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RESEARCH ARTICLE

Contributing factors to secondary traumatic stress and vicarious posttraumatic growth in therapists

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Abstract

Alongside the recognized potential negative repercussions of working as a psychological therapist, there is growing interest in the potential positive impacts of engaging in such work. The current study used a cross-sectional online survey design to explore the impact of a range of demographic, work-related, and compassion-related factors on levels of secondary traumatic stress (STS) and vicarious posttraumatic growth (VPTG) in an international sample of 359 psychological therapists. Hierarchical multiple regressions demonstrated that burnout, lower levels of self-compassion, having a personal trauma history, reporting a higher percentage of working time with a trauma focus, and being female were the statistically significant contributors to STS scores, explaining 40.8% of the variance, $F(9, 304) = 23.2, p < .001$. For VPTG, higher compassion satisfaction, higher self-compassion, higher STS, a higher percentage of working time with a trauma focus, fewer years qualified, being male, and having a personal trauma history were all statistically significant contributors, explaining 27.3% of the variance, $F(10, 304) = 11.37, p < .001$. The findings illustrate the potential risk and protective factors for developing STS and clarify factors that may increase the likelihood of experiencing VPTG. Implications for psychological therapists and the organizations and institutions for which they work are considered along with potential directions for future research in the discussion.

The work of psychological therapists often involves high levels of exposure to client accounts of traumatic events. These experiences can have a significant negative impact on clinician well-being, including contributing to compassion fatigue and secondary traumatic stress (STS; Bride et al., 2004). STS has become a particular concern considering the symptoms are similar to those of posttraumatic stress disorder (PTSD; American Psychiatric Association

[APA], 2013; e.g., the intrusive reexperiencing of traumatic material, increased arousal, avoidance of emotions), with an estimated 5%–15% of therapy practitioners predicted to have clinical levels of these difficulties (Bercier & Maynard, 2015).

Despite the psychological challenges involved in delivering trauma therapy, potential benefits for clinician well-being and development have also been observed.

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Posttraumatic growth (PTG) refers to positive cognitive, emotional, interpersonal, and spiritual consequences following trauma exposure. PTG is believed to occur across five domains, which include self-perception, interpersonal relationships, and life philosophy, leading to changes such as realizing personal strength, seeing new possibilities for the future, and having a new appreciation for life (Tedeschi & Calhoun, 2004). These changes may occur as a result of the psychological struggle to make meaning of the trauma and have been associated with greater life satisfaction (Manning-Jones et al., 2015). A related concept, vicarious posttraumatic growth (VPTG), refers to positive changes occurring after vicarious exposure to trauma, including clinician experiences of listening to trauma narratives in therapy (Arnold et al., 2005).

Models of both PTG and VPTG suggest that posttraumatic stress and PTG are positively correlated, implying that VPTG is dependent upon traumatic material being appraised as stressful to facilitate growth (Kjellenberg et al., 2014; Manning-Jones et al., 2015; Tedeschi & Calhoun, 2004). However, the role of specific risk factors for the development of STS and VPTG remains contentious. History of significant personal trauma has been linked to a heightened risk of STS, based on the notion that indirect exposure to new traumatic material may trigger previous traumatic experiences and reactions (Pearlman & MacIain, 1995). Nevertheless, studies have found no difference in STS levels between therapists with or without a history of trauma exposure (e.g., Ortlepp & Friedman, 2002). The research is similarly unclear regarding clinician trauma history and VPTG, with some investigations reporting a positive association (Kjellenberg et al., 2014) and others no association (Manning-Jones et al., 2015).

Professional and clinical factors are also likely to be relevant in the development of STS and VPTG (Manning-Jones et al., 2015). Several studies have found a “dose of exposure” effect wherein clinicians with higher numbers of clients with PTSD on their caseload experience higher levels of STS (Craig & Sprang, 2010; Jenkins et al., 2011), whereas other studies have reported associations between more trauma cases and both lower levels of STS and higher VPTG (e.g., Baird & Jenkins, 2003; Brockhouse et al., 2011; Linley & Joseph, 2007). The interpretation of the latter finding is that repeated exposure to trauma narratives potentially reinforces changing cognitive schemas in the therapist over time (Brockhouse et al., 2011). Experienced clinicians may be more likely to develop both STS and VPTG, as higher levels of direct experience with trauma clients would mean heightened exposure to potentially traumatic material (Ben-Porat, 2015; Kjellenberg et al., 2014). Supervision could act as an important buffer in this process, increasing the likelihood of VPTG by providing space to process complex therapeutic experiences while

also offsetting the development of STS (Craig & Sprang, 2010).

Although demographic and clinical factors related to STS and VPTG have been a significant focus in the empirical literature, studies examining the contribution of more nuanced clinician individual factors in the evolution of these concepts have also yielded important findings. Compassion satisfaction (CS), defined as the pleasure and fulfillment therapists obtain from helping others, has exhibited inverse relationships with burnout and STS (Stamm, 2010). Given that CS is also associated with increased empathy (Wagaman et al., 2015), which, in turn, has been suggested as an important factor associated with VPTG (Manning-Jones et al., 2015), it is plausible that CS may impact VPTG and positive changes related to professional identity. A related concept, self-compassion, has been proposed to facilitate the development of PTG based on previous research suggesting it may be a protective factor for trauma adaptation (e.g., Dahm et al., 2015) as well as an important individual difference variable in coping with stress (Allen & Leary, 2010). The value of using self-compassion exercises as a self-care strategy for helping professionals to mitigate adverse outcomes, such as STS, is an emerging area of interest (Nelson et al., 2018; Thielemen & Caccaitore, 2014).

Given the proposed association between clinician well-being and positive therapy outcomes in the literature (Beutler et al., 2004), understanding the personal and professional factors relevant to VPTG is an important avenue of study to support staff well-being and, in turn, ensure positive client outcomes. As the previous literature review illustrates, significant uncertainty remains in understanding the precise personal and professional factors that impact the development of STS and VPTG. The present study aimed to address this issue by exploring the unique contribution of multiple demographic (i.e., age, gender, and history of personal trauma), professional (i.e., number of years qualified, percentage of work with a trauma focus, and satisfaction with clinical supervision), and other individual variables (i.e., CS, self-compassion, and burnout) hypothesized to contribute to STS and VPTG.

METHOD

Participants

This study employed a cross-sectional online survey design. Participants were considered to meet inclusion criteria if they were 18 years of age or older and worked, past or present, as a therapist with individuals who had experienced trauma. A total of 506 individuals accessed the online survey; those who did not complete the survey (i.e.,

dropped out) were excluded from data analysis in line with their right to withdraw from the study. This resulted in a final sample of 359 participants. Demographic characteristics were compared between individuals who completed the survey and those who did not, and no significant differences were found.

Procedure

Following approval from the relevant ethics committee, an initial draft of the survey was uploaded to the Qualtrics online survey platform and piloted with 10 therapists-in-training and the research team. Following amendments, the final version was uploaded to Qualtrics, and data collection began in March 2020. A brief description of the study and a direct link to the survey were shared on Twitter (now X) using a professional account set up specifically to disseminate the research. The information and link were also shared on Facebook groups for psychological therapists and via emails to relevant organizations and clinicians providing trauma-related services whose details were publicly available online. It was not possible to estimate the response rate of the study given the varied nature of the recruitment approach.

Measures

Demographic characteristics

A demographic questionnaire was developed for the study and captured information related to the following factors: age, gender, profession, years qualified, percentage of therapeutic work with a focus on trauma (range: 0–100%), and satisfaction with clinical supervision. The questionnaire also included a yes/no question asking whether participants had a personal history of direct trauma exposure based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013). All questions related to clinical practice were asked in the present tense and related to current practice.

Professional quality of life

The Professional Quality of Life Scale (ProQOL; Stamm, 2010) is a 30-item scale commonly used to assess the positive and negative impacts helping professionals may experience because of their role. The ProQOL has three subscales assessing CS, burnout, and STS. Participants are asked how frequently they have experienced a range of feelings in the last 30 days, scoring items on a 5-point Lik-

ert scale ranging from 1 (*never*) to 5 (*very often*), with higher scores reflecting higher levels of each construct.

Although the ProQOL is the most commonly used measure for assessing CS, burnout, and STS in health care professionals, queries over the robustness of the measure's construct validity have been reported (Hemsworth et al., 2018; Heritage et al., 2018; Samson et al., 2016). Despite these noted concerns, to ensure consistency and allow comparison with existing research, the original three-factor version of this measure was used. In the current study, Cronbach's alpha values for the CS, STS, and Burnout subscales were .91, .81, and .91, respectively.

PTG

The Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) is a 21-item scale that is used to measure PTG across five domains, including appreciation of life, relating to others, personal strength, new possibilities, and spiritual growth. To reflect VPTG, the PTGI was adapted, consistent with previous studies (e.g., Manning-Jones et al., 2015), to ask participants whether changes had occurred as a result of their clinical work with clients with a history of trauma. Participants were asked to rate the extent to which they felt changes had occurred within themselves because of their work, scoring items on a 5-point Likert scale ranging from 0 (*I did not experience this change*) to 5 (*I experienced this change to a very great extent*), with higher scores indicating higher levels of VPTG. The validity of the PTGI has been established in many quantitative studies and is the most widely used instrument to assess PTG (Shakespeare-Finch et al., 2013). Additionally, the measure has shown strong high test-retest reliability (Zerach & Shalev, 2015) and has demonstrated strong content and construct validity in studies as a measure of vicarious PTG (e.g., Doherty et al., 2020). In the present sample, Cronbach's alpha for the PTGI was .94.

Self-compassion

The Self-Compassion Scale (SCS; Neff, 2003) is a 26-item scale used to measure beliefs and attitudes about self-compassion across the following domains: self-kindness, common humanity, mindfulness, self-judgment, isolation, and overidentification. Participants were asked to rate items on a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). A total SCS was obtained by computing a mean score of the six subscales (range: 1–5), with higher scores indicating higher levels of self-compassion. The measure has demonstrated satisfactory validity across a series of studies (Neff, 2003). Although the SCS has

received some questions regarding the extent to which the factor structure generalizes across populations (Williams et al., 2014), research has demonstrated that one overall factor of self-compassion can explain over 90% of the variance in clinical and nonclinical samples (Neff & Germer, 2017). Furthermore, the measure has been shown to demonstrate good test-retest reliability (Deniz et al., 2008). In the present sample, Cronbach's alpha for the SCS was .94.

Data analysis

To address the research aims, two hierarchical multiple regressions were employed. For the outcome variable of STS, the contributing demographic variables (i.e., age, gender, personal trauma history) were entered at Step 1, professional factors were entered (i.e., years qualified, percentage of work with a trauma focus, and satisfaction with supervision) in Step 2, and individual factors (i.e., self-compassion, CS, and burnout) were added in Step 3. For the outcome variable of VPTG, demographic variables were entered in Step 1, professional factors were added in Step 2, individual factors in Step 3, and STS was added in the final step. Regarding categorical variables, gender was coded as 1 for "male" and 0 for "female" for the analyses; a reference category was not made for other gender identities due to a small sample size ($n = 4$). Personal trauma history was coded as 1 for "yes" and 0 for "no." Supervision satisfaction was dummy-coded as 1 for "somewhat or extremely satisfied" and 0 for "somewhat or extremely dissatisfied."

The requisite assumptions of independence, linearity, multicollinearity, homoscedasticity, and adequate sample size were checked and met within the data for hierarchical regression analyses. All analyses were conducted using IBM SPSS Statistics (Version 26), and missing data were dealt with using listwise deletion.

RESULTS

Descriptive statistics

A total of 359 participants from 24 countries completed the survey, with the United States (25.1%), England (24.8%), and Northern Ireland (18.7%) the most represented. The age range of the sample was 26 to 77 years, with a mean participant age of 42.50 years ($SD = 10.48$). In terms of professional background, the sample was largely made up of clinical psychologists (44.8%), followed by psychotherapists (18.9%) and counselors (12.0%). The number of years participants had been qualified as a therapist ranged from

0 to 50, with a mean of 11.07 years ($SD = 9.36$). For trauma history, 58.8% of participants reported having a personal history of trauma exposure based on DSM-5 PTSD diagnostic criteria.

The means and ranges for all major scales used are displayed in Table 1, and bivariate correlations are presented in Table 2. Based on suggested raw score categorizations by Stamm (2010) for low (22 or less), moderate (23–41), and high (42 or higher) STS, CS, and, burnout, the results indicated that 59.3% ($n = 213$) of participants reported low levels of STS, and 40.7% reported moderate levels ($n = 146$). No participants scored within the high range for STS. For CS no participants scored within the low range, 65.74% ($n = 236$) scored within the moderate range and 34.26% ($n = 123$) scored in the high range. Over half the sample (54.6%, $n = 196$) reported moderate levels of burnout, whereas the remainder of the sample reported low levels (45.40%, $n = 163$).

Explanatory variables of STS

A three-step hierarchical multiple regression was used to examine the impacts of potential contributing variables on the outcome variable, STS. The effects of demographic variables (i.e., age, gender, and personal trauma history) were entered in Step 1. All three variables significantly contributed to the model and explained 7.2% of the variance in STS, $\Delta F(3, 310) = 7.97, p < .001$. In Step 2, professional factors were entered (i.e., years qualified, percentage of work with a trauma focus, and satisfaction with supervision) and explained a further 2.8% of the variance in STS, with the percentage of work with a trauma focus being an additional significant contributing variable, $\Delta F(6, 307) = 3.19, p = .024$. In Step 3, self-compassion, CS, and burnout were added, and these variables explained a further 30.8% of the variance observed. This final model as a whole explained 40.8% of the variance in STS, $F(9, 304) = 23.2, p < .001$. In order of contribution, the significant contributing variables in the model were burnout, self-compassion, personal trauma history, the percentage of work with a trauma focus, and gender. Unstandardized regression weights, coefficient standard errors, standardized regression weights, and R^2 change values, by step and contributing variable, are presented in Table 3.

Explanatory variables of VPTG

A four-step hierarchical multiple regression was used to examine the contribution of various factors on VPTG. The effects of demographic variables were entered in Step 1. Gender and personal trauma history significantly

TABLE 1 Means and ranges for study measures

Construct	Measure	M	SD	Range	Potential range
Secondary traumatic stress	PROQOL	21.50	5.19	10–37	0–50
Compassion satisfaction	PROQOL	38.91	5.87	24–50	0–50
Burnout	PROQOL	23.40	5.60	11–38	0–50
Vicarious posttraumatic growth	PTGI	32.10	18	0–81	0–84
Self-compassion	SCS	3.38	0.72	1.42–4.92	1.00–5.00

Note: PROQOL = Professional Quality of Life Scale; PTGI = Posttraumatic Growth Inventory; SCS = Self-Compassion Scale.

TABLE 2 Pearson correlations for study constructs

Construct	Measure	Compassion satisfaction	Burnout	Vicarious posttraumatic growth	Self-compassion
Secondary traumatic stress	PROQOL	-.29**	.57**	.17*	-.42**
Compassion satisfaction	PROQOL	–	-.71**	.26**	.45**
Burnout	PROQOL		–	-.09	-.55**
Vicarious posttraumatic growth	PTGI			–	.16**
Self-compassion	SCS				–

Note: PROQOL = Professional Quality of Life Scale; PTGI = Posttraumatic Growth Inventory; SCS = Self-Compassion Scale.

** $p < .01$ (two-tailed).

TABLE 3 Summary of hierarchical regression for variables contributing to secondary traumatic stress

Variable	B	SE B	β^a	ΔR^{2b}
Step 1				.072***
Age	-0.076	0.03	-.15**	
Gender	-2.13	0.83	-.14*	
Personal trauma history	1.86	0.58	.17**	
Step 2				.028*
Age	-0.121	0.04	-.25**	
Gender	-2.14	0.83	-.14*	
Personal trauma history	1.76	0.58	.17**	
Years qualified	0.06	0.05	.11	
% of work with a trauma focus	0.03	0.01	.14*	
Supervision satisfaction	1.17	0.86	.07	
Step 3				.308***
Age	-0.03	0.04	-.06	
Gender	-1.55	0.68	-.10*	
Personal trauma history	1.43	0.49	.14**	
Years qualified	0.04	0.04	.07	
% of work with a trauma focus	0.02	0.01	.12*	
Satisfaction with supervision	-0.48	0.71	-.03	
Self-compassion	-1.17	0.39	-.17**	
Compassion satisfaction	0.12	0.06	.13	
Burnout	0.52	0.07	.57**	

^aSignificance calculated using t test.

^bSignificance calculated using F statistic.

* $p < .05$. ** $p < .01$. *** $p < .001$.

contributed to the model and 6.4% of the variance in VPTG was explained, $\Delta F(3, 310) = 7.01, p < .001$. In Step 2, professional factors were entered and explained a further 10.5% of the variance in VPTG, with years qualified and percentage of work with a trauma focus being additional significant contributors, $\Delta F(3, 307) = 12.96, p < .001$. In Step 3, self-compassion, CS, and burnout were added, and these variables explained a further 7.6% of the variance observed, $\Delta F(3, 304) = 10.16, p < .001$. Finally, STS was added in Step 4 and explained 2.8% of the variance observed in VPTG. The final model explained 27.3% of the variance in VPTG, $F(10, 304) = 11.37, p < .001$. In order of contribution, the significant explanatory variables in the model were CS, self-compassion, STS, percentage of work with a trauma focus, years qualified, gender, and personal trauma history. Unstandardized regression weights, coefficient standard errors, standardized regression weights, and R^2 change values, by step and contributing variable, are presented in Table 4.

DISCUSSION

The present study found the most salient contributing factors to STS were burnout, lower levels of self-compassion, having a personal trauma history, a higher percentage of work with a trauma focus, and female gender. For VPTG, higher CS, higher self-compassion, higher STS, higher percentage of work with a trauma focus, fewer years qualified, male gender, and having a personal trauma history were significant contributors. These findings suggest that vicarious exposure to trauma appears to have a dose effect on both STS and VPTG, which has important implications for how therapist trauma caseloads are managed to best support these individuals and their clients. Self-compassion may also be both a notable protective factor from STS, as well as an important factor in increasing the likelihood of experiencing VPTG, highlighting that this trait and skill is worth promoting in the clinical workforce.

The finding that men were more likely to experience VPTG contradicts previous research, wherein the dominant trend has been that female therapists experience higher levels of growth. Such conflicting results suggest that the role of gender in therapy reactions is complex and requires more in-depth scrutiny (Linley & Joseph, 2007; Manning-Jones et al., 2015). However, it is important to note the current sample was predominantly female, which may have influenced this finding. The consistent role of personal trauma history as an explanatory variable of both STS and VPTG is congruent with the extant research base and can be understood within current PTSD theoretical frameworks. Prior trauma can have a disruptive impact on cognitive schemata relating to one's self, others, and the

world (Galloucis et al., 2000), which may be reactivated or reinforced within therapists by vicarious exposure to further traumatic material.

The percentage of work with a trauma focus was the only significant professional variable that contributed to higher levels of both STS and VPTG. This is consistent with previous findings that higher cumulative levels of exposure to vicarious trauma predict both STS and growth (e.g., Brockhouse et al., 2011; Craig & Sprang, 2010) and may suggest that the dose of exposure is not only applicable to the negative sequelae of vicarious trauma exposure but may also potentially impact positive sequelae. It is important to highlight, however, that the association between exposure and growth is more nuanced, as the level of clinician experience (i.e., years qualified) negatively predicted VPTG, which is contrary to the intuitive assumption that more vicarious exposure directly equates to more years of experience (Kjellenberg et al., 2014). One interpretation could be that the earlier stage of professional development and aspirations of newer therapists may lead to them processing their experiences more positively, enabling growth (Ben-Porat et al., 2020). More experienced therapists who have been negatively impacted by therapy work may be more likely to reduce their level of trauma work or leave the profession completely (Pearlman & McIan, 1995).

A surprising finding was that satisfaction with clinical supervision was not a significant factor in the development of STS of VPTG. This is in contrast with previous studies of both student and qualified therapist samples, which have found that satisfaction with supervision has explained variance in growth (Ben-Porat et al., 2020); however, the current sample may have been more heterogeneous in terms of expectations and experiences of supervision given the diverse backgrounds, work settings, and countries of practice included.

The emergence of burnout as the most significant explanatory factor of STS lends support to the idea that exhaustion and depleted resources may leave individuals vulnerable to further negative impacts of their work context, such as STS (Ben-Porat, 2015). On the other hand, positive factors, such as CS, made the most substantive contribution to VPTG. It is possible that compassion-related factors can be developed to become personal resources for therapists, acting as buffers against the impacts of STS by allowing the broadening of a person's mindset, cognitive reframing skills, and positive meaning-making (Allen & Leary, 2014). The observed negative association between self-compassion and STS may reflect the adaptive skills involved in self-compassion, including a willingness to engage with painful thoughts and emotions that protect against secondary traumatization and the use of less helpful coping strategies (e.g., avoidance; Ehlers & Clark, 2000; Leary et al., 2007).

TABLE 4 Summary of hierarchical regression for variables contributing to vicarious posttraumatic growth

Variable	<i>B</i>	<i>SE B</i>	β^a	ΔR^{2b}
Step 1				.064***
Age	−0.18	0.09	−.11	
Gender	6.54	2.88	.13*	
Personal trauma history	7.87	2.01	.22***	
Step 2				.105***
Age	0.03	0.14	.02	
Gender	6.29	2.73	.12*	
Personal trauma history	6.22	1.92	.17**	
Years qualified	−0.32	0.16	−.17*	
% of work with a trauma focus	0.18	0.03	.30***	
Supervision satisfaction	−2.44	2.83	−.05	
Step 3				.076***
Age	−0.02	0.14	−.01	
Gender	5.87	2.63	.11*	
Personal trauma history	5.15	1.90	.14**	
Years qualified	−0.38	0.15	−.20*	
% of work with a trauma focus	0.15	0.03	.24***	
Satisfaction with supervision	−1.17	2.75	−.02	
Self-compassion	4.53	1.51	.19**	
Compassion satisfaction	0.86	0.24	.28***	
Burnout	0.58	0.25	.19*	
Step 4				.028***
Age	0.01	0.13	.00	
Gender	7.03	2.61	.14**	
Personal trauma history	4.09	1.89	.11*	
Years qualified	−0.41	0.15	−.21**	
% of work with a trauma focus	0.13	0.03	.22***	
Satisfaction with supervision	−0.81	2.71	−.02	
Self-compassion	5.41	1.50	.22***	
Compassion satisfaction	0.77	0.23	.25**	
Burnout	0.19	0.27	.06	
STS	0.75	0.22	.22**	

Note: STS = secondary traumatic stress.

^aSignificance calculated using *t* test.

^bSignificance calculated using *F* statistic.

p* < .05. *p* < .01. ****p* < .001.

The study illustrates that the development of STS and VPTG cannot be explained by any variable in isolation but rather by a combination of factors. This has important implications for therapists, as well as their training and employing organizations, especially when thinking about strategies to promote well-being and how to support therapists to best meet their own needs and, in turn, best meet the needs of their clients. Nelson et al. (2018) reported that few training programs or health organizations actively teach personal self-care strategies or implement institutional initiatives even though such concepts are often

encouraged among therapists. Specific guidance and role-modeling by relevant senior that promotes a culture where self-care is considered essential as opposed to optional may represent an important support for novice therapists; consideration should be given to incorporating this type of guidance in health organization policies and practice (Hopkins & Proeve, 2012; Shapiro et al., 2007).

The study has several limitations. First, given the cross-sectional nature of the study design, the results should be interpreted with caution with regard to the association between the variables presented here and both STS and

VPTG. Longitudinal research is required to truly explore the impact of variables such as burnout, self-compassion, and CS on STS and VPTG, and vice versa. As participants in this study tended to have low levels of STS and high levels of CS, this may be interpreted as a restriction of range, and further longitudinal research would also benefit from exploring the distribution of scores on these constructs in this population. An adapted version of the PTGI was used to measure VPTG. As this measure was designed to measure direct PTG, it may not fully capture all aspects of VPTG, particularly those relevant to professional identity, as discussed (Manning-Jones et al., 2015), and may also risk blurring the line between changes and, indeed, trauma symptoms that are attributable to direct and vicarious exposure in individuals with direct traumatic experiences. Future research would benefit from the development of a specific psychometric measure of VPTG in professional contexts. It is widely acknowledged that the ProQOL is the most commonly used measure for assessing CS, burnout, and STS in health care professionals. However, concerns remain over the construct validity of the subscales; in particular, studies across several languages have suggested that the Burnout and STS subscales have the potential to be improved (Hemsworth et al., 2018; Heritage et al., 2018; Samson et al., 2016). Although researchers have argued that recoding items, removing items, or using a two-factor model or higher-order model may improve the validity and reliability of this measure (Galiana et al., 2017; Geoffrion, et al., 2019; Hemsworth et al., 2018; Heritage et al., 2018), the original three-factor measure was used in this study to allow comparison across the literature. The context in which the research took place is also relevant given that data collection commenced alongside the COVID-19 pandemic. The impacts of working during this time, including adaptations to how therapists worked (e.g., virtual work) and the potential increase in isolation and stress among clinicians, were not reflected in the questions asked but may have impacted the results, including levels of burnout, and sample bias in terms of motivation to self-select for the study. Finally, in the interest of brevity, personal trauma history and the percentage of work with a trauma focus were measured using binary coding. This limited the depth of analysis and interpretation that was possible with these variables, and future research would benefit from capturing more substantive information about these factors, such as the nature and duration of trauma exposure.

To conclude, the present study demonstrates that many factors make important contributions to the development of both STS and VPTG in therapists. The findings may highlight the importance of preventative initiatives being considered on both the individual and systemic level to protect against STS, particularly in female therapists with a history of personal trauma and those clinicians who


exclusively work with clients who are seeking or require trauma-focused intervention. The novel findings in relation to self-compassion in particular may inform such initiatives in training and work contexts and should be the focus of future research in this area.

OPEN PRACTICES STATEMENT

The study reported in this article was not formally preregistered. Neither the data nor the materials have been made available on a permanent third-party archive; requests for the data or materials should be sent via email to the lead author at [email].

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