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Understanding Vicarious Trauma and Burnout in Mental Health Care: A Study of Psychologists, Social Workers and Nurses

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ABSTRACT
Secondary traumatic stress, staff turnover, and compassion fatigue pose a major threat to mental health workers because they are regularly exposed to clients' negative experiences. Looking at the effect of these factors, this study aimed to assess the extent of psychological challenges experienced by psychiatric social workers, psychologists, and psychiatric nurses working in mental health settings across Chennai. Both structured and closed-ended questions were administered and self-completed by 45 participants using convenience sampling in psychiatric hospitals and rehabilitation centers in a specific city. The Burnout, Compassion Fatigue, and Vicarious Trauma Assessment from the Crisis & Trauma Resource Institute Inc. was used to determine the level of vicarious trauma, burnout, and compassion fatigue among mental health professionals by gender and occupational roles, and it was evident that the level of vicarious trauma, burnout, and CF varied. Importantly, the authors also observed that the level of burnout among psychiatric nurses was considerably higher than that among psychologists and social workers, which underlines the emotional nature of the nurses' job and the corresponding stress experienced by them. Moreover, female workers stated more often in the survey than male workers that they had a high level of VT, which indicates that gender-related factors may play a role in deciding on the level of secondary traumatic stress related to vicarious trauma. The results of this study emphasize the importance of designing accurate prevention programs and implementing effective interventions to counteract the negative impact of vicarious trauma and burnout. The urged mental health organizations should i) adopt inclusive wellness programs for their staff, ii) offer education on building emotional resilience and coping strategies, and iii) offer mental health support to their employees. Therefore, it is imperative that a number of considerations be made with regard to overcoming these challenges for the notable increase in the welfare of mental health workers and the effectiveness of the services rendered to clients. Additional studies are required to identify interventions that will help decrease the positive probability of acquisition of vicarious trauma, burnout, and compassion fatigue among mental health care professionals practicing different professions.

Keywords: Psychiatric Social Worker, Psychologist, Psychiatric nurse, Vicarious trauma, burnout, Compassion fatigue, Mental health professionals

1. Introduction

Vicarious trauma, on the other hand, defines the level of psychological stress that results from listening to and analyzing stories of trauma that other people have been through, especially in the course of their work. This type of vicarious trauma is common among counselors, therapists, social workers, psychiatric nurses, and other professionals who encounter traumatized clients on a daily basis. These reactions can mimic the effect of first-degree trauma survivors and may include features such as low energy, increased anxiety, obsession, and altered philosophy of life (Pearlman & Saakvitne, 1995). That is why understanding of vicarious trauma's applicability is in the fact of its widespread influence on—and the consequences it has for—the mental well-being of the professionals who are to support trauma victims. The potential consequences of vicarious trauma, if not kept in check, include burnout, poor job satisfaction, and compromised quality of services, which in the long run will affect the therapy process and client's results (Bride, 2007).

1.1 Objective

The aim of this research is to establish how many such workforces undergo vicarious trauma through their work,

the effects of such trauma, and, finally, the presence, nature, and efficiency of measures used to prevent such instances. Therefore, the study seeks to offer an understanding of how mental health professionals might be assisted in their line of duty in order to have better well-being, thereby offering their best to their clients.

The research questions guiding this study were as follows:

What is the incidence density ratio of new cases of vicarious trauma in various mental health professions

This raises the question of what causes mental health professionals to be easily affected by vicarious trauma.

This leads to the following question: What measures can be taken by organizations and people to reduce the effects of vicarious trauma

1.2 Overview of Vicarious Trauma

2 Vicarious trauma differs from second-hand traumatization in that it focuses on the emotional shift that occurs in practitioners who listen to victims' accounts. This process modifies cognitive schemata with reference to safety, trust, self-esteem, intimacy, and control, as indicated by Pearlman and Saakvitne (1995). On the other hand, direct trauma is primary and involves a person suffering a traumatic event, while vicarious trauma is indirect in that it relies on a person's identification with other traumatized individuals. This type of trauma has been increasingly discussed in occupations that involve caregiving or work that otherwise demand emotional work. Vicarious traumatization first appeared at the end of the twentieth century because of the study of the effects of trauma survivors' professionals. The first theoretical efforts were undertaken in the field of therapists' and counselors' vicarious trauma, pointing to the fact that processes that are essential to therapeutic relationships, such as empathy, may result in therapists' trauma-like symptoms (Figley, 1995). Later, the concept of vicarious trauma became broader to encompass other workers and organizations, such as social workers, health care givers, and emergency services persons who often work with trauma. As previously mentioned, the Trauma Transmission Theory is the primary framework for comprehending vicarious trauma. As presented by Herman (1992), this theory holds that it is possible to transfer the effects of traumatic events from one person to another through identification, hence subscribing to empathic engagement, where the emotions and psychological conditions of one person become those of the other. This theory explains why one must set boundaries on how one handles emotions, especially when working in a traumatic setting. The effects of vicarious trauma on mental health professionals are widespread and manifest in multiple areas of an individual's life. Research has demonstrated that exposure to client trauma generates feelings of emotional fatigue, objective cynicism, and a reduced sense of competence, which are signs of burnout (Maslach and Leiter, 2016). It is evident that every profession has a different vulnerability to vicarious trauma, and some studies have shown higher risks of vicarious trauma to social workers and psychiatric nurses than to psychologists (Meadors & Lamson, 2008). Studies have shown that vicarious trauma affects all fields of the counseling profession, although it varies depending on the duties and extent of traumatogenic contact. In one study, psychiatric nurses, who interacted with patients with high psychological needs, displayed higher levels of vicarious trauma than psychologists, who may receive regular supervision (Meadors and Lamson 2008). Other populations with high levels of vicarious trauma include social workers, especially those in child protection and crisis intervention services (Bride 2007).

Recent research has also revealed differences in the effects of vicarious trauma in a comparative analysis of mental health careers. One study revealed that compared to psychologists or social workers, psychiatric nurses had greater scores on the measures of emotional exhaustion and depersonalization, which might be explained by the fact that psychiatric nurses come closer to their patients and spend more time with them, as well as their job responsibilities (Hinderer et al., 2014). Another study showed that social workers who worked on cases of child abuse reported higher levels of vicarious trauma, underlining the fact that the type of trauma exposure determines the level of vicarious trauma experienced by workers (Bride, 2007). As it will be seen, there are various symptoms that can be associated with vicarious trauma, these include emotions, Physical health, and behaviours. Psychologically, those who suffer from this condition can lack feelings, be anxious all the time, and have thoughts that interfere with their normal functioning. One can experience physical signs such as exhaustion, headache, and other stress-like complications. Behaviorally, some manifestations of vicarious trauma include avoidance behavior, decreased sensitivity, and challenges in differentiating between self and clients (Pearlman & Saakvitne, 1995). Positively, there are short-term and long-term physiological effects that may include chronic stress, depression, and hopelessness, which may affect the health of individuals and the output of workers (Maslach & Leiter, 2016). Prior studies have indicated that female mental health workers are more vulnerable to developing PTSS than male workers (Newell & MacNeil, 2010). This could be because women are known to be more emotional and sympathetic than men, which might make them more sensitive and therefore more likely to be affected by vicarious trauma. In addition, cultural factors such as social norms and gender expectations could play

a role in how males and females perceive and disclose trauma. It is essential to consider the nature of trauma and the extent of employees' identification with clients while evaluating the possible development of vicarious trauma. Vicarious traumatization from individuals or settings depends on the most sensitive populations by virtue of their professional standard tasks, including children or sexual assault survivors and professionals working in high-risk settings (Figley 1995). The extent of empathy that is characteristic of such positions can also enhance or exacerbate the risk of vicarious trauma as well as the extent of absorption of the traumatic effects of clients' experiences. Several aspects of the work environment and the support structure existing in an organization are essential for defining cases of VT. Some factors known to worsen the impact of vicarious trauma include workload, lack of support, and supervision (Bell et al., 2003). On the other hand, supervision, professional development and positive working culture are some of the ways an organization can reduce the effects of vicarious trauma. There is much to be done to address the impact of vicarious trauma from the perspective of mental health professionals. These are taking personal responsibility for one's state of health, such as personal exercise and relaxation methods, mindfulness, and meditation to stress (Christopher & Maris, 2010). One way of developing responses to the pressure of working with trauma survivors also involves personal growth and the management of work-life balance. Organizations also have a great responsibility to ensure that they minimize their experiences of vicarious trauma by ensuring that they put in place measures to support mental health professionals. Some effective interventions offer a chance to access counseling services, encourage the use of assertive communication, and reduce workload (Bell, Kulkarni, & Dalton, 2003). Training in the identification and prevention of vicarious trauma may help empower professionals with information and strategies that can help them avoid the negative impact of the form of trauma. It should also be said that increasing attention should be paid to the issue of vicarious traumatization as part of the educational process for different specialists who work in the sphere of mental health. The purpose of this infographic is to raise awareness of the common signs and symptoms of vicarious trauma, and simple coping measures can be taken to check for traumatic reactions. Training programs should raise awareness about self-care, building and maintaining boundaries, and asking for help when necessary (Harrison & Westwood, 2009). Secondary traumatic stress is a pertinent problem in the mental health workforce, regardless of specialization. Therefore, it is important to know the extent of its occurrence, its effects, and its risk factors to be better positioned to help affected individuals. Hence, using individual and organizational solutions, mental health care professionals may be prepared to deal with the emotional exposure engaging in work processes, enhancing their conditions, and, in turn, the outcomes of the clients' treatment.

2. Material and Methods

2.1 Study Design

The current study employed a descriptive cross-sectional study design to establish the incidence of VT among mental health workers inclusive of social workers, psychologists, and psychiatric nurses. A descriptive design is useful in providing a snapshot of a particular population and is commonly applied in the studies whose objective is to describe the state of a given phenomenon at a given point in time (Burns & Grove, 2005). Cross-sectional research design enables the researcher to assess different variables in a certain population at once thus enabling the determination of current prevalence levels of vicarious trauma and other related psychological disorders like burnout and compassion fatigue.

2.2 Participants

The participants for the study comprised of 45 mental health professionals in psychiatric and rehabilitation contexts. Out of all the participants, 15 were psychologists, 15 were psychiatric nurses, and the rest were social workers, which made it possible to retain required parity in the results by various professions in Mental health stream. The inclusion criteria for participants were as follows:The inclusion criteria for participants were as follows:

1. Professional Role: More specifically, participants must work in the mental health field in capacity as a social worker, clinical psychologist or psychiatric nurse.

2. Work Setting: Participants have to be employed in a psychiatric hospital or rehabilitation centre or any other similar setting that a client shares traumatic story quite often.

3. Experience: Participants must have been in their current positions for not less than one year to warrant sufficient exposure to traumatized client cases.

In this study convenience sampling was used implying that subjects chosen were those who were easily accessible

and willing to participate during the time of data collection. Although it is a non-random technique and may result in selection bias, it was preferred because of the realities of gaining access to such personnel in particular clinical environments.

2. 3 Instruments

In order to assess the levels of vicarious trauma, burnout, and compassion fatigue of participants that have been exposed to RBT education the 21-item Burnout, Compassion Fatigue, and Vicarious Trauma Assessment was used including questions created by the Crisis & Trauma Resource Institute Inc. This measure has been employed in numerous quantitative studies concerning secondary trauma to genic stress in various healthcare fields, and its validity was confirmed by Bride et al. The assessment includes three subscales: The assessment includes three subscales:

1. Burnout Subscale: Assesses the levels of burnout which is a kind of exhaustion that occurs in staff undertaking emotional work. Some example items are "I get frustrated with my work; I get stressed at work; I feel emotionally burnt out."

2. Compassion Fatigue Subscale: Frequently evaluates the respondent's ability to lose own capacity to empathise or care for other people due to the constant work with the survivors of trauma. An example term is "numbness when there is suffering in the community".

3. Vicarious Trauma Subscale: Assesses the level of distress and trauma symptoms happened with participants in relation to Clients' Traumatic Stories. Some sample items are things like; "I have had threatening dreams that are work related."

Each item is also given on the Likert scale of 1-5, ranging from Never to Very Often: The score for each factor can range between 21 and 105, the higher score representing higher degree of burnout, compassion fatigue or vicarious trauma.

2.4 Data Collection Procedures

In this study, data were collected for one month time frame from the 30.01.2024 to 01.07.2024 of the participants worked on both paper-pen based and online questionnaires preferred by students and those available during weekends and evenings. The participants were directly contacted and included the psychiatric hospitals and rehabilitation centres; The survey questionnaires were then completed after obtaining informed consent from the participants.

These were self-administered questionnaires and the respondents were requested to fill them out in private so as to maintain confidentiality. People had the choice to complete the survey in their own time, and either in a quite area in their working environment or online through a secure website survey. The combination of two and more methods was intended to increase response rates as well as to include the persons, who might prefer one or another kind of survey completion.

2.5 Data Analysis

The collected data were analyzed using **IBM SPSS Statistics software** (version 26), a widely used tool for statistical analysis in social sciences research. The following statistical procedures were employed:

1. **Descriptive Statistics:** Used to summarize the demographic characteristics of the sample (e.g., age, gender, marital status, years of experience) and to describe the overall levels of burnout, compassion fatigue, and vicarious trauma among the participants. Measures of central tendency (mean, median) and dispersion (standard deviation) were calculated.

2. **Inferential Statistics:**

- **Independent t-tests** were conducted to examine gender differences in the levels of vicarious trauma, burnout, and compassion fatigue. The t-test formula is given by:

$$t = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{\frac{s_1^2}{n_1} + \frac{s_2^2}{n_2}}}$$

Where
and are the $\bar{X}_1$ $\bar{X}_2$ sample means
and are the s_1^2 s_2^2 sample variance

n1 and n2 are the sample sizes for the two groups (males and females).
This formula is used to calculate the t-statistic for comparing the means of two independent groups.

Where**Pearson correlation coefficients** were used in order to analyse the correlations between age and levels of vicarious trauma, burnout, and compassion fatigue. The Pearson correlation formula is:

$$r = \frac{\sum(X_i - \bar{X})(Y_i - \bar{Y})}{\sqrt{\sum(X_i - \bar{X})^2 \sum(Y_i - \bar{Y})^2}}$$

Where
X_i and Y_i are individual sample points,
$\bar{x}$ and $\bar{y}$ are the means of the respective variables.

This formula is used to calculate the Pearson correlation coefficient,
Which measures the strength and direction of the linear relationship between two variables.

o To compare the scores of the three groups of occupational status, namely social workers, Psychologists and Psychiatric nurses test of the hypothesis correlating their scores with level of vicarious trauma, burnout and compassion fatigue, chi-square analysis were conducted. The chi-square test formula is:

$$\chi^2 = \sum \frac{(O_i - E_i)^2}{E_i}$$

Where
O_i is the observed frequency,
E_i is the expected frequency under the null hypothesis.
This formula is used to calculate the Chi-square Statistic,
Which tests the independence of two categorical variables or the goodness of fit of an observed distribution to an expected one.

2.6 Ethical Considerations

To ensure that the rights of the participants and their welfare were well protected, this study followed the ethical procedures. The Ethics Review Board gave permission to carry out the research before data collection began. All the participants provided their consent after explaining to them that the information they will provide will be confidential and their identities will remain unknown. All the participants were told that they had a right to withdraw from the study at any time without any consequences being faced on them. Collected data were made secure and only shared with the members of the research team and that participants' confidentiality and the accuracy of the research results were preserved.

III. Results and Discussion

3. 1 Factors Related to Stress and Its Relationship with Demographic Data

Descriptive data of the sample of 45 mental health professionals formed an essential background for interpreting the current levels of burnout, compassion fatigue, and vicarious trauma. Again, as shown by 53. 3% male and 46. 7% female distribution and 77. 7% of the respondents being married, there may exist stress-protective mechanism. Meta-analysis of various studies has indicated that while on-duty stress may be transmitted to the home front, married people are likely to have their stress relieved by support from their spouse (Meadors & Lamson, 2008). This support can be very important for such employees that work under stressful conditions, for instance, counseling services providers whereby employees working in this field are exposed constantly to stressful experiences of the clients they are handling. A conducive relationship with a partner may improve the skills in handling the various tasks hence decreasing the chances of developing burnout and compassion fatigue. However,

it is also evident that family support reduces stress but it does not eradicate it since even with family support the professionals continue to take job stress back home with them.

3. 2 Types of Scaling for Burnout, Compassion Fatigue, and Vicarious Trauma

3. 2. 1 Burnout: Incidence and risk Factors

It is worrying that 31% of the participants expressed high likelihood of burnout while 11% expressed high likelihood of extremely high burnout rate (Figure 1). This is typical of mental health occupations, as the workers are under pressure and more specifically, overwhelmed by a heavy workload, emotional requirements, and the challenge of coping with a client's severe mental health issues, as pointed noted by (Maslach, Jackson, & Leiter, 2016). In this case burnout refers to emotional exhaustion whereby professional is overwhelmed by the work they are doing, and this reduces their efficiency and may feel detached from what they are doing. The findings support the work of Hinderer et al. (2014) who pointed out that burnout rate is higher among healthcare employees who work in organizations where the employees encounter stress and emotionally demanding circumstances in their work environment regularly. Long hours, work pressure and burnouts also have a toll on the professionals' health as well as compromise the quality of care offered. They found out that cases of burnout in the workplace result to reduced job satisfaction, high absenteeism and high turnover. These things underline the importance of the organizational interventions that can prevent the burnout of workers such as proper work-life balance, proper supplies and assistance, timely mental health breaks. Incorporation of such practices means that healthcare organizations will transform their working environment, focusing the welfare of the worker and the patient in equal measures.

3. 2. 2 Compassion Fatigue: The Emotions Experienced

Compassion fatigue was identified as a major factor among the respondents with 42 % stating that they had experienced it. 2% who responded as high risk and 4. Where it reaches extremely high levels, the prevalence is 4% as depicted in the Figure 1. Secondary traumatization or compassion fatigue is a state in which workers are overwhelmed by the amount of empathy and compassion they are expected to show while dealing with the clients (Figley, 1995). This condition has been described as the 'cost of caring' and is due to the realization that one acquires an intolerant attitude to pain and suffering from years of exposure to such distressed people. The results that were obtained in this study indicate the high levels of compassion fatigue that mental health professionals go through, including those workers who attend to clients who have terrible cases of trauma or long-standing mental illnesses. This, in turn, results in manifestation of several symptoms such as reduced sensitivity, limited empathy and reduced capacity to care for clients. Such symptoms can be problematic in the therapeutic relationship since clients may pick up on their caregiver's emotional distance, which may in turn erode trust in the process of rehabilitation (Newell & MacNeil, 2010). Mental health organisations should therefore ensure that training programs are in place to prevent compassion fatigue among the professionals. Some measures include mindfulness training, supervision, and peer support to enable the practitioners to regulate emotions and avoid compassion fatigue and, therefore, continue to be compassionate to their clients.

3. 2. 3 Vicarious Trauma: A Concealed Danger

It was determined that 37 of the study participants had developed vicarious trauma.

Of these attributes, those with the highest scores include:

Noise level that 8% of the respondents reported as extremely high (Figure 1).

Secondary traumatic stress or vicarious traumatization involves the development of symptoms like those of the traumatized clients among the workers.

These include intrusive thoughts, hypervigilance and anhedonia (Pearlman and Saakvitne, 1995). This condition is worst since it is chronic and usually develops for some time before the patient or a health care provider realizes this condition is severe. In fact, the results of this research can be compared to Bride (2007), according to who vicarious traumatous responses were high among practitioners of mental health suggesting that it is a severe hazard of the career.

This shows that quite an alarming rate of the staff provided mental health care, experience vicarious trauma and must, therefore, warrant adequate support structures from their organizations. Such systems should incorporate

the following: training in vicarious traumatization, provision of counselling services for the staff, and matters concerning debriefing and supervision. Finally, a trauma-sensitive workplace culture which recognizes the bitter fact of secondary traumatization of workers can be another approach that can be taken. Through addressing vicarious trauma, organizations are thus helping the professionals to maintain their mental well-being and prevent cases of burnouts and improve the quality of services they offer to clients.

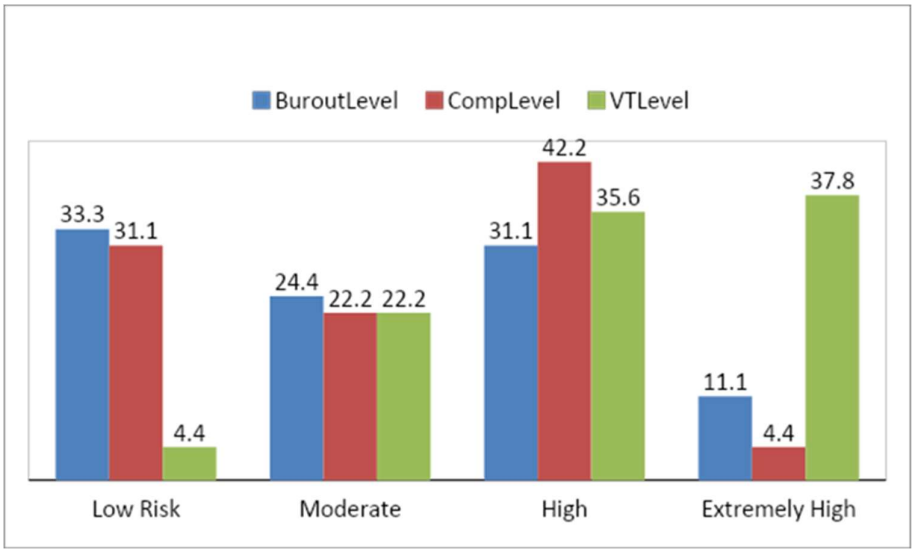

Figure 1: Distribution respondents based on the levels of Burnout, Compassion Fatigue, and Vicarious Trauma

3. 3 The Role Age Place in Compassion Fatigue and Vicarious Trauma

The study also revealed that age has moderate and positive correlation with compassion fatigue ($r= 0.295$, $p < 0.05$) as shown in Table 1, which means that professionals who are older will experience more of compassion fatigue. This result could be because of a compounded effect of traumatization on the job as the older the professional, the longer they are into the job therefore the more likely they have had to handle more traumatized clients (Figley, 1995). This is especially so because as the professionals get older, they are likely to be emotionally drained thus making it hard for them to be empathetic. This agrees with the view that compassion fatigue is secondary traumatic stress disorder that accumulates with time.

Notably, the study failed to show that there was a relationship between age and burnout ($r = 0.137$, $p = 0.368$) and vicarious trauma ($r = 0.003$, $p = 0.985$), or that burnout and vicarious trauma could be linked to age, Therefore, it can be posited that burnout and vicarious trauma might depend on other issues. These finding suggest that age may not be a significant factor with regards to compassion fatigue but that other factors can play a more significant role in burnout and vicarious trauma. This calls for an intervention, which targets different age-groups, in the mental health profession. Further research is needed to better understand these relationships in order to generate the best approaches for the prevention and treatment of compassion fatigue and vicarious trauma throughout the lifespan.

Table 1: Relationship between Age and Burnout, Compassion Fatigue, and Vicarious Trauma

		Age	Vicarious Trauma Overall	Burnout	Compassion Fatigue	Vicarious Trauma
Age	Pearson Correlation	1	.195	.137	**.295***	.003
	Sig. (2-tailed)		.200	.368	.049	.985
	N	45	45	45	45	45

*. Correlation is significant at the 0.05 level (2-tailed).

3. 4 Gender differences in vicarious trauma burn out and compassion fatigue

The results have shown the existing gender differences in the levels of vicarious trauma with female professionals having higher levels than men (t = 0. 552, p < 0. 05) indicated in Table 2. This is in line with past studies done which indicate that females are possibly more susceptible to VTV because of higher levels of empathy and emotionality than males (Newell &MacNeil,2010). Female officers might appear to be at higher risk since they are brought up to be compassionate and caring hence get easily involved with clients and may end up suffering from the trauma that they go through daily. Such gender differences explain why organisations today must adopt gender-sensitive approaches when implementing workplace mental health programmes; this involves coming up with specific solutions that are meant for the specific emotional requirements of women employees.

It is noteworthy that there was no statistical difference observed between the burnout and compassion fatigue scores between males and females therefore it may be concluded that the mentioned facets of work stresser may not be affected by gender. This finding could mean that as much as gender is a factor in vicarious trauma, it isn't as key in burnout and compassion fatigue. This speaks volumes on the severity of these psychological ailments and underlines the fact that in management of clinician burnout and psychological conditions, this means that there are several things to look at: coping modes, workplace, and organizational framework all deserve consideration when it comes to developing strategies for supporting mental health workers (Meadors & Lamson, 2008).

Table 2: Comparing Gender and vicarious trauma

Gender/ Vicarious Trauma	Gender	N	Mean	Inferential statistics
Vicarious Trauma Overall	M	24	63.67	t=0.552, p<0.05 **Sig**
	F	21	66.19	
Burnout	M	24	18.71	t=0.747, p>0.05 Not Sig
	F	21	20.57	
Compassion Fatigue	M	24	19.21	t=0.717, p>0.05 Not Sig
	F	21	20.52	
Vicarious Trauma	M	24	25.75	t=0.347, p>0.05 Not Sig

3. 5 The Relationship between Occupation and Vicarious Trauma, Burnout, and Compassion Fatigue

3. 5. 1 Vicarious Trauma

The analysis of data presented in Table 3 showed that there was not a statistically significant correlation between the occupation of participant and level of identified vicarious trauma (X2 = 9, 160; p > 0, 05); however, the highest level of vicarious trauma was revealed in Psychiatric nurses. Such a conclusion leads to the assumption that although VTC is a common phenomenon for most of the fields of mental health, the role of psychiatric nurses is to perform certain tasks that make them subjects of traumatic stress. Employed in many facilities with high patient to nurse ratio, psychiatric nurses are dealing with severe traumatized and mentally ill patients on a daily basis (Hinderer et al., 2014). These conditions can cause more staff to internalize patients' trauma, which will worsen the degrees of secondary traumatization among these workers.

Table 3: Association between Occupation and the Levels of Vicarious Trauma

Occupation	Levels of Vicarious Trauma				Total
	Low Risk	Moderate	High	Extremely High	
Psychologist	0	2(16.7%)	7(58.3)	3(25%)	12(100%)
Psy Nurse	2(10.5%)	4(21.1%)	3(15.8%)	10(52.6%)	19(100.0%)
PSW	0	4(28.6%)	6(42.9%)	4(28.6%)	14(100.0%)
Total	2(4.4%)	10(22.2%)	16(35.6%)	17(37.8%)	45(100.0%)

3.5.2 Compassion Fatigue

Table 4 shows that there was no relationship between the respondents' occupation and level of compassion fatigue (X2 = 8. 228, p > 0. 05). However, the descriptive findings shows that the psychiatric nurses experienced high levels of compassion fatigue than the psychologists and social workers. Specifically, 47. 4% of psychiatric nurses would be considered as having high levels of secondary traumatization or compassion fatigue while 10. 5% belonged to the extremely high-risk group compared with 58. 3% of the psychologists who had high level but no extremely high-level Teachers with only high level & 21.4% of the total psychiatric social workers who completed the survey described having extremely high compassion fatigue with no cases reported on high levels of compassion fatigue. These implications indicate that due to the character of psychiatric nursing, as it involves acute patient's episodes, high rotation, and the necessity to stay alert, the level of burnout and compassion fatigue may be higher in such nurses (Hinderer et al., 2014).

The non-descript statistical correlation could be due to this large variability that might be seen in experience and response from one occupation to another. However, even with no clear correlation found, more focus should be placed on the higher rates of compassion fatigue among the psychiatric nurses because these workers are more susceptible to emotional exhaustion, detachment and poor empathy owing to many emotional demands they handle through their working experience (Figley 1995). Organizations for mental health must ensure application of effective interventions that help diminishing compassion fatigue from psychiatric nurses and these include Education of the nurses on ways of managing their emotions, opportunity to engage in proper practice of self-care and access to health services for psychiatric disorders. Preventing and reducing compassion fatigue may be possible by creating organizational culture that can recognize emotional stress that nursing work brings and can regularly offer time for staff members to discuss their experiences.

Table 4: Association between Occupation and the Levels of Compassion Fatigue

Occupation	Levels of Compassion Fatigue				
	Low Risk	Moderate	High	Extremely High	Total
Psychologist	2(16.7%)	3(25.0%)	7(58.3%)	0%	12(00.0%)
Psy Nurse	5(26.3%)	3(15.8%)	9(47.4%)	2(10.5%)	19(00.0%)
PSW	7(50.0%)	4(28.6%)	3(21.4%)	0%	14(100.0%)
Total	14(31.1%)	10(22.2%)	19(42.2%)	2(4.4%)	45(100.0%)

3.5.3 Burnout

When it comes to the relationship between occupation type and burnout levels table 5 shows the results where Chi-square is calculated to be X2=14. 693, p < 0.05. The data reveal that the positions of psychiatric nurse are at risk the most; 26. 3% extremely burnout as compared to only 14.3% of the total of the number of psychiatric social workers and none of the total number of psychologists. Mercifully, this important result demonstrated that

occupational stressors are closely linked to burnout. Psychiatric nurses work in pressured situations when handling and tending to patients with mental health disorders; this is cognate emotional and physical drudgery. This high stress environment added to the fact that to be able to attend to clients, one must have to be more of a friend, a counselor even a cheerleader means that these professionals are in line to be stressed out chronically if proper check and balance is not done (Maslach, Jackson & Leiter, 2016).

The elevated levels of burnout among the psychiatric nurses bring out the need to have focused efforts to counter the causal factors common to this career choice. Possible measures could be the distribution of workload to avoid overloading of nurses, making certain that team has enough number of staff members, and creating positive working environment which will encourage interaction and sharing of information. Also, considerations such as taking routine practice checks on mental health, holding stress management sessions, and ensuring availability of mental health support for the nurses can however help down Well, it is true that potential solutions to the rising burnout levels include; Another area that organizations should also pay attention to is work environment and employee relations where attention should be made to ensure that employees are also being valued and supported. When burnout causes have are promptly dealt within an organization, working condition for staff and the quality of the services offered to patients are enhanced (Hinderer et al., 2014).

Table 5: Association between Occupation and the Levels of Burnout

Occupation	**Levels of Burnout**				
	Low Risk	Moderate	High	Extremely High	**Total**
Psychologist	5(41.7%)	1(8.3%)	6(50.0%)	0%	12(100.0%)
Psy Nurse	3(15.8%)	5(26.3%)	6(31.6%)	5(26.3%)	19(100.0%)
PSW	7(50.0%)	5(35.7%)	2(14.3%)	0%	14(100.0%)
Total	15(33.3%)	11(24.4%)	14(31.1%)	5(11.1%)	45(100.0%)

3.6 Implications for Practice and Policy

The results of this study are relevant to practice and policy of care within mental health environments. Such high levels of VT, burnout, and CF presented in the study raise a demand for the organizational support and regulation of the workers' mental states. Mental health organizations should incorporate healthy workplace check-ups encompassing mental health assessments, authorization to counseling services and education on coping and fortitude mechanisms. Another key area where policies should be developed includes workload, staffing and work-life balance to discount burnout and compassion fatigue.

There is a need to design interventions that will enhance the awareness of workforce in mental health on vicarious trauma, burnout and compassion fatigue. These programs should be made mandatory in the continuing professional development of all mental health personnel and be developed with regards to the roles and responsibilities of mental health practitioners of different age, gender and ethnicity. It is thus critical to adopt gender-sensitive strategy, especially because women professionals are more exposed to vicarious trauma. This means that mental health organizations should embrace diversity and realize that every person needs support in different ways to develop a supportive workforce that will translate to good quality service delivery to the clients (Newell & MacNeil, 2010).

4. Conclusion

In this research, the important and permanent challenges of vicarious trauma, compassion fatigue, and burnout among employees in the field of mental health have been described in detail, and a high level of psychological consequences of these conditions has been identified. Vicarious traumatization is a type of secondary stress that occupational fields related to mental health care, as of psychologists, social workers, and psychiatric nurses entail contact with clients' traumatic pasts. But this exposure can cause serious psychological effects which in turn affect the well-being and productivity of such officers. Therefore, the results are clear: the psychosocial impact of providing care to the emotionally and psychologically wounded extends far beyond the transactional level and has

significant and sometimes enduring consequences for the mental health workers themselves. This research paper established that there are high and low levels of vicarious trauma, compassion fatigue and burnout based on the professional level, years of service, gender and tasks performed at the workplace. For example, a study established that psychiatric nurses are among the most distressed workers. It could be linked to the fact that most of them work in settings whereby they frequently and intensely encounter unstable patients that present with acute psychiatric symptoms, which in essence demand significant emotional work and virtually makes patients a potential source of chronic stress. Chronic daily stress stemming from the constant exposure to high-risk situations coupled with the need to deliver constant care in environments that are often inadequately endowed only amplify the specific risk of burnout in the said group. This is alarming finding since burnout not only reduces the well-being of those professionals, but it also impacts negatively on the quality of services that they are able to offer to those seeking healthcare services. Other predictors which were however found to influence the degree of vicarious trauma included gender where the female mental health professionals reported high level of vicarious trauma compared to the male counterparts. This may be due to social and cultural norms which foster nicer or more sympathetic tendencies in females than in males making the female social workers more likely to absorb the client's trauma. This paper shows that female professionals are more vulnerable to develop vicarious trauma; thus, calling for gender-sensitive models for the creation of support mechanisms and interventions. Any model developed for women in this profession should embrace the emotional demands that women encounter and should have solution packages for handling these circumstances well. Some previous research investigating practitioners have reported healthy levels of resilience and minimal levels of secondary traumatization, however, the current literature paints the picture of high levels of burnout and compassion fatigue among the practitioners. Since this problem is so prevalent, it implies that the existing structures of support and services may not be sufficient to cater for mental health professionals. Implications for mental health care organisations present the need for a rethink in organisational support initiatives to develop work climates that enhance staff mental health. To overcome these challenges, the mental health practitioners must invest efforts to engage in coping and positive adaption strategies. Supervision can be a source of intervention during which the field practitioner is helped to debrief and may prevent a condition known as emotional fatigue. Some of the benefits of peer's support groups are that they are capable of providing an element of support where people with such related ailments can come together and share their experiences and this makes them to feel that they are not alone. Cognitive coping strategies that can be effectively used by professionals include mindfulness stress reduction, relaxation and other time management approaches.

It is, therefore, very important for organisations to take an active interest and proactive approach in taking care of the welfare and psychological health of employees. It is therefore important to put in place extensive training measures that prepare professionals adequately to identify and deal with vicarious trauma, burnout, and compassion fatigue. These should be implemented alongside other training and development activities and with regard of roles and organizational groups of the personnel. Furthermore, the creation of work environment that will allow free discussion, sufficient resources to allow sufficient rest from work and work-life balance can prevent such conditions. Further studies are required for purposes of establishing the best approaches and methods of supporting the mental health pros who are employed on these positions and improving their work satisfaction. Further research should investigate individual and unique aspects of factors contributing to vicarious trauma, burnout and compassion fatigue and their moderating effects. In this way, researchers can propose the specific interventions tailored on the need of various professional categories to assist mental health practitioners deliver the best quality of service while preserving their own well-being. Therefore, it is important to note that the care givers themselves have their mental health at stake. Management of mental health practitioners ensure they offer better care and attention to themselves to give the best to their clients. Both the persons working in organizations and the persons seeking assistance themselves must take preventive measures concerning the psychological effects of vicarious trauma, burnout, and compassion fatigue that can otherwise spoil the potential and the atmosphere of delivering the mental health support.

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