

# Reducing the Cost of Caring: Indirect Trauma Exposure on Mental Health Providers

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Most mental health clinicians treating trauma survivors are exposed to repeated details of clients' traumatic experiences, and some of these clinicians may experience symptoms of indirect trauma through vicarious traumatization (VT), which has the potential of negatively impacting professional quality of life (ProQOL). The ProQOL Scale was developed to measure both negative and positive effects of working with those who have experienced traumatic stress. The purpose of this study was to determine if clinicians who are trained in eye movement desensitization and reprocessing (EMDR) therapy, as compared to trauma-focused cognitive behavioral therapy (TF-CBT) and prolonged exposure (PE), would relate to aspects of their ProQOL differently. Second, it was hypothesized that the ProQOL model would predict VT in TF-CBT and PE clinicians, but not in EMDR therapy clinicians. Fifty-four trauma clinicians who reported their primary modality of treatment as EMDR, PE, and TF-CBT were studied. Participants completed a survey that included demographic information, the ProQOL Scale, and the Vicarious Trauma Scale (VTS). Hierarchical ordinary least squared regression revealed that the empirical ProQOL model did not predict VT scores in EMDR therapy clinicians as it did for non-EMDR therapy clinicians. This study implies that there could be aspects of the EMDR therapy methodology that may support a clinician's healthy worldview when empathetically bonding with traumatized clients, thereby fostering longevity for both clients and clinicians.

**Keywords:** EMDR; vicarious traumatization; professional quality of life; mental health providers; compassion fatigue; compassion satisfaction

**W**ith the growing body of knowledge and treatment for clients with posttraumatic stress disorder (PTSD), the notion that the psychological effects of traumatic events, such as childhood sexual abuse, domestic violence, war, and terrorism, reach beyond those who are directly exposed is not new (Bride et al., 2007; Hunt, 2018; Molnar et al., 2020). Over the past 20 years, researchers have known that the professional quality of life (ProQOL) of those working with trauma survivors is at risk (Stamm, 2010; Zaccari, 2017). Although

working with traumatized populations can be a rewarding profession, the emotional demands of the work can negatively impact the practitioner in a chronic way (Kapoulitsas & Corcoran, 2015; Kinman & Grant, 2020). Despite the prompts for self-care practices, the current literature suggests there is limited research to suggest what factors need to be considered to offset the risk of vicarious traumatization (VT) in trauma-treating mental health practitioners.

In the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, criterion A was only met if

a person directly experienced or witnessed an event (*DSM-IV*; American Psychiatric Association [APA], 1994). However, the diagnostic criteria for PTSD in both *DSM-5* (APA, 2013) and the *DSM-5* text revision (*DSM-5-TR*; APA, 2022) have made explicit that repeated exposure to the aversive details of a traumatic event during the course of one's professional duties qualifies as a criterion A stressor (Hensel et al., 2015). The *DSM-5-TR* lists examples of this criterion A stressor as first responders collecting human remains and police officers repeatedly exposed to details of child abuse (APA, 2022). Similarly, when treating trauma survivors, most mental health clinicians are exposed to listening to repeated details of a client's traumatic experience and may themselves exhibit symptoms characterized by intrusive imagery related to the client's trauma (criterion B), avoidance (criterion C), negative alterations in cognition or mood (criterion D), and hyperreactivity (criteria E) that results in significant functional impairment over 1 month (APA, 2022).

Working directly with traumatized clients is associated with increased symptoms of vicarious traumatization (Lanier & Carney, 2019) and compassion fatigue (CF; Brown et al., 2022; Figley, 1995). A qualitative study of nine counseling psychologists found that all the participants described negative emotional responses to traumatic stories (e.g., horror, anger, sadness, and fear) and feeling overwhelmed by these emotions. Participants also reported more distress themselves, being mistrustful of other people, and being hypervigilant of potential dangers (Merriman & Joseph, 2018). These symptoms of indirect trauma impact the personal and working lives of those affected and extend to the quality of care delivered (Bride et al., 2007; Choi, 2011).

## Vicarious Traumatization

Vicarious traumatization (VT) occurs when there is empathic engagement with a client's trauma, there is exposure of human cruelty to the therapist, and there is a re-enactment of said trauma within the therapeutic setting (Adams & Riggs, 2008). This results in a profoundly negative shift in the trauma clinician's cognitive schemas about themselves, others, and the world (Bride et al., 2007; Dunkley & Whelan, 2006; Hensel et al., 2015; Pearlman & Mac Ian, 1995). The concept of VT was first coined by McCann and Pearlman (1990) and is estimated to affect 45.9% of mental health counselors. The current literature confirming the negative impact of VT calls for preventative interventions and developments to be made on behalf of trauma-treating clinicians (Molnar et al.,

2020) as VT may result in anxiety, suspiciousness, depression, somatization, intrusions, and increased feelings of personal vulnerability if not addressed (Adams & Riggs, 2008; Tabor, 2011).

Mental health clinicians experiencing higher levels of overwhelming exhaustion and professional insufficiency have also been more likely to express an intention to leave the occupation, and patients may have poorer outcomes than those with clinicians who are not affected by VT (Bergman et al., 2015; Jimenez et al., 2021; Raquepaw & Miller, 1989). With professional performance and vocational stability at stake, a better understanding of the professional factors (i.e., theoretical orientation and treatment type) associated with the manifestation and development of adverse effects of VT is necessary. However, little has been explored concerning how a clinician's trauma treatment type and level of VT relate to their professional quality of life. If training in one specific type of trauma treatment can be a way to attenuate adverse outcomes associated with risks of working in the field of psychotherapy, then professional development becomes a necessity rather than an obligation.

## Professional Quality of Life and Vicarious Trauma

In recent years, researchers have been encouraged to examine protective factors in the treatment of trauma as it relates to agency infrastructure provided by employers (Spangler et al., 2012). The gold-standard theory for addressing both positive and negative effects of treating trauma is the concept of Professional Quality of Life (ProQOL; Stamm, 2010). The ProQOL model can be divided into two constructs: compassion satisfaction (CS) and CF. CS is described as the satisfaction individuals derive from performing their work-related tasks and is proposed to offset the negative aspects of their work (Hooper et al., 2010). Conversely, CF is an acute, affective phenomenon that engenders emotional strain on trauma-treating professionals and may resemble clients' symptoms (e.g., avoidance and numbing; Figley, 1995; Rauvola et al., 2019).

In addition to effects of indirect trauma, a recent study revealed that counselors had higher rates of adverse childhood experiences (ACEs) for all 10 adverse experiences measured by the ACEs questionnaire, created to study early childhood trauma and deprivation experiences, than the original Felitti et al. (1998) ACEs study (Brown et al., 2022). For the sample in this study, the authors indicated that 43% scored four or more ACEs (Brown et al., 2022), which may be relevant, as

previous research has revealed that mental health clinicians may be drawn to treating traumatized populations potentially because of their own personal history (Conteh et al., 2017; Leung et al., 2022). ACEs have been shown to be a predictor of compassion fatigue. Emphasizing the positive aspects of ProQOL can represent a protective factor in terms of a clinician's longevity in the field, and VT represents a significant risk factor. Furthermore, VT can be especially detrimental when considering the role of organizational politics (e.g., stressful conditions and workplace bureaucracy), caseload size, and the influx of acute patients who have experienced multiple forms of trauma (e.g., dual diagnosis centers; Garcia et al., 2016; Somoray et al., 2017). As suggested by Grimmet and Galvin (2015), there are multiple factors that must be considered when identifying potential reasons that influence a clinician's decision to continue or discontinue eye movement desensitization and reprocessing (EMDR) as a practice. There are pertaining factors (e.g., previous training and loyalty to other modalities), training factors (e.g., adequacy of training structure, confidence in trainer, and funding of training practices), post-training (e.g., consultation availability and inability to integrate concepts with previously learned modalities), and socioenvironmental factors (e.g., employment setting, lack of supervision/consultation, and employer facilitating participation in EMDR support activities).

### Compassion Satisfaction

Larsen and Stamm (2008) proposed CS to be the sense of accomplishment or joy that mental health professionals gain from doing their jobs well. CS is composed of three elements: (a) the level of satisfaction that a person derives from their job; (b) how well a person feels they are doing in their job, related to the levels of competency and control they feel; and (c) the level of functional and structural social support that a person has (Stamm, 2002).

Herman (1992) reported that mental health professionals working with trauma populations felt a deepened sense of integrity, allowing them to better understand others while also feeling more inspired by their clients' courage. CS has been found to reduce compassion fatigue as it provides motivation, stamina, interest, and a sense of accomplishment in aiding clients to overcome trauma (Bride et al., 2007); suggesting that CS may be the reason that many people enter helping professions. These benefits are heightened performance, positive attitude toward work, enhanced value, or greater hope for positive outcomes (Kulkarni et al., 2013).

### Compassion Fatigue

Mental health professionals are taught to be compassionate and empathic toward their clients. However, to view the world from the perspective of suffering, there is a reasonable probability that they also suffer. This emotional cost to clinicians can be profound and is characterized by CF, which is the experience of exhaustion, anger, and irritability in response to the engagement with clients' trauma narratives (Mathieu & Taylor, 2007). Mental health clinicians experiencing CF may express a jaded outlook on their profession and reduced effort to ameliorate clients' traumatic symptoms, resulting in poorer treatment outcomes (Molnar et al., 2020). Clinicians may also engage in detrimental isolating behaviors, such as decreased consultation with colleagues and decreased support-seeking with friends and family (Naturale, 2015).

Factors found to increase the risk of developing CF include continued exposure to patients' stories, heightened emotions of family members, burnout, trauma-related stress, failure to maintain self-care, and practitioners' empathy levels (Collins & Long, 2003; Figley, 2002; Fox & Carey, 1999; Sodeke-Gregson et al., 2013).

### Trauma Treatments

The literature has suggested that utilization of evidence-based practices produces statistically significant decreases in compassion fatigue (burnout and secondary traumatic stress) and increases in compassion satisfaction (Craig & Sprang, 2010). Nevertheless, few researchers have investigated how being trained in a particular evidenced-based practice for treating trauma can be utilized to mitigate the damaging consequences of indirect trauma. Several different sources have collectively identified the following trauma treatments as the most consistently recommended practices: EMDR therapy, trauma-focused cognitive behavioral therapy (TF-CBT), and prolonged exposure (PE) therapy (Benish et al., 2008; Blankenship, 2017; Cusack et al., 2016; Nisenoff, 2008; Wilk et al., 2013). Thus, the present study will focus on the three treatments for trauma that have been widely studied to be highly effective.

EMDR therapy was developed by Francine Shapiro (2017), and she stated that EMDR therapy is "an interactive, intrapsychic, cognitive, behavioral, body-oriented therapy" whose goal is "to rapidly metabolize the dysfunctional residue from the past and transform it into something useful" (pp. 50). The model on which EMDR therapy is based, Adaptive Information Processing (AIP), posits that much of

psychopathology is due to the maladaptive encoding and incomplete processing of traumatic or disturbing adverse life experiences, which impair the ability to integrate these experiences adaptively. EMDR therapy, via bilateral stimulation (BLS), facilitates the effective reprocessing of traumatic events or adverse life experiences and associated beliefs to an adaptive resolution (Shapiro, 2017).

EMDR therapy consists of a three-pronged approach that works on the past, the present, and the future through an eight-phase model consisting of history taking, preparation, assessment/activation, desensitization, installation, body scan, closure, and re-evaluation (Shapiro, 2017). Additionally, a factor distinguishing EMDR therapy and other trauma treatments is the notion that listening to the trauma narrative is not necessary for a client's remission of symptoms. Not having to hear a client's trauma narrative repeatedly is a potentially protective component. According to McCann and Pearlman (1990) and Pearlman and Saakvitne (1995), it was thought that clinicians' exposure to graphic and traumatic material might influence their level of vicarious traumatization. In comparison, other trauma treatments such as TF-CBT (Cohen & Mannarino, 2015) and PE (Eftekhari et al., 2006) both stated in their manuals that listening to the trauma narrative is an essential step in treating trauma. TF-CBT is a variant of cognitive behavioral therapy (CBT), a therapy aimed at changing the way a person thinks about themselves, others, and the world. This model is composed of psychoeducation, relaxation, affective expression and modulation, cognitive coping and processing, and a trauma narrative.

Moreover, PE therapy is an exposure-based form of CBT that is a set of techniques designed to help patients confront their feared objects, situations, memories, and images (Hembree et al., 2003). This treatment involves education about common reactions to trauma, breathing retraining, development of a hierarchy of feared situations, repeated in vivo exposure to situations or objects that the client is avoiding because of trauma-related distress and anxiety, and repeated, prolonged imaginal exposure to the trauma memories in detail (i.e., revisiting the trauma memory in imagery; Foa et al., 2013). Through in vivo and imaginal exposure, clients are hypothesized to habituate to trauma-related fears and the traumatic memory by repeatedly recounting the memory until their fear declines gradually. Thus, like TF-CBT, PE may also expose a mental health clinician to trauma vicariously due to the repeated and prolonged exposure to the client's trauma memories.

## The Present Study

There is evidence to support that trauma-treating mental health clinicians are negatively impacted (Jimenez et al., 2021), which can be referred to as the "cost of caring." Clinicians experiencing symptoms of VT have a negatively altered worldview and may find it difficult to separate work life and personal life. To address the complexity of the adverse effects of indirect trauma on mental health professionals treating trauma, this study explores the degree that CS, CF, and VT vary as a function of the type of trauma treatment provided. It was hypothesized that clinicians who provide EMDR therapy, as compared to TF-CBT and PE, would have lower scores on VT and CF, as well as higher scores on CS. Additionally, it was hypothesized that the approach of trauma protocols (e.g., extent of sharing trauma narratives in sessions) would influence how trauma-treating clinicians conceptualize the role of therapist-directed, versus client-centered, healing (Zabukovec et al., 2000); therefore, the empirically supported ProQOL model (Stamm, 2010) would predict VT in TF-CBT and PE clinicians, but not in EMDR therapy clinicians.

## Method

### Participants

Approval for this study was obtained from the California State University, Fullerton Institutional Review Board (IRB). There were 54 participants between the ages of 25 and 72 ( $M = 44.91$ ,  $SD = 12.26$ ) recruited through emails, Listserv, and Facebook groups (for demographics, see Table 1). Participants were trained clinicians with years of experience ( $M = 22.21$ ,  $SD = 8.04$ ) in at least one of the following trauma treatments: EMDR, TF-CBT, and PE. Most respondents reported being in supportive work environments with at least three or more supports (85.2%; e.g., workshops, conferences, and support groups) and most respondents (90.7%) also reported engaging in at least three or more self-care activities outside of work.

**TABLE 1. Percentages of Demographic Breakdown of the Participants in the Full Sample**

Factor	Level 1	Level 2	Level 3
Race	White (79%)	Non-white (17%)	Declined to state (4%)
Gender	Female (64%)	Male (30%)	Non-binary (6%)
Work setting	Private practice (59%)	Community MH (35%)	Both (4%)

As such, the presently recruited sample was deemed to be fairly healthy in terms of work–life balance and integrated systems to ease work-related distress.

## Materials

ProQOL is theoretically composed of two constructs, CS and CF and can be measured using the 30-item Scale (ProQOL-5; Stamm, 2005). A combination of high CS and low CF, scores is the most favorable result, and the reverse indicates significant work distress. The ProQOL-5 is a self-report instrument and has a response format ranging from *never* (0) to *very often* (5) and has three subscales: CS, Burnout, and Secondary Traumatic Stress (STS; Heritage et al., 2018; Stamm, 2010). According to Stamm (2010), CF is composed of two associated constructs: Burnout and STS. CS ( $\alpha = .87$ ), Burnout ( $\alpha = .72$ ), and STS ( $\alpha = .80$ ) were all found to have good internal consistency in the normative sample (Stamm, 2005, 2010; Sprang et al., 2019). In the present sample, CS ( $\alpha = .88$ ), Burnout ( $\alpha = .70$ ), and STS ( $\alpha = .78$ ) were also revealed to have acceptable internal consistency.

VT was measured by the Vicarious Trauma Scale (VTS; Vrkleviski & Franklin, 2008), an 8-item self-report survey. The measure is scored on a 7-point Likert scale from *strongly disagree* (1) to *strongly agree* (7). Scores of each of the eight items were summed for an overall score ranging from 8 to 56. In the present sample, the VTS was revealed to have good internal consistency ( $\alpha = .80$ ).

## Procedure

Participants were sent an email that contained an invitation to participate in the study and a link to the informed consent, demographic survey, and the study instruments (administered via Microsoft Forms). The estimated time to complete the survey was 30–45 minutes. One of the initial questions asked participants, “Which form of trauma treatment do you provide?” Eight reported providing more than one of the included trauma treatments and were thus excluded. Each scale represented discrete constructs. Higher scores on the CS scale indicate a higher level of functioning and a greater degree of gratification from one’s ability to be an effective caregiver (Stamm, 2005). Higher scores on the burnout and STS scales indicate that the person is at higher risk for CF (Stamm, 2005). Scores were calculated by reversing the ratings on some items and summing the items for each subscale. Per the recommendations of the ProQOL manual (Stamm, 2010), all scores were converted to standard

scores using the *t*-distribution. Each scale was standardized on a *t*-distribution ( $M = 50$ ,  $SD = 10$ ).

## Results

A large effect size was expected when subjecting VT to the empirically supported ProQOL model. According to G\*Power, a total sample size of 48 was needed to obtain adequate power ( $1-\beta = .9$ ). Fifty-four trauma clinicians participated in the present study: EMDR therapy clinicians ( $n = 21$ ) and TF-CBT/PE clinicians (non-EMDR therapy clinicians;  $n = 32$ ). Assumption checks were assessed to ensure normality, homoscedasticity, absence of multicollinearity, and conceptual fidelity. Normality plots and scatterplots were consulted to confirm linearity, homoscedasticity, and normality. The absence of multicollinearity was supported with low variance inflation factors (VIF) values ( $< 2.45$ ) and tolerance values above  $.40$ . Pearson correlation coefficients were conducted to confirm that CF and CS were indeed independent constructs prior to including these closely related predictors in the same model predicting VT in EMDR therapy clinicians ( $r = .18$ ,  $p = .470$ ) and non-EMDR therapy clinicians ( $r = -.33$ ,  $p = .083$ ).

Both groups were assessed for mean differences across the included ProQOL predictors using independent samples *t*-tests (for means, see Table 2). In terms of CS, the difference between EMDR therapy clinicians ( $M = 52.77$ ,  $SD = 7.69$ ) and non-EMDR therapy clinicians ( $M = 48.06$ ,  $SD = 11.05$ ) was not significant,  $t(49) = 1.69$ ,  $p = .098$ ,  $d = .48$ . There was also no significant difference between EMDR therapy clinicians ( $M = 49.13$ ,  $SD = 12.01$ ) and non-EMDR therapy clinicians ( $M = 50.27$ ,  $SD = 17.19$ ) in terms of CF,  $t(47) = -0.11$ ,  $p = .913$ ,  $d = .03$ . There were also no pre-existing differences between EMDR therapy clinicians ( $M = 50.74$ ,  $SD = 11.54$ ) and non-EMDR therapy clinicians ( $M = 49.53$ ,  $SD = 9.04$ ) in terms of VT scores,  $t(52) = 0.43$ ,  $p = .668$ ,  $d = .12$ .

VT was regressed on CF and CS for both groups of clinicians. For non-EMDR therapy trauma clinicians (Table 3), the model significantly predicted VT,  $F(2, 25) = 11.36$ ,  $p < .001$ ,  $R^2 = .48$ . CF significantly predicted VT,  $t(27) = 3.48$ ,  $p = .002$ ,  $\beta = .53$  [.06, .21], and CS negatively and significantly predicted VT,  $t(27) = -2.73$ ,  $p = .011$ ,  $\beta = -.47$  [-.70, -.10]. For EMDR therapy clinicians (Table 4), the model also significantly predicted VT,  $F(2, 16) = 11.08$ ,  $p < .001$ ,  $R^2 = .58$ . CF significantly predicted VT,  $t(18) = 4.39$ ,  $p < .001$ ,  $\beta = .72$  [.13, .38], but CS did not significantly contribute to the model,  $t(18) = 0.90$ ,  $p = .381$ ,  $\beta = .28$  [-.30, .74]. Post-hoc analyses using G\*Power confirmed that the large effect sizes

**TABLE 2. Measures of Central Tendency on t-Distribution for CS, CF, and VT in the Present Sample**

Variable	Trauma	n	Mean (SD) <sup>a</sup>	Cohen's <i>d</i>
	Treatment			
CS	EMDR therapy	21	52.77 (7.69)	.48
	Non-EMDR therapy	30	48.06 (11.05)	
CF	EMDR therapy	19	49.13 (32.06)	.03
	Non-EMDR therapy	30	50.27 (37.19)	
VT	EMDR therapy	21	50.74 (11.54)	.12
	Non-EMDR therapy	33	49.53 (9.04)	

**Note.** CS = compassion satisfaction; CF = compassion fatigue; VT = vicarious traumatization.  
<sup>a</sup>t-distribution ( $M = 50, SD = 10$ ).

in both regression models achieved adequate power ( $1-\beta > .9$ ). Zero-order correlations between CS, CF, and VT were calculated for the full sample to further illustrate the revealed associations (Table 5).

## Discussion

VT presents significant concern as a psychological occupational hazard for mental health professionals, and efforts should be made to mitigate the possibility of becoming vicariously traumatized (Evces, 2015). The purpose of this study was to provide possible insights into attenuating the effects of VT in clinicians treating traumatized populations. This study examined how trauma treatment type influences a clinician's professional quality of life through indirect trauma as conceptualized by the literature as VT, CF and CS.

The first hypothesis expected that EMDR therapy clinicians, as compared to TF-CBT and PE clinicians, would have lower scores on VT and CF, as well as higher scores on CS. This hypothesis regarding group differences between EMDR therapy and non-EMDR therapy (i.e., TF-CBT and PE) clinicians was not

**TABLE 3. Regression Coefficients for Model Predicting VT in Non-EMDR Therapy Clinicians**

Model 1	<i>F</i> (2, 25)	<i>p</i>	<i>R</i> <sup>2</sup>	Durbin-Watson
	11.36	< .001	.48	1.74
Predictors	<i>t</i> (27)	<i>p</i>	$\beta$	$\beta$ [95% CI]
CF	3.48	.002	.53	[.06, .21]
CS	-2.73	.011	-.47	[-.70, -.10]

**Note.** CF = compassion fatigue; CS = compassion satisfaction.

**TABLE 4. Regression Coefficients for Model Predicting VT in EMDR Therapy Clinicians**

Model 1	<i>F</i> (2, 16)	<i>p</i>	<i>R</i> <sup>2</sup>	Durbin-Watson
	11.08	< .001	.581	2.17
Predictors	<i>t</i> (18)	<i>p</i>	$\beta$	$\beta$ [95% CI]
CF	4.39	< .001	.72	[.13, .38]
CS	0.90	.381	.28	[-.30, .74]

**Note.** CF = compassion fatigue; CS = compassion satisfaction.

supported, but the difference between the two groups of clinicians in terms of CS was trending in the predicted direction ( $p < .1$ ) in favor of EMDR therapy clinicians. There is a trending difference for higher CS in EMDR therapy clinicians as compared to the non-EMDR therapy clinicians in the sample, which suggests, per the empirical definition of CS, that EMDR therapy clinicians may be feeling more capable to be successful in treating clients, which could be potentially protective in terms of longevity in the helping profession.

The second hypothesis expected that the empirical ProQOL model would not significantly predict VT in EMDR therapy clinicians as it would for TF-CBT and PE therapy clinicians. This hypothesis was supported in the current results since both CF and CS (empirical ProQOL model) significantly predicted VT for TF-CBT and PE therapy clinicians. The current results supported the proposition that VT was associated with CF; moreover, VT was negatively and significantly associated with CS as well for TF-CBT and PE therapy clinicians. Conversely, the empirical ProQOL model did not predict VT for EMDR therapy clinicians: CS did not significantly predict VT. For TF-CBT and PE therapy clinicians, the ProQOL model was predictive of a negatively impacted world view (VT). Similar to a clinician's ProQOL, VT involves a balance of both CF and CS. The current results also extend this finding to EMDR therapy clinicians as there may be aspects of

**TABLE 5. Correlation Table Between the Three Variables of Interest (i.e., CS, CF, and VT) for the Full Sample**

	CS	CF	VT
CS	1	-.192	-.238*
CF	-	1	.643**
VT	-	-	1

**Note.** CS = compassion satisfaction; CF = compassion fatigue; VT = vicarious traumatization.  
 \*  $p < .050$ ; \*\*  $p < .001$ .

this methodology that may protect an EMDR therapy clinician's CS from contributing significantly to the negative world view generally associated with VT.

The current findings may suggest that EMDR therapy's methodology does not contribute to the association between CS and VT for EMDR therapy clinicians. As mentioned above, one possible mechanism is the fact that in EMDR therapy, the client is not required to share their trauma narrative in any detail with an EMDR therapy clinician for effective resolution. Additionally, EMDR therapy clinicians are taught to instruct the client to mindfully notice the integration of cognitive, affective, and somatic experience through each set of eye movements or other bilateral stimulation while remaining silent (Landin-Romero et al., 2018; Shapiro, 2017). The client and the EMDR therapy clinician may be able to balance dual awareness of both the trauma event and the present moment during the bilateral stimulation since the client is not sharing any information at this time (Hase, 2021). In addition to the client not being required to share any details of the trauma, the EMDR therapy clinician also does not have to constantly look to identify cognitive distortions, which may add to a clinician's focus on the trauma narrative. The moment after each set of bilateral movements is meant to allow the client to describe their current experience, facilitating the integration of adaptive information (Shapiro, 2017). Moreover, the potential therapeutic aspects of EMDR therapy can be applied flexibly to prevent VT in a variety of settings: from first responders in medically acute settings (Keenan & Royle, 2007) to the group modality for clinicians exposed to significant child abuse (Tsouvelas et al., 2019).

In comparison, PE requires the client to repeatedly recount the details of their trauma to the clinician, which places the clinician at risk of indirect traumatization (Foa et al., 1999). TF-CBT also instructs their clinicians in their trainings that they must have the client discuss parts of the disturbing narrative intensely to address the concern that avoiding the trauma narrative will maintain the client's symptoms (Cohen et al., 2017). In a study surveying psychologists' attitudes toward utilization of PE, psychologists were reported to be apprehensive to complete the steps regarding trauma narratives due to discomfort or concern that engaging in the exposure may cause harm (Becker et al., 2004). Others argue that therapists may be likely attuned to the heightened negative affect and physiological arousal that are reported during the development and processing of the trauma narrative (Neelakantan et al., 2019). Therefore, the use of trauma narratives may account for this study's findings

that revealed CF and CS were found to be associated with VT in TF-CBT and PE clinicians in this sample.

## Limitations and Future Directions

This study acknowledges that the modest sample size may need to be considered when interpreting the results. A larger sample size may have increased the statistical power to detect a significant difference between the groups of clinicians in terms of CS. Furthermore, the Veterans Health Administration and Department of Defense (VA/DoD) and the American Psychological Association (APA) agree that in addition to EMDR therapy, PE, and TF-CBT, cognitive processing therapy (CPT) is also a strongly recommended empirically supported trauma treatment, which has two separate protocols that either include discussion of a trauma account or not (Watkins et al., 2018). According to Garcia and colleagues (2016), CPT with the account (CPT-A) was stressful and indirectly traumatic for clinicians who provided this treatment daily to veterans within the Veteran's Health Administration. Thus, future studies may benefit from acquiring more information on how CPT without the account (CPT-C) influences VT and ProQOL. Future studies on larger samples will be helpful to investigate the influence of demographic factors, possibly as covariates or in a moderation analysis. Future studies may also benefit from gathering participants directly from specialty clinics that only provide EMDR therapy as one method of controlling treatment fidelity, or directly operationalizing and measuring "client disclosure of trauma narrative." These additional considerations and future directions may help provide more protective factors and approaches to reduce the cost of caring for mental health professionals.

Since EMDR therapy's methodology could effectively treat clients without repeated exposure of traumatic material while avoiding the responsibility to co-narrate (identify, correct, and restructure cognitive distortions), the pessimistic perspective shift of VT could be minimized. EMDR therapy clinicians may not have to balance their perceptions of being able to do their job well with symptoms of VT. EMDR therapy clinicians have been taught that clients do not need to share their trauma narratives and clients are given instructions to "let whatever happens, happen," and to "just notice" the trauma, without interruptions from the clinician (Shapiro, 2017). It may also be that the eye movements or other forms of bilateral stimulation draw both the client's and the clinician's attention away from the distressing material just enough to allow for an "integrated cognitive-affective inner exploration"

balancing both the “there and then” with the “here and now” (Matthijssen et al., 2021; Shapiro, 2017). Due to the de-emphasis of exposure to the client’s trauma narrative, detailed descriptions, and cognitive fallacies, EMDR therapy may reduce the risk of VT and, ultimately, premature resignation from the field compared to other trauma treatments (i.e., PE and TF-CBT).

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