.89	7	1	32
Number of therapy sessions per week	821	18.76	8.94	20	0	50
Number of PTSD patients treated	797	47.83	218.71	15	0	5400
Number of refugee patients treated	395	11.97	27.34	5	0	250
Number of refugee patients with PTSD treated	395	8.32	17.94	3	0	150

parallelised by using an identical wording except for the names of the described persons as well as their country of origin. For a maximum parallelization between the refugee versus nonrefugee vignettes, the nonrefugee vignettes were designed with the same traumatic experience during a vacation as the refugee vignettes experienced during flight. All six vignettes are depicted in Figure 1.

2.4.3 | ProQOL

The ProQOL is a self-assessment instrument designed to evaluate the impact of working with individuals who have coped with significant traumatic stress (Stamm 2010). It includes 30 items rated on a 5-point Likert scale (1, *Never* to 5, *Very often*), equally divided into three subscales: compassion satisfaction (e.g., 'My work makes me feel satisfied'), BO (e.g., 'I feel worn out because of my work as a [helper]') and STS (e.g., 'I think that I might have been affected by the traumatic stress of those I [help]'). These subscales demonstrated acceptable to high internal consistency, with Cronbach's alpha values

TABLE 2 | Demographic information about participating LPTs and PiTs.

Variable	N = 821	
	n	%
Training status		
Completed training	590	71.9
Currently in training	203	24.7
Diploma or master's degree without training	24	2.9
Other	4	0.5
Type of licence		
Psychotherapist for children and adolescents	154	18.8
Psychological psychotherapist	350	42.6
Psychological psychotherapist also licensed for treating children and adolescents	65	7.9
Medical psychotherapist	17	2.1
Other	5	0.6
Employed by a clinic/hospital	93	11.7
Own practice	472	59.5
Approved for public health care insurance	473	59.6
Specific trauma training ^a		
EMDR	316	38.5
TF-CBT	319	38.9
NET	235	28.6
Imaginary rescripting	232	28.3
Hypnotherapy	140	17.1
CPT	88	10.7
Play therapy	80	9.7
Somatic experiencing	36	4.4
Other	168	20.5
None	131	16.0
Gender		
Female	687	83.7
Male	129	15.7
Diverse	5	0.6
Working with refugees		
Yes	399	48.6
Migration background ^a		
Yes, myself	38	4.9

(Continues)

TABLE 2 | (Continued)

Variable	N = 821	
	n	%
Yes, my parents	61	7.4
Flight experience		
Yes	8	1.0
Therapeutic approach ^a		
Behavioural therapy	623	75.9
Psychodynamic approach	213	25.9
Systemic	48	5.8
Other	31	3.8

Abbreviations: CPT, cognitive processing therapy; EMDR, eye movement desensitization and reprocessing; NET, narrative exposition therapy; PiT, psychotherapist in training; LPT, licensed psychotherapist; TF-CBT, trauma-focused cognitive behavioural therapy.

^aMultiple answers possible.

of $\alpha = 0.88$, 0.75 and 0.81 , respectively (Stamm 2010). Higher scores indicate greater levels of each dimension (range 10 to 50), with cut-offs for low, moderate and high levels as specified for each scale.

2.5 | Statistical Analyses

As the research question only distinguished between patients with and without a refugee background, the treatment readiness ratings for the Ukrainian and Syrian vignettes were combined for the analysis and compared to the ratings for the nonrefugee vignettes. First, we tested all statistical requirements for our statistical tests to be performed. To compare the ProQOL ratings between psychotherapists who had already treated refugee patients and those who had not, we then conducted a *t*-test for independent samples for each of the ProQOL subscales. To analyse potential predictors for therapists' treatment readiness, a hierarchical multiple regression was performed with treatment readiness as the dependent variable. As a first block, we included the ProQOL subscales in our regression model. In addition, the vignette characteristics (refugee vs. nonrefugee) were added in a second block. The third block further included the refugee-specific treatment experience of the therapists as a dichotomous variable (previous psychotherapy with refugees: yes vs. no) in interaction with the refugee background of the case vignette. The fourth block then also considered the interaction of each ProQOL subscale with the refugee background of the case vignette.

3 | Results

3.1 | Descriptive Statistics

The final data set consisted of $N = 821$ participants ($n = 590$ LPTs, $n = 203$ PiTs, $n = 24$ master's/diploma degree holders without licensure, $n = 4$ with other qualifications) with a mean age of $M = 45.44$ years ($SD = 12.21$, $Mdn = 44$). The vast majority of

TABLE 3 | Distribution of the vignettes.

Vignettes	N = 821	
	n	%
Flight—Ukraine—male	143	17.4
Flight—Ukraine—female	143	17.4
Flight—Syria—male	135	16.4
Flight—Syria—female	140	17.1
No flight—Germany—male	141	17.2
No flight—Germany—female	119	14.5

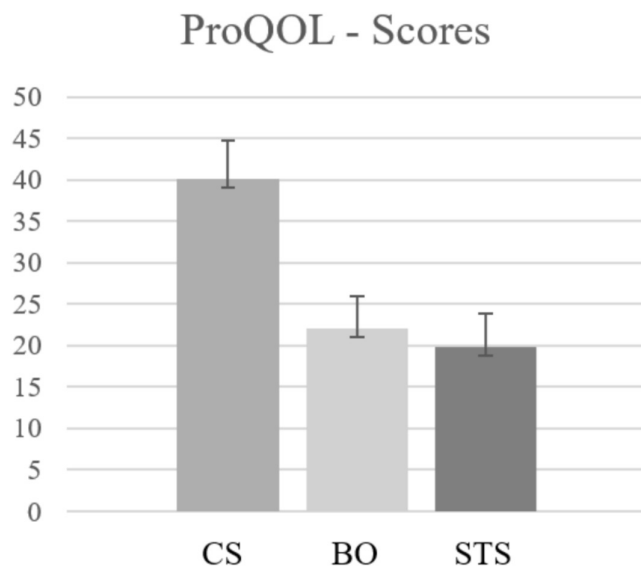


FIGURE 2 | ProQOL-Scores of the participating psychotherapists (BO, burnout; CS, compassion satisfaction; STS, secondary traumatic stress).

the participants were female (83.7%, $n = 687$). Five participants identified as gender diverse, 12.3% ($n = 99$) reported a migration background, with $n = 8$ having been refugees themselves. Additionally, $n = 399$ (48.6%) had prior experience working with refugees. Further information about sociodemographics can be found in Tables 1 and 2.

The distribution of the vignettes can be found in Table 3. The overall mean readiness to treat the vignette patient was $M = 80.31$ ($SD = 22.65$; $Mdn = 87$; $Min = 0$; $Max = 100$, $N = 821$), with 60.3% of the participants scoring above the mean. The ProQOL showed moderate CS levels ($M = 40.14$, $SD = 4.60$, $Mdn = 40$) and low BO ($M = 22.02$, $SD = 3.97$, $Mdn = 22$) and STS levels ($M = 19.80$, $SD = 4.13$, $Mdn = 19$). ProQOL-Scores are shown in Figure 2.

On average, participants who had already worked with refugees reported more CS ($M = 40.53$, $SE = 0.22$) than those who had not ($M = 39.77$, $SE = 0.22$). This difference, 0.76 , BCa 95% CI [0.131, 1.387], was significant [$t(818.97) = 2.37$, $p = 0.009$] and represented a small effect size, $d = 0.17$. Furthermore, therapists who had previously worked with refugees reported

less BO on average ($M = 21.71$, $SE = 0.19$) than those who had not ($M = 22.32$, $SE = 0.20$). This difference, -0.60 , BCa 95% CI $[-1.147, -0.060]$, was significant as well [$t(819) = -2.18$, $p = 0.015$] with a small effect size, $d = -0.15$. There was no significant difference for STS.

3.2 | Models to Predict Treatment Readiness

The results of the hierarchical regression analysis indicated that all four models were statistically significant ($p < 0.001$). Model 1, which included the three ProQOL scales as independent variables, explained 6.6% of the variance in the treatment readiness [$F(3,817) = 20.43$, $p < 0.001$, $n = 821$]. It was found that with an increase in CS, readiness also increased significantly by a factor of 1.05 ($\beta = 0.21$, $p < 0.001$). CS remained significant across all subsequent models. In contrast, with an increase in STS, readiness decreased significantly by a factor of -0.43 ($\beta = -0.08$, $p = 0.047$). STS did not prove to be a significant predictor in any of the following models.

Model 2 explained 9.3% of the variance in the treatment readiness [$F(4,816) = 22.13$, $p < 0.001$, $n = 821$]. The allocation of a flight vignette significantly lowered the therapists' treatment readiness by -8.16 ($\beta = -0.17$, $p < 0.001$). The negative correlation between flight vignette and treatment readiness remained significant in Models 3 and 4.

The inclusion of the interaction variable (previous work experience with refugees and flight vignette) as a predictor in Model 3 explained a further 3.2% of the variance [$F(5,815) = 22.36$, $p < 0.001$, $n = 821$]. It can be observed that participants who had previously worked with refugees and were assigned a flight vignette demonstrated an average increase in treatment readiness of 8.30 ($\beta = 0.17$, $p < 0.001$).

The final model accounted for 11.7% of the variance following the inclusion of the three interaction variables (ProQOL scales and flight vignette) [$F(8,812) = 14.58$, $p < 0.001$, $n = 821$]. The interactions of the three ProQOL subscales (BO, CS and STS) with the flight vignette did not contribute significantly to the final regression model. For more information, see Table 4.

4 | Discussion

The aim of this study was to find out whether the ProQOL of German psychotherapists influenced their readiness to treat refugees. We aimed to replicate the results of Schlechter et al. (2020) and to find out whether the readiness to treat refugees was influenced by previous treatment of refugees. We have hypothesized that (1) previous experiences in working with refugees has an impact on the ProQOL (BO, STS and CS) of German psychotherapists; (2) the ProQOL (BO, STS and CS) of German psychotherapists influences their readiness to treat refugees with PTSD symptoms; (3) previous experience in treating refugees will lead to a higher readiness to treat refugees.

In conclusion, the assessed sample had moderate CS scores and low BO and STS scores. Those participants who had previously

worked with refugees reported elevated CS and diminished BO levels. Higher CS and lower STS were associated with greater readiness to treat vignette patients in general. The vignette experiment showed a significantly lower readiness of psychotherapists to treat patients with a refugee background. Participants who had previous experience of working with refugees and had received a flight vignette reported higher readiness to treat refugee patients. However, the ProQOL had no impact on treatment readiness regarding refugees.

Based on the results of the ProQOL, the ProQOL among the psychotherapists in this study was generally favourable as CS was moderate on average, while BO and STS were small. It was found that previous experience in psychotherapy with refugees does not lead to higher STS scores among practitioners. This is contrary to previous research (Brooks et al. 2022; Ghafoori et al. 2024; Kizilhan 2020; Roberts et al. 2021). They even reported more CS, like in the study of Posselt et al. (2019), and less BO than those who had no experience with psychotherapy with refugees. These differences in CS and BO might be based on special interests and engagement of psychotherapists. It is possible that psychotherapists with a high devotion to psychotherapy with refugees feel more compassion towards this population. Watching refugee patients gain independence and confidence as they overcome systematic barriers and move forward in life can empower service providers by reinforcing the effectiveness and value of their services (Puvimanasinghe et al. 2015). Given that BO symptoms may occur due to coping difficulties (Ghafoori et al. 2024), it is possible that our sample learned self-care strategies or attended training to prevent BO and STS (Hernández et al. 2010). Brooks et al. (2022) linked lower organizational support to higher STS scores and lower social support to anxiety among service providers working with Syrian refugees. Therefore, it is possible that there is a stronger support network in our sample that was not captured. Further research should focus more on the possible reasons for the difference in BO between psychotherapists working with refugees and those without such experiences. Knowledge and strategies for BO prevention, long hours, demanding workload (Ghafoori et al. 2024) and valence of therapy experiences with PTSD patients with and without a refugee background should be considered as potential predictors for BO and ProQOL in general. Additionally, psychotherapists with a low quality of life might not have participated in the study due to their own distress and a lack of time. Thus, more comprehensive assessments are needed to prevent biases due to self-selection. For example, incentives could be used to motivate psychotherapists with a lower ProQOL to still participate in such a study.

When considering the influence of ProQOL on treatment readiness for the described vignette patients, CS was related positively and STS negatively to treatment readiness. Higher STS might reduce readiness to treat PTSD patients, as STS may cause clinicians to avoid activities that remind them of the trauma (Stamm 2010). However, the influence of STS on treatment readiness disappeared when considering the refugee background of the vignette. In contrast, CS seemed to be a more stable predictor for the readiness to treat a patient with PTSD symptoms, regardless of their refugee background. Duden et al. (2020) reported positive effects of working with refugees, including finding meaning in their work. It is possible that this meaning lies in

TABLE 4 | Multiple regression.

	Readiness to treat					<i>R</i> ²	<i>Adj. R</i> ²
	<i>b</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>		
Model 1						0.07	0.07
Constant	49.90 (25.47, 74.34)	12.45		4.01	<0.001		
ProQOL Sumscore CS	1.05 (0.64, 1.46)	0.21	0.21	5.01	<0.001*		
ProQOL Sumscore BO	-0.15 (-0.69, 0.39)	0.27	-0.03	-0.55	0.582		
ProQOL Sumscore STS	-0.43 (-0.85, -0.01)	0.22	-0.08	-1.99	0.047*		
Model 2						0.10	0.09
Constant	55.11 (30.95, 79.27)	12.31		4.48	<0.001		
ProQOL Sumscore CS	1.05 (0.64, 1.46)	0.21	0.21	5.08	<0.001*		
ProQOL Sumscore BO	-0.17 (-0.70, 0.36)	0.27	-0.03	-0.63	0.529		
ProQOL Sumscore STS	-0.39 (-0.80, 0.03)	0.21	-0.07	-1.82	0.068		
Flight vignette	-8.16 (-11.34, -4.98)	1.62	-0.17	-5.04	<0.001*		
Model 3						0.12	0.12
Constant	54.74 (30.87, 78.61)	12.16		4.50	<0.001		
ProQOL Sumscore CS	1.03 (0.62, 1.43)	0.21	0.21	5.02	<0.001*		
ProQOL Sumscore BO	-0.12 (-0.64, 0.41)	0.27	-0.02	-0.43	0.665		
ProQOL Sumscore STS	-0.38 (-0.79, 0.03)	0.21	-0.07	-1.80	0.072		
Flight vignette	-12.34 (-15.95, -8.73)	1.84	-0.25	-6.71	<0.001*		
Refugee Work \times flight vignette (interaction variable)	8.30 (4.75, 11.84)	1.81	0.17	4.59	<0.001*		
Model 4						0.13	0.12
Constant	40.84 (-0.52, 82.19)	21.07		1.94	0.053		
ProQOL Sumscore CS	1.02 (0.31, 1.73)	0.36	0.21	2.83	0.005*		
ProQOL Sumscore BO	0.26 (-0.64, 1.15)	0.46	0.05	0.57	0.572		
ProQOL Sumscore STS	-0.08 (-0.80, 0.65)	0.37	-0.01	-0.20	0.839		
Flight vignette	-12.28 (-15.89, -8.67)	1.84	-0.25	-6.68	<0.001*		
Refugee work \times flight vignette (interaction variable)	8.09 (4.54, 11.64)	1.81	0.17	4.47	<0.001*		
ProQOL Sumscore BO \times flight vignette (interaction variable, centred)	-0.56 (-1.66, 0.54)	0.56	-0.08	-1.00	0.319		
ProQOL Sumscore STS \times flight vignette (interaction variable, centred)	-0.43 (-1.31, 0.45)	0.45	-0.07	-0.96	0.339		
ProQOL Sumscore CS \times flight vignette (interaction variable, centred)	-0.01 (-0.87, 0.85)	0.44	-0.00	-0.02	0.982		

Note: *p*, significance, * highlights the significant *p*-values ($p \leq 0.05$).

Abbreviations: *b*, regression coefficient, confidence interval is shown in brackets; β , standardized coefficient beta; BO, burnout; CS, compassion satisfaction; ProQOL, professional quality of life; *SE B*, standardized error; STS, secondary traumatic stress; *t*, test statistics.

our participants' stable compassion satisfaction. Nevertheless, a supportive network and specialist supervision are essential for the ProQOL of psychotherapists working with traumatized refugees (Duden et al. 2020; Peñuela-O'Brien et al. 2023; Puvimanasinghe et al. 2015).

Our study demonstrated that the treatment readiness towards PTSD patients with a refugee background was lower than towards PTSD patients with the same traumatic event but without a refugee background. Not the symptoms of PTSD but only the refugee status was relevant for treatment readiness. This is consistent with the findings of Dumke and Neuner (2022) and Schwegler et al. (2025). The facets of ProQOL did not influence the readiness to treat the refugee vignette. Accordingly, CS as an aspect of ProQOL positively influenced the readiness to treat PTSD patients, but not the readiness to treat refugees with PTSD. Therefore, further research needs to explore potential predictors for the treatment readiness towards refugee patients beyond the ProQOL including BO, CS and STS. Factors affecting the treatment readiness towards refugees might be attitudes towards refugees in general (Dumke and Neuner 2022; Schwegler et al. 2025), lack of language skills or personal fears and doubts (Schlechter et al. 2020). At the time of the survey, 24.7% of the participants were in training. This could mean that self-doubt and a lower level of experience and confidence in treating refugees with PTSD may lead to a lower level of readiness. On the other hand, PITs have a lower caseload and receive closer supervision, which should be used to encourage them to treat refugees. Removing barriers at the structural level can be achieved, for example, through improved cooperation between institutions to reduce the burden on psychotherapists regarding refugees' needs beyond their scope of practice (Peñuela-O'Brien et al. 2023). Another aspect is simplifying the process of securing funding for treatment and interpreters (Duden et al. 2020).

When considering therapists' experiences with psychotherapy with refugees next to their ProQOL and the patients' refugee status, the effects of therapists' CS and patients' refugee background remained stable. There was an additional interaction between the vignette patient's refugee background and therapists' previous experiences with psychotherapy with refugees. If psychotherapists had already treated refugees, they reported a higher treatment readiness for refugee patients than those who had not. This could be attributed to the aforementioned empowerment (Duden et al. 2020) and meaningfulness of working with refugees (Puvimanasinghe et al. 2015). The results are consistent with the findings of Schlechter et al. (2020) and have been successfully replicated. The lower readiness to treat refugee patients in comparison to nonrefugee patients may be attributed to the presence of participants in the sample who have no prior experience working with refugees or treating PTSD. Thus, fostering first treatment experiences with a refugee patient, for example, during psychotherapy training, might enhance therapists' readiness to treat further refugee patients. Special training and information on psychotherapy with refugees is needed to avoid helplessness and loss of confidence (Peñuela-O'Brien et al. 2023). Additionally, further research should also consider that the interaction between a patient's refugee background and psychotherapeutic experiences with refugees could be moderated by a third variable. The already mentioned therapists' attitudes towards refugees or their trauma-specific training could

act as such moderating variables and could be examined in studies including special training trials and control groups.

4.1 | Limitations

For the recruitment of participants, we used a random selection of psychotherapeutic associations and training institutes. All members of these associations and institutions with available contact information had the opportunity to see the study invitation. However, participation was voluntary and thus self-selection is likely. It is likely that more psychotherapists with a special interest in treating PTSD participated in the study. This is also a possible explanation for the generally high treatment readiness among the participants. Therefore, an overestimation of the level of treatment readiness based on a self-selection bias is possible. Conversely, therapists with higher BO and STS scores may have been unable to participate due to a lack of capacity to complete additional surveys. Additionally, the high level of treatment readiness in this study could be based on social desirability. The anonymous study design and the experimental case vignettes were used as strategies to reduce potential effects of social desirability. In order to include as many psychotherapists as possible, we set the age of the patient in the vignette to 19 years, allowing both adult and child and adolescent therapists to participate. Some may have reservations or preferences for this transitional age group, which may have influenced treatment readiness. Further subdivision of the vignettes would have weakened the statistical power. However, the heterogeneous sample should be taken into account when interpreting the results.

At the time of recruitment, there was increased media coverage of the invasion of Ukraine and the resulting displacement of people. As the media can also play an important role in shaping public attitudes towards refugees (Kosho 2016; Tsai et al. 2023), this could have an impact on the treatment readiness that we did not capture and thus should be considered in the interpretation of the results.

Health care systems vary among different countries and thus, the results of this study may not be fully generalizable to psychotherapists in other health care systems. Even though we assessed the refugee background of the participants, the number of psychotherapists with such a background was very small ($n = 8$; 1.0%). Due to this lack of heterogeneity in cultural backgrounds, we could not consider the own refugee background of the psychotherapists as a correlate in the analyses. This might limit the generalizability of the results for countries with more cultural heterogeneity among psychotherapists.

5 | Conclusions

This study aimed to assess the ProQOL among psychotherapists in Germany and relate this to their treatment readiness towards PTSD patients with and without a refugee background. Moreover, therapists' previous experiences with refugee patients were also considered. Even though our results demonstrated that the ProQOL was favourable on average for our participants, CS and BO differed depending on previous psychotherapy experience with refugees.

Regarding treatment readiness for PTSD in total, only CS proved to be a stable positive predictor. None of the ProQOL subscales influenced the treatment readiness towards refugee patients. Therapists' treatment readiness was lower for patients with a refugee background than for those without a refugee background, when controlling symptoms and traumatic experiences. However, when psychotherapists reported previous treatment of refugees, they had a higher average treatment readiness for the described refugee patients. Our results on treatment readiness need to be considered when discussing the improvement of psychotherapeutic treatment for PTSD patients and refugee patients with PTSD. Interventions to encourage first treatment experiences with refugees and to improve CS of psychotherapists seem to be relevant. Therefore, trauma-specific training also with regard to refugee patients as well as supervision could be helpful. This might increase the treatment readiness for PTSD and refugee patients among psychotherapists and thus improve psychotherapeutic care for this population.

Author Contributions

Pia Maria Schwegler and Katharina Gossmann designed the study and prepared the manuscript draft. Pia Maria Schwegler, Katharina Gossmann and Theresa Neumann recruited participants and collected data, with Pia Maria Schwegler conducting the statistical analysis. Katharina Gossmann and Rita Rosner supervised the study, while Katharina Gossmann also provided guidance on the statistical analysis and interpretation of the results. All authors reviewed, revised and approved the final version of the manuscript.

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Ethics Statement

The study was approved by the Institutional Review Board of the Catholic University of Eichstätt-Ingolstadt in December 2022 (Ethics Approval Number: 121-2022).

Consent

All participants provided written informed consent to take part in the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The generated and analysed data along with the statistical code used for the analyses are available on request from the corresponding author. These materials are not publicly accessible due to privacy considerations and ongoing analyses.

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Publication 3

Title	Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study
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My contribution	I collected the data within a greater trial and conceptualized the research question. I performed, interpreted the statistical analyses, and drafted the manuscript. I initiated and completed the submission process and integrated the reviewers' feedback.
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RESEARCH

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Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study

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Abstract

Background Burnout symptoms and secondary traumatic stress are especially high among Child Welfare Workers (CWWs) and psychotherapists and might have increased since the recent increase in refugee numbers. Little is known about the wellbeing of CWW and psychotherapists working with unaccompanied young refugees (UYR), especially in German child and youth welfare facilities where they work closely together. This study aims to assess levels of compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS) in German CWWs and psychotherapists, examining connections to demographic variables and group differences.

Methods $N = 198$ CWW and $N = 97$ psychotherapists were assessed via the Professional Quality of Life Scale (ProQOL). Descriptive statistics, t-test for independent samples, correlations between the ProQOL scales and hierarchical regression analyses with demographic variables as predictors were computed.

Results Both samples showed average to high levels of CS, and low to average levels of BO and STS. CWWs scored significantly higher than psychotherapists on BO and STS. In CWW, demographic variables were not associated with CS, BO or STS. Among psychotherapists, previous experiences in working with UYR ($\beta = 0.38$; $p < .001$) were positively associated with CS. Factors such as weekly therapy sessions ($\beta = -0.35$, $p = .001$) and the psychotherapist's migration background ($\beta = -0.20$, $p = .048$) were negatively associated with STS. The number of PTSD cases treated ($\beta = 0.27$, $p = .018$) and additional training ($\beta = 0.31$, $p = .006$) were positively associated with STS.

Conclusion Among psychotherapists, prior experience in working with UYRs may contribute to elevated levels of CS, whereas a higher number of previously treated PTSD cases appears to be associated with increased STS. Further research on the influence of sociodemographic variables is needed for CWWs to identify protective and risk factors. Supporting and training CWWs and psychotherapists is crucial for quality treatment of traumatized UYRs.

Keywords Child welfare workers, Psychotherapists, Unaccompanied young refugees, Compassion satisfaction, Burnout, Secondary traumatic stress, ProQOL

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Introduction

According to the United Nations High Commissioner for Refugees (UNHCR) the number of refugees worldwide has increased over the years (currently 36.4 million) [1]. This includes unaccompanied refugee minors, who are often exposed to traumatic events during their flight [2]. In Germany, child welfare workers (CWW) and psychotherapists work closely together to support UYR.

In general, CWW and psychotherapists belong to occupational groups described as likely to experience psychological distress and emotional burden [3–6]. These stressful experiences may result in feelings of overwhelming responsibility and strained personal relationships [7]. In addition, the workload and high levels of organizational demands have further increased in the last years, and cases are often characterized by complexity and severity, resulting in a high emotional burden for CWW and psychotherapists [8]. Persistent psychological distress can lead to mental and physical exhaustion [9], exit-seeking behaviors and work withdrawal [10]. Moreover, the CWW's daily contact with physically, sexually, and emotionally abused children puts them especially at risk to develop burnout (BO) symptoms, secondary traumatic stress (STS) or a lack of compassion satisfaction (CS) [8, 11–13].

For both, CWW and psychotherapists, a particular challenging field is the work with unaccompanied young refugees (UYR). In Germany, the number of UYR has increased [14] and studies have indicated a higher prevalence of mental disorders among UYR [15–19]. Thus, there is a great need for mental health interventions tailored to the needs of UYR [20]. In the work with refugees, the likelihood of secondary exposure to traumatic events is high for therapists and social workers. Research has shown that BO and STS symptoms are possible consequences of working with a highly traumatized population [21–24]. In their review, Roberts and colleagues [23] reported that individuals working professionally and voluntarily with forcibly displaced people had pooled prevalence rates of 29.7% for high-level BO and 45.7% for moderate to severe-level STS, respectively. In the work with refugees, specific demands include a heightened emotional impact of work, cultural or language barriers and additional administrative obstacles regarding their residence status and other refugee-specific topics [25]. Lastly, working with refugee children seems to be associated with higher STS scores compared to working with refugee adults [21].

For STS, studies with social workers have reported various risk factors, such as female gender, younger age, or years of work experience [8, 12, 26]. Moreover, with increasing years of experience, BO and STS increase while CS seems to decrease. However, an earlier study by Avieli and colleagues [27] showed in a sample of social

workers and therapists that with the increase in years of experience, STS and BO levels decreased significantly, whereas CS levels increased. Thus, in terms of experience, it is unclear whether it should be considered a risk or protective factor and how this may differ depending on the professional role.

Regarding therapists, various risk factors are discussed [28, 29]. Yang and Hayes [30] reported risk factors for BO such as a lack of perceived job control, a demanding case-load, and psychotherapists' mental health such as trauma history. It has also been found that personal trauma experience is a risk factor for compassion fatigue [31]. Moreover, a personal history of trauma and flight experience favors higher levels of STS [21]. Furthermore, Simionato and Simpson [29] found a significant correlation between younger age, having less work experience, and being overinvolved in client problems with moderate to high levels of BO. Regarding STS, some studies have shown that a greater number of patients with PTSD is associated with increased STS [32, 33], while CS appears to increase with work experience [27, 34].

Among professionals who provide therapeutic support to refugees, rapport, and supervision and particularly the alliance with the supervisor was related to well-being, such as professional growth, balance, and employing boundaries [35]. Furthermore, Denkinger and colleagues [21] found that a secure attachment style can function as a protective factor preventing STS in a sample of psychologists, psychotherapists, interpreters, social workers, volunteers, and others who provided treatment and support to refugees from Iraq. Among therapists who provide therapeutic services for traumatized refugees, higher rates of self-efficacy and trauma-specific training led to lower levels of STS [36]. In a study by Plakas and colleagues [37] prior educational level could not be identified as an influencing factor on CS, BO or STS among social workers, coordinators, fieldworkers, or others working with refugees. It has not been investigated whether the therapeutic background (i.e. CBT, depth psychology etc.) has an influence on STS, BO, and CS scores.

Although there appears to be an increase in research that captures the impact of working with refugees in social workers and mental health professionals, there is a lack of knowledge about the wellbeing of CWW and licensed psychotherapists working with UYR. However, this is particularly important as UYR rely more heavily on social workers than accompanied young refugees or refugee adults. Social workers and therapists frequently adopt a more parental position. The aim of the present study is to identify levels of CS, BO, and STS in German CWW and licensed psychotherapists, examine differences between the two groups of professionals, as well as to investigate the influence of demographic and work-related variables on these dimensions. Demographic and

work-related variables vary depending on the respective group. For more detail see Sect. [Statistical analysis](#).

Materials and methods

Ethical considerations

Written informed consent was obtained from all individual participants included in the study. The studies involving human participants were reviewed and approved by ethics committees at The Ulm University (No. 243/19) and at The Catholic University of Eichstätt-Ingolstadt (No. 004–19). All data collection is carried out in accordance with the relevant guidelines and regulations following the Declaration of Helsinki.

Study design and data collection

Participant data were collected between 2020 and 2022 within a greater trial [38]. The main study aims at comparing a stepped care approach to a treatment as usual for UYR. Therefore, psychotherapists were recruited to provide trauma-focused cognitive behavioral therapy [39] to the UYR. The social workers were recruited for external assessments and the implementation of a trauma-focused group intervention “Mein Weg” [40] in the Child and Youth Welfare Service (CYWS) facility. CWWs were recruited through the CYWS facilities where they were employed. Recruitment strategies for CYWS facilities included letters of invitation and telephone contact, digital information events and flyers. A website was created, and press interviews were conducted [38]. Psychotherapists were recruited via email through professional associations and personalized letters. The inclusion criteria for psychotherapist participants were: (1) licensed as either child and adolescent psychotherapists, or psychological psychotherapists, (2) agreement to treat up to three refugees with TF-CBT and (3) comply with all other study regulations. Additional information on recruitment strategies and inclusion criteria can be found in the study protocol [38]. Levels of CS, BO, and STS of CWW and psychotherapist participating in the trial were assessed at baseline. The data presented here corresponds to the baseline assessment before any intervention for the participating UYR had started. Thus, this cross-sectional survey was conducted at a time where some of the psychotherapists may have never worked with refugees but had declared their willingness to treat refugees within the trial. Demographic data were collected using two different standardized questionnaires. There were questions that were only suitable for one group or the other (e.g. for psychotherapists, “On average, how many therapy sessions do you have per week?”).

All participants completed the Professional Quality of Life Scale (ProQOL) [41]. The ProQOL measures the positive and negative effects of working with people who have experienced extremely stressful events. The

self-report inventory contains 30 items on a five-point-Likert-Scale (1 = never, 2 = rare, 3 = sometimes, 4 = often, 5 = very often). It consists of three scales: Compassion Satisfaction (10 items, e.g., “I get satisfaction from being able to help people”), Burnout (10 items, e.g., “I feel trapped by my job as a helper”) and Secondary traumatic stress (10 items, e.g., “I feel depressed because of the traumatic experiences of the people I help”). In the present sample, Cronbach’s alpha for the scales are satisfactory (CS: $\alpha=0.88$, BO: $\alpha=0.75$, STS: $\alpha=0.81$). The scales were calculated according to the manual with a higher value on a scale meaning a higher expression of the respective dimension (range 10–50). Recommended cut-off scores are low (0–22), moderate (23–41) and high (42–50) [41].

Participants

The sample ($N=374$) was composed of two different groups: (1) CWW ($n=266$) who worked in 47 different CYWS facilities, and (2) licensed psychotherapists ($n=108$) participating in the abovementioned trial and working together in the care for UYR. 43 cases of the CWW were excluded from analysis due to a high amount of missing data and 24 cases were excluded due to outliers. Regarding the psychotherapists, 3 cases were excluded due to a high amount of missing data and 8 cases were excluded due to outliers. Missing items refer to the fact that less than 50% or none of the ProQOL items were completed. Moreover, some of the socio-demographic data were completely missing. This left an overall sample of $n=295$, CWW ($n=198$, age $M=35.42$, $SD=10.82$, 72.7% female) and psychotherapists ($n=97$, age $M=44.90$, $SD=8.62$, 81.4% female). For further information about the participants, see Tables 1 and 2.

Statistical analyses

All analyses were performed using IBM SPSS Statistics (Version 28.0.0.0). Alpha level of statistical significance was set at $p<.05$ for all analyses. Outliers were identified using studentized excluded residuals, Cook’s distance, and leverage values [42, 43]. Means and standard deviations were calculated for all variables. Level of CS, BO and STS were also calculated and interpreted using cut-off scores [41]. Partial correlations between ProQOL scales were calculated. Due to the missing prerequisite of normal distribution in the STS score, the correlation with the other scales was performed using Kendall-Tau-b. Bias-corrected and accelerated bootstrap 95% CIs were used. A t-test for independent samples was performed to detect significant differences between the two groups (CWW and psychotherapists) regarding CS, BO, and STS. Additionally, the Mann-Whitney-U test was performed due to the lack of a normal distribution of the STS data from the CWW.

Table 1 Sociodemographic characteristics of the CWW sample

Characteristics	CWW (N=198)
Age	$M = 35.42$ ($SD = 10.82$)
Sex	144 female (72.7%)
Graduation (school)/educational level	95 (48%) GCE 72 (36.4%) A-levels 29 (14.6%) advanced technical 2 (1%) college certificate GCSE O-levels secondary school leaving certificate
Study or training	111 study (56.1%)
Additional training	40.4%
Work experience in general (years)	$M = 8.95$ ($SD = 7.77$)
Work experience in current facility (years)	$M = 4.01$ ($SD = 3.54$)
Work experience with UYR (months)	$M = 41.87$ ($SD = 32.03$)

Note. GCE A-levels = General Certificate of Education Advanced Level, GCSE O-levels = General Certificate of Secondary Education Ordinary Level, UYR = unaccompanied young refugees

Hierarchical regression analyses were conducted for each of the three factors CS, BO and STS and groups (CWW and psychotherapists). Regression models were estimated for both groups based on previous research findings. The prerequisites for the hierarchical regression analyses were checked and implemented in advance. As

Table 3 Block wise added variables of the hierarchical regression

Group	Model	Variables included
CWW	Model 1	Age
	Model 2	Gender
	Model 3	Years of work experience, experience with UYRs
	Model 4	Education level, training or academic study, further education
Psychotherapist	Model 1	Age, gender, migration background
	Model 2	Years since license acquisition, previous work with refugees, number of PTSD cases, sessions per week
	Model 3	Training in trauma therapy, schema therapy, hypnotherapy, systemic therapy
	Model 4	Professional background in psychology, social work, teaching, pedagogy, social pedagogy
	Model 5	Therapeutic approaches in depth psychology, behavioral therapy
	Model 6	Work with children and youth, work with adults

presented in Table 3, sociodemographic and work-related variables were included block wise as independent variables in the hierarchical regression analyses.

Results

Descriptive data of the ProQOL scores as well as the correlations of the ProQOL scales for both groups can be found in Tables 4 and 5.

Table 2 Sociodemographic characteristics of the psychotherapist sample

Characteristics	Psychotherapists (N=97)
Age	$M = 44.90$ ($SD = 8.62$)
Sex	79 female (81.4%)
Migration background	15.5% 3.1% born in a different country 10.3% parents born in a different country 2.1% one parent has another citizenship)
Professional Background	37.1% pedagogy 28.9% psychology 21.6% social work 21.6% social pedagogy 9.3% teaching
Treatment clientele/acquisition of the license to practice medicine	92.8% licensed psychotherapist for children and youth 5.2% licensed psychotherapist for adults 5.2% licensed psychotherapist for adults and children/youth Duration in years since the acquisition of the license to practice medicine: $M = 7.87$ ($SD = 6.29$)
Additional training	70.1% 16.5% systemic therapy, 33% trauma therapy, 10.3% schema therapy, 32% EMDR, 7.2% hypnotherapy
Therapy sessions per week	$M = 22.77$ ($SD = 7.72$)
Work experience with UYR	63.9%
Number of PTSD patients that have already been treated	$M = 13.68$ ($SD = 15.81$)
Therapeutic approach	Behavioral Therapy = 85.6%, Depth Psychology = 13.4%, others = 1%
Patients to treat	Children and Youth = 92.8%, Adults = 5.2%, both = 5.2%

Table 4 Descriptive data of the ProQOL scores for CWW and psychotherapists

	CWW (<i>n</i> = 198)					Psychotherapists (<i>n</i> = 97)					
	<i>M</i>	<i>SD</i>	Range	Low	High	<i>M</i>	<i>SD</i>	Range	Low	Moderate	High
CS	39.72	4.22	29–49	0%	35.4%	40.06	4.10	29–49	0%	60.8%	39.2%
BO	21.94	4.18	13–34	59.1%	0%	19.10	3.55	11–28	80.4%	19.6%	0%
STS	21.17	4.12	13–35	67.2%	0%	18.12	3.43	12–26	89.7%	10.3%	0%

Note. CS = compassion satisfaction, BO = burnout, STS = secondary traumatic stress

Differences between CWW and psychotherapists

Regarding the BO scale, there was a significant difference between the BO scores of the psychotherapists ($M=19.10$; $SD=3.55$; $n=97$) as compared to CWW ($M=21.94$; $SD=4.18$; $n=198$), with mean difference of -2.84 (95%-CI [-3.81 , -1.87]) lower for the psychotherapists, $t(293) = -5.75$, $p < .001$. It did represent a medium-sized effect, $d = -0.71$. In addition, there was a significant difference between STS of psychotherapists ($M=18.12$; $SD=3.43$; $n=97$) and the CWW ($M=21.17$; $SD=4.12$; $n=198$), with mean difference of -3.05 (95%-CI [-4.00 , -2.10]) lower for the psychotherapists, $t(293) = -6.30$, $p < .001$. It did represent a medium-sized effect, $d = -0.78$. The Mann-Whitney-U-test showed that the STS levels in psychotherapists ($Mdn=19.10$) differ significantly from CWW, ($Mdn=21.17$), $U=5712.00$, $Z=-5.67$, $p < .001$. There was no significant difference between CS scores of the psychotherapists ($M=40.06$; $SD=4.10$; $n=97$) and the CWW ($M=39.72$; $SD=4.22$; $n=198$), with mean difference of 0.34 (95%-CI [-0.68 , 1.35]), $t(293)=0.656$, $p=.513$, $d=0.08$.

Additional analysis revealed a significant difference between CS scores of psychotherapists who have worked with refugees before ($M=41.24$; $SD=3.87$; $n=68$) and those who have not ($M=37.92$; $SD=4.21$; $n=37$), with mean difference of -3.32 (95%-CI [-4.93 , -1.7]), $t(103) = -4.07$, $p < .001$, $d = -0.83$. There were no significant differences regarding BO and STS. Comparing CS scores of psychotherapists with therapy experience working with refugees and CWW, CWW reported significant lower CS levels with mean difference of -1.42 (95%-CI [-2.62 , -0.23]), $t(258) = 0.654$, $p = .02$, $d = -0.34$.

Results of hierarchical regression analysis regarding demographic variables and ProQOL subscales

Hierarchical regression analyses for CWW can be found in Table S1 (additional file 1). All predictors were non-significant.

Detailed information on the models of the hierarchical regression for psychotherapists can be found in the additional file 1 (Table S2). Regarding the association between demographic variables and ProQOL subscales among psychotherapists, model 3 was able to explain the greatest significant amount (27%) of variance in CS [$F(13, 83) = 2.35$, $p = .01$]. The model revealed previous work with UYR as a significant predictor for CS ($\beta = 0.34$; $p = .002$).

Furthermore, model 6 was able to explain the greatest significant amount (39.4%) of variance in STS [$F(22, 74) = 2.18$, $p = .007$]. The analysis revealed that a higher number of weekly therapy sessions was associated with lower levels of STS ($\beta = -0.35$, $p = .002$). Treating more cases diagnosed with PTSD was associated with higher levels of STS ($\beta = 0.26$, $p = .041$). Participants who had

Table 5 Correlations (*r*) of the ProQOL scores for CWW and psychotherapists

	CWW (<i>n</i> = 198)			Psychotherapists (<i>n</i> = 97)		
	CS	BO	STS	CS	BO	STS
CS	1	-0.475** [-0.571, -0.374]	-0.110* [-0.220, -0.010]	1	-0.524** [-0.660, -0.376]	-0.200* [-0.388, 0.001]
BO	-0.475**	1	0.363** [0.268, 0.448]	-0.524**	1	0.514** [0.319, 0.692]
STS	-0.110* ^a	0.363*** ^a	1	-0.200*	0.514**	1

Note. ** $p < .001$ und * $p < .05$. BCa bootstrap 95% CIs reported in brackets. CS = compassion satisfaction, BO = burnout, STS = secondary traumatic stress. ^a correlation was performed using Kendall-Tau-b

undergone additional training with a focus on trauma therapy reported higher STS levels ($\beta = 0.34$, $p = .009$). Participants with a migration background reported less STS ($\beta = -0.20$, $p = .05$). There was no significant predictor for BO (see additional file 1, Table S2).

Discussion

The aim of the present study was to identify levels of CS, BO, and STS in German CWW who work with UYR and licensed psychotherapists and to determine whether there was a difference between these two groups. Furthermore, we investigated whether demographic variables were associated with different levels in the ProQOL dimensions. In our overall sample, the participants reported average levels of BO and STS. Previous studies reported more average- to high-level scores on BO and STS among caregivers, refugee relief workers, professionals, and volunteers [21–24], whereas in our samples, mainly below average to average and no above average scores on BO and STS were found. The CS scores ranged from average to above average. Given that participants were likely already highly interested in working with refugees, CS levels may be elevated. Consequently, the sample mean may exceed that of the general population and should be taken into account when interpreting the results. Furthermore, differences in BO and STS scores between this and other studies may be due to differences in the areas of work. For example, working in receptive and transit centers [24] or working exclusively with women and children who may have experienced sexualized violence [21]. The social workers in our study worked in residential youth groups and the psychotherapists treated UYR alongside people without experience of flight and trauma. Additionally, 36.1% of therapists had not worked with refugees by the time the data was collected. Based on this study, future research should distinguish between different professional groups and areas of work with refugees.

Although the difference was small, psychotherapists scored significantly lower on the BO and STS scales than CWW. Little is known about the differences between professional groups working with refugees or UYR. Živanović and Marković [24] could not find any difference between occupational groups providing different

types of services to refugees, i.e. legal, psychological, medical, or translational services. However, it seems that occupational stress is higher in CWW than in other professions due to various factors like higher caseloads, time pressure, being short staffed, working overtime, administrative regulations and protecting child safety [3, 4]. In our sample, the reason for the differences could be the nature and intensity of the contact. While CWW accompany children and young people in their everyday lives for several hours a day, up to 5 days a week, psychotherapists only see their clients in one to two hour sessions on a weekly basis. Another possibility are differences in training. Therapists learn about the treatment of PTSD during their undergraduate and postgraduate training, whereas social workers receive less intensive training. However, being trained in therapies with a traumafocus was associated with higher STS in our sample. It should also be noted that our group of psychotherapists had not all worked with UYR or carried out trauma therapy at the time of the analysis. Conversely, comparing therapists who have worked with refugees to those who have not revealed no differences in BO or STS scores. The analysis revealed that therapists with experience treating refugees had higher CS scores than those without. This suggests a positive effect associated with this work. These therapists also scored significantly higher on CS than the CWW group, which may reflect professional differences or statistical effects due to the groups' different sample sizes. If these are professional differences, adapting labor policies to address challenges such as overtime, staff shortages, and high case numbers [3, 4] may reduce BO and STS while improving CS among CWW. However, as this is a cross-sectional survey, the generalizability of the results is limited. A longitudinal study is necessary to observe changes in CS, BO, and STS over time.

Surprisingly, there were no significant predictors in the hierarchical regression for CWW in all models. This finding is contrary to earlier studies that found that female gender and younger age are risk factors for BO and STS [8, 12]. However, in terms of work experience, our results fit the literature as some studies suggest that it puts CWW at risk [8, 26], while others indicate it as a protective factor [27]. When considering a floor effect, given the somewhat lower scores on the ProQOL scales in our

sample, it may be that the gender and age did not come into effect. It may also be necessary to consider variables other than those we included. One possible predictor could be personal trauma history, as other studies have shown that CWW's own trauma history has an impact on CS and STS [21, 31]. Furthermore, we included the predictors work experience in years and in the current facility. However, it might be more important to consider working hours, shift times or overtime, as these may better represent the workload that could be experienced as a burden or cause emotional distress [6]. It is possible that CWW seek intervisory support from their colleagues. Support from team members has been reported to be essential for well-being [35] and may be a protective factor not captured by the variables in our study.

Among psychotherapists, hierarchical regression results indicated that higher numbers of weekly therapy sessions were associated with lower levels of STS. In this regard, studies are inconsistent, as in some, a positive correlation between the proportion of time spent with traumatized clients and the development of STS was shown [21], while in others, the opposite [44] or no correlation [24] was found. It should be noted that in the present study, we only asked about the number of therapy sessions per week, not specific to PTSD.

The observed association between the number of PTSD cases treated and increased STS scores warrants further investigation. It seems that it is not necessarily the number of patients per week that increases the STS score, but rather the total number of PTSD cases that are treated. These findings are consistent with those of Hensel and colleagues [33], who indicated that the proportion of time spent working with traumatized patients may be more important than the actual number of patients. When selecting cases, psychotherapists should consider this connection and arrange for parallel supervision when treating a high volume of trauma patients. Furthermore, future research should more rigorously collect data on the proportion of traumatized clients treated, trauma characteristics and treatment approaches to further evaluate this aspect.

Unexpectedly, participants who had undergone additional training focused on trauma therapy reported higher levels of STS. Earlier research indicated that the specific trauma training or more education should lead to a lower burden [44]. It is possible that psychotherapists with trauma training also have greater interest in treating PTSD and therefore take on more PTSD cases on average. This explanation aligns with our result that a higher PTSD caseload was associated with more STS. However, the possibility of habituation is important to consider. Additionally, it is unclear how much supervision psychotherapist with advanced trauma training still received which may have an impact on their STS scores [35]. The

literature agrees on the need for trauma training, education, and supervision in the field of working with refugees [21, 24, 31, 35]. Moreover, continued supervision remains essential even for experienced psychotherapists who have treated a higher number of trauma cases. It should not be assumed that increased clinical experience reduces the need for supervision.

Another result was that psychotherapists with a migrant background reported lower STS scores. One potential explanation is that language barriers or cultural differences are less pronounced, leading to greater understanding and openness. In addition, their own migration history could also lead to higher resilience and thus lower STS values. However, Denkinger and colleagues found that a person's own history of flight is a risk factor for STS [21]. Therefore, flight experience and migration background must be considered separately. Furthermore, psychotherapists with a migration or refugee background should receive more support. Although their experiences could offer valuable insights to improve care for UYR, they remain underrepresented in research and should be more actively included.

Furthermore, the analysis showed that greater experience in working with refugees was associated with higher levels of CS. Additionally, there are no significant differences in BO and STS based on whether or not psychotherapists have previously treated refugees. This finding is not consistent with the findings of Mavratza and colleagues [31] who found that working with migrants had a negative impact on professional quality of life, which they attributed to a possible influence on the BO and compassion fatigue scales. Plakas [37] was also able to show that an increase in work experience in humanitarian aid was associated with an increase in BO and a decrease in CS. However, it should be noted that these studies did not exclusively survey psychotherapists but also social workers, nurses, nursing assistants, coordinators, field workers and more. Furthermore, it is possible that psychotherapists with a higher CS trait are more likely to work with refugees. However, these findings suggest that working with refugees can be professionally rewarding. Early-career and experienced psychotherapists alike should be encouraged to engage in this field and provided with the necessary support.

Limitations

This study has some limitations. First, the sample size varied substantially depending on the group. Subsequently, some of the analyses contained only a few participants and missed statistical power. In addition, some of the psychotherapists (36.1%) had not yet worked with refugees at the time of the survey. To ensure generalizability, future research should survey only therapists who already have experience in working with UYR. Moreover,

questions should have been asked about personal trauma histories and personal experiences of flight. Additionally, we did not assess supervisory support in CWW or psychotherapists. This may be necessary for obtaining further information on work-related stress factors. Another aspect affecting the sample is the context of the project in which the data were collected. It aims to implement a low-threshold care service for UYR. The CYWS facilities as well as the psychotherapists who register with the project have a certain interest and motivation to work with this special cohort. Therefore, the possibility of a selection bias cannot be ruled out. Furthermore, the data is cross-sectional, whereas longitudinal data could have provided more accurate information on the development of professional quality of life in the work with UYR. Due to the explorative approach, the results can only be generalized to a limited extent. This should be considered when interpreting our results and reviewing them in future studies.

Conclusion and implications

In sum, BO and STS were present in CWW and psychotherapists, but levels were lower than expected. Psychotherapists had lower STS and BO scores than CWW, suggesting greater exposure to stress for CWW. However, no significant predictors could be detected in the hierarchical regression of the CWW. Among psychotherapists, a greater number of PTSD cases was associated with higher STS scores. It has been shown that a greater number of weekly therapy sessions was linked to lower STS scores. Psychotherapists with trauma training reported higher levels of STS. Having a migration background was associated with lower STS values. Furthermore, psychotherapists with experience in working with refugees reported higher levels of CS than those without.

Given the aforementioned limitations, several implications for future research and professional development emerge. To ensure the quality of treatment and care, it is important to support and train CWW and psychotherapists working with refugees. By doing so, potential barriers or fears of treatment can be removed. This includes adequate trauma-specific training as well as training on the topic of flight in general. Training should be provided not only in clinical settings but also in pedagogical and educational areas to equip young adults in social professions with basic knowledge. Additionally, studies often reference the added stress of working with refugees. However, it is possible that working with UYR can also be fulfilling and not solely diminish professional quality of life. Future research should address the role of occupational groups, treatment approach, and migration background of the psychotherapist. Furthermore, identifying risk and protective factors among CWW is important. Predictors such as trauma history, workload,

and the importance of supervision or intervision support should be considered. Research in the field of professionals working with UYR should increase as it could support professionals' quality of life and ultimately benefit their patients.

Abbreviations

BO	Burnout
CS	Compassion Satisfaction
CWW	Child Welfare Workers
CYWS	Child and Youth Welfare Service
proQOL	Professional Quality of Life Scale
PTSD	Posttraumatic Stress Disorder
STS	Secondary Traumatic Stress
UYR	Unaccompanied Young Refugees

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s13034-025-00942-0>.

Supplementary Material 1: Table S1 and S2: Coefficient of the hierarchical regression analyses (CWW & psychotherapists).

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Author contributions

The authors' responsibilities were as follows: The BETTER CARE project was designed and implemented by R.R., E.P. and C.S. The data were collected by P.S., B.K., J.T., E.P. and C.S. P.S. and B.K. performed the statistical analysis. P.S. and J.T. drafted the manuscript. B.K., J.T., R.E., E.P., C.S. and R.R. critically reviewed the manuscript. The final supervision was carried out by R.R. All authors read and approved the final manuscript.

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Data availability

Our data were collected by the research group and are not publicly available. The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Written informed consent was obtained from all individual participants included in the study. The studies involving human participants were reviewed and approved by ethics committees at The Ulm University (No. 243/19) and at The Catholic University of Eichstätt-Ingolstadt (No. 004–19). All data collection is carried out in accordance with the relevant guidelines and regulations following the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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LIST OF PUBLICATIONS

Original Research

1. **Schwegler, P. M.***, Gossmann, K.*, Neumann, T., Moser, A., Speth, T., & Rosner, R. (2025). Psychotherapists' readiness to treat PTSD: the influence of refugees' country of origin. *European Journal of Psychotraumatology*, *16*(1), <https://doi.org/10.1080/20008066.2025.2456381>
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2. **Schwegler, P. M.**, Neumann, T., Rosner, R., & Gossmann, K. (2025). Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A Cross-Sectional Vignette Study. *Clinical Psychology and Psychotherapy*, *32*(3), <https://doi.org/10.1002/cpp.70076>
3. **Schwegler, P. M.**, Kasparik, B., Thielemann, J., Eilers, R., Pfeiffer, E., Sachser, C., & Rosner, R. (2025). Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*, *19*(77), <https://doi.org/10.1186/s13034-025-00942-0>

Conference Contribution

1. **Schwegler, P. M.**, Kasparik, B., Thielemann, J., Eilers, R., Pfeiffer, E., Sachser, C., & Rosner, R.. (2024, September 18th to 20th) *Professional quality of life of child welfare workers and psychotherapists working with traumatized young unaccompanied refugees in Germany: a cross-sectional study*. Poster presented at the 2024 Summer School of BETTER CARE and BESTFORCAN, Catholic University of Eichstätt-Ingolstadt, Eichstaett, Germany.
2. **Schwegler, P. M.**, Neumann, T., Unterhitzenberger, J., & Gossmann, K. (2026, March 19th to 21st). Presentation about *Psychotherapists' Readiness to Treat Refugee Patients and the Influence of Professional Quality of Life: A Cross-Sectional Vignette Study* within the symposium „Die Versorgung Geflüchteter in Deutschland – Psychotherapeut*innen zwischen Behandlungsbereitschaft und praktischer Umsetzung [The Provision of Care for Refugees in Germany – Psychotherapists Between Treatment Readiness and Practical Implementation]“ at the annual conference of the German Society for Psychotraumatology 2026 (Deutsche Gesellschaft für Psychotraumatologie, DeGPT): Rassismus, Diskriminierung und gesellschaftliche Ungleichheit – Psychotraumatologie intersektional gedacht, Berlin, Germany.

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