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Secondary Traumatization in Mental Health Workers

Ruh Sağlığı Çalışanlarında İkincil Travmatizasyon

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ABSTRACT

Secondary traumatic stress is an important issue that indirectly affects the mental health professionals. This research was conducted to examine the relationship between secondary traumatization, occupational burnout, and compassion fatigue among mental health workers. In line with this aim, a study was carried out using a relational screening method, employing a Semi-Structured Interview Form, Secondary Traumatic Stress Scale, Maslach Burnout Inventory, and Compassion Fatigue Scale. The study involved a total of 400 mental health professionals, comprising 298 females (74.5%) and 102 males (25.5%) aged between 24 and 65 years. The findings revealed that the avoidance, arousal, and emotional violation sub-dimensions of secondary traumatic stress significantly predicted occupational burnout, explaining 37% of the variance in the outcome variable. It was observed that the arousal and emotional violation sub-dimensions of secondary traumatic stress were not significant predictors for compassion fatigue. However, the avoidance sub-dimension significantly predicted compassion fatigue, explaining 12% of the variance in the outcome variable. The study highlighted that engaging with traumatized individuals indirectly posed a risk for professions providing mental health services due to the impact on their well-being.
Keywords: Secondary traumatization, occupational burnout, compassion fatigue

ÖZ

İkincil travmatik stres ruh sağlığı çalışanlarını dolaylı yönden etkileyen önemli bir problemdir. Bu araştırma ruh sağlığı çalışanlarında ikincil travmatizasyon, mesleki tükenmişlik ve merhamet yorgunluğu arasındaki ilişkiyi incelemek için gerçekleştirilmiştir. Bu amaç doğrultusunda ilişkisel tarama yöntemi kullanılarak yapılan çalışmada, Yarı Yapılandırılmış Görüşme Formu, İkincil Travmatik Stres Ölçeği, Maslach Tükenmişlik Ölçeği, Merhamet Yorgunluğu Ölçeği kullanılmıştır. Çalışma 24-65 yaş arasında olan 298 kadın (%74,5) 102 erkek (%25,5) olmak üzere toplam 400 ruh sağlığı profesyoneli ile yürütülmüştür. Bulgular sonucu ikincil travmatik stresin kaçınma, uyarılma ve duygusal ihlal alt boyutlarının mesleki tükenmişliği anlamlı düzeyde yordadığı, sonuç değişkenindeki varyansın %37"sini açıkladığı saptanmıştır. İkincil travmatik stresin uyarılma ve duygusal ihlal alt boyutlarının merhamet yorgunluğu için anlamlı bir yordayıcı olmadığı, kaçınma alt boyutunun merhamet yorgunluğunu anlamlı düzeyde yordadığı, sonuç değişkenindeki varyansın %12'sini açıkladığı saptanmıştır. Örselenmiş bireylerle yoğun etkileşimde bulunmanın ruhsal yardım hizmeti sağlayan meslek grupları açısından dolaylı olarak bir risk oluşturduğu ortaya koyulmuştur.
Anahtar sözcükler: İkincil travmatizasyon, mesleki tükenmişlik, merhamet yorgunluğu

Introduction

For over a century, mental health professionals have been practicing their profession by providing therapeutic interventions to individuals dealing with negative life events, changes in emotional states, and reduced functionality in their living spaces. Undoubtedly, one of the most sensitive subjects in the field of psychotherapy is the study of psychological trauma. According to the definition in the International Classification of Diseases (ICD-10, 1993), trauma refers to the long or short-term responses to events or situations that affect many people and cause distress. The idea that a stressful experience could lead to lasting psychological damage first emerged in 1870, following the Franco-Prussian War, when soldiers began to rethink their experiences, prolonged reaction times, reduced frequency of reactions, and the experience of anhedonia. Psychiatrists termed this condition "traumatic neurosis" (Norman 1989). Since the 19th century, with the acceptance that trauma can also result from psychological causes, the definition of trauma in the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been revised. In DSM-IV, a two-criteria definition of trauma was made; for Criterion A1, trauma was defined as an event involving the threat of death, serious injury, or a threat to physical integrity. With DSM-IV, the concept of secondary traumatization was also accepted. When the patient recounts the

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traumatic event, the mental health professional becomes a secondary witness to the trauma and experiences a compelling need to repeatedly retell the traumatic incident for it to be resolved, leading to the emergence of the concept of secondary traumatization (APA 2013). It is known that psychologically similar reactions can occur in both the person who has experienced trauma and the person exposed to trauma by listening to it.

Among the symptoms of secondary traumatization are the following:

1. Re-experiencing: It is when the person listening to the trauma experiences it through nightmares and anxiety as a result of establishing high empathy (Lerias and Byrne 2003, Erdener 2019).
2. Avoidance: Avoidance refers to distancing oneself from people and environments where the trauma can be recalled, withdrawal, and the development of negative thoughts and beliefs about the future (Erdener 2019).
3. Increased arousal: Increased arousal is characterized by symptoms such as anger outbursts, restlessness, loss of control, overprotectiveness, disrupted sleep hygiene, eating disorders, reluctance, and hopelessness experienced by the individual who witnesses secondary trauma (Salston and Figley 2002, Erdener 2019).
4. Lack of concentration: The lack of concentration, as discussed by Kahil (2016), has been characterized by physical symptoms such as heart palpitations, high blood pressure, digestive problems, chills, and sweating (Kaya 2015).

The World Health Organization's (WHO) disease classification system, the ICD, states that trauma should be of a nature that could cause significant distress in almost every person, in ICD-10 (WHO 1993). In ICD-11 (WHO 2023), it is defined as "exposure to an extremely threatening or frightening event." In DSM-5, secondary traumatization is mentioned under the heading of post-traumatic stress disorder (PTSD), and it is accepted as a diagnostic criterion for secondary traumatization. According to DSM-5, individuals can experience traumatic stress indirectly through witnessing a traumatic event or having knowledge about it, in addition to direct exposure to a traumatic event (APA 2013).

Steed and Downing (1998) associated this with an empathic approach, stating that the fundamental reason for mental health professionals experiencing similar emotions as the traumatized individual when listening in detail to someone who has experienced a traumatic event is to exhibit an empathic approach toward the person. Figley (1995) defined this traumatization as the "cost of caring" resulting from the development of empathy in mental health professionals. The experiences that secondary traumatization brings to mental health professionals in the literature are referred to as compassion fatigue, empathy fatigue, and burnout (Pak et al. 2017). Due to the therapeutic bond and communication established with their clients, mental health professionals often deal with a wide range of emotions such as anger, shame, fear, anxiety, sadness, guilt, helplessness, and despair, and they confront the traumatic experiences of individuals. These emotions that arise during the session and their relationship with the client's emotions can sometimes pose a difficult situation for the mental health professional and push the clinician towards feelings of inadequacy and helplessness. This situation poses a risk of burnout for the mental health professional (Maslach and Jackson 1981).

Maslach, who developed the burnout scale, defined burnout as the experience of physical exhaustion, weariness, and helplessness resulting from intense emotional demands in one-on-one or face-to-face interactions with people in one's job (Düz 2015). Burnout, which leads to the loss of energy, both physically and emotionally, in people's work lives, can significantly affect both their personal and professional lives (Sağlam Arı and Çına Bal 2008). As a result of experiencing burnout, individuals feel a decrease or loss of the sense of pride and satisfaction that comes with success (Maslach and Leiter 1997). Individuals experiencing burnout may exhibit conditions such as failure to complete tasks, arriving late to work, postponing tasks, a decrease in performance, and reduced job satisfaction (Maslach et al. 2001). Joinson (1992) also pointed out that there is a unique form of burnout that affects caregivers and described this condition as compassion fatigue. According to Joinson (1992), compassion fatigue represents a form of burnout that highly affects caregivers. (Pehlivan and Güner 2018). Figley considered it as exposure to the emotional consequences of an indirect trauma that occurs while helping individuals who have directly experienced traumatic stress (Alan 2018). Doman (2010) stated that the attempts of healthcare professionals to help people in distress and their liking to be with them eventually lead to compassion fatigue. It is clear that the concepts of compassion fatigue and secondary traumatic stress are terms that complement each other, as shown in the studies and research in the field by Joinson (1992) and Figley (1995).

Mental health professionals sometimes serve a population at risk, particularly when dealing with individuals with severe mental disorders. In such cases, there may be acute phases of cases, and great efforts may be required for crisis management and intervention. Additionally, in the literature, attention has been drawn to experts evaluating sexual abuse, stating that there are significant differences in the behaviours and attitudes of experts before and after the assessment of abuse (Çolak et al. 2012). Birck (2001) even stated that mental health professionals serving torture victims experience secondary trauma, even showing symptoms similar to those shown by individuals who have experienced trauma. Personal trauma history is also considered a risk factor for the development of secondary traumatic stress. In this regard, Brewin and colleagues (2000) stated that the presence of such a trauma history leads professionals to indirectly experience the trauma again, causing them to show more anxiety symptoms.

It is important to note that a traumatic experience affecting a person is not solely dependent on them experiencing the situation themselves. Listening to a traumatic event and providing services to the person who experienced it can have an indirect impact on individuals (APA 2013). In this context, mental health professionals are considered a high-risk group. Secondary traumatization in this at-risk group can affect both professional performance and private life, as well as psychological well-being (Argentero and Setti 2011). In line with the literature, the aim of this research is to examine the relationship between secondary traumatization, professional burnout, and compassion fatigue in mental health professionals. In this context, the study contributes to the literature by presenting scientific evidence of the negative consequences faced by individuals in this profession due to the adverse outcomes they experience as a result of their profession.

Furthermore, the presence of secondary traumatic stress in mental health professionals can lead to a decrease in the effectiveness of treatment, premature termination of the therapy process, or negative consequences due to an unresolved trauma in their own personal history, which can affect the therapeutic relationship. In this context, addressing the potential difficulties faced by mental health professionals, who are considered a high-risk group, is seen as important for both psychologists and individuals seeking treatment from them.

Method

This research is a quantitative study that collected data using a Likert-type questionnaire. The research adopts a descriptive and cross-sectional study design, utilizing a correlational survey model. The predictor variable is secondary traumatization, and the outcome variables are professional burnout and compassion fatigue. Data were collected from psychologists working in various cities in Turkey (Istanbul, Aydin, Bursa) by the researchers of this study, who are undergraduate psychology students and doctoral faculty members. The data were collected in the spring of 2023, and the minimum wage for the spring of 2023 was 10,008 TL net and 8,506.80 TL gross.

Sample

The research sample was composed of individuals selected using an appropriate sampling method. The study's population consists of mental health professionals aged 24-65 living in Turkey between 2022 and 2023. The exclusion criteria for the study include unwillingness to participate, being under 24 years old, being over 65 years old, not working in the field of mental health, having a medical diagnosis. The exclusion criteria were established based on the reference provided by Taş (2023). Data were collected from participants through face-to-face and online interviews and through meetings at the counselling centers where they worked, as well as reaching out to psychologists in different cities through social media on online platforms. In this regard, the number of face-to-face and online participants is not equal. Eighteen psychologists were reached via social media, so it was not possible to determine whether there was a difference between the data of those participating in face-to-face and online interviews.

According to unknown population sampling, under the conditions of wanting to work with a 5% margin of error, at least 384 participants should be interviewed (Cohen 1988). However, taking into account factors such as elimination due to a depression diagnosis in some questionnaires, we reached 404 people in our research, and the decision was made with a total sample of 400 participants. Therefore, information obtained from 400 individuals was evaluated instead of 404.

Procedure

Ethical approval for the study was obtained by submitting an application to the Ethics Committee of T.C. Nişantaşı University, Institute of Social Sciences, on 25.09.2022, under protocol number 2021/42, before commencing the study. During the design phase of the research, permission was obtained from Private

Counselling Centers in Istanbul and Bursa, where the interviews would take place, by providing information about the research. Permission for the research was granted with a signed approval document by the institution's authorities. Before the study commenced, voluntary informed consent forms were obtained from the participants. In addition, structured interview forms with questions about the participants' mental states and past medical histories were used to collect information.

The study's participants were provided with information by the researcher, and they were asked to complete the Semi-Structured Interview Form, Secondary Traumatic Stress Scale, Compassion Fatigue Scale, and Maslach Burnout Scale. The time participants took to complete the scales ranged from 20 to 30 minutes.

Measures

In the course of the research, a Semi-Structured Interview Form, Secondary Traumatic Stress Scale, Compassion Fatigue Scale, and Maslach Burnout Scale were used.

Semi-Structured Interview Form

This form, prepared by the researchers following a literature review, includes questions about the participants' sociodemographic characteristics, such as gender, marital status, and parenthood, as well as information related to their professional life, including average working hours and experience with traumatic events in their careers. It comprises 15 questions.

Secondary Traumatic Stress Scale (STSS)

This scale, developed by Bride and colleagues (2004), measures the post-traumatic stress symptoms experienced by individuals who come into contact with traumatized individuals due to their profession. The scale includes three sub-dimensions named intrusion, avoidance, and arousal. The scale has a possible score range of 17-85, with higher scores indicating a higher level of impact. Bride and colleagues (2004) calculated the internal consistency coefficient for STSS as 0.94, and for the emotional intrusion, avoidance, and arousal sub-scales, they calculated 0.83, 0.89, and 0.85, respectively. They also used structural equation modelling techniques. Confirmatory factor analysis, performed to measure factorial validity, supported the three-factor structure of the scale. The Secondary Traumatic Stress Scale sums the scores corresponding to the responses given to the items. There are 17 items in the scale, and it is a five-point Likert scale (1= Never, 5= Very Often). Yıldırım and colleagues (2018) conducted an adaptation of the scale for healthcare professionals and reported the reliability coefficient as 0.91 for the overall scale, 0.84 for emotional intrusion, 0.78 for avoidance and 0.82 for arousal.

Compassion Fatigue Scale

This scale, developed by Pommier (2011), was adapted into Turkish by Akdeniz and Deniz (2016). The scale consists of 24 items and is a five-point Likert scale (1= Strongly Disagree, 5= Strongly Agree). The scale includes six dimensions: compassion (items 6, 8, 16, 24), detachment (items 2, 12, 14, 18), post-traumatic growth (items 11, 15, 17, 20), negative effects (items 3, 5, 10, 22), self-awareness (items 4, 9, 13, 21), and rumination (items 1, 7, 19, 23). The items that make up the Detachment, Negative Effects, and Rumination dimensions of the scale are negative, while the items in the Compassion, Post-traumatic Growth, and Self-awareness dimensions are positive. Akdeniz and Deniz (2016) determined the Cronbach's Alpha value for the scale as 0.85.

Maslach Burnout Scale

This scale, developed by Maslach and Jackson (1981) is a seven-point Likert-type scale (1= Never and 7= Always). It consists of 22 items and has three sub-dimensions: emotional exhaustion, depersonalization, and personal accomplishment. The Turkish adaptation of the scale was carried out by Ergin (1992) and was reorganized based on a study group of 235 individuals. In the original form, the response options were seven steps, such as never, a few times a year, once a month, a few times a month, once a week, a few times a week, and every day, but it was decided to reorganize them into a five-point scale: never, very rarely, sometimes, often, always. Ergin (1992) calculated the Cronbach Alpha reliability coefficient as 0.83 for emotional exhaustion, 0.65 for depersonalization, and 0.72 for a decrease in personal accomplishment. Girgin Yıldırım reported the reliability coefficient as 0.87 for emotional exhaustion, 0.74 for personal accomplishment, and 0.63 for depersonalization.

Statistical Analysis

All analyses conducted in this research were performed using the Statistical Package for the Social Sciences (SPSS) version 27. Before applying statistical analyses, the assumption of normal distribution was tested. In this

context, skewness and kurtosis values for the scales were examined. Skewness and kurtosis coefficients for all measurement tools fall within the range of -2 to +2 (Hahs-Vaughn and Lomax 2020). Based on these results, parametric tests were preferred for statistical tests. Pearson Correlation analysis, which tests the relationship between the scales, was used for parametric analysis, while Independent Samples t-test and ANOVA test were used to compare scale scores based on demographic variables. Multiple Linear Regression was performed to test predictability. In the regression analysis, secondary trauma was used as an independent variable, and compassion fatigue and burnout variables were used as dependent variables. Before conducting the regression analysis, linearity and normality assumptions were examined (Büyüköztürk 2003). In addition, whether there is multicollinearity among the independent variables was also examined. To detect multicollinearity issues, attention was given to ensure that the independent variables have a correlation below 0.90, and the condition of Variance Inflation Factor (VIF) values exceeding 10 and tolerance values below 0.10 was also checked (Pallant 2007). After confirming that the assumptions were met, the regression model was established using the "stepwise" method. The aim of this method is not to include the independent variable in the regression model if it does not have significant predictability on the dependent variable. According to this result, the most suitable independent variable or variables will be included in the model. All analyses were conducted at a 95% confidence interval, with a reference p-value of 0.05.

Results

Sociodemographic characteristics of the participants are presented in Table 1.

Table 1. Sociodemographic characteristics of participants

Variable		n	%
Gender	Female	298	74.5
	Male	102	25.5
Education Level	Undergraduate	117	29.3
	Master's Degree	222	55.5
	Doctorate and above	61	15.3
Marital Status	Married	166	41.5
	Single	211	52.8
	Divorced	23	5.8
Child Status	None	262	65.5
	1	84	21.0
	2 or more	54	13.5
Socioeconomic Level	Minimum wage	33	8.3
	Above minimum wage	277	69.3
	High	90	22.5
Total		400	100

n: Subsample size, %: Percentage

The participants' occupational background and distribution of practices are included in Table 2. The mean scores and standard deviations of Maslach Burnout Scale, Compassion Fatigue Scale, Secondary Traumatic Stress Scale are presented in Table 2. Correlations between these scales are included in Table 4.

From the correlation analysis, it was observed that there exists: A weak negative correlation between the duration of work experience in the profession and compassion ($r = -.11$, $p < 0.05$). Weak positive correlations between the number of weekly working hours and various aspects including burnout ($r = .15$, $p < 0.01$), emotional exhaustion ($r = .22$, $p < 0.01$), depersonalization ($r = .17$, $p < 0.01$), secondary traumatic stress scale ($r = .21$, $p < 0.01$), avoidance ($r = .22$, $p < 0.01$), arousal ($r = .15$, $p < 0.01$), and emotional violation ($r = .21$, $p < 0.01$). Modest negative correlations were found between weekly working hours and compassion fatigue ($r = -.19$, $p < 0.01$), compassion ($r = -.13$, $p < 0.01$), indifference ($r = -.17$, $p < 0.01$), awareness of sharing ($r = -.17$, $p < 0.01$), detachment ($r = -.22$, $p < 0.01$), mindfulness ($r = -.19$, $p < 0.01$), and relationship break ($r = -.11$, $p < 0.05$).).

Table 2. Distribution of participants' occupational information			
Variable		**n**	**%**
Years of experience in the profession	0-1 years	39	9.8
	1-3 years	110	27.5
	3-5 years	64	16.0
	5-10 years	84	21.0
	10+ years	103	25.8
Average weekly working hours	Below 40 hours	199	49.8
	40 hours	92	23.0
	40-50 hours	77	19.3
	50 and above	32	8.0
Exposure to physical/verbal violence or requests for special relationships by patients or their relatives	Yes	135	33.8
	No	240	60.0
	Undecided	25	6.3
Experience of developing mental issues due to traumatic events encountered in professional life	Yes	103	25.8
	No	297	74.3
Belief that people in the immediate environment approach only to share psychological problems	Yes	291	72.8
	No	58	14.5
	Undecided	51	12.8
Decrease in social life due to having to listen to too many problems in professional life	Yes	175	43.8
	No	178	44.5
	Undecided	47	11.8
Times when being seen as an expert by patients, their relatives, or the immediate environment makes it difficult to meet even physiological needs	Yes	174	43.5
	No	172	43.0
	Undecided	54	13.5
Periods when working is necessary despite having experienced a traumatic event in personal life	Yes	299	74.8
	No	84	21.0
	Undecided	17	4.3
Belief that rest is not possible outside office hours due to the risk of suicide, psychotic attacks, etc.	Yes	69	17.3
	No	278	69.5
	Undecided	53	13.3
Experience of expecting professional behaviour from people even outside office hours	Yes	367	91.8
	No	16	4.0
	Undecided	17	4.3
	Total	400	100.0

n: Subsample size, %: Percentage

Table 3. Descriptive statistics of Maslach Burnout Inventory, Compassion Fatigue Scale, and Secondary Traumatic Stress Scale					
Scale	**N**	$\bar{X}$	**SD**	**Skewness**	**Kurtosis**
Maslach Burnout Inventory	400	18.83	10.79	0.66	-0.05
Emotional Exhaustion	400	9.04	5.76	0.75	0.15
Depersonalization	400	2.82	2.97	1.38	1.85
Low Personal Accomplishment	400	6.97	4.21	0.68	0.34
Compassion Fatigue Scale	400	85.96	18.62	-0.73	0.46
Compassion	400	14.26	3.48	-0.60	0.02
Indifference	400	13.93	3.61	-0.47	-0.12
Awareness of Sharing	400	14.30	3.80	-0.68	0.15
Detachment:	400	14.81	3.64	-0.76	0.06
Conscious Awareness	400	14.66	3.43	-0.92	0.78
Relationship Break	400	14.01	3.72	-0.59	-0.28
Secondary Traumatic Stress Scale	400	31.30	10.89	0.97	0.62
Avoidance	400	13.05	4.63	0.90	0.47
Arousal	400	9.38	3.86	0.86	0.14
Emotional Violation	400	8.88	3.32	1.11	1.17

N: Sample size, $\bar{X}$: Mean, Sd: Standard Deviation

Burnout displayed moderate negative associations with compassion fatigue ($r = -.39$, $p < 0.01$), compassion ($r = -.28$, $p < 0.01$), indifference ($r = -.38$, $p < 0.01$), awareness of sharing ($r = -.31$, $p < 0.01$), detachment ($r = -.37$, $p < 0.01$), mindfulness ($r = -.37$, $p < 0.01$), and relationship break ($r = -.31$, $p < 0.01$). It exhibited moderate positive

relationships with secondary traumatic stress ($r = .65$, $p < 0.01$), avoidance ($r = .64$, $p < 0.01$), arousal ($r = .59$, $p < 0.01$), and emotional violation ($r = .56$, $p < 0.01$).

Tablo 4. Correlations between Maslach Burnout Inventory, Compassion Fatigue Scale, and Secondary Traumatic Stress Scale

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Years of Experience in the Profession	1																
2. Weekly Working Hours	.27**	1															
3.Maslach Burnout Inventory	.01	.15**	1														
4.Emotional Exhaustion	.02	.22**	.91**	1													
5.Depersonalization	.05	.17**	.77**	.63**	1												
6.Low Personal Accomplishment	-.04	.00	.78**	.51**	.41**	1											
7.Compassion Fatigue Scale	-.06	-.19**	-.39**	-.31**	-.46**	-.25**	1										
8.Compassion	-.11*	-.13**	-.28**	-.17**	-.28**	-.29**	.86**	1									
9.Indifference	-.02	-.17**	-.38**	-.33**	-.49**	-.17**	.87**	.65**	1								
10.Awareness of Sharing	-.07	-.17**	-.31**	-.22**	-.34**	-.24**	.79**	.63**	.59**	1							
11.Detachment	.01	-.22**	-.37**	-.33**	-.46**	-.19**	.88**	.65**	.81**	.60**	1						
12. Conscious Awareness	-.07	-.19**	-.37**	-.29**	-.38**	-.27**	.88**	.79**	.69**	.71**	.70**	1					
13. Relationship Break	.00	-.11*	-.31**	-.26**	-.42**	-.13**	.87**	.73**	.75**	.53**	.76**	.69**	1				
14. Secondary Traumatic Stress Scale	.00	.21**	.65**	.66**	.57**	.37**	.06	.21**	-.01	.18**	-.10*	-.01	.01	1			
15.Avoidance	.05	.22**	.64**	.65**	.59**	.35**	-.01	.14**	-.09	.15**	-.15**	-.04	-.06	.94**	1		
16.Arousal	-.03	.15**	.59**	.60**	.45**	.37**	.12*	.24**	.06	.22**	-.04	.04	.06	.93**	.81**	1	
17.Emotional Violation	.00	.21**	.56**	.58**	.52**	.28**	.06	.20**	.01	.11*	-.08	-.03	.05	.89**	.75**	.74**	1

**p<0,01, *p<0,05

Emotional exhaustion demonstrated moderate negative correlations with compassion fatigue ($r = -.31$, $p < 0.01$), compassion ($r = -.17$, $p < 0.01$), indifference ($r = -.33$, $p < 0.01$), awareness of sharing ($r = -.22$, $p < 0.01$), detachment ($r = -.33$, $p < 0.01$), mindfulness ($r = -.29$, $p < 0.01$), and relationship break ($r = -.26$, $p < 0.01$). It showed moderate positive associations with secondary traumatic stress ($r = .66$, $p < 0.01$), avoidance ($r = .65$, $p < 0.01$), arousal ($r = .60$, $p < 0.01$), and emotional violation ($r = .58$, $p < 0.01$).

Depersonalization indicated moderate negative correlations with compassion ($r = -.28$, $p < 0.01$), indifference ($r = -.49$, $p < 0.01$), awareness of sharing ($r = -.34$, $p < 0.01$), disconnection ($r = -.46$, $p < 0.01$), conscious mindfulness ($r = -.38$, $p < 0.01$), and relationship termination ($r = -.42$, $p < 0.01$). It also displayed moderate positive associations with secondary traumatic stress scale ($r = .57$, $p < 0.01$), avoidance ($r = .59$, $p < 0.01$), arousal ($r = .45$, $p < 0.01$), and emotional violation ($r = .52$, $p < 0.01$).

Low sense of personal achievement showed moderate negative correlations with compassion fatigue ($r = -.25$, $p < 0.01$), warmth ($r = -.29$, $p < 0.01$), indifference ($r = -.17$, $p < 0.01$), awareness of sharing ($r = -.24$, $p < 0.01$), disconnection ($r = -.19$, $p < 0.01$), conscious awareness ($r = -.27$, $p < 0.01$), and termination of relationship ($r = -.13$, $p < 0.01$). It exhibited moderate positive relationships with secondary traumatic stress scale ($r = .37$, $p < 0.01$), avoidance ($r = .35$, $p < 0.01$), arousal ($r = .37$, $p < 0.01$), and emotional violation ($r = .28$, $p < 0.01$). Additionally, a slight positive correlation was found between compassion fatigue scale and arousal ($r = .12$, $p < 0.05$).

Compassion displayed slight positive correlations with secondary traumatic stress ($r = .21$, $p < 0.01$), avoidance ($r = .14$, $p < 0.01$), arousal ($r = .24$, $p < 0.01$), and emotional violation ($r = .20$, $p < 0.01$). Awareness of sharing showed slight positive associations with secondary traumatic stress scale ($r = .18$, $p < 0.01$), avoidance ($r = .15$,

p < 0.01), arousal (r = .22, p < 0.01), and emotional violation (r = .11, p < 0.05). Disconnection exhibited slight negative correlations with secondary traumatic stress scale (r = -.10, p < 0.05) and avoidance (r = -.15, p < 0.01).

Table 5. Variables of secondary trauma predicting burnout

Variablesr	B	EH	β	t	p	%95 CI	
Constant	-1.78	1.27		-1.40	0.162	[-4.27	0.71]
Avoidance	1.00	0.16	0.43	6.17	0.000*	[0.68	1.32]
Arousal	0.38	0.19	0.14	1.97	0.050*	[0.00	0.75]
Emotional Violation	0.45	0.20	0.14	2.28	0.023*	[0.06	0.84]

CI: Confidence Interval, B: Regression Coefficient, SE: Standard Error, β: Standardized Regression Coefficient, t: T-Test Value, p: Significance Value, *p<0.05

The regression analysis reveals that avoidance, arousal, and emotional violation are predictors of burnout. The R2 value stands at .43, signifying that these variables account for 43% of the variance in the dependent variable (F (3,396) = 101.18, p < .001). Specifically, avoidance had a significant positive prediction for burnout (β = .43, p < .001), while both arousal (β = .14, p < .05) and emotional violation (β = .14, p < .05) also exhibited significant positive predictions for burnout. Notably, among these variables, avoidance emerges as the most explanatory factor for burnout.

Table 6. Variables of secondary trauma predicting compassion fatigue

Variables	B	SE	β	t	p	%95 CI	
Constant	103.95	2.62		39.66	<.001*	[98.80.	109.10]
Avoidance	-1.38	0.19	-0.34	-7.28	<.001*	[-1.75.	-1.01]

CI: Confidence Interval, B: Regression Coefficient, SE: Standard Error, β: Standardized Regression Coefficient, t: T-Test Value, p: Significance Value

The regression analysis suggests that arousal and emotional violation did not serve as significant predictors for compassion fatigue. However, avoidance behavior emerged as a predictor for compassion fatigue. The R2 value stands at .12, explaining 12% of the variance in the outcome variable (F (1,398) = 53.05, p < .001). Specifically, avoidance displayed a significant negative prediction for compassion fatigue (β = -.34, p < .001).

Discussion

The study's identification of a significant link between burnout and secondary traumatic stress aligns with Mann's (2005) research on mental health nurses, which observed a positive relationship between stress and emotional exhaustion. Another study focusing on individuals in psychiatry found that half of the participants experienced burnout (Kaçmaz, 2005). Additionally, Creamer and Liddle (2005) and Zara and İçöz (2015) demonstrated that mental health professionals may encounter both secondary traumatic stress and occupational burnout. Experts in this field have underscored that prolonged exposure to emotional stresses and high levels of empathy towards others can pose a risk factor for burnout (Rudaz et al., 2017). Culver et al. (2011) reported that professionals frequently exposed to their clients' traumatic stories may develop symptoms resembling post-traumatic stress disorder.

In their scholarly works, Birinci and Erden (2016) highlighted the significance of personal trauma history in secondary trauma, suggesting that professionals with such experiences tend to face higher levels of secondary traumatic stress. Therialt et al. (2015) underscored that therapist's issues can lead to emotional detachment and early termination of treatment. Additionally, Christopher and Maris (2010) evaluated compassion fatigue, secondary trauma, and countertransference issues among mental health workers as risk factors influencing their responses to patients. Craig and Sprang (2010) pointed out that experience plays a role in increased compassion fatigue and burnout levels among social workers and psychologists, indicating that more experienced individuals exhibited lower scores.

Another notable finding from this research highlights a significant connection between burnout and compassion fatigue. Coetzee and Klopper (2010) also emphasized the progressive nature of compassion stress, noting the accumulation of stress over time. A study examining secondary traumatization levels and predictive risk factors among mental health professionals suggested that variables such as age, workload, and the frequency of trauma-related interviews were linked to increased levels of vicarious traumatization (Altekin 2014). Furthermore, another study indicated a correlation between individuals' levels of compassion fatigue and burnout with their psychological problems (Hiçdurmaz and İnci 2015). Zahgini et al. (2020) reported that heightened levels of emotional labor and job stress amplified the burnout syndrome in nurses, potentially linked to blurred professional boundaries and high levels of personal sacrifice among professionals.

Moreover, the present study uncovered a significant relationship between compassion fatigue and secondary traumatic stress. In prior literature, Figley (1995) addressed compassion fatigue, highlighting burnout and exposure to secondary traumatic experiences, particularly stressing the indirect exposure of mental health professionals to their clients' negative life events. Another study focusing on professional groups working with sexually abused children reported symptoms of PTSD in half of the participants (Çolak et al. 2012). These findings may relate to factors such as the young age of the cases with whom professionals interact and the nature of trauma experienced being man-made.

The research also revealed weak positive relationships between weekly working hours and the Maslach Burnout Inventory and its subscales, emotional exhaustion and depersonalization. Similarly, weak positive correlations emerged between weekly working hours and the Secondary Traumatic Stress Scale, as well as its variables - avoidance, arousal, and emotional violation. These results echo previous studies indicating connections between employment duration, high workloads, and increased emotional exhaustion and secondary traumatic stress among workers.

Conversely, this research demonstrated weak negative correlations between weekly working hours and the Compassion Fatigue scale, consistent with findings in Katula's (2015) study, which emphasized the role of work duration in compassion fatigue levels. Another study conducted in Istanbul reinforced these findings, highlighting the duration of work and education level as significant variables associated with compassion fatigue among hospital healthcare workers (Kişmir and İrge 2020). These results may reflect participants' heightened empathy and exposure levels.

However, the research has limitations. Information about participants is confined to the Semi-Structured Interview Form and scale-based questions, restricting the data to values measured by the scales. The study's participant pool is limited to 400 individuals, primarily accessed online, representing only a fraction of mental health workers. Additionally, due to its cross-sectional nature, the study cannot establish cause-and-effect relationships.

Conclusion

This research has revealed that intensive interaction with traumatized individuals poses a mental risk for professionals in helping professions. Increasing the competence of mental health workers in dealing with traumatic experiences is believed to be effective in reducing symptoms of secondary traumatic stress. Psychologists seeking avenues of satisfaction outside of work and sharing the responsibility for high-risk patient groups with experts in the field are recommended. Increasing reward sources within organizations and focusing on meeting the individual needs of mental health professionals are necessary. Making adjustments in workload and working hours, as well as regularly monitoring the symptoms of traumatic stress by organizations, are among the preventive measures that can be taken. In future studies, the relationship between secondary traumatization, professional burnout, and compassion fatigue in mental health professionals working in the public sector and the private sector can be investigated. Group interventions can be conducted for mental health professionals, and longitudinal studies can be carried out.

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