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Secondary posttraumatic growth among therapists working with addicted people after traumatic events – the role of empathy and secondary self-efficacy

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Aim of the study: Professionals working with people after traumatic events may experience positive posttraumatic changes, occurring in the form of secondary posttraumatic growth (SPTG). The occurrence of SPTG may be determined by empathy and secondary self-efficacy. The purpose of this study was to establish the associations between empathy, secondary self-efficacy and SPTG, including the mediating role of secondary self-efficacy in the relationship between empathy and SPTG.

Subject or material and methods: The study group comprised 130 therapists working with clients with addiction: substance abusers and behavioral addicts. In total, the results of 115 respondents were analyzed: age 22 to 69 years (M=40.79, SD=10.57), 61.7% were women. The Secondary Posttraumatic Growth Inventory (SPTGI), the Empathic Sensitivity Scale (EES) and the Secondary Trauma Self-efficacy (STSE) Scale were used.

Results: A high level of SPTG was presented by 34% of respondents; 45% reported an average level and 21% a low level. SPTG was associated with two of three aspects of empathy (empathic concern and perspective taking) and secondary self-efficacy. Secondary self-efficacy increases the positive effect of empathy on SPTG.

Discussion: Among therapists working with addicted clients who have experienced traumatic events, higher empathic engagement and secondary self-efficacy beliefs seem to favor the occurrence of secondary positive posttraumatic changes

Conclusions: A greater ability to notice positive post-traumatic changes may increase the effectiveness of the therapist's work.

empathy; indirect exposure to trauma; secondary posttraumatic growth; self-efficacy; therapists

INTRODUCTION

Secondary posttraumatic growth

When working with people who have undergone traumatic experiences, professionals for instance therapists, are themselves exposed to trauma, but of indirectly. In such cases, they may also suffer from the negative consequenc-

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es of this indirect trauma, expressed in the form of secondary traumatic stress (STS); this can be seen as the equivalent of posttraumatic stress disorder (PTSD) experienced following direct exposure to trauma.

The professionals experiencing indirect trauma may also see positive changes resulting from helping others. In such cases, they can experience secondary posttraumatic growth (SPTG), also known as vicarious posttraumatic growth (VPTG) or professional posttraumatic growth [1]. This phenomenon is defined as deriving meaning and developing positive changes through a vicarious traumatic exposure [2]. Such growth is also treated as a result of witnessing the resilience displayed by a client and their ability to overcome adversity [3,4] According to Berger [3] witnessing positive changes in direct survivors who effectively cope with experienced trauma can trigger the same changes in others associated with them and with whom they have close relationships. SPTG is also related to *compassion satisfaction*, which can be regarded as the opposite of compassion fatigue. Compassion satisfaction is the term given to the positive aspect of clinical work with clients who have experienced trauma and refers to the positive feelings derived from helping others [5,6].

The positive changes included in SPTG are equivalent to those ascribed to the posttraumatic growth (PTG) experienced by people who have themselves been victims of trauma. They concern changes in self-perception, relationships with others and philosophy of life [2,7-10]. The occurrence of these changes has been confirmed by interviews conducted with therapists working with victims of violence-related trauma [2,11]; these indicate that respondents manifested greater sensitivity and compassion, greater self-confidence, increased tolerance and empathy, a better understanding of trauma victims, greater acceptance of their reactions and behaviours, and a more accurate recognition of their ability to cope effectively. Some of the surveyed therapists emphasized that, as a result of working with traumatized clients, they began to appreciate their own lives more. Most of the respondents also noticed spiritual changes, manifested mainly in deepened faith. They also emphasized that these spiritual changes contributed to the expansion and deepening of their own spirituality and religiosity.

However, it should be noted that despite the similarities between SPTG and PTG, some differences exist between these phenomena. Arnold et al. [2] indicates that people experiencing SPTG exhibit slightly greater overall resistance than those with PTG; however, they also display slightly less change in their sense of personal strength. Some differences are also possible regarding changes in the spiritual domain: those who directly experience traumatic events tend to indicate a personal increase in spirituality, while those who help trauma victims report their spirituals broadening, expressed in a general acceptance of what cannot be changed. There are also some aspects unique to SPTG, for instance increasing awareness of work as a value, the need to increase professional capabilities and competences, or job satisfaction, as a result of witnessing the clients' growth [4,10,12,13].

Vicarious growth after trauma is often explained using models developed for posttraumatic growth, particularly the functional-descriptive model of PTG developed by Tedeschi and Calhoun [14] and Tedeschi et al. [15], which draws on cognitive psychology and the existential approach. The model assumes that PTG occurs when, following trauma, people experience changes in their perception of themselves and the world; this results in a deeper understanding of the experienced traumatic events and the changes their ability to give them meaning. The authors emphasize that this process is complex and includes stages of stagnation or even regression, indirectly indicating that the experienced trauma can yield both positive and negative consequences.

The VPTG in trauma workers model, developed by Cohen and Collens [16], see also: Ogińska-Bulik & Juczyński [9-10] indicates that professionals working with trauma victims also experience positive changes concerning their beliefs about the world and self, their personal values and everyday life. As a result of working with traumatized people, these professionals, may display high resistance to traumatic events, an increase in compassion, wisdom, self-awareness, self-esteem and self-confidence, greater value of life, and assign greater importance to family and friends. According to Cohen and Collens [16], these positive effects stem from empathic engagement of helpers in the

problems experienced by the trauma survivors. Such engagement may initially lead to stress and negative emotions; however, using personal resources and taking remedial action, it can reduce stress and lead to growth.

The relationship between empathy, self-efficacy and SPTG

Many factors determine the occurrence of SPTG, including various personal resources, for instance empathy and self-efficacy. Omdahl and O'Donnell [17] define empathy as empathic concern, willingness to communicate and emotional contagion. According to Davis [18], empathy is understood as the reaction of one individual to the observed experiences of another. To provide effective assistance, the therapist must demonstrate empathic concern and involvement in the client's problems, and this may be contributed to the occurrence of positive post-traumatic changes, revealed in the form of SPTG [7] or compassion satisfaction [19].

Research conducted among professionals exposed to indirect trauma, including therapists, has confirmed a positive relationship between empathy and SPTG [9,20-22]. Empathy appeared to be a positive predictor of SPTG and all its factors, except changes in the spiritual sphere, in a group of therapists working in private clinics and the public sector [7].

Empathy was also positively correlated with compassion satisfaction among school counselors exposed to indirect trauma [23]. However, O'Sullivan and Whelan [24] did not identify any significant association between empathy and the level of SPTG in telephone counselors. As such, the precise role of empathy in the development of positive effects following indirect exposure to trauma remains unclear. It is worth remembering that empathy is a risk factor for the occurrence of STS [9,20,25].

It is also worth emphasizing that while empathy can influence SPTG directly, it can also indirectly affect it through cognitive aspects, including cognitive coping strategies with trauma. A study of three professional groups exposed to secondary trauma (therapists, social workers, probation officers) conducted by Ogińska-Bulik and Michalska [22] showed that positive cognitive restructuring and resolution/acceptance strategies were mediators of the relationship between empathy and SPTG. Also, Wong and Yeung [26] indicate that cognitive processing of trauma played a mediating role in the relationship between self-compassion and the occurrence of growth after trauma.

Another factor that seems to be positively related to SPTG is self-efficacy, a term that refers to perceptions of one's ability to overcome problems and realize certain actions required to perform successfully in life [27]. It may influence vulnerability to stress, motivations to persevere in difficult situations, resilience to adversity, and the decisions and actions a person may make in life [28]. Self-efficacy seems to have a fundamental role in the process of adaptation to trauma. Social cognitive theory implies that strong self-efficacy may enable individuals to identify important opportunities for promoting individual growth [27-29].

However, what seems to play a particularly important role in secondary positive posttraumatic change is not so much generalized self-efficacy, but the specific form, defined as secondary trauma self-efficacy (STSE). It is understood as "the perceived ability to cope with the challenging demands resulting from work with traumatized clients and perceived ability to deal with the secondary traumatic stress symptoms" [29, p. 918]. However, few studies have examined the relationships between STSE and SPTG.

In a group of nurses and doctors, it was found that a high sense of professional competence and a high assessment of work values, which can be identified with self-efficacy beliefs, positively correlated with SPTG [30]. Compassion satisfaction and high work value ratings were associated with SPTG among social workers [31].

Secondary self-efficacy was positively related to SPTG in a group of mental health care providers working with returning soldiers in the USA, although this relationship was weak [29]. A positive association was found between secondary self-efficacy and compassion satisfaction in a group of school counselors exposed to indirect trauma [23].

Additionally, Shoji et al. [32] found that the relationship between secondary traumatic stress at Time 1 and secondary posttraumatic growth at a later point (Time 2), was mediated sequentially

by secondary trauma self-efficacy at Time 1 and social support at Time 2. The results suggest that enhancing self-efficacy assists the process of adaptation after indirect exposure to trauma. However, in a study of police officers working with people impacted by trauma, secondary self-efficacy was not correlated with SPTG [33]. This indicates a need for further research in this area, especially since there is no research on therapists working with addicts who have experienced traumatic events.

The aim of the present study was to establish the level of secondary posttraumatic growth in a group of therapists working with addicted clients who had experienced traumatic events. It also examines the links between SPTG and empathy and secondary self-efficacy and evaluates the mediating role of secondary self-efficacy in the relationship between empathy and SPTG. The study is based around a model of PTG [14-15,34] that indicates that both personality predispositions, and cognitive activity play a significant role in the occurrence of positive posttraumatic changes. It is also in line with the VPTG in trauma workers model by Cohen and Collens [16], emphasizing the role of empathic involvement, and social cognitive theory which implies that strong self-efficacy may promote posttraumatic growth [27-29].

METHODS

The study participants were recruited online, or via e-mails sent to several substance abuse inpatient and outpatient treatment units in Poland. After receiving prior initial approval of the study, the measurement tools were sent, and later collected, by the authors, or persons trained by the authors. The study involved 130 therapists who had worked with addicted clients. For inclusion in the study, all participants had to have had at least one year's experience of working with addicts (substance and/or behaviors), who had experienced traumatic events in their life. The respondents were informed about the purpose of the study, its anonymity and voluntary nature. From this group, 115 therapists, that is 71 (61.7%) women and 44 (38.6%) men, completed the delivered questionnaires, met the inclusion criteria, and were qualified for analysis. The age of the respondents ranged from 22 to 69 years (M=40.79, SD=10.57) and their work experience from 1 to 40 years (M=12.27, SD=9.75). Most of the therapists (95%) had worked with clients demonstrating various forms of addiction, for instance drugs, gambling and shopping, but mainly alcohol; only 5% had specialized in a particular form of addiction, for instance alcohol or drug addiction.

The participants completed 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. Additionally, three standard measurement tools were used.

The first was the Secondary Posttraumatic Growth Inventory (SPTGI), developed by Ogińska-Bulik and Juczyński [35]. It was designed to measure positive posttraumatic changes related to exposure to indirect trauma in professionals. The tool contains 12 statements ("I have learned to accept others more") assessed by participants on a 6-degree scale. The SPTGI measures four factors, namely (1) New challenges and increased professional skills, (2) An increase in spiritual experiences and a sense of responsibility for others, (3) Greater self-confidence and appreciation of life, and (4) An increase in acceptance and acting for the benefit of others. Each factor is composed of three statements. The tool obtained very good indicators for reliability, expressed by Cronbach's α coefficient: .90 for the overall scale and .71, .85, .89, and 0.87 for the four respective individual factors.

The Empathic Sensitivity Scale (ESS) is a modification of the Interpersonal Reactivity Index. It was developed by Kaźmierczak et al. [36] based on Davis's theory of empathy [18]. It contains 28 items evaluated on a five-point scale, covering three aspects of empathy: 1. empathic concern, that is the tendency to be compassionate with people who have failed, 2. personal distress, that is the tendency to experience anxiety, distress, or discomfort in response to strong negative experiences of other people, 3. perspective taking, understood as the ability to "go beyond oneself" when communicating with other people. Empathic concern and personal distress refer to emotional empathy, and perspective tak-

ing to its cognitive aspect. The Cronbach's alpha score is of 0.74 to 0.78, what indicates for good reliability.

The Secondary Trauma Self-Efficacy (STSE) is a tool developed to assess one's perceived ability to cope with the challenging demands resulting from working with traumatized clients and dealing with secondary traumatic stress symptoms. It consists of seven items ("How capable I am to deal with my emotions [anger, sadness, depression, anxiety] about working with these people"). The participants are asked to indicate their responses on a seven-point Likert-like scale, ranging from 1 (very incapable) to 7 (very capable). The tool includes a single factor and obtains good internal consistency, with a Cronbach's alpha score of 0.87 [29].

STATISTICAL ANALYSES

The data was analysed using IBM SPSS, version 25. The distributions of the data met the requirements for normality. Means, standard deviations and Pearson correlation coefficients were calculated. Following this, the PROCESS procedure was used to confirm the mediating role of secondary self-efficacy in the relationship between empathy and SPTG, including the factors of SPTG.

RESULTS

The descriptive statistics (M, SD) regarding SPTG, empathy, secondary 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	32.98	9.05	3.94	9.79	9.19	34.93	19.61	32.67	39.00
SD	10.66	3.15	3.22	3.35	3.36	6.15	4.77	4.39	4.79
1. SPTG – total	–								
2. Factor 1	.82***	-							
3. Factor 2	.62***	.23**	-						
4. Factor 3	91***	.73***	.43***	–					
5. Factor 4	.89***	.72***	.38***	.79***	-				
6. Empathic concern	22*	.14	.12	.24**	.25**	–			
7. Personal distress	-.02	-.12	.14	.03	-.10	.29**	–		
8. Perspective taking	.26**	.25**	-.02	.25**	.31***	.58***	– .03	-	
9. Secondary self-efficacy	.15	.23*	-.07	.10	.21*	– .22*	– .43***	-.01	-

Notes:

Factors: 1. New challenges and increased professional skills; 2. An increase in spiritual experiences and a sense of responsibility for others; 3. Greater self-confidence and appreciation of life; 4. An increase in acceptance and acting for the benefit of others

p – significance level

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

The therapists participating in the study generally demonstrated an average intensity of SPTG (M=32.98, SD=9.05). According to norms developed for SPTGI [35] 24 participants (20.9%) reported a low level of SPTG, 52 (45.2%) an average level and 39 (33.9%) a high level. No significant difference in SPTG was found between men (M=33.11, SD=9.79) and women (M=31.28, SD=11.71, t=0.89). SPTG was not associated with age (r=0.14) or work experience (r= 0.16).

The therapists showed a slightly higher level of all three aspects of empathy than a group of professionals working with trauma survivors studied by Ogińska-Bulik and Juczyński [9]. They also demonstrated a slightly lower level of secondary self-efficacy than mental health care providers working with returning soldiers in the USA [29] and by Polish police officers working with people after traumatic events [33].

Two of the considered three aspects of empathy, *viz.* empathic concern and perspective taking, appeared to be positively associated with SPTG and some of its domains. Personal distress was not related to SPTG. Additionally, two aspects of empathy, *viz.* empathic concern and personal distress, are negatively correlated with secondary self-efficacy. Secondary self-efficacy appeared not to be associated with SPTG, but it was related to two factors of SPTGI: Factor 1. New challenges and increased professional skills and Factor 4. An increase in acceptance and acting for the benefit of others.

The next stage of the analysis checked the intermediary role of secondary self-efficacy in the relationship between empathy and SPTG using the bootstrapping procedure proposed by Preacher and Hayes [37]. A mediating effect occurs when an intermediary variable (here secondary self-efficacy) lowers the predictive value of an independent variable (empathy) regarding a dependent variable (SPTG). In turn, suppression is indicated when the intermediary variable increases the predictive value of the independent variable regarding the 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 one significant model regarding SPTG total, referring to empathic concern (Fig. 1a), and another model regarding one domain of SPTG, which also refers to empathic concern (Fig. 1b).

Empathic concern and secondary self-efficacy appeared to be positive, albeit poor, predictors of SPTG (total) and factor 4 (An increase in acceptance and acting for the benefit of others). In both cases, empathic concern was a negative predictor of secondary self-efficacy. The introduction of secondary self-efficacy increased the strength of the relationship between empathic concern and SPTG; this indicates suppression, and that the introduction of this variable increased the positive effect of empathic concern on SPTG.

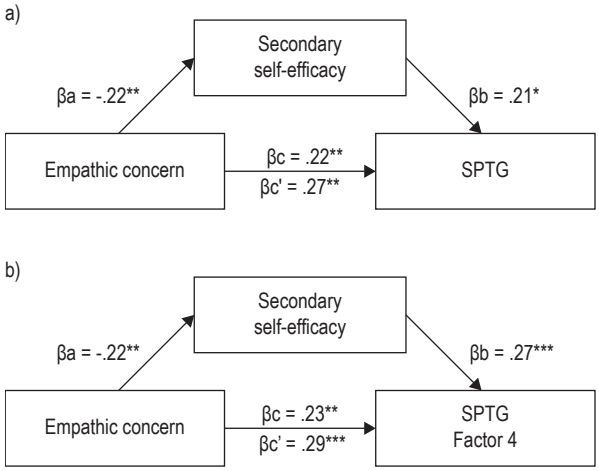

Figure 1. Models of relations between Empathic concern, Secondary self-efficacy and Factor 4 SPTG

Notes:

βa, βb – indirect effect; βc – total effect; βc' – direct effect

p – significance level

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

DISCUSSION

The effectiveness of therapy and the recovery of a client may be substantially influenced by the state of mental health of the therapist, or of other professionals. As such, there is a need to better understand the effects of indirect exposure to trauma.

Our findings confirm that the examined therapists had experienced positive effects of indirect exposure to trauma while working with addicts after traumatic events, although to varying degrees. More precisely, 34% of respondents showed a high level of SPTG, while 45% of therapists reported an average level and 21% a low level. These data are similar to those obtained in other Polish studies involving therapists and other professionals exposed to indirect trauma [9,17,22]. No significant difference in the degree of secondary positive posttraumatic changes was noted between men and women. SPTG was not associated with age or work experience.

Two of three aspects of empathy, *viz.* empathic concern and perspective taking, positively correlated with SPTG and its some domains. This indicates that a higher tendency to be compassionate with people (empathic concern) and the ability to "go beyond oneself" when communicating with other people (perspective taking) is associated with greater SPTG. It worth mentioning that both the emotional and cognitive aspects of empathy were positively related to secondary positive posttraumatic changes. The lack of re-

lationship between personal distress and SPTG seems understandable: experiencing distress, negative emotions or discomfort in response to traumatic experiences of other people is not conducive to perceiving the positive changes resulting from helping them.

The obtained data on relationships between empathy and SPTG are similar to those obtained from other studies concerning therapists and other professionals exposed to indirect trauma. For example, SPTG was also found to have a positive relationship with empathic concern and perspective taking, but not with personal distress, in a study including women representing therapists, social workers and probation officers helping victims of trauma related to violence [22]. Perspective taking also appeared the predictor of SPTG in a group of therapists in research conducted by Juczyński et al. [20].

While appreciating the positive impact of empathy on the occurrence of secondary positive post-traumatic changes, we should not forget that empathy also promotes the occurrence of negative changes expressed in the form of STS, as indicated by numerous studies [9,17,20,25].

It is also worth noting that empathic concern and personal distress appeared to be negatively correlated with secondary self-efficacy. This result seems interesting. This may suggest that empathic involvement in the problems experienced by the clients and their negative emotions may inhibit the therapist's belief in their potential to cope with the experienced trauma.

Secondary self-efficacy appeared not related to SPTG total, but it was associated with its two factors: Factor 1. New challenges and increased professional skills and Factor 4. An increase in acceptance and acting for the benefit of others. This indicates that a belief in the ability to cope with trauma experienced by clients may, to some extent, favor the development of positive effects of indirect exposure to trauma by the therapist. The positive role of secondary self-efficacy in SPTG may be an effect of its association with other cognitive efforts that can predict various health-related outcomes, for instance beliefs about the world and self, or a sense of control over the environment. It may also result from its association with personal resources possessed by the therapist, for instance resiliency, self-esteem or optimism, or satisfaction with work and life. This seems to be confirmed by the results obtained in a group of Polish psychotherapists [38], which indicate a positive relationship between generalized self-efficacy and life satisfaction.

However, it should be noted that available data do not provide a clear picture of the relationship between secondary self-efficacy and SPTG. Self-efficacy, measured with the STSE Scale, was found to be positively, but poorly, associated with SPTG in a group of mental health care providers working with returning soldiers in the USA, although this relationship was weak [29]. In turn, it did not appear to be related with SPTG in a group of police officers exposed to secondary trauma [9]. It is possible that the perceived ability to deal with trauma experienced by others plays a greater role in preventing the negative consequences of secondary trauma exposure than in yielding positive effects.

The presented research is not without limitations. Its cross-sectional nature does not allow conclusions to be drawn about cause-and-effect relationships. Also, as the surveyed group of therapists was not very large and the majority of respondents were women, the findings cannot be generalized to all therapists working with people with addiction. Additionally, there was no analysis of the traumatic events experienced by the clients or when they occurred, nor of any traumatic events directly experienced by the therapists, which could have influenced the obtained results.

Despite the mentioned limitations the findings bring new content regarding the scope of conditions concerning the positive consequences of indirect exposure to trauma among therapists working with addicted clients who have experienced traumatic events. Our findings confirm that both empathy (except its personal distress aspect) and secondary self-efficacy are important for the occurrence of SPTG. A key advantage of this study is that it provides an insight into a less frequently studied professional group, that is therapists, and that it used a new measurement tool intended for examining professionals exposed to indirect trauma, the Secondary Posttraumatic Growth Inventory. It should also be emphasized that most research on indirect trauma focuses on the negative effects, and little research examines its positive consequences.

Our findings may provide inspiration for further research into other determinants of SPTG in therapists working with addicts after traumatic experiences, especially since knowledge regarding secondary posttraumatic changes in this professional group has been very limited. This research may concern cognitive variables, for instance challenges for core beliefs, ruminating about the clients' experiences or cognitive coping strategies, as well as other personal resources, including personality traits and also organizational factors, for instance workload, job engagement and work satisfaction. Longitudinal studies would also seem desirable to capture changes in SPTG.

It is also worth paying attention to the practical importance of the research, especially considering that it is possible to modify self-efficacy. Enhancing self-efficacy may help the process of adaptation after indirect exposure to trauma: it can not only protect against the negative effects of secondary exposure to trauma, but also promote its positive consequences. As such, it would be beneficial to broaden trauma management competence among therapists, including increasing secondary self-efficacy. It is also worth expanding the empathic abilities of therapists, while not forgetting that empathy is also a risk factor for the development of secondary traumatic stress. It is also worth remembering about other factors that may contribute to the occurrence of secondary positive posttraumatic changes, for instance social support and self-care practices.

CONCLUSIONS

Therapists working with addicted people after traumatic events have experienced secondary positive posttraumatic changes to a similar extent as other professionals exposed to indirect trauma. Empathy and secondary self-efficacy favour the occurrence of SPTG. Additionally, secondary self-efficacy appears to increase the positive effects of SPTG.

Greater empathy and greater confidence in the ability to cope with the trauma experienced by their clients favour the occurrence of secondary positive posttraumatic changes among therapists. In turn, the occurrence of SPTG in therapists may increase their job and life satisfaction and improve the efficiency of their work.

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