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The negative effects of indirect exposure to trauma in therapists working with individuals with addiction who have experienced traumatic events – the role of empathy and secondary self-efficacy

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Summary

Aim. Paradoxically, helping others exposes helpers to secondary traumatization. Its determinants include both work-related factors and individual characteristics. The purpose of this study was to determine the relationships between empathy, secondary self-efficacy, and secondary traumatic stress (STS).

Material and methods. The results obtained from 115 therapists (*M* age = 40.79; *SD* = 10.57) working with clients with addiction were analyzed. Three standardized measurement tools were used: the Secondary Traumatic Stress Inventory (STSI), the Empathic Sensitivity Scale (EES), and the Secondary Trauma Self-Efficacy (STSE) scale.

Results. Only 15.7% of respondents were found to be at high risk of STS. The main predictor of STS was empathic concern. Secondary self-efficacy partly mediated the relationship between empathic concern and STS. Although the rate of secondary traumatization in the group of therapists is not high compared to other professional groups, it is worth paying attention to factors that protect against STS.

Conclusions. To reduce the risk of disorders resulting from secondary exposure to trauma, personal resources, including self-efficacy, should be developed. It is also beneficial to develop the ability to cope with the trauma of others by applying self-care practices.

Key words: empathy, secondary traumatic stress, therapists

Introduction

Many individuals who struggle with addiction have also experienced trauma; thus, addictions occurring among adults, particularly substance-related, may result from traumatic events, experienced primarily in childhood. According to Bride et al. [1],

substance users are four to 10 times more likely than non-users to suffer from posttraumatic stress disorder (PTSD). It has been found that the lifetime prevalence of PTSD among individuals with drug or alcohol use disorders is estimated to range from 36% to 50% [1]. According to Missouridou [2], up to two-thirds of addicted individuals exhibit current subclinical PTSD symptoms, indicating that trauma exposure is universal in this population. This is not surprising, as substance abuse is often a means of coping with trauma, as suggested by the self-medication model [3, 4]. It should also be noted that addictions may not only result from trauma but also contribute to it, for example by increasing the risk of accidents.

Nearly all (97%) of the substance abuse counselors participating in the study by Bride et al. [1] reported having traumatized clients on their caseload. Therefore, there is a clear need for therapists working with addicted clients to take into account the traumatic events that their clients have experienced. Such a situation, when an addicted person reveals trauma-related experiences to professionals, exposes therapists to an increased risk of indirect trauma and its negative effects – trauma becomes a shared experience. Fortunately, as Missouridou [3] emphasizes, it is unlikely to be as intense for the caregiver as it was for the client.

Secondary trauma as an occupational risk

The negative consequences of indirect trauma are usually manifested in the form of secondary traumatic stress (STS) symptoms; these may lead to the development of secondary traumatic stress disorder (STSD), which is the equivalent of PTSD experienced by people who have been directly exposed to trauma. STS is described as the stress response experienced by people who have close contact with a survivor of trauma. Figley [5, p. 10] defines it as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other—it is the stress resulting from helping or wanting to help a traumatized or suffering person". Hence, professionals who come into continued and close contact with trauma survivors may also experience similar reactions, becoming indirect victims of the trauma [6]. These reactions reflect the symptoms of PTSD exhibited by the direct recipient of the traumatic events, such as intrusion, avoidance, negative changes in cognition or mood, and increased arousal and reactivity [7]. It is worth noting that these symptoms are also similar to those of *compassion fatigue*, observed among people working in health care, especially psychiatric care [8].

In reference to the negative effects of exposure to indirect trauma, McCann and Pearlman [9] proposed the term *vicarious traumatization*, understood as a response to negative information coming from traumatized clients. While a wealth of research on the secondary impact of traumatic events on helping professionals has been gathered

over the past three decades, data on the prevalence of the negative effects of indirect exposure to trauma among therapists remain ambiguous. Froman [10] estimates the extent of STS occurrence to be between 8% and 62%. A review of studies conducted among clinicians working with individuals who have suffered sexual violence [11] found the prevalence of STS symptoms to range from 8% among trainee therapists to 50% among those working with victims of violence on a daily basis. A study of psychotherapists, social workers, and interpreters working with traumatized women and children in Iraq identified secondary traumatization in 22.9% of the study participants, with 8.6% demonstrating a high level of STS [12]. The mentioned differences in the intensity of STS experienced by therapists may result from, among other factors, variations in measurement methods, professional experience, intensity of contact with clients, location of therapy, client categories (adults, children), and also from the fact that some of the studies simultaneously covered different groups of professionals working with people after traumatic experiences.

According to a Polish study [13], 14.3% of women representing three groups of professionals working with people experiencing violence (therapists, social workers, and probation officers), demonstrated a high intensity of STS. The highest intensity of STS symptoms was reported by social workers, and the lowest by therapists. Another Polish study [14] found that among five groups of professionals working with people after traumatic experiences (therapists, paramedics, nurses, social workers, and probation officers), therapists showed the lowest severity of STS; in this group, only 7.5% revealed a high risk of STSD, compared to as much as 45.8% of paramedics. Kulik et al. [15] found that 9.8% of surveyed psychotherapists working during the COVID-19 pandemic experienced high or very high intensity of STS symptoms. In turn, Rzeszutek et al. [16] reported a higher level of STS symptoms among psychiatrists compared to psychotherapists.

Few studies have analyzed the prevalence of STS among therapists working with addicted clients who have experienced traumatic events. The study by Bride et al. [1] conducted among substance abuse counselors found that 75% of the respondents experienced at least one symptom of STS in the week prior to the study, 56% met the criteria for at least one of the core symptom clusters (intrusion, arousal, avoidance), and 19% met the core criteria for a diagnosis of PTSD. Additionally, the experience of STS affected the quality and effectiveness of service: more than a third of counselors in the study reported a desire to avoid working with some clients, and more than a quarter exhibited detachment, emotional numbing, or irritability. It is worth noting that such experiences may interfere with a counselor's ability to engage clients in regaining their health and in building a therapeutic relationship.

The role of empathy and self-efficacy in the development of secondary traumatic stress

Empathy can be seen as the reaction of one individual to the observed experiences of another [17]. Omdahl and O'Donnell [18] defined empathy as empathic concern, willingness to communicate, and emotional contagion. Empathy has been implicated in the acquisition of STS symptoms in Figley's models [19], namely the Compassion Fatigue Theory, the Trauma Transmission Model and the Compassion Stress and Fatigue Model. It has also been identified in the recently developed Compassion Fatigue Resilience Model [20]. The importance of empathy in the development of STS is also emphasized by the Empathy-based Stress Model proposed by Rauvola et al. [21]. The authors assume that the effect of indirect exposure to trauma and empathic involvement in helping traumatized clients is manifested as stress resulting from empathy, and expressed in the form of compassion fatigue or STS.

Empathy, expressed mainly as empathic concern, is considered a risk factor for secondary traumatization [19]. On the other hand, it is known that empathy is essential for providing effective assistance to clients. In this way, a paradox of empathy emerges: empathy is needed to increase work effectiveness, but at the same time may also foster the occurrence of negative effects of indirect exposure to trauma. Many studies have identified a positive relationship between empathy and STS [14, 22-25]. However, a study by O'Brien and Haaga [26] among trainee therapists found no relationship between empathy and the negative consequences of indirect trauma. Conversely, a study conducted among social workers indicated a negative relationship between empathy and STS, which suggests that empathy may play a protective role [27]. Higher levels of empathy were also related to a lower risk of STS development in a study of Australian social workers and psychologists [28]. This presents an unclear picture of the relationship between these variables and highlights the need for further research.

A factor that is also associated with secondary traumatic stress is self-efficacy. The term *self-efficacy* is used to describe individuals' perceptions of their ability to overcome problems and perform the actions necessary to succeed in life [29]. A person's beliefs about their self-efficacy may influence their vulnerability to stress, motivations to persevere in difficult situations, resilience to adversity, and ultimately, the decisions and actions they take in life [30]. Self-efficacy appears to be a fundamental factor in the process of adaptation to trauma.

Several studies have hypothesized that individuals with high self-efficacy may be better prepared to handle difficult, stressful situations and experience fewer adverse effects as a result. A similar pattern may occur within the context of indirect exposure to trauma. Ortlepp and Friedman [31] found that self-efficacy was related to lower levels of compassion fatigue. Work-related self-efficacy was associated with lower levels of secondary traumatic stress in a study conducted by Bonach and Heckert

[32]. It has also been shown that people with low STS tend to assign high value to work and have a strong sense of professional competence, which can be equated with work-related self-efficacy [33].

For professionals exposed to indirect trauma, secondary trauma self-efficacy (STSE) seems to play a particularly important role. STSE is defined as "the perceived ability to cope with the challenging demands resulting from work with traumatized clients and the perceived ability to manage secondary traumatic stress symptoms" [34, p. 918].

STSE was found to correlate negatively with STS among nurses, paramedics, and social workers providing services to civilian populations who had directly experienced a traumatic event [34]. In another study, self-efficacy beliefs played a mediating role in the relationship between stress appraisal and compassion satisfaction in rescue workers [35]. In turn, Shoji et al. [36] conducted two longitudinal investigations exploring the mediating effects of social support and STSE in the relationship between STS and secondary posttraumatic growth in a group of health care providers exposed to secondary trauma. It was found that in the relationship between STS and secondary traumatic growth, STSE facilitated perceived social support, suggesting that enhancing self-efficacy helps professionals in the process of adapting after indirect exposure to trauma.

Aim of the study

This research aimed to assess the level of secondary traumatic stress in a group of therapists working with addicted clients who had experienced traumatic events, and to establish the links between STS, empathy, and secondary trauma self-efficacy, including the mediating role of secondary self-efficacy in the relationship between empathy and STS. The predictors of secondary traumatic stress were also identified. It was hypothesized that empathy would be positively related to STS, while self-efficacy in dealing with the trauma of others would be negatively related, and that the belief in self-efficacy would mediate the relationship between empathy and STS.

Material and methods

Participants

The study participants were recruited online or via e-mail sent to several substance abuse inpatient and outpatient treatment units in Poland. The questionnaires were sent and collected by the author or persons trained by the author, after prior initial approval of the study, in the period from January to June 2023. A total of 130 therapists who had worked with addicted clients participated in the study. The criterion for inclusion

in the study was at least one year of experience working with individuals who were addicted (to both substance and behaviors), who had experienced traumatic events in their lives. All respondents were informed about the purpose of the study and its anonymity, as well as the voluntary nature of the study.

From this group, 115 therapists, i.e., 71 (61.7%) women and 44 (38.6%) men, who completed the delivered measurement tools and met the inclusion criteria were qualified for the analysis. Their age ranged from 22 to 69 years (M = 40.79 SD = 10.57), and their work experience ranged from 1 to 40 years (M = 12.27 SD = 9.75). Most of the therapists (95%) had worked with clients with various forms of addiction, such as alcohol (majority), drugs, gambling, and shopping; only 5% had specialized in particular forms of addiction, such as alcohol or drug addiction.

Measurement tools

The present study employed a survey that included questions about sex, age, years of experience as a therapist working with addicts, and a question whether the respondent had worked with clients who had experienced traumatic events, along with the following three standard measurement tools:

(1) The *Secondary Traumatic Stress Inventory* (STSI) is a modified version of the PTSD Checklist for DSM-5 (PCL-5) developed by Weathers et al. [37] and adapted to Polish conditions by Ogińska-Bulik and Juczyński [38]. The inventory is designed to assess professionals who provide assistance to people after traumatic experiences. The STSI consists of 20 statements (e.g., "To what extent did you have repeated, unpleasant and unwanted memories of stressful client events"), describing the basic symptoms included in the four PTSD criteria: B. Intrusion; C. Persistent avoidance of trauma-related stimuli; D. Negative cognitive and emotional changes; and E. Increased arousal and reactivity. In accordance with the instructions, respondents indicate the extent to which they experienced the mentioned reaction during the previous month while providing assistance to people after traumatic events. The degree of response is indicated on a 5-point scale, ranging from "not at all" (0), "slightly" (1), "moderately" (2) and "significantly" (3) to "very much" (4). A score of 33 or above indicates a high probability of a diagnosis of secondary traumatic stress disorder. The tool has very good psychometric properties; Cronbach's α coefficient is very high (0.95).

(2) The *Empathic Sensitivity Scale* (ESS) is a modification of the Interpersonal Reactivity Index, based on Davis's theory of empathy [17] and developed by Kaźmierczak et al. [39]. The scale contains 28 items (e.g., "I often have tender, concerned feelings for people less fortunate than me") evaluated on

a 5-point scale (from 1 – "I completely disagree" to 5 – "I completely agree") and measures three components of empathy: (1) empathic concern, i.e., the tendency to be compassionate toward people who have failed, (2) personal distress, i.e., the tendency to experience anxiety, distress, or discomfort in response to strong negative experiences of other people, and (3) perspective taking, i.e., the ability to "go beyond oneself" when communicating with other people. Empathic concern and personal distress refer to emotional empathy, while perspective taking refers to its cognitive aspect. The internal consistency of the scale is good, with Cronbach's α coefficients ranging from 0.74 to 0.78.

(3) The *Secondary Trauma Self-Efficacy* (STSE) scale was developed by Cieślak et al. [34] to assess the perceived ability to cope with the challenging demands resulting from working with traumatized clients and dealing with secondary traumatic stress symptoms. The STSE consists of seven items (e.g., "How capable am I to deal with my emotions [anger, sadness, depression, anxiety] about working with these people"). The participants indicate their responses on a 7-point Likert-like scale, ranging from 1 ("very incapable") to 7 ("very capable"). The STSE is a reliable one-factor scale, with a Cronbach's α coefficient of 0.87 [34].

Statistical Analysis

The data were analyzed using IBM SPSS, version 25. The distributions of the data met the requirements for normality. In the first step of the analysis, means and standard deviations were calculated, and Pearson correlation coefficients were used to establish relationships between variables. Following this, stepwise regression analysis was used to identify the predictors of STS. Finally, the mediating role of secondary trauma self-efficacy in the relationship between empathy and secondary traumatic stress was established using the PROCESS procedure.

Results

Means and standard deviations (*M, SD*) of STS, empathy, secondary trauma self-efficacy, and correlation coefficients between variables are presented in Table 1.

Table 1. **Means, standard deviations and correlation coefficients between variables**

Variables	1.	2.	3.	4.	5.	6.	7.	8.	9.
M	19.96	5.02	1.87	6.54	6.52	34.94	19.61	32.67	39.00
SD	12.48	3.18	1.40	4.59	4.63	6.16	4.77	4.39	4.79
1. STS – total	-								

table continued on the next page

2. Intrusion	0.88***	-							
3. Avoidance	0.74***	0.65***	-						
4. Negative changes in cognition and mood	0.95***	0.79***	0.63***	-					
5. Increased arousal and reactivity	0.93***	0.70***	0.61***	0.84***	-				
6. Empathic concern	0.60***	0.58***	0.42***	0.59***	0.51***	-			
7. Personal distress	0.09	0.08	0.07	0.00	0.05	0.29**	-		
8. Perspective taking	0.47***	0.50***	0.39***	0.44***	0.39***	0.58***	-0.03	-	
9. Secondary self-efficacy	-0.31***	-0.26**	-0.25**	-0.33***	-0.26**	-0.22*	-0.43***	-0.01	-

M – arithmetic mean; *SD* – standard deviation; ***$p < 0.001$; **$p < 0.01$; *$p < 0.05$

The studied therapists, working with addicted clients, revealed a low intensity of STS symptoms. Assuming a cut-off point of 33 for the STSI, as indicated by Ogińska-Bulik and Juczyński [14], only 18 (15.7%) showed a high level of STS, indicating high risk of STSD, and 97 participants (84.3%) reported a low level of STS, indicating low risk of STSD. No significant difference in STS was found between men ($M = 21.63$, $SD = 13.61$) and women ($M = 17.68$, $SD = 10.15$, $t = – 1.54$). STS was negatively related to length of work experience ($r = – 0.23$, $p < 0.01$), but it was not associated with age ($r = – 0.04$).

The surveyed group of therapists working with individuals with addiction showed a slightly higher intensity across all three aspects of empathy compared to therapists helping other groups of clients [14]. The level of secondary self-efficacy related to trauma exposure among the studied therapists was slightly lower than that observed in mental health care providers working with returning soldiers in the USA [34] and in Polish police officers working with people after traumatic events [40].

Two of the three aspects of empathy considered in the study, i.e., empathic concern and perspective taking, were positively associated with STS and all of its symptoms, indicating that they may contribute to the occurrence of STS. In turn, personal distress was not related to STS. Secondary self-efficacy was negatively related to STS and all of its symptoms, which indicates that belief in the ability to

cope with clients' trauma may protect against the development of negative effects of indirect exposure to trauma.

The next stage of the analysis assessed the predictors of STS. To identify the predictors of the severity of secondary traumatic stress, a multiple regression model was created using the forward stepwise procedure. Only variables significantly correlated with the severity of STS were included in the model, i.e., two aspects of empathy (empathic concern and perspective taking), secondary self-efficacy, and work experience. Tolerance indicators and the VIF parameter were checked, as multicollinearity may occur when the relationship between variables is strong. The basic assumption regarding the use of multiple linear regression was met. The results are presented in Table 2.

Table 2. **Predictors of secondary traumatic stress**

	Beta	Error of Beta	*B*	Error of B	*t*	*p* <
Empathic concern	0.43	0.09	0.86	0.18	4.65	0.001
Secondary self-efficacy	-0.21	0.07	-0.54	0.19	-2.79	0.01
Perspective taking	0.20	0.09	.056	0.26	2.15	0.05
Work experience	0.10	0.07	-0.12	0.09	-1.29	ns
$R = 0.66$; $R2 = 0.44$; $F(4, 110) = 2251$; $p < 0.001$						

Beta – standardized regression coefficient; *B* – unstandardized regression coefficient

The predictors of STS were found to be two aspects of empathy and secondary self-efficacy. Together with work experience, these variables explain 44% of the variance of the dependent variable. Empathic concern has a greater contribution, explaining 36% of the variance, while secondary self-efficacy and perspective taking each account for only 4%. These data indicate that a high level of STS may be predicted mainly by a high level empathic concern. The next stage of the analysis examined whether secondary self-efficacy acts as a mediator in the relationship between empathy and STS in therapists exposed to secondary trauma. The bootstrapping procedure proposed by Preacher and Hayes [41] was used. A mediating effect occurs when an intermediary variable lowers the predictive value of an independent variable on a dependent variable. A 95% confidence interval was assumed for the analysis. For each path in the mediation models, standardized β coefficients were calculated. The conducted mediation analysis revealed only one significant model, which involved empathic concern (Figure 1).

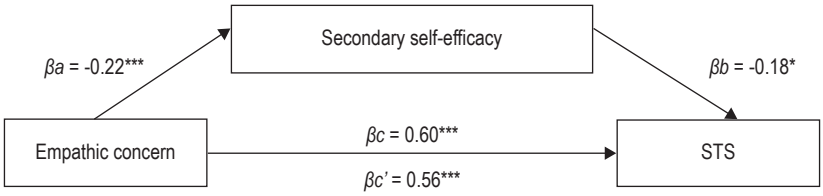

Figure 1. **The mediating role of secondary self-efficacy in the relationship between empathic concern and secondary traumatic stress**

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

Empathic concern was found to be a positive predictor of STS and a negative predictor of secondary self-efficacy, which in turn was a negative predictor of STS. The effects of empathic concern on STS were reduced when secondary self-efficacy was used as a mediator, although it remained statistically significant. The result indicates partial mediation.

Discussion

There is an ongoing need for research into the effects of indirect exposure to trauma among therapists, as their health status can significantly influence both the effectiveness of therapy and the recovery of their clients. However, one should remember about the costs of helping, which do not apply only to the helpers themselves: the presence of STS in therapists can also affect their clients, family members, friends, acquaintances, and significant others [19]. The obtained research results indicated a relatively low severity of STS among therapists working with individuals with addiction who had been exposed to trauma. This confirms the findings of previous research, which show that therapists are less susceptible to secondary traumatic stress compared to other professionals [14].

Secondary traumatic stress was positively related to two aspects of empathy, i.e., empathic concern and perspective taking, and negatively related to secondary self-efficacy. All three mentioned variables served as predictors of STS. The results show that empathy, expressed as the tendency to feel compassion for people who have experienced failure and the ability to "go beyond oneself" when communicating with others, increases the risk of negative effects resulting from indirect exposure to trauma. Hence, both emotional and cognitive forms of empathy may contribute to the development of STS; however, a greater role should be attributed to empathic concern. The results support the claims made by Figley [19], who proposed that empathy, expressed mainly as empathic concern, is the main risk factor for secondary traumatization. This was also confirmed by the results of the present mediation analysis, which indicated that the inclusion of secondary self-efficacy as a mediator did not significantly affect the rather strong relationship between empathic concern and STS.

Our findings are also consistent with other data. A positive relationship was found between empathy and the negative effects of indirect exposure to trauma among trauma workers in South Africa [23], and among mental health professionals [25]. STS was positively related to all three aspects of empathy in a group of therapists, and to empathic concern in a group of Polish clergymen supporting or accompanying individuals who have experienced traumatic situations [22].

Our results confirm that empathy plays a paradoxical role in therapists. Working as a therapist requires empathy, which involves concern for others, understanding their feelings, compassion, and emotional co-expression. In other words, without empathy, there is no emotional resonance and no effective help. However, while empathy increases therapeutic effectiveness, it can also increase the risk of developing STS. This may suggest that, in order to protect their own mental health, therapists should temper their level of empathy when working with individuals after traumatic experiences – at least to some extent, but not so much as to reduce the effectiveness of their work.

It should also be noted that an inverse relationship between the variables is possible, i.e., persistent STS symptoms may lead to a significant decrease in the level of empathy and development of burnout, which in turn would result in negative consequences for patients. Therapists who have experienced secondary traumatic stress, as Robinson-Keilig [42] points out, have been found to be at risk of doing harm to their clients through non-empathic distancing, victim blaming, poor professional judgment, or the use of ineffective therapy.

Despite proving to be a poor predictor of STS and only a partial mediator in the relationship between empathy and STS, secondary self-efficacy nevertheless seems to play a protective role against the negative effects of indirect exposure to trauma, which is consistent with the expectations and findings from other studies [31, 33, 34, 36]. Its protective role may stem from its association with other beliefs that predict various health-related outcomes, including beliefs about the world, the self, or one's sense of control over the environment [30]. This protective role of secondary self-efficacy may also result from its association with other personal resources that therapists may have, such as resilience, self-esteem, or optimism. It is worth noting that self-efficacy is a cognitive coping strategy – one that can be modified to bolster its protective function against the negative consequences of indirect exposure to trauma.

However, it is important to note that secondary self-efficacy appears to have a limited protective role. It is possible that the surveyed therapists working with clients with addiction show slightly lower confidence in their own effectiveness in coping with trauma experienced by others than other professionals helping individuals after traumatic experiences. As indicated earlier, the studied therapists exhibited slightly lower secondary self-efficacy compared to mental health care providers working with returning soldiers in the USA [34] and Polish police officers working with individuals

after traumatic events [40]. It should also be taken into account that there are many other factors that may determine the severity of STS in professionals exposed to indirect trauma, including poor work engagement and low job satisfaction.

Limitations and implications for practice

The present study has certain limitations. First of all, it was a cross-sectional design, which does not allow for conclusions to be drawn about causality of the identified relationships. Furthermore, the examined group of therapists was not very large, and the majority of respondents were women; therefore, our findings cannot be generalized to all therapists working with individuals with addiction. Finally, there was no analysis of the traumatic events experienced by the clients or of their timing, nor was the impact of traumatic events directly experienced by the therapists themselves taken into account, which could have influenced the obtained results.

Despite the indicated limitations, our findings contribute new insights regarding the scope of conditions concerning the negative consequences of indirect exposure to trauma in therapists working with clients with addiction who have experienced traumatic events; a key finding is the importance of empathy. An advantage of the study is that it provides insight into a less frequently studied group of professionals. It also employed a new measurement tool – the Secondary Traumatic Stress Inventory, based on DSM-5 criteria.

Our findings may provide inspiration for further research into other cognitive indicators that may be associated with STS, such as challenges for core beliefs or ruminating about the clients' experiences. Organizational factors, such as workload, work engagement, and job satisfaction, and their relationships with STS also seem important, as do the personality characteristics of therapists. Additional ideas for further research include longitudinal studies that would make it possible to capture changes in STS over time.

One practical implication of this research is that the findings may be used to support the development of preventive programs aimed at reducing STS in professionals working with individuals with addiction after traumatic events. Clinical supervision has been suggested as a promising workforce development strategy to help therapists gain a deeper understanding of clients and increase client-therapist communication [3]. It would also be beneficial to broaden trauma management competence to include increasing secondary self-efficacy. While it is important to be able to maintain a distance between the help giver and the client, it also necessary to implement practices aimed at self-care. Self-care is an important factor that enhance the ability of professionals working with trauma survivors to effectively assist others and improve the quality of their work and personal lives [43, 44].

Conclusions

Symptoms of secondary traumatic stress occurring in therapists exposed to indirect trauma may include, among others, the result of a high degree of empathic concern. In turn, a high level of secondary self-efficacy seems to protect against the development of STS. Although therapists working with clients with addiction are less prone to the negative effects of secondary trauma compared to other professionals, they should nevertheless endeavour to protect their own mental health; therefore, they should aim to develop competences in dealing with secondary trauma. In addition, they should be encouraged to utilize all possible forms of social support. These may not only reduce the severity of STS but also increase the likelihood of secondary positive posttraumatic changes, expressed in the form of vicarious posttraumatic growth.

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