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DEPERSONALISATION IN WOMEN PROVIDING PSYCHOSOCIAL SUPPORT SERVICES**

Abstract. *The article examines the relationship between depersonalisation and the provision of psychosocial support among women in helping professions. The aim of the study was to determine the extent to which depersonalisation, as a consequence of occupational burnout, is present in women working in these professions, and to identify the factors that predict it. The research was a quantitative empirical cross-sectional study that applied a descriptive/analytical approach. The sample included 302 women from the Western Balkans. The findings show that approximately one-third of the participants exhibited mild symptoms of this phenomenon, whereas 12.5% had moderate to high levels. It was revealed that marital status, holding a professional licence, intercultural training, and international/intercultural experience are predictors of depersonalisation levels.*
Keywords: *burnout, depersonalisation, helping professions, secondary traumatisation, vulnerable groups, gender.*

INTRODUCTION

Burnout is defined as a psychological syndrome characterised by three key dimensions: emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment (Maslach and Jackson 1981; Maslach and Leiter 2016). The phenomenon was initially identified among professionals working in human-service fields, such as healthcare, social work, and education. However, research has shown that burnout can occur across a wide range of occupations (de Hert 2020). The burnout concept further developed by Maslach and colleagues laid the foundation for numerous subsequent studies and assessments of the syndrome, including the *Maslach Burnout Inventory* (MBI).

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As a central dimension of burnout, depersonalisation refers to the development of a negative, cynical, and emotionally detached attitude to the recipients of services (Maslach et al. 2001). Functionally, it is a mechanism of emotional self-defence via which professionals attempt to preserve personal stability when faced with the excessive demands of others (Maslach et al. 2001; Kristensen et al. 2005). In this context, depersonalisation may manifest as a decline in empathy, a sense of alienation, and emotional emptiness in interactions with clients, as well as through the instrumentalisation of relationships, whereby clients are no longer perceived as individuals with unique needs (Bakker et al. 2003). Empirical evidence further indicates that high emotional labour demands, including those in service professions, are linked to emotional burnout (Šadl and Osolnik 2023), thereby reinforcing the fact that depersonalisation is a key dimension of burnout.

In the empirical literature, depersonalisation has been associated with a range of negative outcomes, such as reduced quality of professional services, increased conflicts during client interactions, higher rates of absenteeism, and a strong intention to leave the profession (Leiter and Maslach 2009; Taris et al. 2005). Such consequences are particularly detrimental in helping professions where a high degree of emotional engagement, availability, and empathic responsibility is expected.

In this study, depersonalisation was examined as a distinct dimension of burnout through use of the MBI (Maslach et al. 1996). The investigation focused on women employed in professions that provide psychosocial support, including counselling, psychotherapy, social work, cultural mediation, healthcare, humanitarian work, and fieldwork, with the aim of gaining a deeper understanding of this form of emotional distancing.

REVIEW OF LITERATURE

Psychosocial Support

Psychosocial support is a form of professional assistance provided to traumatised and vulnerable groups, and a specific risk factor in occupational burnout.

Psychosocial support encompasses a range of activities that enhance the psychological wellbeing of individuals and communities in crises, and entails professional engagement sensitive to the local context (IASC 2007). Support of this type involves assisting others through guidance, protection, care, and the improvement of health for individuals who have experienced adverse life circumstances (Chart et al. 2014; Kopřiva 1997; Musil 2004, as cited in Čopkova 2022). It refers to various forms of emotional, social and psychological assistance provided to individuals faced with stress, trauma, poverty, social exclusion, and other unfavourable life conditions. The World Health Organization (WHO 2013) emphasises the importance of integrated psychosocial support, notably in work with vulnerable groups exposed to traumatic experiences. The professionals providing these services are typically engaged in specific helping professions, and encompass healthcare workers, psychologists, psychiatrists, psychotherapists,

social workers, cultural mediators, and others. Their role involves delivering psychological first aid, assessing the acute needs of clients, listening to their concerns, and connecting them with relevant services capable of providing appropriate support (Đurović and Biro 2019).

Psychosocial support is given to different populations, including children, elderly, refugees, asylum seekers, victims of human trafficking, and other vulnerable groups. In this context, professionals are continuously exposed to emotionally demanding situations. Authors accordingly describe how general practitioners, psychiatrists, psychotherapists, counsellors, and social workers are especially at risk of experiencing the negative effects of such work, including the development of depersonalisation (Vićentić et al. 2010).

Depersonalisation as a Result of Providing Psychosocial Support in Helping Professions

Research data suggest that burnout syndrome at work is particularly prevalent among professionals in helping professions, with those engaged in the protection and promotion of mental health facing especially high risk (Vićentić et al. 2010). The authors refer to professionals working with traumatised and multiple vulnerable populations, such as victims of violence, torture, forced displacement, and migrant groups. They believe that prolonged exposure to others' suffering in the mentioned contexts, coupled with a lack of systemic support, significantly adds to the risk of developing depersonalisation (Vićentić et al. 2010). Further, they note that professional engagement in this field involves continuous and emotionally intense work with clients, which "requires a special interpersonal dimension" (Vićentić et al. 2010, 742) in daily practice. It is also shown that, in the course of working with individuals who have experienced trauma, professionals may develop symptoms which are not a result of direct personal experiences, but stem from prolonged exposure to the trauma narratives of others (Figley 1999).

Depersonalisation as a psychological phenomenon refers to a state in which an individual experiences a sense of detachment from their own thoughts, body and emotions, which can be profoundly disorienting and disruptive to daily functioning (Maslach et al. 2001). In this way, it can manifest as a defence mechanism against overwhelming emotions and empathic overload, and be defined as an identity disturbance characterised by the subjective experience of being detached or estranged from oneself (APA 2013). Authors explain that depersonalisation is associated with both occupational burnout and secondary traumatisation (Kanios et al. 2021). They add that in the context of burnout, depersonalisation is characteristic of various professions, including helping professions, whereas with secondary traumatic stress (STS) it largely occurs among professionals who are indirectly exposed to traumatic experiences (ibid.). Common health consequences of secondary traumatisation include symptoms of depersonalisation, PTSD, anxiety, depression, burnout, fatigue, and related conditions (Greinacher et al. 2019).

Research in this area indicates that continuous exposure to the trauma and suffering of others – common in fields like child protection (Endsjø et al. 2024), work with victims of violence, war veterans, or chronically ill patients – can lead to secondary traumatic stress (STS) among service providers, which might raise the likelihood of burnout (Endsjø et al. 2024). Persistent empathic engagement and confrontation with the extreme emotional demands of the job gradually deplete the capacity for compassion, causing professionals (often unintentionally) to resort to depersonalisation as a defence mechanism to continue functioning. This is supported by findings that people who frequently work with abused children or traumatised populations exhibit higher levels of burnout symptoms, including emotional detachment from clients, than those free of occupational burdens (Endsjø et al. 2024).

Despite individual differences, burnout – and particularly depersonalisation – is the result of a cumulative process. It encompasses not simply the intensity of the workload but also the lack of support, weak systems for evaluating work, and insufficient recognition of the emotional effort invested (Maslach et al. 2001; Schaufeli et al. 2009). Bride et al. (2004) and Figley (2002) emphasise that the timely identification of depersonalisation symptoms in helping professions is crucial, not only for safeguarding the mental health of professionals themselves but for ensuring the quality of services provided to highly vulnerable clients as well.

In international practice concerned with professional protection and employee wellbeing within helping professions, structured forms of support are implemented on multiple levels – beginning with the individual (self-regulation, resilience), extending to teams (supervision, mentoring support), and encompassing the organisation (workload distribution, rotation, work protocols) (SAMHSA 2014). These mechanisms, along with organisational policies that define mandatory supervision intervals and assure access to crisis support, help lower the risk of burnout and depersonalisation.

Researchers suggest that organisations could indirectly influence employees' levels of emotional exhaustion by adapting existing procedures and selection processes, along with investing in training and coping programmes (Šadl and Osolnik 2023). However, a review of psychological, sociological and management literature examining the role of protective factors and coping strategies in maintaining health and wellbeing reveals that most studies primarily focused on individual resources (Urdih Lazar et al. 2019).

Depersonalisation and Gender

Studies highlight the importance of considering gender differences while discussing the mechanisms of how depersonalisation is manifested (Marković et al. 2024; Özbay and Bülbül 2024). Authors note the existence of differences regarding how men and women cope with stress and trauma: men are more likely to employ problem-focused strategies; women tend to seek emotional support (Fu

and Wang 2023; Jay et al. 2019; Olff 2017). Olff (2017) argues that social support is especially valuable for women, and that its absence is one of the most common predictors of negative trauma outcomes. On top pf gender, other sociodemographic variables have been shown to be associated with burnout, including age, education, marital status, and work experience (Glomazić and Vidović 2024; Marković et al. 2024). Nevertheless, as the authors point out, further research is needed to clarify the nature of these correlations.

These differences may influence how mental health professionals experience and assess their own capacities for coping with traumatic experiences, with gender potentially playing a significant role in shaping psychological resilience (Özbay and Bülbül 2024). Available data indicate that women, on average, report emotional symptoms like anxiety, depression, and feelings of helplessness more frequently than men (Kindermann et al. 2017; Olff 2017; Baum et al. 2014). Higher levels of empathy, which are more often observed in women, may lead to deeper emotional engagement while working with trauma survivors, thereby making them more vulnerable. A meta-analysis of 12 studies showed a significant gender difference in susceptibility, with women exhibiting higher levels of secondary traumatisation symptoms compared to men (Baum et al. 2014). Other authors have reported that their research showed men displayed significantly higher levels of depersonalisation than women (Greenglass et al. 1990). They explain these findings by noting that even though men experienced greater work-related stress than women, unlike women, they did not employ common coping strategies.

Baum and colleagues (2014) stated that gender differences are also evident in coping with stress and traumatic content. Women more often seek social support and express emotions openly, using coping strategies and investing in friendships and cultural activities, whereas men tend to apply strategies characterised by emotional withdrawal or attempt to solve problems by themselves without recourse to others (Olff 2017; Greenglass et al. 1990). According to some analyses, women are especially vulnerable to secondary traumatisation in environments where social support is limited and there is a high level of emotional avoidance (Baum et al. 2014).

In the context of professional practice, women employed in fields such as social work, psychotherapy and healthcare are often more susceptible to burnout and depersonalisation due to the combination of intensive emotional engagement and cultural norms that reinforce caregiving roles. In comparison, men working in the same sectors may experience pressure to conceal signs of emotional vulnerability, which may hinder the timely recognition and treatment of symptoms (Glomazić and Vidović 2024). Cross-cultural comparisons also reveal differences; for instance, in the United States, gender disparities in secondary traumatisation are less pronounced than in some other countries, revealing the significance of cultural and professional factors in shaping both the experience and expression of these symptoms (Baum et al. 2014).

Understanding gender differences in the manifestation and mechanisms of depersonalisation is essential for gaining deeper insights and developing tailored preventive and intervention strategies.

METHOD

The study was conducted as a quantitative cross-sectional empirical analysis, employing a descriptive/analytical approach. The article examines the relationship between depersonalisation and the provision of psychosocial support among women in helping professions. The aim of the research was to assess the extent to which depersonalisation, as an outcome of occupational burnout, is present in the female population within helping professions, as well as to identify the factors that predict it.

The general hypothesis guiding the research is that depersonalisation, as a dimension of occupational burnout, is present among women providing psychosocial support, and its intensity depends on sociodemographic and professional characteristics.

Based on the theoretical framework and previous findings, the following specific hypotheses were formulated:

- **H1:** Depersonalisation is present among women providing psychosocial support, with a portion of the sample expected to exhibit moderate to high symptoms.
- **H2:** The level of depersonalisation varies according to sociodemographic characteristics.
- **H3:** Professional characteristics, including additional training and holding professional licences, help predict the level of depersonalisation.

The study was conducted on a sample of 302 women providing psychosocial support across various institutions in the Western Balkans. For the purposes of the research, the standardised MBI was used, together with an online questionnaire used to collect demographic and professional data.

The collection of primary data was conducted from April to June 2024 in six Western Balkan countries. The sample consists of female professionals employed in non-governmental organisations (NGOs) – including centres, shelters, and safe houses – as well as reception and transit centres operating in the field of mixed migration, and specialised services like counselling centres. Invitations to participate in the survey were distributed through official institutional and association mailing lists, as well as internal communication channels. Inclusion criteria required participants to be women over the age of 23, employed in the provision of psychosocial support, with a minimum 6 months of professional experience. It was assumed that providers of psychosocial services possess specific qualifications for their roles. The sample was therefore intentionally limited to highly educated respondents; namely, those holding at least a university degree or equivalent qualification necessary to work in this field. The focus on

women was guided by two considerations: the predominance of women in helping professions and the intention to precisely examine the risk profile and predictors of depersonalisation within the population statistically most represented in these roles. While this focus does not imply the exclusion of men, it represents a targeted phase of research that could be expanded subsequently through comparative studies.

Statistical Analysis

IBM SPSS Statistics, version 25, was used for the statistical processing of the data. The analysis began with a descriptive overview in which frequencies and percentages were calculated for sociodemographic variables. To examine the latent structure of the Depersonalisation scale, exploratory factor analysis (EFA) was conducted, while the scale's internal consistency was verified using Cronbach's alpha coefficient as a standard indicator of reliability.

For numerical variables, the range, mean with the corresponding standard deviation, median, and interquartile range were reported, while categorical variables were presented using frequencies and percentages.

Finally, to examine the relationship between general sociodemographic characteristics and professional experience variables with scores on the Depersonalisation scale, multivariate linear regression analysis was conducted, allowing for the simultaneous assessment of the effects of multiple predictors.

RESULTS

Table 1 presents the basic demographic characteristics of the sample, which included a total of 302 participants. The respondents' mean age was 41.10 years (SD = 10.05), ranging from 23 to 67 years. The most represented age group was 34 to 43 years (40.1%), while the fewest participants were in the oldest category, 54 to 67 years (12.3%).

The sample included participants from six countries in the region. The largest number of respondents were from Serbia (26.5%), followed by Bosnia and Herzegovina (18.9%) and Montenegro (15.2%). The remaining countries were more evenly represented: Albania (13.9%), North Macedonia (13.2%) and Kosovo (12.3%).

Regarding marital status, the majority of participants were married (56.6%), with those who were single comprising just over one-quarter of the sample (26.3%). Divorced participants accounted for 13.1%, and widows for 4%.

Concerning educational background, all participants had attained at least a university degree. Most had completed undergraduate studies (67.2%), while 32.8% held a postgraduate degree or doctorate.

Table 1: GENERAL INFORMATION ABOUT THE PARTICIPANTS

	N = 302
Age (years), Mean (Std. Deviation), Min – Max	41.10 (10.05), 23.0 – 67.0
Age categories:	
23 – 33	69 (22.8%)
34 – 43	121 (40.1%)
44 – 53	75 (24.8%)
54 – 67	37 (12.3%)
Country:	
Serbia	80 (26.5%)
Bosnia and Herzegovina	57 (18.9%)
Montenegro	46 (15.2%)
North Macedonia	40 (13.2%)
Kosovo	37 (12.3%)
Albania	42 (13.9%)
Marital status:	
Single	78 (26.3%)
Married	168 (56.6%)
Divorced	39 (13.1%)
Widow	12 (4%)
Education level:	
Secondary education	0 (0.0%)
Higher education (Bachelor's degree)	203 (67.2%)
Postgraduate studies/Doctorate	99 (32.8%)

Source: Autor's primary survey data.

Table 2 provides an overview of the participants' professional characteristics with regard to their training, licences, type of engagement, and populations of clients they work with.

As concerns therapeutic training, 36.4% of the participants reported having attended related programmes, yet 63.6% had not received such education. A similar distribution was observed for specialised training related to working with trauma – 49.0% of the participants had received this type of training, whereas 51.0% had not.

Over half the participants (55.6%) held a professional licence to provide services, although 44.4% do not. Some form of intercultural training was reported by 59.6% of the participants, whereas 40.4% had not received such preparation. Regarding international and intercultural experience, 52.6% of the participants indicated holding such experience, while 47.4% did not.

Table 2: PROFESSIONAL WORK EXPERIENCE IN SERVICE PROVISION

	n (%)
Therapeutic training:	
Yes	110 (36.4%)
No	192 (63.6%)
Trauma-specific training:	
Yes	148 (49.0%)
No	154 (51.0%)
Professional service provider licenses:	
Yes	168 (55.6%)
No	134 (44.4%)
Some form of intercultural training:	
Yes	177 (59.6%)
No	120 (40.4%)
General international/intercultural experience:	
Yes	159 (52.6%)
No	143 (47.4%)
Type of work:	
Counseling	173 (57.3%)
Psychotherapy	37 (12.3%)
Social work	155 (51.3%)
Cultural mediation	40 (13.2%)
Humanitarian work	110 (36.4%)
Healthcare	37 (12.3%)
Field work	77 (25.5%)
Type of service recipient:	
Asylum seekers	100 (33.1%)
Migrants	120 (39.7%)
Victims of violence	239 (79.1%)
Victims of human trafficking	55 (18.2%)

Source: Autor's primary survey data.

With respect to the type of work performed, counselling (57.3%) and social work (51.3%) were the activities most frequently reported. A substantial proportion of participants was also engaged in humanitarian work (36.4%) and field activities (25.5%), whereas psychotherapy (12.3%), healthcare provision (12.3%) and cultural mediation (13.2%) were less represented, albeit remained relevant.

Regarding the service recipients, the majority of participants were working with victims of violence (79.1%), followed by migrants (39.7%) and asylum seekers (33.1%), while 18.2% reported working with victims of human trafficking.

Table 3: DESCRIPTIVE STATISTICS AND SUMMARY OF THE RESULTS FROM THE EFA ON THE DEPERSONALIZATION

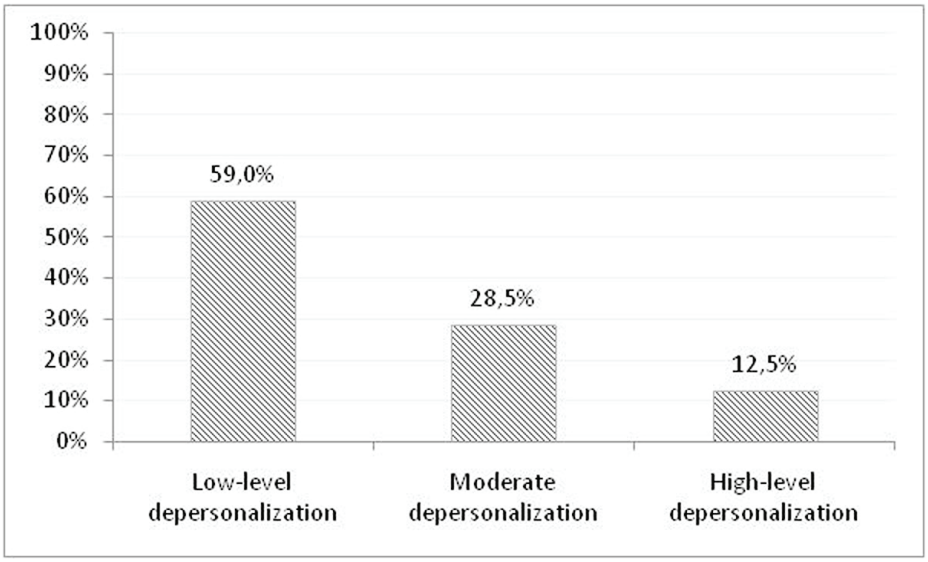
Items and Total Scores	Min–Max	Me	IQR	M	SD	α	Factor loadings (57,9%)#
Depersonalization Item 1	0 – 6	0.00	1.00	0.75	1.53	0.763	0.810
Depersonalization Item 2	0 – 6	0.00	2.00	1.24	1.83	0.760	0.733
Depersonalization Item 3	0 – 6	0.00	2.00	1.40	1.98	0.742	0.817
Depersonalization Item 4	0 – 6	0.00	1.00	0.84	1.71	0.770	0.698
Depersonalization Item 5	0 – 6	1.00	2.00	1.14	1.59	0.770	0.738
Depersonalization Total Score	0 – 30	4.00	6.00	5.40	6.60	0.815	

Note. **p < .01; Me = Median; IQR = Inter-quartile range; M = Mean; SD = Std. Deviation; α = Cronbach's alpha.
Depersonalization Item 1 = *I get the feeling that I treat some clients/colleagues impersonally, as if they were objects;* Depersonalization Item 2 = *I have become more callous to people since I have started doing this job*; Depersonalization Item 3 = *I'm afraid that my work makes me emotionally harder*; Depersonalization Item 4 = *I'm not really interested in what is going on with many of my colleagues*; Depersonalization Item 5 = *I have the feeling that my colleagues blame me for some of their problems*.
#Percentage of the variance accounted the factor; EFA= Exploratory factor analysis (Varimax rotation).
Source: Autor's primary survey data.

Table 3 presents descriptive statistics for all measured variables, along with Cronbach's alpha values and factor structure. The results of the exploratory factor analysis (EFA) show depersonalisation is a unidimensional construct. Bartlett's test of sphericity was significant ($\chi^2 = 578.08$, df = 10, $p < 0.001$) and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was satisfactory (0.721). The reliability of the depersonalisation scale is good, as indicated by the high Cronbach alpha coefficient ($\alpha = 0.815$). It is important to note that the removal of any of the five items would not further increase the alpha value.

The mean total score for depersonalisation was 5.40 (SD = 6.60). When examined by category, 59.0% of participants exhibited a low level of depersonalisation, 28.5% a moderate level, while 12.5% of women providing psychosocial support services a high level of depersonalisation (Graph 1).

Graph 1: DEPERSONALIZATION CATEGORY



Source: Autor's primary survey data.

Table 4 presents the results of the linear regression models with the total depersonalisation score as the dependent variable. The basic model accounts for 16.3% of the variance in depersonalisation, with marital status categories emerging as statistically significant predictors. Single women ($\beta = 0.27$; 95% CI: 0.24–7.81; $p < 0.05$) and divorced women ($\beta = 0.57$; 95% CI: 7.45–14.85; $p < 0.01$) exhibited higher depersonalisation scores compared to the reference group.

In the full model, which explained 60.7% of the variance in depersonalisation, marital status remained a significant predictor: single women ($\beta = 0.49$; 95% CI: 4.30–10.41; $p < 0.01$) and divorced women ($\beta = 0.52$; 95% CI: 7.17–13.05; $p < 0.01$) exhibited higher levels of depersonalisation. In addition, participants holding a professional licence to provide services ($\beta = 0.42$; 95% CI: 4.29–6.81; $p < 0.01$) and those possessing international or intercultural experience ($\beta = 0.26$; 95% CI: 2.13–4.91; $p < 0.01$) also demonstrated higher levels of depersonalisation.

On the other hand, participation in some form of intercultural training emerged as a protective factor since it significantly reduces depersonalisation levels ($\beta = -0.35$; 95% CI: –6.22 – -3.35; $p < 0.01$).

Table 4: LINEAR REGRESSION MODELS OF THE ASSOCIATION BETWEEN GENERAL INFORMATION, PROFESSIONAL EXPERIENCE, AND DEPERSONALIZATION

	Basic model (Beta CI 95%) Adj. R^2 = 16.3	**Full model** (Beta CI 95%) Adj. R^2 = 60.7
Age	0.03 (-0.65 – 0.10)	-0.06 (-0.20 – 0.10)
Marital status (ref.: widowed)		
Married	0.23 (-0.26 – 6.39)	0.41 (2.87 – 8.05)
Single	0.27 (0.24 – 7.81)*	0.49 (4.30 – 10.41)**
Divorced	0.57 (7.45 – 14.85) **	0.52 (7.17 – 13.05)**
Education (ref.: higher education)		
Postgraduate studies/Doctorate	0.02 (-1.17 – 1.80)	0.08 (-0.02 – 2.35)
Therapeutic training (ref.: no)		
Yes		-0.023 (-1.66 – 1.22)
Trauma-specific training (ref.: no)		
Yes		0.05 (-0.73 – 2.17)
Professional service provider licenses (ref.: no)		
Yes		0.42 (4.29 – 6.81)**
Some form of intercultural training (ref.: no)		
Yes		-0.35 (-6.22 – -3.35)**
General international/intercultural experience (ref.: no)		
Yes		0.26 (2.13 – 4.91)**

*p < 0.05; **p < 0.01.
Source: Autor's primary survey data.

DISCUSSION

The study results indicate a relatively low average level of depersonalisation among women providing psychosocial support, with the majority of participants falling into the mild symptom category. This finding does not fully align with our first hypothesis. However, it is important to note that nearly one-third of the participants exhibited moderate levels of depersonalisation, while 12.5% experienced it with a high intensity. Although quantitatively smaller, this subgroup requires particular attention as symptoms of secondary traumatisation and depersonalisation can substantially undermine the quality of professional interactions and self-assessed efficacy in working with traumatised individuals (Vićentić et al. 2010; Glomazić et al. 2025).

Our second hypothesis (H2), which states that depersonalisation varies depending on sociodemographic characteristics, was partially confirmed – marital status emerged as a significant predictor, with higher levels of depersonalisation observed among unmarried and divorced participants. Similarly, the third hypothesis (H3) may also be considered partly confirmed because the findings show that professional characteristics – including additional training and holding professional licences – contribute to predicting the level of depersonalisation.

Low median values for individual scale items suggest that most participants did not experience a significant development of detachment or emotional distancing, which may be associated with the presence of certain protective factors like holding professional licences, training, and intercultural experience. Nonetheless, the fact that nearly half the sample had not received specific training on trauma (51.0%) and that 44.4% of participants did not hold a professional licence could indicate potentially weaker foundations for preventing secondary traumatisation which in the long term might manifest as symptoms of depersonalisation. Findings of the regression analysis further explain this paradox: while a professional licence and international experience are associated with higher depersonalisation scores (probably due to more intensive exposure to demanding professional situations), certain types of intercultural training emerged as protective factors (Kindermann et al. 2017). This suggests that the content and structure of the training play a crucial role in mitigating risk, rather than their mere formal presence.

When considering local specificities, it is important to note that the conditions in the Western Balkans – including the post-conflict legacy, transient migration routes, and chronic resource constraints, coupled with project-based funding mechanisms – heighten professionals' exposure to complex cases and sustained pressures. The inconsistent quality and duration of intercultural and trauma-focused training help explain why the mere presence of such programmes is insufficient.

A key finding pertains to the professional context – women engaged in counselling, social work, field activities, and work with victims of violence and migration are subjected to multiple emotional demands. The data indicate that 79.1% of the participants were working with victims of violence, and nearly 40% with migrants and asylum seekers. These client groups are inherently highly trauma-exposed, thereby subjecting helping professionals to repeated secondary traumatisation (Glomazić and Mikić 2022; Kindermann et al. 2017). Even though most women in the sample demonstrated resilience, the presence of moderate and high scores on the depersonalisation scale indicates that professional exposure is not without consequences, notably in the context of prolonged emotional engagement. In this regard, the findings further suggest that individual circumstances (such as marital status) may serve as a significant predictor: single and divorced participants reported higher levels of depersonalisation, which may reflect a combination of reduced social support and increased vulnerability to occupational stress.

An important contribution of this study lies in the analysis of the gendered dimensions of depersonalisation. Some findings in the literature suggest that women, due to higher levels of empathy and culturally conditioned expectations related to caregiving, may exhibit greater sensitivity to secondary traumatisation (Baum et al. 2014), a conclusion that should be interpreted with caution. Yet, when the issue is examined within a broader context, depersonalisation among women cannot be viewed solely as an individual reaction, but as a reflection of institutional and societal factors that shape their professional roles (Glomazić and Vidović 2024). Cultural norms which position women as 'natural caregivers' simultaneously make them more emotionally vulnerable and burden them with a heightened sense of responsibility, thereby adding to the risk of emotional distancing as a form of self-protection.

Interestingly, despite the presence of protective factors such as international experience and intercultural training (present with about half the participants), symptoms of depersonalisation were not fully eliminated. This may point to the complexity of the phenomenon, and the fact that structural resources such as training are not always sufficient unless accompanied by continuous psychological support and supervision. In this respect, our findings suggest that education is an important, yet insufficient, condition for resilience.

Moreover, while the study did not examine the direct relationship between personality traits and depersonalisation, previous research suggests that characteristics such as neuroticism may increase vulnerability to emotional exhaustion, while extraversion appears to serve as a potential protective factor (Bakhshi et al. 2021). Future research could focus on combining data on personality traits with professional resources in order to more precisely define risk profiles within helping professions.

The results of the research ultimately highlight the need for systemic attention directed to women in helping professions who work with highly traumatised populations. While most of them demonstrated signs of resilience, there are clear indicators of risk for emotional distancing and diminished connectedness with service users. Professional support should thus not rely solely on training and technical expertise, but also on creating spaces for emotional reflection, supervision, and the recognition of vulnerability as a legitimate aspect of professional practice.

CONCLUSION

The research results confirm that depersonalisation among women providing psychosocial support, although on average of low intensity, constitutes a genuine professional risk calling for systemic attention. Unmarried and divorced women appear particularly vulnerable as they have higher scores on the depersonalisation scale, which shows the importance of personal and social context in shaping professional experience. Further, the presence of a professional licence and international experience, while associated with higher levels of depersonalisation,

likely reflects greater exposure to more complex and demanding professional situations. At the same time, intercultural training emerged as a protective factor, stressing the need for systemic investment in educational programmes that equip professionals to work effectively in multicultural and trauma-affected contexts.

In a broader sense, the study findings suggest the prevention of depersonalisation cannot rely solely on individual resilience or occasional training, and instead requires an integrated approach that combines professional resources, continuous psychological support, and institutional mechanisms of protection. Such a framework would not only ensure the protection of practitioners' mental health, but additionally maintain the quality and ethical standards of services delivered to the most vulnerable social groups.

The study has several limitations related to its cross-sectional design and reliance on self-reported data, which do not allow for causal inferences. The sample is also non-representative and was formed using the snowball sampling method, with no male comparison group included. Empathy and culturally mediated gender expectations were also not directly measured.

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DEPERSONALIZACIJA MED IZVAJALKAMI PSIHOSOCIALNE PODPORE

Povzetek. *Ta članek raziskuje povezanost med depersonalizacijo in psihosocialno podporo pri ženskah v poklicih pomoči. Namen raziskave je bil ugotoviti, v kolikšni meri je depersonalizacija kot posledica izgorevanja na delu navzoča v ženski populaciji v poklicih pomoči, ter prepoznati njene prediktivne dejavnike. Raziskava je bila izvedena kot kvantitativna empirična presečna študija z deskriptivno-analitičnim pristopom. V vzorec sta bili vključeni 302 ženski na območju Zahodnega Balkana. Ugotovitve raziskave kažejo, da približno tretjina udeleženk kaže blage simptome, medtem ko je pri 12,5 % žensk zabeležena zmerna do visoka izraženost tega pojava. Rezultati so pokazali, da so zakonski stan, strokovne licence, interkulturno usposabljanje ter mednarodne/interkulturne izkušnje pomembni prediktorji ravni depersonalizacije.*

Ključni pojmi: *izgorelost, depersonalizacija, poklici pomoči, sekundarna travmatizacija, ranljive skupine, spol.*