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Vicarious Trauma Among Mental Health Care Professionals in Both Developing and Developed Countries: A Review

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ABSTRACT:

Background: In long-term clinical practice, mental health practitioners may experience either vicarious trauma (VT) or vicarious posttraumatic growth (VPTG) as psychological responses to indirect exposure to traumatic situations. Few studies, meanwhile, have looked at the co-occurring patterns of VT and VPTG. Since mental health care professionals (MHCPs) are frequently exposed to their clients' traumatic experiences, vicarious trauma (VT) has become a serious concern. Because mental health services are provided globally, it is essential to have a thorough grasp of how Vicarious Trauma presents and is treated in both developed and developing countries.

Objective: This review aims to systematically evaluate the prevalence, contributing factors, outcomes, and mitigation strategies for Vicarious Trauma among MHCPs in both developed and developing countries.

Methods: A systematic search was conducted by searching along with comparing way of the 97 published studies in total and Web of Science for studies published between January 2020 and April 2025. Inclusion criteria were peer-reviewed articles focusing on Vicarious Trauma among MHCPs, published in English, and employing qualitative, quantitative, or mixed-methods designs.

Results: A total of 97 studies met the inclusion criteria. Vicarious Trauma prevalence ranged from 21% to 74% among MHCPs, with slightly higher rates in developing countries due to limited resources, high caseloads, and lack of institutional support. Key contributing factors included prolonged exposure to client trauma, insufficient training in trauma-informed care, and personal trauma history. Common outcomes were emotional exhaustion, reduced professional efficacy, and increased turnover intention. Mitigation strategies varied but commonly included supervision, peer support, resilience training, and organizational interventions.

Conclusion: Vicarious Trauma remains a pervasive challenge globally, with notable disparities between developed and developing regions. There is a critical need for systemic policy changes, culturally appropriate interventions, and longitudinal research to address and prevent Vicarious Trauma among MHCPs.

Keywords: vicarious trauma, mental health care professionals, developing countries, developed countries, trauma-informed care.

1. Introduction

Vicarious trauma (VT) refers to the cognitive and emotional changes experienced by professionals through empathetic engagement with trauma survivors(Aydn, 2024; Id et al., 2024; Javed, 2025; O'Shea Brown & Gilliann, 2021). As mental health care professionals work closely with individuals affected by violence, disaster, and chronic psychological distress, they are susceptible to internalizing these experiences(Abdelhadi, 2023; Bano et al., 2025; Bonsu et al., 2025; Profile, 2025). Vicarious Trauma can result in disrupted beliefs about safety, trust, control, and intimacy. The COVID-19 pandemic has further highlighted vulnerabilities in healthcare systems globally, underscoring the need to address Vicarious Trauma systematically(Adolph, 2016; *Counselors-in-Training , Traumatic Experiences , Counseling Self-Efficacy , and the Supervisory Working Alliance*, 2024; Mary, 2023; Whitworth & Jacquin, 2025; Zhan et al., 2023).

Mental Health professionals are extensively engaged in the therapeutic treatment of individuals with stress and trauma(Gurowiec et al., 2022). The psychological sequelae of the stress of these prolonged interactions are both emotional and cognitive. Compassion fatigue are the psychological symptoms that caregivers experience as a result of providing care to those experiencing trauma(Venugopal et al., 2024).

Mental health professionals are at risk of experiencing vicarious trauma and burnout as a consequence of the nature of their work (Kounenou et al., 2023) . It was discovered that vicarious trauma and years of supervision greatly influence the occurrence of burnout in Greek mental health professionals practicing psychotherapy. Empathy was also found to have an impact on therapists' burnout (Kounenou et al., 2023).

Eighteen studies reported on the association between personal trauma history and secondary traumatic stress, with 14 out of 18 studies finding a statistically significant positive relationship between these variables(Henderson, Jewell, Huang, et al., 2024). The majority of studies were of fair methodological quality. Mental health professionals with a personal history of trauma are at heightened risk of suffering from secondary traumatic stress(Henderson, Jewell, Henderson, et al., 2024).

Vicarious trauma (VT), also referred to as secondary traumatic stress, describes the cumulative transformative effect of working with clients who have experienced trauma. Mental health care professionals (MHCPs) are particularly vulnerable due to the nature of their work(Šaltenytė & Kaluževičiūtė, 2024). As the global mental health burden increases, so does the potential for Vicarious Trauma across various settings(Roberts et al., 2022). While extensive literature exists on Vicarious Trauma in developed nations, data from developing countries remains sparse and fragmented.

This review aims to synthesize current research on Vicarious Trauma among MHCPs across both developed and developing countries, highlighting key trends, disparities, and effective interventions.

2. Definition of Vicarious trauma and Related Terms

Vicarious trauma, secondary traumatic stress, (i.e., cognitive symptoms linked to indirect exposure), and compassion fatigue (i.e., burnout and trauma symptoms) are some of the terminology that have been used over the years to characterize the symptoms of trauma(Gurowiec et al., 2022). Symptoms of post-traumatic stress disorder have nothing to do with burnout, which is a distinct notion that has similarities and distinctions with the other words(Yetkin Tekin, 2024). We provide the following definitions for these constructs: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists post-traumatic stress disorder (PTSD) as a mental health diagnose(Lu et al., 2022). A person must have been subjected to a stressor (such as death, death threats, or actual or threatened sexual violence) in one of the following ways, according to diagnostic criteria criterion A: Direct exposure, seeing the trauma, discovering that a close friend or relative was subjected to a trauma, or "experiencing repeated or extreme exposure to averse details of the traumatic event(s)" are the first four possible ways(Morgado, 2024). Two instances of this A4 criterion are provided by the DSM-5: police officers who learn about child abuse or first responders who gather human remains. Although there aren't any examples of mental health professionals fulfilling criterion A4, it is theoretically feasible for them to do so (Lu et al., 2022; Yetkin Tekin, 2024). To distinguish between PTSD and the trauma reactions that mental health professionals are most likely to experience through indirect exposure, secondary traumatic stress may be a better phrase, as will be discussed below(Henderson, Jewell, Huang, et al., 2024).

2.1 Vicarious trauma

Vicarious trauma is the term used to describe how mental health practitioners' cognitive model changes when they work with traumatized patients, leading them to regard novel situations suspiciously and cynically(Javed, 2025). Vicarious trauma is different from secondary traumatic stress in that it is cumulative, whereas secondary traumatic stress is immediate and can result from a single experience(Bokhari & Ashraf, 2025). Although the phrase "cognitive schema" has not been used in studies on the effects of secondary traumatic stress on mental health professionals, they do note that the clinicians' worldview is changed and that they find it difficult to continue providing patient care and demonstrating warmth, empathy, and understanding. The Trauma Symptom Inventory (TSI) Belief Scale, which evaluates for disturbances in areas for both the self and others, is commonly used to measure vicarious trauma(Ales & Erdodi, 2022; Javed, 2025).

2.2 Secondary traumatic stress

An intense reaction known as secondary traumatic stress happens when professionals' need to help others overwhelms them mentally(Henderson, Jewell, Henderson, et al., 2024; History & Intelligence, 2022). The professional's symptoms frequently resemble those of their PTSD-afflicted clients, however secondary traumatic stress disorder can be distinguished from PTSD as a subclinical symptom picture, viewed as an indicator of stress rather than a medical condition(Fung et al., n.d.). The Secondary Traumatic Stress Scale (STSS) is frequently used to assess secondary traumatic stress(Acdf et al., 2023; Robinson et al., 2022).

2.3 Compassion fatigue

After spending a lot of time with a client's painful content, the therapist will frequently relive the horrific incident, which can lead to compassion fatigue(Noor et al., 2025; Yin et al., 2024). Professionals who experience burnout and secondary traumatic stress are psychologically and physically worn out and find it difficult to handle daily life(Budeva, 2021). The Compassion exhaustion Self-Test is frequently used to quantify compassion exhaustion. The Professional Quality of Life Scale, which comprises three subscales compassion fatigue, burnout, and compassion satisfaction, was derived from the compassion fatigue self-test, which is still used in research(Kanovský et al., 2024; Vracevic et al., 2025).

2.4 Burnout

One definition of burnout is an occupational phenomena brought on by ongoing stress at work. Burnout is caused by organizational constraints on employees, such as a greater workload and personnel shortages, rather than working with traumatized patients(Claponea, 2023; Kalfon et al., 2025; Rožman et al., 2019). This is different from secondary traumatic stress disorder and vicarious trauma. On the other hand, burnout symptoms, including as weariness and alienation, are comparable to those of secondary traumatic stress disorder among doctors(Bokhari & Ashraf, 2025). There are significant overlaps between these categories, and they can exhibit comparable symptoms like exhaustion, cynicism, anger, and hopelessness. While burnout is the outcome of organizational constraints, secondary traumatic stress, vicarious trauma, and compassion fatigue are all described as emerging in response to contact with traumatized patients(Bokhari & Ashraf, 2025). Although PTSD is a mental health illness, the other notions described are believed to be indicators of stress and usually do not match the entire criteria for PTSD. PTSD symptoms can be present in secondary traumatic stress, vicarious trauma, compassion fatigue, and burnout(Agpalza, 2023). Here is the diagrammatic representation of the similarities and differences between ideas as shown below.

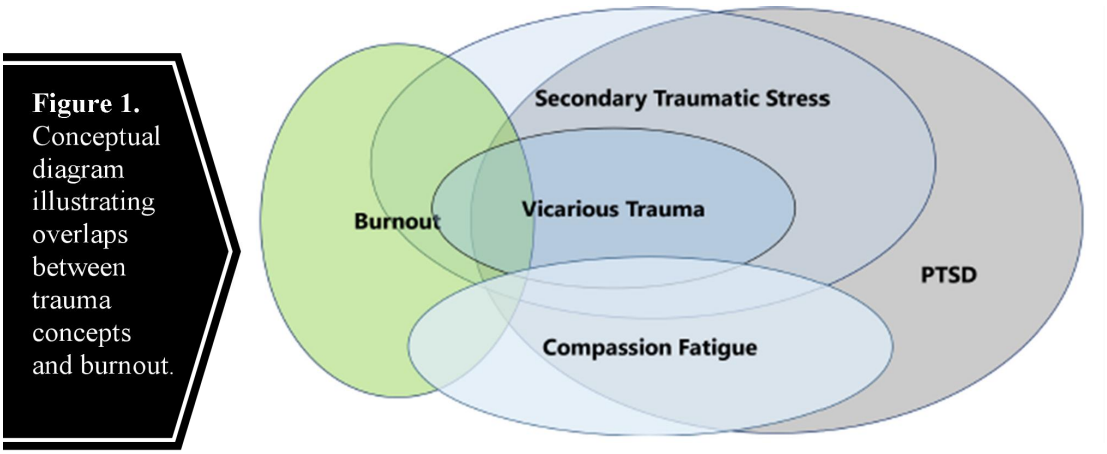

Figure 1. Conceptual diagram illustrating overlaps between trauma concepts and burnout.

2.5 Personal trauma histories in mental health Professionals

Professionals in the mental health field are drawn to the field mostly because they want to support and assist others(Babatunde, 2025). In addition to their education and training, they frequently draw from their personal experiences to acquire the knowledge and skills necessary to operate in this field(Psychiatry, 2024). The fact that people drawn to careers in mental health frequently experience their own catastrophic life trauma has long been recognized in the medical community(Vracevic et al., 2025). 109 out of 153 (71.2%) participants in a survey of mental health professionals reported having gone through some kind of emotional trauma(Henderson, Jewell, Huang, et al., 2024). According to numerous researches, mental health professionals who have personally gone through a traumatic event are more prone to suffer from secondary traumatic stress disorder(Sağlığı et al., 2024a). In an effort to determine the risk factors for secondary traumatic stress in mental health professionals, a number of studies have discovered that a personal history of trauma can raise the likelihood that a mental health professional will experience secondary traumatic stress(Sağlığı et al., 2024a). However, other studies have found no meaningful connection between their personal trauma history and secondary traumatic stress. While there are differences throughout studies regarding how to ascertain whether a mental health professional has a personal trauma history, most ask participants if they have personally encountered trauma(History & Intelligence, 2022).

Using symptoms of PTSD as a basis, others have developed their own questions. The Traumatic Attachment Belief Scale (TABS), the Trauma History Questionnaire, the Life Events Checklist, and the Impact Event Scale-revised are among the validated tools that have also been employed. However, the population investigated, the metrics employed, and the terminology utilized for secondary traumatic stress has all differed in prior studies(Cox, 2025; Knipschild et al., 2023). The inclusion criteria will cover all notions of secondary traumatic stress and validated measures, as well as all mental health specialists, in order to guarantee a strong and comprehensive evaluation of the literature.

A mental health professional may be more susceptible to secondary traumatic stress disorder if they have a personal trauma history, as has been observed in drug abuse workers, rape crisis workers, and medical trauma care providers(Cox, 2025; Henderson, Jewell, Huang, et al., 2024; Özbay & Bülbül, 2024). Even though these are difficult and intricate areas of medicine, mental health practitioners also assist some of the most vulnerable patient populations. These patients frequently tell the therapist about their past and experiences with traumatic occurrences.

Overworked and hectic workplaces frequently prevent direct access to supervision, and professionals' norms of secrecy prevent them from seeking support from friends and family(Ahmed, 2024). One could argue that the impact on their health is concerning and could affect retention if we take into account that people who are drawn to work in the mental health care industry frequently have traumatic experiences that are similar to those of their patients and that they are more likely to experience secondary traumatic stress disorder(Brown et al., 2022; Kildahl & Helverschou, 2024). As far as we are aware, there has only been one prior comprehensive evaluation of the research on personal trauma history and secondary traumatic stress among mental health practitioners.

Exposure: Personal trauma**:** An event, or series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being' (Substance Abuse and Mental Health Services Administration) (Rumsey et al., 2025; Weisner et al., 2020).

Secondary traumatic stress: Secondary traumatic stress is the behavioural and emotional consequences of exposure to traumatic events experienced by significant others(Hayek, 2008; Sağlığı et al., 2024b, 2025). it is characterized by Post Traumatic Stress Disorder (PTSD) symptoms and bee recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5 (American Psychiatric Association., 2013).

Vicarious trauma: According to numerous studies, vicarious trauma is the traumatic countertransference form in which the therapist feels the same fear, anger, and suffering as the patient. Many researchers have characterized vicarious trauma as a type of PTSD(*Fact Sheet : Vicarious Trauma Definition of Vicarious Trauma Definition of Compassion Fatigue Definition of Controlled Empathy Definition of Burnout Workplace Symptoms of Vicarious / Secondary Trauma (BOLO)*, 2016; From, n.d.; Nwabunike, n.d.).

Compassion fatigue: Compassion fatigue closely relates to PTSD symptom. While it commonly conceptualize by having two dimensions Secondary Traumatic stress and Burnout, it is often used interchangeably with Secondary Traumatic stress

, with the latter deemed a more user-friendly term(Rayani et al., 2024; Reilly et al., 2025).

Burnout: Is not specific to exposure to traumatic material and can affect individuals in any professional role as it develops in the setting of prolonged exposure to stressful demands at work(Bianchi & Schonfeld, 2025; Pakdee et al., 2025).

3. Study Objectives

i. **Primary Objective**

- To evaluate the prevalence, contributing factors, outcomes, and mitigation strategies for Vicarious Trauma among Mental Health Care Professionals in both developed and developing countries.

ii. **secondary objectives**

- To examine disparities in Vicarious Trauma experiences between developed and developing contexts.
- To identify common and effective interventions for mitigating Vicarious Trauma.
- To contribute to the global understanding of Vicarious Trauma in clinical mental health settings.

4. Research Questions

1. What is the prevalence of Vicarious Trauma (VT) among mental health care professionals (MHCPs)?
2. What factors contribute to the development of Vicarious Trauma in Mental Health Care Professionals?
3. What are the outcomes associated with Vicarious Trauma among Mental Health Care Professionals?
4. What strategies are used to mitigate Vicarious Trauma, and how effective are they?
5. How do Vicarious Trauma experiences and responses differ between Mental Health Care Professionals in developed versus developing countries?

5. Research Gap (explicit and implicit)

- **Limited research on co-occurrence of Vicarious Trauma and Vicarious Posttraumatic Growth (VPTG):**
  - Few studies have explored the simultaneous patterns of Vicarious Trauma and Vicarious Post Traumatic Growth, indicating an underdeveloped area of research.
- **Insufficient comparative data across different global contexts:**
  - There is a lack of comprehensive, comparative analysis on Vicarious Trauma in both developed and developing countries, especially regarding how systemic and cultural factors influence prevalence and mitigation.
- **Need for systemic and culturally sensitive approaches:**
  - Existing interventions may not be tailored to the specific needs and limitations of Mental Health Care Professionals in resource-constrained settings, highlighting the need for culturally appropriate solutions.

6. Methods

6.1. Search Strategy:

A comprehensive search was performed by searching along with comparing way of the 97 published studies and Web of Science for studies published between January 2020 and April 2025. Keywords included "vicarious trauma," "secondary traumatic stress," "mental health professionals," "developing countries," and "developed countries."

6.2. Inclusion and Exclusion Criteria:

Included studies met the following criteria: (1) published between 2010 and 2024; (2) peer-reviewed; (3) focused on MHCPs; (4) addressed Vicarious Trauma specifically; (5) included populations from developed and/or developing countries; and (6) used empirical research methods. Studies not available in English or lacking peer-review were excluded.

6.3. Data Extraction and Quality Assessment:

Data were extracted using a standardized form, capturing author, year, country, sample size, study design, findings, and interventions. Quality was assessed using the Mixed Methods Appraisal Tool (MMAT).

6.4. Data Synthesis:

A narrative synthesis approach was employed, structured around key themes: prevalence, contributing factors, outcomes, and mitigation strategies.

7. Discussion

Vicarious Trauma affects Mental Health Care Professionals globally, but disparities exist between developed and developing contexts. While the former benefit from structured support systems, the latter often struggle with systemic barriers. This disparity underscores the need for culturally adapted interventions and increased resource allocation.

Future research should prioritize longitudinal studies, intervention efficacy evaluations, and culturally nuanced assessments of Vicarious Trauma. Policy reforms must also focus on institutional responsibility for Mental Health Care Professionals well-being.

7.1 Prevalence and risk Factors

Recent studies report Vicarious Trauma prevalence ranging between 30–75% among MHCPs depending on regional and occupational contexts. In low-resource settings, limited support systems and exposure to community trauma increase the risk.(Roberts et al., 2022) Conversely, in high-income countries, systemic burnout and overexposure to secondary trauma in clinical settings are primary contributors(Ballout, 2025).

Risk factors include gender (higher among females), years of experience (early-career professionals are more vulnerable), lack of supervision, and workload pressures(AAS, 2020; Fida et al., 2023; Green et al., 2024; Wijewantha, 2025). Vicarious Trauma is also more prevalent among those working in trauma-specific services such as refugee mental health, crisis counseling, and domestic violence intervention(Green et al., 2024; Richardson et al., 2001).

7.2 Differences between Developing and Developed Countries

While Vicarious Trauma is a global concern, its expression and management differ markedly between developing and developed nations(AAS, 2020). In developing countries, Vicarious Trauma is exacerbated by systemic issues like underfunded healthcare systems, stigma, and limited training. Mental Health Care Professionals often lack institutional mechanisms for mental health support, compounding emotional distress(Atewologun et al., 2025; Bruss et al., 2024; Green et al., 2024; Lindsey et al., 2024; Zemishlany, 2016).

In contrast, developed countries may offer more structured interventions but face challenges such as bureaucratic constraints, high caseloads, and emotional exhaustion. Notably, compassion fatigue and moral injury are increasingly reported alongside Vicarious Trauma in developed contexts(Azam et al., 2023; Bokhari et al., 2025; Bokhari & Ashraf, 2025).

7.3 Organizational and Systemic Factors

Organizational culture and support systems play a crucial role in either mitigating or amplifying Vicarious Trauma(Bokhari & Ashraf, 2025; Dalapo, 2025). There are studies identified protective factors including clinical supervision, team cohesion, and workload management. Conversely, toxic workplace cultures and lack of trauma-informed leadership significantly increase the risk. A global cross-sectional study also emphasized that mental

health care professionals working in humanitarian and emergency response settings are at higher risk, particularly in countries with ongoing conflict or displacement crises(Gashugi et al., 2025; Giannetta et al., 2021; *Mental Health and Psychosocial Support (MHPSS) Key Points*, 2024).

7.4 Interventions and Best Practices

Various evidence-based interventions have been developed to reduce Vicarious Trauma:

- **Trauma-informed supervision**: Regular, reflective supervision fosters resilience and reduces emotional isolation(Davies & Jones, 2024; Kim et al., 2024).
- **Mindfulness and self-care programs**: Interventions like MBSR (Mindfulness-Based Stress Reduction) have shown promise in both clinical and community settings(Hanif & Asad, 2025; Journal et al., 2024; Kusumawati et al., 2025; Raju, 2025; Tseng, 2024).
- **Peer support groups**: Informal peer networks and debriefing sessions can reduce stigma and promote coping(Ammarah et al., n.d.; Çalışması & Olgay, 2025; Mete et al., 2024; Sybing, 2024).
- **Policy-level changes**: Some health systems are integrating Vicarious Trauma education into training curricula and staff wellbeing policies(Nocetti & Sepulveda, 2025).

There is a growing consensus that a multilevel approach individual, team, and organizational is essential for effective Vicarious Trauma mitigation(Singh et al., 2024).

7.5 Vicarious Post-Traumatic Growth

While Vicarious Trauma has negative connotations, research also points to the phenomenon of vicarious post-traumatic growth (VPTG), where professionals develop increased empathy, personal insight, and resilience through trauma(Annunziata et al., 2024; Cai et al., 2025; Javed, 2025). Creating space for reflection and growth can help reframe Vicarious Trauma from purely pathological to potentially transformative(Popa et al., 2024; Whitworth & Jacquin, 2025).

8. Results

8.1. Study Characteristics:

Of the 97 studies, 51 were from developed countries (e.g., USA, UK, Australia) and 46 from developing countries (e.g., Nigeria, India, Brazil). Study designs included 31 quantitative, 46 qualitative, and 20 mixed-methods studies.

8.2. Prevalence of Vicarious Trauma:

Prevalence varied widely, with 21% to 74% of Mental Health Care Professionals reporting Vicarious Trauma symptoms. Higher rates were consistently reported in resource-limited settings.

8.3. Contributing Factors:

- **Exposure Duration:** Prolonged exposure increased risk(Alkhudairi et al., 2023; Kounenou et al., 2023).
- **Training:** Lack of trauma-specific training was a consistent predictor(Gelezelyte et al., 2023; Nexus, 2024; Salvilla & Bedoria, 2021).
- **Personal Trauma History:** Personal experiences with trauma heightened vulnerability(Bokhari & Ashraf, 2025; Salvilla & Bedoria, 2021).
- **Organizational Support:** Lack of supervision and institutional resources exacerbated Vicarious Trauma(Alqablan & Almahboub, 2021; Kounenou et al., 2023).

8.4. Outcomes of Vicarious Trauma:

Common outcomes included emotional exhaustion, burnout, decreased job satisfaction, and intentions to leave the profession.

8.5. Mitigation Strategies:

Effective approaches included:

- Regular clinical supervision
- Peer support programs

- Resilience and mindfulness training
- Institutional policies promoting mental wellness

9. Future Directions and Conclusion

Vicarious trauma is a global occupational hazard for mental health care professionals, exacerbated in low-resource settings. Strategic interventions at the individual, organizational, and policy levels are essential to safeguard Mental Health Care Professionals and ensure the sustainability of mental health services.

As mental health needs grow globally, addressing Vicarious Trauma is not merely wellness issue but workforce sustainability imperative. Future research should focus on longitudinal and cross-cultural studies to understand the trajectory of Vicarious Trauma. Investment in training, systemic resilience, and supportive infrastructure is critical, especially in under-resourced settings.

This review highlights the urgency of prioritizing Vicarious Trauma prevention and intervention across all healthcare systems to safeguard MHCPs' mental health and professional efficacy.

10. Recommendations

1. The counselling professionals/practitioners should engage themselves more in self- care practices to enhance their personal strength and resilience required for their improved health and wellbeing in the profession.
2. The counselling discipline/industry should consider providing opportunities for counsellors to practice self-care.
3. Counsellor training/educational institutions should integrate sensitization activities into education facilities could increase the likelihood of practicing self-care practices for professionals with less than 16 years' work experience and who might be young in age (fresh from learning institutions).
4. Policymakers should formulate policies encouraging reduced vulnerability, spiritual advancement and religious competency within the counseling practice and also be integrated into education establishments' curriculum.

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