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ROLE OF VICARIOUS POSTTRAUMATIC GROWTH IN MITIGATING SECONDARY TRAUMATIC STRESS AND COMPASSION FATIGUE AMONG MENTAL HEALTH PROVIDERS

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Abstract

For mental health professionals dealing with trauma survivors, secondary traumatic stress and compassion fatigue are occupational threats. Whereas Compassion fatigue results from persistent emotional exhaustion due to empathetic engagement, secondary traumatic stress results from indirect exposure to traumatic events. Both conditions can impact work performance, leading to burnout, lower job satisfaction, and reduced client care. Emerging research indicates that vicarious posttraumatic growth—the positive psychological transformation resulting from exposure to others' trauma—may function as a protective factor. The current research examines the role of vicarious posttraumatic growth in mitigating the adverse effects of Secondary traumatic stress and compassion fatigue. A correlational cross-sectional investigation was carried out with professionals in trauma-exposed environments. Two hundred twenty-four participants completed validated self-report instruments that evaluated secondary traumatic stress, compassion fatigue, and vicarious posttraumatic growth. A moderation analysis was performed to evaluate the interaction effect of vicarious posttraumatic growth on the connection between secondary traumatic stress and compassion fatigue. Analysis demonstrated a significant positive association between secondary traumatic stress and compassion fatigue, whereas it was significantly negatively correlated with vicarious posttraumatic growth. Secondary traumatic stress emerged as a significant positive predictor of compassion fatigue. The relationship between secondary traumatic stress and compassion fatigue was significantly moderated by vicarious posttraumatic growth. While secondary traumatic stress and compassion fatigue pose significant challenges for mental health providers, vicarious posttraumatic growth offers a promising counterbalance. By fostering meaning-making, emotional support, and resilience, vicarious posttraumatic growth moderates the negative effects of trauma exposure and promotes professional sustainability. Future research should further explore interventions that enhance VPTG and its role in maintaining the well-being of mental health providers in high-stress environments.

Keywords: Secondary traumatic stress, compassion fatigue, vicarious posttraumatic growth, moderating effect, mental health providers

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INTRODUCTION

Mental health providers working with trauma survivors face an increased risk of secondary traumatic stress (STS) and compassion fatigue (CF) (Sprang et al., 2018). Secondary traumatic stress is characterized as the emotional distress that arises from indirect exposure to another person's trauma (Figley, 1995) and represents a significant occupational hazard in caregiving professions. Despite being linked, STS and CF are less well understood regarding these two emerging constructs (Ormiston et al., 2022; Barbee et al., 2023).

STS refers to the behaviors and feelings that naturally develop due to learning about a traumatic event as it occurred or was experienced by significant others. A physiological reaction to indirect trauma exposure is typical; however, this reaction does not evolve into secondary traumatic stress unless symptoms endure for over a month (Passmore et al., 2020).

Individuals assisting trauma victims, despite not having directly experienced the trauma themselves, often encounter significant exposure to the effects of such experiences. This prolonged contact may involve listening to detailed accounts of traumatic events, which can encompass narratives of suffering following incidents of violence. Consequently, these individuals begin to perceive the world from the perspective of the traumatized individual, experiencing similar emotions and exhibiting similar reactions or behaviors.

Helpers may become trauma victims due to their assistance to others (Ogińska-Bulik & Bąk, 2022). STS is closely associated with posttraumatic stress disorder (PTSD) and exhibits similar symptoms, including maladaptive emotions such as fear, anxiety, depression, intrusive thoughts, avoidance, and hyperarousal (Wickman, 2023).

Joinson (1992) founded the concept of CF, defining it as a unique form of fatigue affecting healthcare professionals (Gustafsson & Hemberg, 2022). CF results from the accumulated impact of secondary trauma seen by caregivers of those in distress (Goldberg, 2022). Figley (1995) subsequently introduced the term compassion fatigue (CF), characterizing it as a condition of exhaustion and dysfunction—biological, physiological, and emotional—arising from prolonged exposure to compassion fatigue (Marshman et al., 2021). CF may stem from the experience of caring for a single patient or incident; however, it is more commonly perceived as the result of numerous caregiving encounters. CF is intricately linked to the notions of STS and vicarious trauma, both of which arise from exposure to the trauma endured by patients rather than the trauma itself. CF is not the only condition that may result from these variables (Cavanagh et al., 2019).

In some instances, secondary traumatic stress is perceived as synonymous with compassion fatigue (Figley, 1995), a variant of compassion fatigue, or as a broader classification of stress that includes compassion fatigue. A new conceptual analysis of empathy-based stress literature suggests that compassion fatigue is a separate category from secondary traumatic stress, indicating that secondary traumatic stress may arise from compassion fatigue (Rauvola et al., 2019).

Healthcare professionals work in an occupational setting that demands being in charge of numerous demanding situations daily, encompassing personal life stressors, prolonged periods of standing, maintaining awareness and concentration, and remaining dedicated to patient care. These expectations may negatively impact their performance and the quality of patient care. Compassion fatigue is a consequence of this job stress, which occurs when an individual's capacity for compassion is overextended (Mottaghi et al., 2020). CF generally manifests subtly and advances gradually. Although initial indications may be overlooked, severe symptoms can emerge suddenly, leading to physical, emotional, and spiritual exhaustion (Lopez et al., 2022).

A study evaluating STS and CF in teachers indicated that, although these concepts are unique, they are not mutually exclusive. Symptoms of STS can exacerbate CF, ultimately reducing the ability to provide adequate care to students (Ormiston et al., 2022). Another study investigating the attributes of teachers pertinent to the effectiveness of trauma-informed care and

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job retention surveyed 163 educators from disadvantaged primary schools serving low-income Latinx pupils. The findings indicated elevated compassion satisfaction and reduced burnout correlated with enhanced perceived efficacy in trauma-informed treatment. In contrast, senior educators and individuals with diminished compassion satisfaction and elevated burnout were more inclined to consider quitting the field. Significantly, neither secondary traumatic stress nor the perceived efficiency of trauma-informed therapy was associated with a heightened desire to depart from the organization (Christian-Brandt et al., 2020).

This association can be further explained in the context of the Trauma Transmission Model and the Empathy-Based Stress Model. Traumatic stress and burnout literature and interpersonal relationships inspired Figley's (1995) trauma transmission model. The model explains trauma transmission and why most acquire STS, but some do not. Empathy was a crucial component. The clinician's attitude toward the victim, trauma exposure, satisfaction from helping, and ability to disengage are other determinants (MacRitchie & Leibowitz, 2010). Helpers use empathy to understand the victim's trauma. They experience issues identical to those of the sufferer, such as sleep issues (Figley, 1995).

Exposure to trauma (a stressor) and empathy (a contextually and personally motivated affective reaction) cause empathy-based stress. This process can lead to unfavorable occupational health reactions, empathy-based tension, and other work-related effects. Empathy-based stress is experienced by anyone who works in a position that exposes them to second-hand trauma (such as a distressing occurrence, repeating events, or chronic conditions) and responds empathically (May et al., 2024; Rauvola et al., 2019).

Despite these risks, not all professionals experience negative outcomes. Research indicates that some individuals undergo vicarious posttraumatic growth (VPTG), a phenomenon where they develop positive psychological changes due to exposure to their clients' resilience and recovery. One of these is posttraumatic growth (PTG). Tedeschi et al. (2018) characterized post-traumatic growth (PTG) as beneficial psychological transformations resulting from the confrontation with trauma or significantly stressful circumstances.

PTG denotes positive psychological transformations following trauma (Whealin et al., 2020). VPTG refers to the development that occurs from exposure to indirect trauma (Arnold et al., 2005). It further posits that exposure to indirect trauma does not always result in adverse outcomes; certain individuals may effectively manage such circumstances (Kalaitzaki & Rovithis, 2021). VPTG arises from individuals' active efforts to derive meaning from their experiences (Melinte, 2023).

Little can be said about STS and VPTG due to the inadequate and inconsistent nature of the studies. Some research suggests a linear relationship, while others imply a curved one. Dar and Iqbal (2020) conducted a cross-sectional study on this topic. Two hundred fifty-eight surgeons, psychiatrists, and physicians who treated crisis victims were recruited. Hierarchical regression showed a curvilinear connection between STS and VPTG after controlling for vicarious and direct trauma.

Oncology nurses were studied for associations with STS-VPTG. The study included 391 oncology nurses. VPTG was moderate to low, and STS was high in the research. STS negatively correlated with VPTG, and empathy mediated this connection (Cai et al., 2024). Another study explored the impact of VPTG on the connection between STS and WA among 231 death care professionals in Northern Italy. Regression analysis was conducted using PROCESS, taking into account interaction effects. The findings demonstrated a negative correlation between STS and WA, while VPTG showed a positive relationship with WA. The connection between STS and VPTG was also found to be statistically significant. The analysis partially supported the hypothesis regarding moderation by VPTG, as the conditional effect was negative and statistically significant at both low and moderate levels of VPTG. However, at high levels of VPTG, STS exposure did not have a negative impact on WA, suggesting that VPTG may play a

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protective role against STS. The findings presented novel ideas concerning the function of VPTG in workplace settings that frequently encounter trauma, including death care (Grandi et al., 2023).

A sample of Turkish child psychiatrists was studied to see whether VPTG moderated the association between STS and burnout (BO). Fifty-nine child psychiatrists completed an online questionnaire for this investigation. The Copenhagen Burnout Inventory, Posttraumatic Growth Inventory, and Secondary Traumatic Stress Scale were used. The study's results were as follows: STS positively correlated with BO ($r = 0.661$, $p < .001$), with VPTG as a moderator. A lower connection between STS and BO was observed in child psychiatrists with higher VPTG (Akdağ et al., 2023).

This association can be explained through psychoanalysis, which claims that the mental apparatus (Breuer & Freud, 1893) allows self-awareness and interpersonal interactions. It fosters subjectivity and allows individuals to compare and arrange their views of reality with the combined perspective, testing reality. According to this perspective, an event viewed as unfavorable by one person may be perceived as positive by another due to neurological and psychological factors (Dell'Osso et al., 2022).

Constructivist self-developmental theory states that direct or indirect environmental experiences shape cognitive schemas. Piaget (1971) defined cognitive schemas as expectations, presumptions, and ideas that help people understand their world. Thus, when someone consistently experiences another's pain, their cognitive schemas shift, affecting their worldview in both positive and negative ways (Daly & Chovaz, 2020).

HYPOTHESES OF THE STUDY

1.There is a positive association between secondary traumatic stress and compassion fatigue.
2.Vicarious posttraumatic growth is negatively linked with secondary traumatic stress and compassion fatigue.
3.Vicarious posttraumatic growth moderates the association between secondary traumatic stress and compassion fatigue.

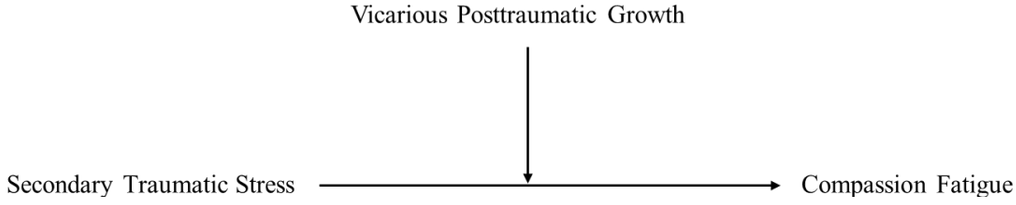

FIGURE 1: HYPOTHETICAL MODEL

METHODS

STUDY DESIGN

This study used a correlational research approach to investigate the relationships between STS and CF. Apart from the correlations, this work also examined the role of interpersonal relationships as moderators. Within the framework of clinical psychology, this strategy facilitated a thorough investigation into the extent to which these factors were associated.

PARTICIPANTS AND SAMPLING

The data were gathered from counseling, psychotherapy, clinical psychology, and trauma-informed therapy professionals. Two hundred twenty-four mental health practitioners in Lahore district participated willingly and were selected using a purposive sampling. The study participants ranged in age from 27 to 45 years ($M = 33.61$, $SD = 4.73$). Of the participants, 78% ($N = 174$) were women, 22% ($N = 50$) were men, 35% ($N = 79$) were single, 64% ($N = 144$) were married, and 1% ($N = 1$) were divorced. Eighty percent ($N = 178$) of the sample possessed an MS/M. Phil, 15% (N=34), held a PhD, while 5% (N=12) of the participants obtained a diploma or other professional certification (see Table 1).

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Vol. 3 No. 4 (2025)

Inclusion and Exclusion Criteria: This study included mental health providers with at least 2 years of experience and a Master's or master 's-level qualification. It excluded individuals engaged in services other than mental health, such as business, medical health, or fitness-related facilities.

INSTRUMENTS

The present study used four instruments: a demographic form, the Professional Quality of Life Scale, the Compassion Fatigue Inventory, and the Posttraumatic Growth Inventory.

1. Demographic Information Form: A demographic information form was used to gather basic information about the participants, including age, gender, marital status, family structure, educational qualifications, duration of work experience, and religion.

2. Professional Quality of Life Scale - 5: The Professional Quality of Life Scale – 5 (ProQOL) (Stamm, 2009) was used to evaluate STS. The participants must answer the 30-item scale themselves, with the items assessing the effects of being employed in the healthcare professions, such as psychology professionals, healthcare personnel, and the social workforce. The scale focuses on Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Sample item includes “I think that I might have been affected by the traumatic stress of those I [help] (item 9). There are three categories of scores. If scores are 22 or less 22, they fall under the low category. If the score ranges from 23 to 41, it is considered moderate. Thirdly, scores above 41 are considered to be of a high degree. This is done for each separate subscale. The internal consistency constants for these scales are Burnout α = .72, Compassion Satisfaction α = .87, and Secondary Traumatic Stress α = .80. Items 1, 4, 15, 17, and 29 are reversed, and the three scales of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress/Compassion Fatigue are summed. Only the STS subscale was used, comprising items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 (a total of 10 items).

3. Compassion Fatigue Inventory: The Compassion Fatigue Inventory (CFI) was used to assess compassion fatigue. CFI was constructed by Eng et al. (2021) to measure the development of CF within psychologists. It can also be applied to individuals associated with other professions who attend to patients. While constructing the inventory, the main objective was to develop items that could be easily distinguished from those of STS and burnout. The scale contained a total of 16 items. The questions that constitute the CFI’s items must be answered on a Likert scale with five response options, ranging from 1 to 5, where 1 is the lowest and 5 is the highest possible. The items were divided into three subscales: 1. reduced compassion (Items 1-9) (Item 2: My will to help has declined. I have started to judge my patients in a way I would not want to), 2. Social Life (Items 9-13) (Item 11: I have started withdrawing from social interaction), and 3. Workplace (Items 14-16). Items 14-16 are reverse-scored (Item 14: I feel that my workplace provides care that aligns with my values, which is scored in the opposite direction). The internal reliability of CFI is strong (α = .91).

4- Posttraumatic Growth Inventory: Posttraumatic Growth Inventory: It is an instrument designed to assess the level of growth undergone by an individual after encountering a traumatic event. Tedeschi and Calhoun (1996) developed the inventory to assess growth and self-development following trauma. The PTGI is an assessment measure required to be filled by the participants themselves; it consists of a total of 21 items arranged into five domains: Personal Strength (PS= 4 items, sample item: I am better able to accept the way things work out), New Possibilities (NP= 5 items, sample item: New opportunities are available which would not have been otherwise), Relating to Others (RO= 7 items, sample item: I learned a great deal about how wonderful people are), Spiritual Growth (SG= 2 items, sample item: I have a better understanding of spiritual matters), and Appreciation of Life (AoL=3 items, sample item: I can better appreciate each day). The response format of the items is a Likert scale with six response options stating the extent to which the subject experienced the noted alterations due to a recognized trauma. The response categories consist of a series of responses ranging from 0 to 5,

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with 0 being the lowest possible score and 5 being the highest score. Scores from each section are summed up at the end. Areas that experience extensive growth are reflected in high scores in those categories. PTGI reports an internal reliability coefficient of α = 0.94. Internal reliability coefficients for each subscale are as follows: PS α = 0.72, AoL α = 0.67, RtO α = 0.85, SG α = 0.85, and NP α = 0.84.

PROCEDURE

Visits to hospitals, clinics, and other healthcare facilities in the Lahore region, as well as word-of-mouth referrals, helped participants to be found via several channels. Those ready to participate were given consent and debriefed on the details of the research. Following assurances of anonymity and confidentiality, as well as respect for participant rights, they were given a questionnaire comprising self-report measures to evaluate STS, CF, and the quality of interpersonal relationships.

Participants were seated in comfortable chairs and directed to complete the questionnaire in a well-lit, quiet setting free from distractions. They were encouraged to answer as sincerely and accurately as might be. Participants often answered the questionnaire in six to seven minutes. Once they were completed, the questionnaires were returned to the researcher, who kept them in a secure location accessible only to authorized staff, thereby preserving anonymity. The researcher's supervisor approved the research plan, and ethical issues were carefully addressed throughout the data collection process.

DATA ANALYSIS TECHNIQUES

Descriptive and inferential statistics were used to analyze the data. IBM Statistical Package for the Social Sciences (SPSS) version 26 was used to calculate the scores of the instrument. Frequency, percentages, standard deviation, skewness, kurtosis, and Cronbach's Alpha reliability were among the descriptive statistical analysis components. Pearson product-moment correlation and regression analysis were run to establish the link between STS and CF. To further investigate the moderating function of interpersonal relationships, a moderation analysis was conducted using the Process Macros in SPSS (version 26).

RESULTS

The preliminary analysis involved data cleaning, resulting in a 100% response rate. The data was gathered through visits to hospitals and clinics in Lahore, utilizing Google Forms. All items were ensured to be addressed. Frequency was calculated to identify any missing data.

Table 1 outlines the descriptive characteristics of the participants in the present research. The participants' ages ranged from 27 to 45 years, with a mean of 33.61 and a standard deviation of 4.73. The research sample consisted of 224 individuals, out of which 174 (78%) were women and 50 (22%) were men; 79 (35%) were single, 144 (64%) were married, and 1 (0.4%) were divorced. Additionally, 178 (80%) had completed MS/M. Phil.., 34 (15%) had obtained a PhD, and 12 (5%) had acquired another professional certification or diploma. 163 (73%) were part of joint families, while 61 (27%) belonged to nuclear families. The duration of work experience ranged from 2 to 17 years, with a mean of 6.45 years and a standard deviation of 3.45 years. Of the participants, 223 (99.6%) adhered to Islam, whilst 1 (0.4%) followed a different religion.

TABLE 1: DESCRIPTIVE CHARACTERISTICS OF STUDY PARTICIPANTS (N=224)

Variables	*Mean*	*SD*	*Min-Max*	*f (%)*
Age	33.61	4.733	27-45	
Gender				
Women				174 (78%)
Men				50 (22%)
Marital Status				
Single				79 (35%)

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Vol. 3 No. 4 (2025)

Married				144 (64%)
Divorced				1 (0.4%)
Qualification				
MS/M. Phil				178 (80%)
PhD				34 (15%)
Diploma/Other Certification				12 (5%)
Family Structure				
Joint				163 (73%)
Nuclear				61 (27%)
Duration of work experience (years)	6.45	3.85	2-17	

TABLE 2: ***CRONBACH'S ALPHA RELIABILITY OF STUDY VARIABLES***

Variables	*n*	*S*	*k*	*M*	*SD*	*α*	Min-Max	
							Actual	Observed
Secondary Traumatic Stress	10	-.37	-1.25	31.65	9.16	.90	10-50	11-46
Compassion Fatigue	16	.08	-1.40	45.11	16.42	.87	16-80	18-74
1-Reduced Compassion	9	.05	-1.00	25.57	8.71	.91	9-45	9-44
2-Social Life	4	.11	-1.37	11.20	4.81	.88	4-20	4-20
3-Workplace	3	.25	-1.48	8.34	3.87	.89	3-15	3-15
Vicarious Posttraumatic Growth	21	.25	-1.51	56.21	26.15	.94	0-105	19-100
1-Personal Strength	4	.17	-1.31	10.85	5.12	.89	0-20	1-20
2-New Possibilities	5	.29	-1.44	13.16	6.36	.92	0-25	3-25
3-Relating to Others	7	.17	-1.35	18.67	8.81	.94	0-35	4-34
4-Spiritual Growth	2	.25	-1.24	5.23	2.67	.82	0-10	0-10
5-Appreciation of life	3	.08	-1.50	8.30	4.19	.88	0-15	1-15

Note: (n)= no of items, (S)= Skewness, (k)= Kurtosis, (M)= Mean, (SD)= Standard Deviation, (α)=Alpha Reliability

Table 2 presents the items, along with their skewness, kurtosis, mean, standard deviation, Cronbach's alpha reliability coefficients, and the minimum and maximum values. Alpha values ranged from 0.82 to 0.98, indicating a classification within the good to outstanding range. According to the criteria established by George and Mallery (2003), the ratings are as follows: ≥ 0.9 – Excellent, ≥ 0.8 – Good, ≥ 0.7 – Acceptable, ≥ 0.6 – Questionable, ≥ 0.5 – Poor, and < 0.5 – Unacceptable (p. 231). The analysis of skewness and kurtosis was used to assess the normality of the data. The skewness values were categorized as excellent. However, the kurtosis data suggested flat peaks and a normal distribution. A result ranging from -1 to +1 is considered exceptional, although a range of -2 to +2 is typically deemed acceptable. Values exceeding ±2 indicate significant nonnormality. A kurtosis beyond +2 implies a peaked distribution, whereas a value below -2 denotes an excessively flat distribution. Skewness and kurtosis values around zero indicate a normal distribution (Hair & Alamer, 2022).

Table 3 shows the correlation analysis of the study variables and their subscales. STS was found to be significantly positively and negatively correlated, respectively, with CF (r = 0.81 ***) and VPTG (r = -0.83 ***). This suggested that CF was positively associated.

STS. The subscales of CF, RC (r = .77***), SL (r = .78***), and WP (r = .76***) were all positively associated with STS. In contrast, all subscales of VPTG were found to be negatively correlated with STS: PS (r = -.77***), NP (r = -.81***), RtO (r = -.80***), SG (r = -.77***), and AoL (r = -.82***). Similarly, all the subscales of VPTG had a negative correlation with the subscales of CF. With STS, VPTG was negatively linked. Table 4 demonstrates moderation analysis. Moderation analysis, using the outcome variable CF, showed that it significantly predicted STS (β = 1.37***). Furthermore, moderation also showed a significant interaction between STS and VPTG (β = 0.01***) with a significant influence of gender (β = -9.54***).

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The illustration above depicts the influence of VPTG moderation on the correlation between STS and CF in a graphical format. When the correlation between STS and CF was most significant, VPTG scores were seen to be low. At a modest amount of VPTG, the strength of the correlation progressively declined. The association's strength was weakest when people reported higher scores on VPTG. The findings demonstrated a significant moderating influence of VPTG.

TABLE 3: ***INTER-CORRELATION BETWEEN SECONDARY TRAUMATIC STRESS, COMPASSION FATIGUE, AND VICARIOUS POSTTRAUMATIC GROWTH***

Variables	1	2	3	4	5	6	7	8	9	10	11
1. Secondary Traumatic Stress	-	.81***	.77***	.78***	.76***	-.83***	-.77***	-.81***	-.80***	-.77***	-.82***
2. Compassion Fatigue		-	.96***	.94***	.91***	-.86***	-.81***	-.83***	-.83***	-.81***	-.85***
3. Reduced Compassion			-	.84***	.80***	-.81***	-.76***	-.79***	-.78***	-.77***	-.80***
4. Social Life				-	.85***	-.84***	-.79***	-.82***	-.81***	-.78***	-.83***
5. Workplace					-	-.78***	-.73***	-.75***	-.75***	-.73***	-.79***
6. Vicarious Posttraumatic Growth						-	.96***	.97***	.98***	.93***	.95***
7. Personal Strength							-	.91***	.93***	.87***	.88***
8. New Possibilities								-	.93***	.89***	.90***
9. Relating to Others									-	.89***	.91***
10. Spiritual Growth										-	.86***
11. Appreciation of Life											-

Note:***=p<.001

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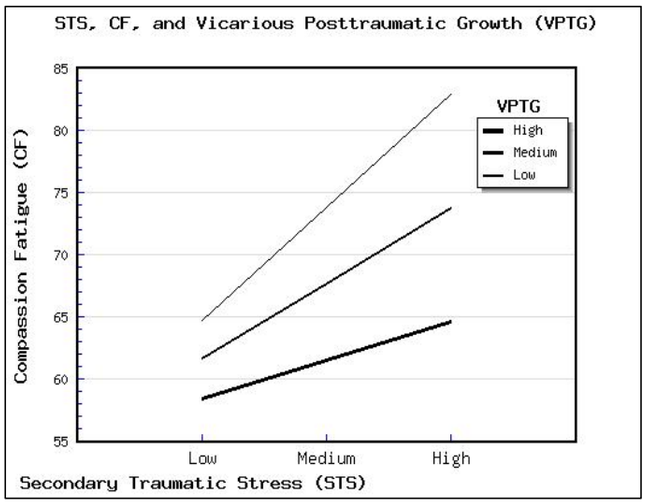

FIGURE 2: MODERATING EFFECT OF VICARIOUS POST-TRAUMATIC GROWTH ON SECONDARY TRAUMATIC STRESS AND COMPASSION FATIGUE

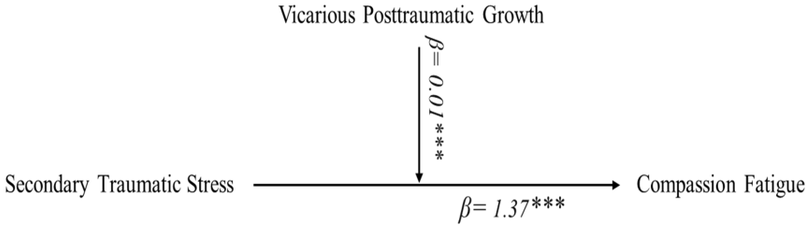

FIGURE 3: EMERGED MODERATION MODEL

TABLE 4: ***MODERATION MODEL OF VICARIOUS POST-TRAUMATIC GROWTH ON SECONDARY TRAUMATIC STRESS AND COMPASSION FATIGUE***

Measures	**Compassion Fatigue (CF)**		
	β	**SE**	**95% CI (LL-UL)**
Moderation Analysis			
Secondary Traumatic Stress (STS)	1.37***	0.25	[0.88, 1.85]
Vicarious Posttraumatic Growth (VPTG)	0.16	0.12	[-0.07, 0.39]
STS×VPTG	0.01***	0.003	[-0.02, -0.006]
Gender	-9.54***	1.61	[-12.72, 6.36]

*Note: *=p<.05, **=p<.01, ***=p<.001. Gender: 1=women, 2 = men*

DISCUSSION

The present study explored the associations between STS, CF, and VPTG and the role of VPTG as a moderator. Its findings emphasize the dual nature of trauma exposure experienced by mental health providers, revealing the potential for both distress and personal growth. Although STS and CF present considerable challenges, the existence of VPTG indicates that engaging in trauma-related work can result in positive outcomes as well.

This study found a positive correlation between secondary traumatic stress and compassion fatigue, supporting the idea that mental health caregivers' emotional well-being might be affected by prolonged exposure to client trauma. Compassion fatigue, which can lead to

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emotional exhaustion, detachment, and professional ineffectiveness, increases with STS. Working with trauma survivors is exhausting and requires protective interventions, as shown by previous research.

The findings supported this hypothesis and previous literature. Ormiston et al. (2022) found that STS and CF were linked and that CF severity increased with STS in teachers. According to the empathy-based stress model (Rauvola et al., 2019), trauma and empathy cause empathy-based stress, which is linked to CF. Trauma-related workplace stressors contribute to empathy-based stress. Secondary trauma and empathy-based strain cause other occupational health effects, work-related emotions, behaviors, and cognitive processes. Mental health workers experience CF and second-hand trauma. Trauma transmission models also explain this relationship. This model says that empathizing with traumatized people causes secondary traumatic stress. More empathy causes secondary trauma symptoms (Figley, 1995; MacRitchie & Leibowitz, 2010).

This study further explored VPTG's five dimensions—Personal Strength, New Possibilities, Relating to Others, Spiritual Growth, and Appreciation of Life—as moderators. Numerous studies have confirmed the moderating function of VPTG. A study examining the correlation between STS and Workability revealed that elevated VPTG levels diminished the significant effect of STS on workability, while low to moderate VPTG levels indicated a statistically significant negative impact of STS on workability. Demonstrating its significant moderating influence (Grandi et al., 2023). Another study supports the findings of the current research. The moderating role of VPTG was assessed on the link between STS and BO among a sample of child psychiatrists. The study's results demonstrated a significant moderating influence of VPTG. A weakened correlation was observed between STS and BO at elevated VPTG levels (Akdağ et al., 2023). The psychoanalytic approach, grounded on theoretical literature, explained these findings. As described by Breuer and Freud (1893), the mental apparatus is the mechanism by which individuals perform reality testing. Any life experience that interrupts the normal flow of life carries the potential risk of trauma. This viewpoint explains why certain individuals perceive an event as favorable, while others view it unfavorably (Dell'Osso et al., 2022).

Another theory that addresses the results is the Constructivist Self-Development theory. Repeated exposure to the victim's traumatic details and narratives alters cognitive schemas, thereby affecting worldviews in both negative and positive ways (Daly & Chovaz, 2020). Continuous exposure to traumatic information that leads to a positive transformation of worldviews indicates that the individual undergoing secondary trauma is progressing towards Vicarious Post-Traumatic Growth (VPTG).

This study offers valuable insights into the relationships between STS, CF, and VPTG among mental health practitioners. The findings have significant implications for individual practitioners, mental health organizations, and policy formulation to enhance provider well-being and the quality of client care. The study's findings suggest the need for establishing workplace support initiatives to mitigate STS and CF while enhancing the well-being of mental health professionals. The significant correlations indicated an increased likelihood of educating mental health providers to identify early indicators of STS and CF. Awareness focused on self-care strategies, professional boundaries, and coping mechanisms could potentially foster VPTG while mitigating negative outcomes. Mental health providers addressing these challenges may struggle to maintain empathy, potentially leading to detachment or emotional exhaustion, which can adversely affect the quality of care delivered. This outcome would bolster the argument for implementing measures to enhance provider well-being and uphold effective therapeutic relationships.

Furthermore, encouraging results associated with VPTG indicate that mental health practitioners might experience personal growth and enhance their resilience through their work with trauma

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survivors. Organizations could enhance this by creating targeted interventions that foster positive psychological results while addressing stressors. Elevated levels of STS and CF could lead to increased turnover rates within the mental health profession. The findings of this study could encourage organizations to explore strategies to reduce these factors, leading to improved job satisfaction, higher retention rates, and enhanced long-term career sustainability for providers. Furthermore, the results of this study may serve as a valuable resource for governments and mental health organizations in developing and implementing improved mental health care policies and regulations that prioritize the well-being of healthcare providers. Prioritizing funding for wellness programs and implementing mandatory support structures for professionals exposed to trauma is essential to mitigate the impacts of STS and CF.

Limitations and Suggestions: Like any other study, this study has limitations that must be acknowledged to ensure a balanced interpretation of the findings. By addressing these constraints, future research can identify areas for enhancement or refinement of the existing work. Furthermore, since mental health clinicians were exclusively recruited from Lahore, the findings may not apply to mental health providers in diverse situations and nations. The applicability of these findings to various mental health professionals, including those serving diverse client populations or operating in distinct clinical environments, is constrained.

Secondly, this study employed self-report measures that may be influenced by potential response biases, such as social desirability or the tendency to overreport VPTG and underreport STS and CF. Participants may have altered their responses to look more resilient or unaffected by work, which could affect STS, CF, and VPTG levels. Triangulation could reduce this prejudice. Researchers can reduce bias by cross-checking self-report data using interviews, behavioral observations, and physiological measures (Qassimi, 2023).

Third, the cross-sectional design made determining the directionality of STS, CF, and VPTG connections difficult. Correlational studies collect data at a single point in time, making causal inference challenging. Moreover, the study did not control potentially confounding characteristics, including personality traits, personal strategies for coping, personal trauma history, etc., which could affect these connections. Finally, the constructs in this study overlap conceptually, which may confound the interpretation of findings by affecting construct validity. Without measurement redundancy, determining each variable's contributions was difficult.

This research sheds light on the constructs under study; however, further research is needed to fill the remaining gaps. Longitudinal studies can clarify causal relationships by demonstrating how these constructs evolve. Generalizability can be addressed by studying various mental health practitioners from different regions, contexts, clinical settings, and specialties. Qualitative methods, such as interviews or focus groups, and controlling for confounding factors, such as coping mechanisms, support systems, and personal experiences, may help explain these factors. Future research should also consider cultural differences in the experience and reporting of these dimensions. This is crucial because cultures view distress and growth differently. Implement and evaluate interventions to reduce STS and CF and develop resilience and VPTG among mental health providers to improve well-being in this population.

Conclusion: The present study revealed that STS and CF were positively correlated, whilst

VPTG was negatively linked with these constructs. The study showed that VPTG significantly moderated the link between STS and CF. These results suggest that interventions for provider well-being should take center stage in mental health facilities to maintain the quality of care and reduce burnout rates. Taking care of mental health professionals is crucial, as it enhances their quality of life and increases the therapeutic support available to clients who need it.

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