VICARIOUS TRAUMATIZATION IN MENTAL HEALTH PROFESSIONALS WORKING AMONG CHILDREN WITH DISABILITIES AND ITS IMPACT ON MOOD AND HOPE

Thesis Submitted for the Award of the Degree of

DOCTOR OF PHILOSOPHY

in

Psychology

by

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DECLARATION

I, hereby declare that the presented work in the thesis entitled "Vicarious Traumatization in Mental Health Professionals Working Among Children with Disabilities and its Impact on Mood and Hope" in fulfilment of degree of **Doctor of Philosophy (Ph.D.)** is outcome of research work carried out by me under the supervision Dr.Vijendra Nath Pathak, working as Associate Professor, in the School of Language and Social Sciences of Lovely Professional University, Punjab, India. In keeping with general practice of reporting scientific observations, due acknowledgements have been made whenever work described here has been based on findings of other investigator. This work has not been submitted in part or full to any other University or Institute for the award of any degree.

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CERTIFICATE

This is to certify that Ms. Feba Percy Paul has completed her Doctor of Philosophy (Ph.D.) in Psychology thesis entitled "Vicarious Traumatization in Mental Health Professionals Working among Children with Disabilities and its Impact on Mood and Hope" under my supervision and guidance. The present work is the result of her original investigation and study. To the best of my knowledge no part of the thesis has ever been submitted to any other University or Institute for the award of any degree or diploma.

Dr. Vijendra Nath Pathak (Supervisor)

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DEDICATION

This thesis is dedicated to God Almighty who has been my source of strength and wisdom. For my unwavering family, whose love and support illuminate my path; to the friends who inspire me daily; and to those who dare to envision a better society—may this work ignite change and foster hope. Together, we can reshape our world, one thoughtful action at a time.

ABSTRACT

Vicarious trauma (VT) refers to the emotional and psychological effects that can occur when individuals, particularly those in helping professions, are exposed to the traumatic experiences of others. This phenomenon is particularly prevalent among mental health professionals, first responders, healthcare workers, and social workers.This study explores Vicarious Traumatization in Mental Health Professionals working among children with special needs and its impact due to Mood Disturbance and levels of Hope.Children with special needs, such as those with autism or developmental disorders, may present unique challenges and stressors for mental health professionals. Many of these children have experienced significant trauma, which can be distressing to witness.The responsibilities of mental health professionals include not only diagnosing and treating mental health issues but also advocating for children and their families. This multi-faceted role can be overwhelming, particularly when navigating systemic barriers within education and healthcare settings. The study uses three tools to gather data – the Adult Hope Scale by C.R. Snyder (1990), the Profile of Mood State- Revised (POMS-R) by Dr. McNair, Dr. Lorr, and Dr. Droppleman (1992), and the Professional Quality of Life Scale, which was developed by Dr. Beth Hudnall Stamm (2009).The sample consisted of Therapists, Counsellors, Psychiatrists, and Special Educators, 125 males and 125 females from Delhi, NCR, working among children with special needs, who participated in the research. The completed questionnaires were scored, and the result showed a mean score of 27 in the Vicarious Trauma dimension, which falls under the Moderate level of clinical distress; 125 participants were placed in the experimental group, while theother 125 participants were placed in the control group.The participants in the experimental group were provided intervention which combined three techniques – Jacobson's Progressive Muscle Relaxation (JPMR) developed by Dr. Edmund Jacobson in the early 20th century; Mindfulness Based Muscle Relaxation (MBSR) developed by Dr. Jon Kabat-Zinn in the late 1970s and and Trauma Informed Cognitive Therapy (TICT) which is an evolution of the Trauma therapy, key figure in developing trauma-informed care include Dr. Judith Herman.The participants who received the intervention we re-evaluated. Pre-intervention, Fatigue, Tension, and Vicarious Trauma levels were moderately high and needed support. Post-intervention, there was a change in the scores, and the levels had reduced in these areas. I hope the same will be true for the higher end pre-test and post-test.

Keywords: Vicarious Trauma, Secondary Traumatic Stress, Children with Disabilities

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VT	Vicarious Trauma
STS	Secondary Traumatic Stress
DSM	Diagnostic and Statistical Manual
PROQOL-5	Professional Quality of Life-Version 5
POMS	Profile of Mood States
AHS	Adult Hope Scale
APA	American Psychological Association
SD	Standard Deviation
T- test	Analysis of Covariance
WHO	World Health Organization
ICD	International Classification of Diseases
CWD	Children With Disabilities

CBT	Cognitive Behavioral Therapy
JPMR	Jacobson's Progressive Muscle Relaxation
MBSR	Mindfulness Based Stress Reduction
TICT	Trauma Informed Cognitive Therapy

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CHAPTER-1

INTRODUCTION

Lenore Terr, while working with children, states that "Psychic trauma occurs when a sudden, unexpected, overwhelming, intense emotional blow or a series of blows assaults the person from outside. Traumatic events are external but quickly become incorporated into the mind". Psychological trauma can be due to watching or hearing of the trauma experiences of the other; this trauma impact is popularly known in three ways: Compassion fatigue, Secondary Traumatic Stress, and Vicarious Trauma. Trauma hurts the mental health of professionals, and several studies have validated the same (Sutton et al., 2022). It has been found that repeated hearing of traumatic experiences, graphic presentation of events, excessive caseload, and lack of experience and training have impacted mental health professionals and, in turn, the organization they serve (Sodeke-Gregson et al., 2013). The impact of trauma varies from individual to individual based on the frequency, degree of impact, expertise of the professional, and so on. There may be short-term and long-term responses to traumatic experiences.

"*I would return from a good day at work feeling exhausted and in despair. Like something has been taken from me; on other days, I feel like something very heavy has been put into my heart. The sadness would not go away at times, making me feel uninterested to take more sessions the next day, until I got to know about Secondary Trauma"- Ms. Molly (Clinical Psychologist at a center for child welfare).*

1.1 Vicarious Traumatization (VT)

Vicarious Traumatization (VT), also known as Secondary Trauma Stress (STS), is considered an outcome secondary to extreme exposure or traumatically stressful events (Stamm, 2012).

It occurs indirectly when caregivers are exposed to stories about the lives and experiences of others or even when watching other individuals in distress. It can be in the form of images or graphic videos leading to the same.

The phrase vicarious traumatization (VT) was introduced by Pearlman & Saakvitne (1995) to depict the significant change in perspective experienced by helping professionals who assist trauma survivors: these helpers observe that their core beliefs about the world can be changed and potentially harmed through continual exposure to traumatic content. Secondary exposure occurs when an individual is exposed to others' traumatic experiences. The symptoms unfold over time and can involve emotional, behavioral, physiological, spiritual, and cognitive issues.

In this study, we focus on the Emotional symptoms,including lasting feelings of grief, sadness, irritability, anger, becoming distracted frequently, and/or experiencing changes in mood or mood disturbance,Spiritual issues can manifest as a diminished sense of hope or purpose, along with feelings of disconnection from both others and the broader world.

Vicarious trauma leaves the professionals questioning their competence, i.e., are they good enough? They feel hopeless as they cannot relieve the other person's suffering. The excessive amount of caseload, paperwork, and expectations of the workplace and the parents has created impacts on practitioner's family lives, too (Patel, 2018)

Vicarious Trauma is only one among the many other terms that are used to describe the impact of trauma on caregivers. Burnout is a term used to describe exhaustion after prolonged work, not being able to achieve or accomplish, and also due to strain from the job. It is a gradual process and is caused by the pressures of work (Figley, 1995).

This present study will focus on mental health professionals commonly working among children with disabilities, which include Psychotherapists, Psychiatrists, Special Educators, and Clinical Psychologists, to identify the levels of Vicarious Traumatization (VT) and what impact that can make on their mood and completion of goals. It will also try to discover management techniques and interventions for mental health care professionals for better performance at work and to improve their emotional and cognitive states. A reference to a Chapter in the Book 'Trauma of Working with Children Experiencing Trauma' by Tracy and Thomas, 2002, highlighting the experience of Kendra, who is a

Child Protection Investigator, shows us an escalation of her symptoms of Vicarious Trauma, which began with stress from an increase in workload, sharing of cases by new healthcare workers to her and then experiencing sleep disturbances panic attacks, and even to a point where she felt whether she could live up to see the following day.

1.2 Historical Perspective

The idea of vicarious trauma emerged in the early 1990s when researchers and practitioners in psychology, social work, and counseling began examining how working with trauma survivors affects the well-being of those who provide that care. Figley (1995) was among the first to investigate this phenomenon, defining vicarious trauma as the "transformation that occurs within the therapist as a result of empathetic engagement with clients' trauma experiences." His pioneering research set the stage for additional studies into how exposure to trauma impacts mental health professionals and caregivers. Subsequent research, such as that conducted by Pearlman and Saakvitne (1995), revealed that therapists working with trauma survivors often experience symptoms like intrusive thoughts, emotional numbness, and heightened arousal, highlighting the need to acknowledge and address the emotional burden associated with this work. As understanding of vicarious trauma expanded, initiatives aimed at developing interventions to lessen its impact also increased. Stamm (1999) introduced the idea of "compassion satisfaction" as a way to balance the negative effects of vicarious trauma, focusing on the positive aspects of helping others and finding meaning in one’s professional role. This shift towards promoting resilience and self-care, alongside addressing the adverse effects of vicarious trauma, represented an important evolution in the field.In recent years, advancements in technology and research have further expanded our understanding of vicarious trauma. For example, digital platforms and online resources have made it easier for caregivers and mental health professionals to access support and information on vicarious trauma. Additionally, neuroimaging studies have provided insights into the neural mechanisms underlying vicarious trauma and its impact on the brain. Despite these advancements, challenges remain in addressing vicarious trauma effectively. The demanding nature of caregiving and mental health work, coupled with systemic issues such as limited resources and high caseloads, can contribute to the risk of vicarious trauma. Organizations and policymakers

need to prioritize the well-being of caregivers and mental health professionals by implementing evidence-based interventions and fostering a culture of self-care and support.

In conclusion, the historical perspective of vicarious trauma in caregivers and mental health professionals highlights the evolution of our understanding of this phenomenon and the efforts to address its impact. By acknowledging the emotional challenges inherent in providing care to trauma survivors and promoting resilience and self-care, we can better support those on the front lines of helping others.

1.3 Clinical Indicators to Identify Vicarious Trauma in Mental Health Professionals as per several research show:

Emotional deregulation

Emotional extremes usually result from being overwhelmed or feeling numb. A longitudinal study conducted by Malta et al. (2009) on Post-Traumatic Stress Disorder (PTSD) among disaster workers highlighted the importance of identifying numbing as a reaction to traumatic stress. Because numbing symptoms can mask emotional responses, family members, counselors, and other mental health professionals might underestimate both the severity of traumatic stress symptoms and the true impact of the trauma.Adults are found to self-medicate themselves by using harmful methods like the use of substances- alcohol; they have been found to have disordered eating, compulsive behaviors like gambling, overworking, repressing, and denial of any reaction felt leading to lack of sleep. On the other hand, some have resorted to using creative and industrious methods to bounce back in times when stress is felt due to dealing with a traumatic event.

Cognitive Disruptions

Intrusive thoughts make the individual believe that he or she is unsafe, making them doubt, feel guilty, hopeless, frustrated, and also develop nightmares. Romano et al., 2007 found that an emotional attachment may develop in case the individuals share the content of experiences, termed mirror idealization. Re-living the experiences of trauma, experiencing, feeling, thinking, and being in memories of the events as if it is happening in the present.

Hope is both a cognitive and emotional aspect of how one perceives the future; as both elements play a role in understanding this concept, it will give an understanding of how professionals plan and design their paths to reach their goals. Loss of connection with oneself, identity issues due to self-doubt, and lack of control.

Psychosomatic symptoms

I feel physically tired and have pains, aches, sweat, and abrupt sleep. There is constant tiredness even after resting. Sleep patterns have been seen to be affected the most, either by difficulty in initiating sleep or excessive sleeping. Studies also show sleep and wake cycles to be disrupted, waking in the middle of the sometimes with nightmares or a startle. (Tracy and Thomas,2002)

1.4. Theoretical Framework Behind Vicarious Trauma

Vicarious Trauma manifests mainly from the constructivist self-development theory, which highlights how ideas and knowledge one has interplay with the information present in the surroundings. A professional's cognitive schema and perception change based on the information the mental health professional receives when the individual shares about trauma (Tripanny et al., 2004). Goleman defines emotional quotient as "the ability to identify, assess and control one's own emotions, the emotion of others and that of groups." Self-awareness helps an individual to be comfortable with their emotions and thoughts. Not just to understand but also to accept those emotions and to regulate them. Such as managing impulses and reactions and how one processes them cognitively. Being emotionally satisfied was found to be more important than even money. Instead, passion for doing the work brought a sustained sense of motivation, clear decision-making, empathy, and social skills.

Snyder's Hope theory complements the cognitive aspects where a person creates pathways to a future goal. This will also require agencies like confidence, motivation, and the ability to achieve the desired goal. Reaching these goals is possible when one removes barriers that may block an individual from reaching the goal. Planning and decision-making are hindered when a caregiver gets emotionally disturbed and cannot decide the case or loses hope of any improvement. Transference from the psychoanalytical theory throws light on how the feelings of children with disabilities get transferred to the caregiver. The empathetic bond can develop a relationship, maybe with a parent figure, which can be studied further. Countertransference is also possible, where the emotions of the therapist can get

transferred to the child; understanding traumatization can help to prevent any unwanted and traumatic emotions from getting passed on. In Hoppe's study of evaluators working among survivors of the concentration camps in the 1950s and 1960s, he found that there are 4 attitudinal patterns.

- Denial: from the evaluator and to downplay the victim's suffering and refusing any feeling of fear, shame, or guilt that develops during the evaluation process.

- Rationalizing: By proving only lip service of understanding the victims, this, in turn, generates objective conclusions.

- Over identification: the victim makes, the evaluator ties himself or herself to the victim's story, and we see a sense of hatred for the Nazis developing underneath the sympathy that the evaluator shows to the victim.

- Controlled identification: This evaluator empathizes, experiences countertransference, does not shut himself off from extreme terror, and even withholds his own judgment.

The attitudinal styles define how a caregiver in a traumatic situation is presented to him or her. There needs to be healthy coping mechanisms, as unhealthy coping styles will harm the caregiver's emotional health. Literature shows that there is a need for developing effective coping styles and also improving workplace strategies to approach the case of Vicarious Trauma. Ethical principles at the workplace must be taken into consideration while working on methods to deal with trauma among professionals. One of the key theories supporting vicarious trauma is the concept of empathy and emotional contagion. According to this theory, This process of emotional contagion can contribute to the development of vicarious trauma in mental health professionals. Another theory that supports vicarious trauma is the cognitive processing model. This model suggests that mental health professionals who are exposed to traumatic stories and experiences may struggle to process and make sense of this information, leading to cognitive distortions and negative beliefs about themselves and the world (Pearlman & Saakvitne, 1995). Over time, these cognitive distortions can contribute to the development of vicarious trauma symptoms, such as intrusive thoughts and emotional numbing. Additionally, the social learning theory provides insights into how vicarious trauma may be transmitted from trauma survivors to mental health professionals. According to this theory, individuals learn through observation and modeling, and mental health professionals who work closely with trauma survivors may inadvertently adopt

maladaptive coping strategies and negative beliefs about trauma and recovery (Bandura, 1977). This process of social learning can contribute to the development of vicarious trauma in mental health professionals. In conclusion, several theoretical frameworks support the concept of vicarious trauma and provide insights into how mental health professionals may be affected by their work with trauma survivors. By understanding the underlying mechanisms of vicarious trauma, mental health organizations can implement strategies to support their staff and prevent the negative effects of vicarious trauma on their well-being.

1.5 Caregiving Children with Disabilities (CWD)

The International Classification of Functioning, Disability, and Health (ICF), established by the World Health Organization, defines disability as the unfavorable interaction between an individual with a health condition and the surrounding context, which includes both physical and attitudinal factors. Disability reflects a wide spectrum of impairments, limitations in activities, and restrictions in participation. Various definitions of disability are utilized by statistical agencies for censuses and surveys, and by legislative bodies to determine eligibility for disability programs or protections under disability rights laws (Fong et al., 2009).

Since definitions of "disability" can vary significantly across different regions, this study will concentrate on the definition relevant to the Indian context to identify Children with Disabilities (CWDs). The Rights of Persons with Disabilities Act (2006) defines a "person with a disability" as an individual who has a long-term impairment—whether physical, mental, intellectual, or sensory—that, when combined with barriers, limits their ability to fully and effectively participate in society on an equal basis with others. The Act identifies 21 specific disabilities, including Blindness, Low vision, Leprosy cured individuals, Hearing impairment, Locomotor disability, Dwarfism, Intellectual disability, Mental illness, Autism Spectrum Disorder, Cerebral Palsy, Muscular dystrophy, Chronic neurological conditions, Specific learning disabilities, Multiple sclerosis, Speech and language disabilities, Thalassemia, Hemophilia, Sickle cell disease, Multiple disabilities including deaf-blindness, Acid attack victims, and Parkinson's disease (Vishwakarma, 2017).

Children with disabilities are at a heightened risk of experiencing abuse. According to a United Nations report regarding vulnerable groups, these children face a 3 to 4 times greater likelihood of suffering emotional, physical, or sexual abuse (World Health Organization, 1999). Caregivers often lack the necessary training and awareness to effectively address the traumatic experiences of these children, which can adversely affect their own mental health. Research indicates that working with children can increase the chances of vicarious trauma among caregivers, such as Mental Health Sign Language Interpreters, who may experience this due to their lack of control in situations, the demands of their roles, and perceived constraints on their ability to manage these experiences (Noor et al., 2020). Furthermore, according to Batson et al., the concept of vicarious trauma is closely tied to empathy; caregivers who empathize deeply with others' pain or distress may be compelled to consider what it would feel like if those experiences happened to them.

1.6 Risk Factors that Exacerbate Chances of Vicarious Trauma

The caregiver or the helper will be overwhelmed and work out trying to understand the concern of the person who has experienced trauma; the thinking and visualizing of the events that caused the person to trauma will make the caregiver driven by compassion to help them.

Self- Sacrificing defense style: Was identified by research on counseling trainees experiencing Vicarious Trauma in research by Adams and Riggs (2004) Several coping strategies are used to help a caregiver come out of this experience- self-care, play, and activities while on the other hand, transforming strategies are to address as a community or even as a workgroup to know ways to manage levels of distress and practice at a personal level. Organizations develop programs like awareness and psycho-education seminars that help the employees work on themselves and mitigate the loss that arises from vicarious trauma.

Allostatic load: This is when a person experiences frequent stress for long periods- his or her wear and tear mechanism is affected psychologically, too. While allostasis allows one to maintain a good balance physiologically and psychologically, chronic stress can create imbalances.Humans are not great when it comes to surprises, especially when challenges knock on our door without a forewarning; it is not easily welcomed by our system. Regulation is best when situations are well-prepared. Factors contributing to vicarious trauma include stressful behaviors from clients, the type of clientele, the work environment, and the socio-cultural context, along with the characteristics of the provider, such as their

personal trauma history, professional growth, and current stressors and sources of support (Pearlman & Mac Ian, 1995). Mental health professionals with heavy caseloads and frequent exposure to their clients' traumatic narratives are at greater risk for developing vicarious trauma (Leung, 2022). Insufficient support from supervisors, colleagues, or the organization can heighten this risk. Those without access to debriefing sessions, supervision, or counseling may find it challenging to manage the emotional demands of their job (Sutton, 2022). Additionally, mental health workers with their own trauma history may be more susceptible to vicarious trauma when working with clients who share similar experiences (Smith et al., 2023).

Empathy and compassion: While empathy and compassion are essential qualities for mental health workers, they can also make individuals more susceptible to vicarious trauma. Feeling deeply for clients and their experiences can lead to emotional exhaustion and burnout.

Inadequate self-care: Mental health workers who do not prioritize self-care practices such as exercise, relaxation techniques, and setting boundaries between work and personal life are at a higher risk of developing vicarious trauma.

Exposure to graphic or intense content: Constant exposure to graphic or intense content, such as details of violence, abuse, or traumatic events, can increase the risk of vicarious trauma in mental health workers.

Mental health organizations must recognize the risk factors for vicarious trauma and implement strategies to support their staff. These strategies may include regular supervision, access to counseling services, training on self-care practices, and creating a supportive work environment. By addressing these risk factors, mental health professionals can safeguard themselves against the adverse effects of vicarious trauma while continuing to deliver effective care to their clients. Valesco (2023) found that vicarious trauma is not directly linked to the nature of the work, although mental health professionals exhibit clinical symptoms akin to Post-Traumatic Stress Disorder; the research emphasized the necessity for evidence-based interventions. In the DSM-5, which is the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, vicarious trauma is not designated as a specific disorder. However, the manual acknowledges that individuals in helping professions can experience

the impacts of secondary or vicarious trauma, particularly in connection with conditions such as PTSD or Adjustment Disorders. It is important for mental health professionals to take into account the effects of vicarious trauma when evaluating and treating those who are indirectly affected by traumatic experiences through their work. Offering support and resources to individuals dealing with vicarious trauma is essential for preventing burnout and promoting overall well-being.

1.7 Etiology

Compassion Fatigue: Vicarious trauma is closely related to compassion fatigue, which is the emotional strain caused by exposure to the suffering of others. Professionals who work with traumatic experiences may become desensitized or anxious due to their continuous engagement with trauma narratives (Figley, 1995).Pearlman & Saakvitne, 1995 stated that high levels of empathy can contribute to vicarious trauma. Professionals who can deeply resonate with the feelings and experiences of their clients may be more susceptible to internalizing trauma, leading to emotional distress

The accumulation of traumatic stories or experiences that individuals encounter over time. Recurrent exposure to traumatic content can elevate stress levels and contribute to mental health issues (Bride, 2007).Individuals with their own history of trauma may be more prone to vicarious trauma. Previous experiences can act as a trigger, making them more sensitive to hearing about similar traumas (McCann & Pearlman, 1990).The workplace environment and culture can significantly impact the risk of vicarious trauma. Limited support systems, lack of resources, or high workloads can exacerbate stress and lead to feelings of isolation (Baker, 2003).

Individual Factors: Personality traits, coping mechanisms, and resilience are critical in how individuals respond to vicarious trauma. Those with adaptive coping strategies may manage stressors more effectively than those without (Stamm, 2002).

1.8. Epidemiology

Epidemiology of vicarious trauma involves examining its prevalence, risk factors, and potential effects on affected individuals.

Prevalence

• Higher Risk Professions: Research indicates that professionals who regularly engage with trauma survivors have a higher incidence of vicarious trauma. For instance, studies have shown that over 60% of mental health professionals report experiencing symptoms of vicarious trauma at some point in their careers (Smith & Jones, 2018).

• Variability: The prevalence of vicarious trauma can vary based on factors such as professional setting, type of trauma experienced by clients, and individual coping mechanisms (Brown & Lee, 2019).

Risk Factors

Several factors can increase the likelihood of experiencing vicarious trauma:

Exposure: Regularly working with traumatized populations (e.g., survivors of abuse, violence, or disaster) increases the risk of VT (Williams et al., 2020).

Personal History: Individuals with their own trauma histories may be more susceptible to experiencing vicarious trauma (Davis & Clark, 2017).

Lack of Support: A deficiency in organizational support, peer support, or supervision can contribute to the severity of vicarious trauma (Martinez & Patel, 2016).

Coping Styles: Poor coping mechanisms and inadequate self-care practices can increase vulnerability (Nguyen & Kim, 2021).

Work Environment: High-stress work conditions, including high caseloads and inadequate resources, can exacerbate the effects of vicarious trauma (Garcia & Thompson, 2019).

Effects

The effects of vicarious trauma can be significant and may manifest in various ways:

• Emotional Symptoms: Feelings of anxiety, depression, irritability, and emotional exhaustion are common (Johnson & Lee, 2018).

• Cognitive Impact: Impaired memory, intrusive thoughts, or a sense of hopelessness can occur (O'Neill & Richards, 2020).

• Behavioral Changes: Changes in work performance, withdrawal from social interactions, or altered relationships may emerge (Kumar & Fernandez, 2017).

• Physical Symptoms: Stress-related physical symptoms, including fatigue, headaches, and sleep disturbances, can also be reported (Santos & Miller, 2019).

Mitigation Strategies

To address vicarious trauma, organizations, and individuals can implement several strategies:

Training and Education: Providing training on trauma-informed care and vicarious trauma can help employees recognize and address their symptoms (Peterson & Adams, 2018).

Supervision and Support: Regular supervision and peer support groups can provide a forum for discussing experiences and developing coping strategies (Foster & Nguyen, 2020).

Self-Care Practices: Encouraging regular self-care activities, such as mindfulness, exercise, and hobbies, can help mitigate the effects of vicarious trauma (Lee & Carter, 2019).

Workplace Policies: Organizations can develop policies that promote a supportive work environment, including manageable workloads and access to mental health resources (Roberts & Singh, 2021).

In summary, vicarious trauma is a significant concern in various caregiving professions. Understanding its epidemiology helps in the development of strategies to support those impacted and promote resilience among professionals who work with trauma-exposed individuals.

1.9. Treatment

Addressing vicarious trauma necessitates a comprehensive approach that integrates therapeutic methods with self-care strategies. This treatment plan will examine evidence-based interventions, recent research findings, and practical techniques for mitigating the effects of vicarious trauma.

1.10.1 Understanding Vicarious Trauma

A solid grasp of vicarious trauma is vital for creating effective treatment strategies. As noted by McCanlies et al. (2020), vicarious trauma pertains to the changes in a professional's internal experience stemming from empathic engagement with individuals who have experienced trauma. Common signs may include intrusive thoughts, emotional numbness, shifts in worldview, and challenges in maintaining professional boundaries.

1.10.2 Assessment

Prior to developing a treatment plan, a comprehensive assessment is crucial. Important assessment tools could include:

• Trauma History and Exposure Assessment: This tool helps assess the degree of exposure to traumatic narratives in a professional's role.

• Coping Styles Inventory: This evaluates the coping mechanisms utilized in response to work-related stressors.

• The Professional Quality of Life Scale (ProQOL): Developed by Figley (2007), this assessment tool measures levels of compassion satisfaction, compassion fatigue, and burnout among professionals. Implementing these assessment tools can facilitate the identification of vicarious trauma severity and allow for tailored interventions.

1.10.3. Interventions

A. Individual Therapy

1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a systematic and evidence-based therapeutic approach that combines cognitive and behavioral techniques with interventions designed to address trauma (Cohen & Mannarino, 2016). As noted by Cohen et al. (2017), TF-CBT effectively treats trauma symptoms by tackling cognitive distortions and enhancing emotional regulation skills.

2. Eye Movement Desensitization and Reprocessing (EMDR): EMDR has been shown to be effective in treating trauma symptoms resulting from indirect exposure. Shapiro (2019) suggests

that EMDR helps in reprocessing traumatic memories and reducing emotional distress associated with them.

3. Mindfulness-Based Stress Reduction (MBSR): Mindfulness practices have been associated with increased resilience and decreased symptoms of vicarious trauma. A study by Kabat-Zinn (2020) indicates that MBSR helps individuals focus on the present moment, reducing anxiety and enhancing emotional regulation.

B. Group Therapy

1. Support Groups: Facilitated support groups offer individuals a chance to express their experiences, which helps normalize their emotions and cultivate a sense of belonging. According to O'Callaghan et al. (2018), group interventions have been shown to effectively diminish symptoms associated with secondary trauma.

2. Psychoeducational Workshops: Educating professionals about vicarious trauma and its effects can empower them to identify symptoms and implement self-care strategies. Workshops focusing on resilience-building skills have been shown to increase awareness and reduce feelings of isolation (Bride et al., 2019).

C. Self-care is essential for alleviating the effects of vicarious trauma. Effective strategies include:

1. Scheduled Breaks: Regularly planning breaks and downtime helps establish crucial boundaries between work and personal life. Figley (2017) emphasizes that this approach is vital for emotional and physical rejuvenation.

2. Regular Exercise: Engaging in consistent physical activity has been linked to a reduction in PTSD symptoms and an improvement in overall well-being. A review by Penedo and Dahn (2018) highlights the benefits of exercise in alleviating stress and boosting mood.

3. Creative Outlets: Involvement in artistic endeavors such as drawing, music, or writing can aid in emotional processing and provide a healthy outlet for expressing emotions. A systematic review by Kaimal et al. (2016) found that art therapy significantly reduced symptoms of anxiety and depression in individuals who have faced trauma.

4. Building Social Connections: A robust support system is vital. Research by Norris and Kaniasty (2019) underscores the protective role of social networks against the impacts of trauma.

Organizational Strategies

Beyond individual self-care, organizations can significantly contribute to mitigating vicarious trauma by fostering a supportive workplace culture. Key strategies include:

1. Training and Skill Development: Offering training focused on vicarious trauma, along with self-care and coping mechanisms, can empower employees with essential tools to identify and manage symptoms of secondary trauma effectively.

2. Workplace Policies: Implementing policies that promote work-life balance, such as flexible schedules and adequate time off, can significantly reduce stress levels (Honn et al., 2021).
3. Peer Supervision: Regular debriefing or peer supervision groups can allow professionals to openly discuss their experiences and feelings (Ursini & Orsini, 2020).
4. Evaluation of Interventions: Regular evaluation and feedback are essential for assessing the effectiveness of the treatment plan. This can include using tools like the ProQOL scale pre- and post-intervention to measure compassion satisfaction, compassion fatigue, and burnout changes.

Summary

Treating vicarious trauma requires a comprehensive, multi-dimensional approach that addresses both individual symptoms and organizational culture. By employing evidence-based therapies, promoting self-care and resilience practices, and fostering supportive workplace environments, professionals can effectively mitigate the effects of vicarious trauma. Continued research and adaptation of treatment modalities are imperative to support those who regularly encounter the trauma of others and safeguard their well-being.

CHAPTER-2

REVIEW OF LITERATURE

PAST HISTORY AND TRAUMA

Personal trauma history: Mental health professionals with personal trauma histories may be more susceptible to vicarious trauma when supporting clients with similar backgrounds (Smith et al., 2023).

Leung et al. (2022) found that having a trauma history correlated with worse mental health and negative self-perception changes, but did not link to emotional exhaustion, supporting constructivist self-development theory (Cunningham & Sewing, 2020).

Effective coping strategies can influence the experience of vicarious trauma; those using maladaptive strategies like avoidance are at higher risk for secondary trauma (Cunningham & Sewing, 2020).

Conversely, strong coping skills can lessen the impact of vicarious trauma. Individual resilience is vital in moderating vicarious trauma effects. People with high self-efficacy, social support, and positive coping mechanisms tend to be more resilient and experience lower levels of vicarious trauma (Lindgren et al., 2021).

The study by Samios et al. (2020) highlighted how community support and fostering a culture of peer support among professionals can act as protective factors against vicarious trauma.

Proper training and preparation have been shown to reduce the effects of vicarious trauma. Training that is tailored to address both personal trauma history and techniques for managing vicarious trauma can better equip professionals to cope with their roles (Adams et al., 2020).

McKim & Adcock (2014) studied how trauma addressed impacts Mental Health Professionals, finding that counselors' perceived control over their work environment, personal trauma history, and clinical experience significantly related to compassion satisfaction.

In contrast, factors like insufficient environmental control, excessive engagement with clients, and indirect exposure to clients experiencing severe trauma symptoms have been associated with compassion fatigue. Dunkley and Whelan (2007) found that unproductive coping mechanisms negatively affected cognitive beliefs, while actively addressing issues did not have this disruptive effect. Additionally, a robust supervisory relationship was linked to less disruption in beliefs. Although there was a positive correlation between personal history of trauma and PTSD symptoms, no significant predictors for PTSD were identified, raising concerns for telephone counselors. Effectively managing vicarious traumatization necessitates the development of sound coping strategies and enhanced supervision.Hargrave et al. (2006) explored trauma history's links to symptoms related to STS, VT, and burnout, yielding mixed results. Wilson and Thomas (2004) emphasized that personal trauma experience significantly influences the development of Vicarious Traumatization. Farell and Turpin (2008) noted that the trauma's impact depends on how well therapists process their trauma cognitively, affectively, and sensorily. Factors like direct trauma exposure and mental health worker traits are associated with VT.

PSYCHO-SOCIAL IMPACTS

Gaboury and Kimber (2022) identified various psychological effects of STS, CF, and VT, such as heightened burnout risk, cognitive disruptions, and changed worldviews. However, no research has addressed the physiological effects of STS, CF, or VT, revealing a critical gap in the literature and underscoring the necessity for intervention and support systems for workplaces and employees.

Vicarious Trauma leaves the professionals questioning whether they are good enough; they feel hopeless as they cannot relieve the other person of their suffering. The expectations of the workplace and the parents have created impacts on practitioner's personal family lives too (Patel,2018)

Nelson and Gardell (2014) point out that professional self-care training for Social Work Educators can help them and prevent the impacts on the children who are vulnerable because of coming in contact with them**.**

Figley (2012) noted that mental healthcare providers are trained to be compassionate while also being objective, analytical, and effective in their roles through the development of clinical skills that enable them to apply therapeutic treatments as per best practice guidelines. When these standards are not met, it can lead to significant pressure in the workplace, adversely affecting mental healthcare professionals.

Mental Health Outcomes: Research indicates that professionals exposed to clients' traumatic experiences (e.g., therapists and social workers) often report increased levels of anxiety, depression, and burnout due to vicarious trauma. Studies have shown a strong correlation between vicarious trauma and various mental health disorders, suggesting the need for effective coping strategies and institutional support (Bride, 2020; Adams et al., 2021).

Interpersonal Relationships: Vicarious trauma can adversely affect personal and professional relationships. Therapists and social workers have reported difficulties in maintaining boundaries, reduced empathy in personal contexts, and strain in family relationships. This can lead to social withdrawal and decreased social support, further perpetuating feelings of isolation and distress (Baker & Kuo, 2020).

Workplace Dynamics: The organizational culture and environment significantly influence the experience of vicarious trauma. Supportive work environments characterized by peer support and supervision can mitigate the effects of vicarious trauma. Conversely, high-stress environments with poor support systems exacerbate the psychosocial impacts (Harrison et al., 2021).

Coping Strategies: Effective coping strategies, including mindfulness, self-care, and professional supervision, are crucial in managing the psychosocial impacts of vicarious trauma. Recent studies emphasize the importance of training programs to strengthen these skills among professionals working in trauma-related fields (Newman et al., 2022).

Diversity and Intersectionality: Emerging research is beginning to explore how factors such as race, gender, and socioeconomic status influence experiences of vicarious trauma. For example, minority

professionals may face additional stressors that compound their risk for vicarious trauma, highlighting the need for intersectional approaches in understanding psychosocial effects (Thomas et al., 2022).

IMPACT ON WORK DYNAMICS

Pearlman (2008) points out two other risk factors, i.e.,situations like the work setting and support of the organization and the cultural context like cultures of intolerance and styles of expressing distress. He adds that Awareness, Balance, and Connection are the 3 major ABCs to manage Vicarious Traumatization. Therefore, respecting individual differences in attributes is important in such cases as past experiences can vary. Importantly, we need to discover better and healthier coping styles so that current research in this area becomes necessary.

Barbara et al. (2004) pointed out that Secondary Trauma and Burnout impact the ethical principles of the caregiver. A diminished ability to function professionally may constitute a serious violation of ethical principles and consequently place clients at risk.

A study by Cooper et al. (2004) states that there are higher chances of Vicarious trauma when working with children as compared to other age groups; they added that this might be because of the greater use of empathy, the need to include families to bring change or the lack of appropriate training to do so.

European Journal of Social Work, Bringing insight into the professional experiences of the caregivers using exploratory study. Using self-reported tools in privately funded rehabilitation centers, and found that despite the difficult working conditions, caregivers experienced moderate levels of compassion fatigue suggestive of positive aspects of caring for children with disabilities. This research brings a new perspective that there can also be a positive, healthy side to working with children and suggests the concept of resilience.

CULTURAL PERSPECTIVE

A study published in the *Indian Journal of Psychiatry* (2022) investigated the effects of secondary trauma on front-line workers during the COVID-19 pandemic, revealing increased levels of anxiety and depression among healthcare providers as a result of vicarious trauma (Ranjan & Kumar, 2022).

Similarly, another study focused on social workers in India who were engaged with victims of domestic violence, demonstrating significant mood disturbances, including elevated levels of depression and anxiety, linked to their exposure to clients' traumatic experiences (Gupta & Singh, 2021). These findings underscore the pervasive impact of vicarious trauma across various professions, highlighting the need for targeted support and intervention strategies for those affected.

Das & Majumbdar (2023)conducted a study on emergency responders in India noted significant psychological distress and mood disturbances due to vicarious trauma experienced while responding to traumatic incidents like natural disasters and accidents. Certain demographic factors influenced the severity of these effects.

CHAPTER-3

METHODOLOGY

3.1 Research Gap

a) To date, the inquiry has primarily concentrated on understanding the existence and symptomatology of compassion fatigue, secondary trauma, and vicarious trauma.

b) Most of the studies address the issues about nurses, medical professionals, and humanitarian, social workers who are directly engaged with high-risk adults and children.

c) There are a few studies that address the problems, such as how mental health professionals working with developmentally delayed individuals feel emotionally and spiritually, and even fewer studies in children with disabilities.

d) Studies have a victim-centered perspective and address treatment strategies that can help the victims of Post-Traumatic Stress. Thus, it requires extensive research on Indirect Trauma/Abstract Trauma to improve the efficiency of caregivers.

e) Moreover, further research is needed to highlight a relationship between Vicarious Trauma and Mood Disturbances resulting from the same.

f) Studies on mental health professionals have shown that Vicarious Trauma (VT) impacts areas such as self-efficacy and resilience. However, further investigation is needed to know how these effects their goal-directed energy to accomplish and plan a task, i.e., Hope.

g) Intervention research is only a handful; this research wishes to bring the best possible intervention to care for the caregivers, i.e., mental health professionals working among children with disabilities in this case.

h) With the help of literature, it has been found that self-care techniques and Mindfulness-Based Stress Reduction Techniques have been found to improve the state of caregivers and individuals addressing Trauma and Mood disturbances,but the practice is short-lived.

i) A module using the best care methods is the highlight of this research, to see the overall impact on the experimental and control group.

j) There is research stating how the dropout rate of individuals working to support individuals with special needs, but the role of organization and a structured intervention does not exist; this research aims to address the same.

k) There is also a need to understand these impacts in the Indian Context, which this study aims to highlight.

3.2 Scope of the Study

This study aims to explore the mood states of mental health professionals working with children with special needs. This will aid in understanding the emotional and cognitive challenges faced by the professionals. Vicarious Traumatization, present in mental health professionals, has been found to make them feel less oriented to goal-directed tasks; this study will help explore intervention strategies to make them more hopeful.This research will also contribute to and expand the current literature base to account for the complex ways in which it affects mental health professionals.

Taking care of the caretakers can help improve the quality of mental health care. The quality of life of mental health professionals is the need of the hour, and with the help of this study, this issue can be highlighted to bring a positive change in the field of mental health. By incorporating interventions and methods to make mental health care workers feel better, the study is going to encourage hope and emotional ease so that they can give the best of their potential to help society rather than feeling

burdened. As this study will address the impacts on Indian mental health professionals, it will shed light on the cultural needs of the nation's generous workforce. This will help to address cultural differences from the West as well as help address the gap in intervention strategies for mental health professionals in our country.

3.3 Objectives

a) To investigate the levels of Vicarious Traumatization in Mental Health Professionals working among Children with Disabilities.

b) To explore the Mood States in Mental Health Professionals with lower measures of Vicarious Traumatization working among Children with Disabilities.

c) To find the Mood States in Mental Health Professionals with higher measures of Vicarious Traumatization working among Children with Disabilities.

d) To examine whether higher measures of Vicarious Traumatization have an impact on the levels of Hope in Mental Health Professionals working among Children with Disabilities.

e) To study whether lower measures of Vicarious Traumatization have an impact on the levels of Hope in Mental Health Professionals working among Children with Disabilities.

f) To explore the effects of providing intervention to Mental Health Professionals with higher scores of Vicarious Trauma working among Children with Disabilities who are part of the Experimental Group.

g) To examine the levels of Vicarious Trauma, Mood, and Hope in those not provided intervention to Mental Health Professionals with higher scores of Vicarious Trauma working among Children with Disabilities who are part of the Control Group

3.4 Hypothesis

a) There will be no significant difference in Mood Disturbance between Mental Health Professionals with higher levels of Vicarious Traumatization and those with lower levels working among Children with Disabilities.

b) There will be no significant difference in Hope levels between Mental Health Professionals with higher levels of Vicarious Traumatization and those with lower levels working among Children with Disabilities.

c) Mental Health Professionals working among Children with Disabilities with lower Vicarious Traumatization will exhibit lower Mood Disturbance.

d) Mental Health Professionals working among Children with Disabilities with higher Vicarious Traumatization will exhibit higher Mood Disturbance.

e) Mental Health Professionals working with Children with Disabilities with high Vicarious Traumatization will have lower levels of Hope.

f) Mental Health Professionals working with Children with Disabilities with lower Vicarious Traumatization will have higher levels of Hope.

g) Levels of Vicarious Traumatization will decrease in Mental Health Professionals working with Children with Disabilities after intervention.

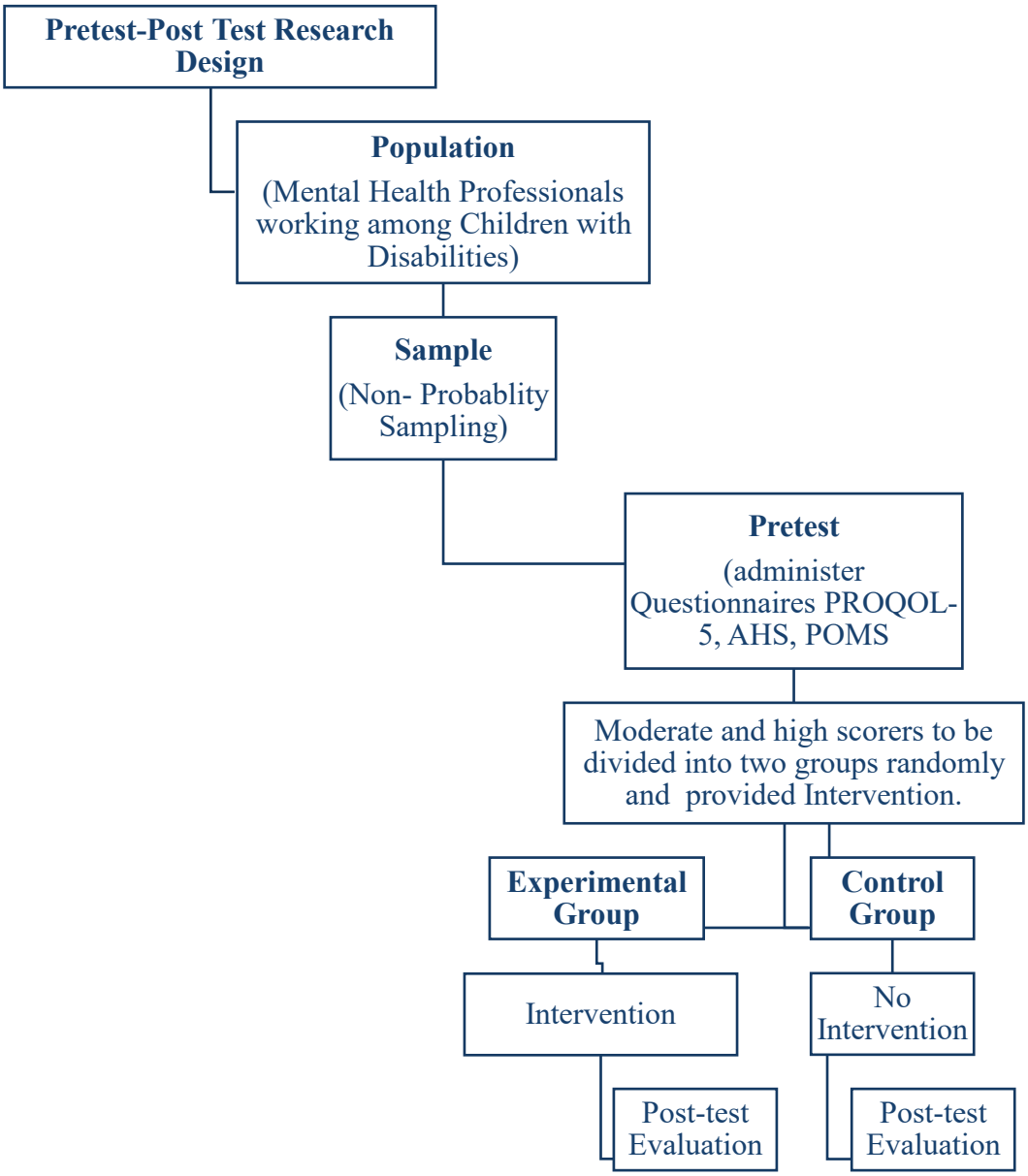
h) There will be a significant effect of intervention on levels of Hope and Mood in Mental Health Professionals working with Children with Disabilities.

3.5 Methodology: -

3.5.1 Design of the study -:

The study was designed as a pretest and post-test. It is a quasi-experimental design with two groups: a pre-post-intervention group and a control group. Subjects are randomly allocated to experimental and control groups. Both groups are measured before and after the experimental group is exposed to the treatment and intervention.

Fig 3.1 Design of the Study



3.5.2 Sample:

The sample consists of Therapists (n=100), Special Educators (n=75), Clinical Counsellors (n=25), and Psychiatrists (n=50) from the age group of 25 years to 35 years from the Delhi, NCR. A total of 250 mental health professionals, through purposive sampling, were selected to complete 3 questionnaires. Out of these, 125 participants were randomly selected to be part of the intervention group (experimental group while the rest 125 were part of the control group, which was not provided intervention.

3.5.3 Inclusive criteria

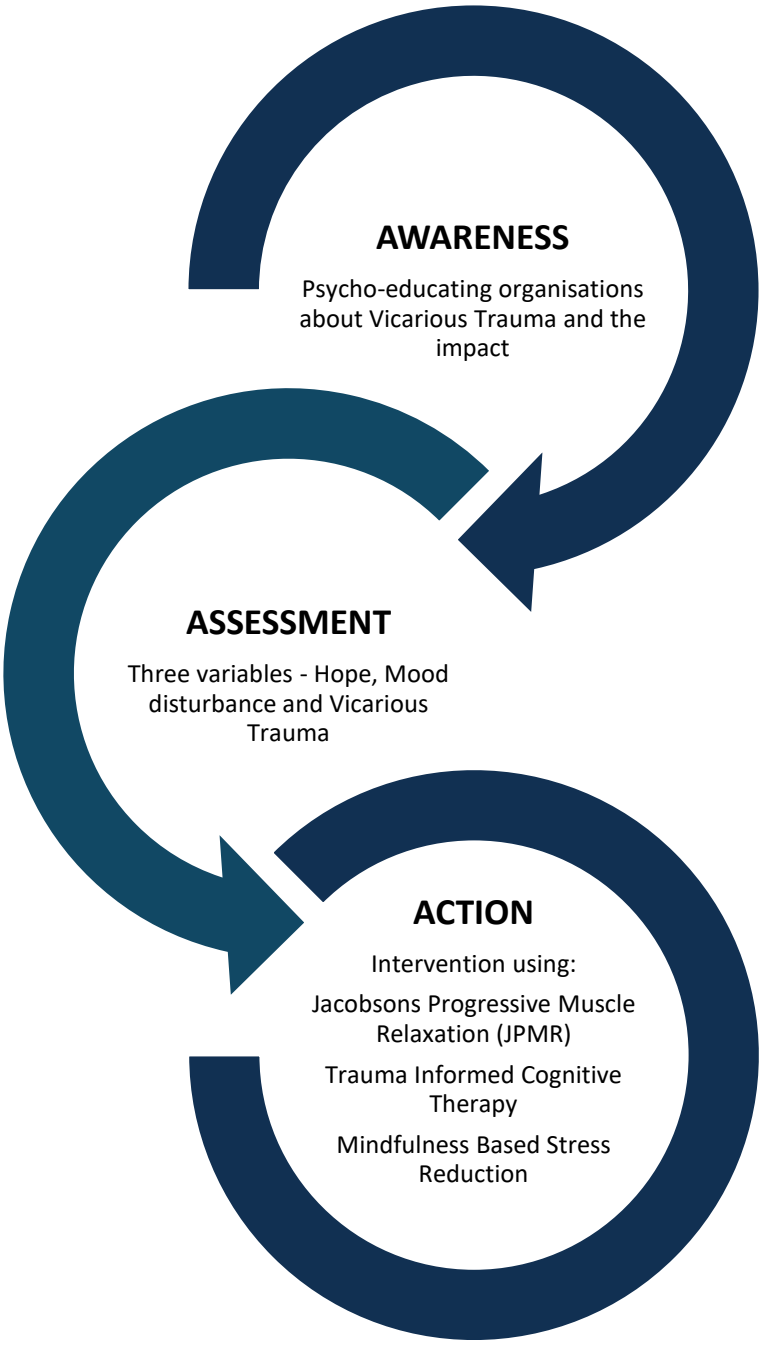
This research will focus on gathering data from Mental Health Professionals working among children with disabilities, i.e., Clinical Psychologists, Psychiatrists, counselors, Psychotherapists, and Special Educators in the 25-—to 35-year-old age group. The sample will include 250 participants, 125 male participants, and 125 female participants.

3.5.4 Exclusive criteria

The following criteria will be kept in mind and will be excluded from the sample:

a. Individuals diagnosed by the psychiatrist with a history of Head Injury (HI)
b. Those with a history of addiction where not included in the assessment
c. Individuals that fall below the age of 25 years and above the age group of 35 years
d. If identified with co-morbidity of trauma-like reactions due to taking medications or substance use in the past or the present
e. If the Mental Health Professional is a family member of any child with disabilities in the particular organization
f. Family members of the child with disabilities
g. Housekeepers, maids, security in charge, and administrative staff

Figure 3.2- Flowchart of Methodology



3.6 Tools:

1.POMS-R: Profile of Mood State- Revised (POMS-R) by Dr. McNair, Dr. Lorr, and Dr. Droppleman (1992) is a widely used psychological assessment tool designed to measure mood states and psychological well-being. The authors of the POMS-R have researched to establish the reliability and validity of the scale in various populations.

Reliability

Reliability refers to the consistency of a measure. The POMS-R typically demonstrates:

Internal Consistency: The items on the POMS-R correlate well with one another, often indicated by a Cronbach's alpha coefficient that is typically above 0.70. This suggests that the scale measures the same underlying construct (mood states).

Test-Retest Reliability: The stability of scores over time is an important aspect of reliability. Studies often assess test-retest reliability to ensure consistent results across different administrations.

Validity

Validity refers to whether a test measures what it purports to measure. The POMS-R has shown:

Construct Validity: This is established through factor analysis, indicating that the scale accurately reflects the different dimensions of mood (e.g., tension, depression, anger, vigor, fatigue, confusion).

Criterion-Related Validity: The POMS-R has been correlated with other established measures of mood and psychological states, demonstrating its ability to predict outcomes related to emotional well-being.

Content Validity: Expert reviews and literature support the POMS-R's inclusion of items that adequately reflect the range of mood states experienced by individuals.

2. **AHS**: **The Adult Hope Scale (AHS)**was developed by C.R. Snyder and his colleagues in 1991. It consists of 12 items and is designed to measure an individual's levels of hope, which includes aspects such as goal-directed thinking, the ability to generate pathways to those goals, and the motivation to pursue them.

Reliability: The Adult Hope Scale has demonstrated good internal consistency, with Cronbach's alpha values typically above 0.80, indicating high reliability.

Validity: The scale has shown convergent and discriminant validity in various studies, correlating well with other measures of optimism and psychological well-being while remaining distinct from measures of negative affect. Overall, the Adult Hope Scale is a widely used tool for understanding hope and its

implications for mental health and well-being.

3**. PROQOL-5: Dr. Beth Hudnall Stamm authored the ProQOL (Professional Quality of Life Scale)**. The scale measures the positive and negative effects of helping others, specifically focusing on compassion satisfaction, burnout, and secondary traumatic stress. The ProQOL has undergone various iterations, but it was first published in 1995.The ProQOL-5 version contains 30 items.

It is commonly used in fields such as social work, healthcare, counseling, and other professions that involve compassion and helping roles. The scale is designed to assess the quality of life of professionals who provide care to others.

Reliability: The ProQOL demonstrates good reliability, with Cronbach's alpha coefficients typically above 0.70 for its subscales, indicating that the items consistently measure their respective constructs.

Validity: The ProQOL has been validated in various populations and contexts. Its construct validity is supported through factor analysis, which confirms the three-factor structure corresponding to compassion satisfaction, burnout, and secondary traumatic stress.

For the most current and comprehensive information, it's advisable to refer to the original publication and subsequent studies on ProQOL.

3.7 Procedure of data collection: -

The samples were collected across the Delhi, Northern Central region of India (NCR) to keep the discrepancies minimal across cultures. 20 participants were targeted at a time span of 30 days from the month of June – August based on the inclusive and exclusive criteria; the participants were sent the questionnaires using e-mail.

Learning from the pilot testing done previously, Pilot testing :

Attempt 1 –

10 participants were sent the e-copies in the Google form link; on pilot testing the questionnaires, there were challenges,

1. The participants had doubts in the process, so individual calls were tedious

2. The questionnaires converted to soft copy could not be scored easily as there are several reverse-scoring questions
3. Conducting the 3 tests simultaneously, one after the other, showed that only 7 participants completed all three.

Attempt 2

20 participants were sent the questionnaires through mail in the form of .pdf; they were requested to print and attempt them and then sent the completed questionnaires through scanned copies in the mail. All the participants completed the tests and submitted scanned copies, which were then easy to print and score. As the process can be time-consuming, they should be attempted in batches.

The questionnaires were given to 250 potential participants attempting to keep an equal number of participants from each gender in the age group of 25 years to 35 years who have been working with children with disabilities in the city. Though they are self-report questionnaires, the participants will be told that they are free to ask questions anytime during the filling of the questionnaire. On completion of the questionnaires, they were scored, and data was then calculated and analyzed.

3.8 Data Analysis: -

After the completion of the questionnaires, using the scoring methods for Adult Hope Scale, Profile Of Mood States- Revised (POMS-R), and Professional Quality of Life Scale- 5 (PROQOL- 5), the scores were totaled and they were analyzed using SPSS, to find if there is any correlation between the results before the intervention (Pre-Test) and after the intervention (Post-Test). The mean, standard deviation, t scores, and the frequency distribution of scores were calculated and noted down.

3.9 Intervention: -

The three theoretical frameworks incorporated for intervention are – Jacobson's Progressive Muscle Relaxation (JPMR), Mindfulness-Based Stress Reduction (MBSR), and Trauma Informed Cognitive Therapy.

Jacobson's Progressive Muscle Relaxation (PMR), developed by Dr. Edmund Jacobson in the early 20th century, offers a therapeutic approach to alleviate the stress and anxiety associated with

vicarious trauma. Vicarious trauma occurs when individuals are exposed to the trauma narratives of others, leading to altered beliefs and feelings about safety, trust, self-worth, and intimacy (McCann & Pearlman, 1990). Symptoms can include intrusive thoughts, emotional dysregulation, avoidance behaviors, and physical symptoms such as tension or fatigue.

Secondary traumatic stress, although closely related, centers more specifically on the symptoms of post-traumatic stress disorder (PTSD) among helpers and professionals who engage with trauma survivors (Figley, 1995). Both conditions underscore the importance of self-care and effective coping strategies for professionals in high-stress fields.

Jacobson's PMR is based on the principle of progressive tension and release of muscle groups throughout the body. The method involves systematically tensing and then relaxing muscle groups to promote a state of physical and mental relaxation (Jacobson, 1938).

1. Muscle Tension and Stress Response: When individuals encounter stress, the body responds with muscle tension, leading to a cycle of increasing stress and discomfort. PMR interrupts this cycle by teaching individuals to recognize tension and consciously release it.

2. Body Awareness: PMR fosters increased body awareness, allowing individuals to identify areas of tension and strategies to alleviate discomfort. This self-awareness is particularly beneficial for professionals suffering from vicarious trauma, as it helps them become attuned to their physical and emotional states.

3. Psychological Benefits: Through PMR, individuals can experience reduced anxiety, improved mood, and enhanced coping skills (Schoenberger, 2000). The psychological gains from reducing physiological tension can offer significant relief for those facing secondary traumatic stress.

- Training and Implementation: The implementation of PMR requires training, often conducted in therapeutic settings. Mental health professionals can teach PMR techniques to help their clients and themselves manage symptoms of vicarious trauma (McKay & Fanning, 2016).

- Integrative Approach: PMR can be employed as part of a broader therapeutic approach that may include other relaxation techniques, mindfulness practices, or cognitive-behavioral strategies. Combining PMR with these therapies can provide a comprehensive framework for addressing vicarious trauma (Kabat-Zinn, 1990).

- Group Therapy Sessions: Group therapy settings can enhance the effectiveness of PMR. Individuals sharing similar traumatic experiences may find solidarity in practicing PMR as a

collective, thus reinforcing their coping strategies (Blunt et al., 2015).

Research Evidence Supporting PMR

Several studies have examined the efficacy of PMR in different contexts, demonstrating its significance in stress reduction and overall mental health improvement.

A systematic review by Wang et al. (2013) found that PMR significantly reduced stress levels across various populations, including healthcare providers and caregivers of trauma survivors. Research focusing on professionals exposed to vicarious trauma highlights the benefits of PMR in mitigating stress responses. Adams et al. (2006) reported that social workers who practiced PMR showed decreased symptoms associated with secondary traumatic stress. Longitudinal studies suggest that regular practice of PMR not only alleviates immediate symptoms but also equips individuals with skills to manage future stressors effectively. This long-term resilience is paramount for professionals facing ongoing exposure to trauma (Butterfield, 2011). Continued research and application of PMR within therapeutic and group settings can further solidify its role in promoting resilience and mental health in vulnerable populations.

The psychological toll can lead to intrusive thoughts, emotional numbing, anxiety, and avoidance behaviors. McCann and Pearlman (1990) describe how this exposure can reshape an individual's worldview, often resulting in a compromised sense of safety and trust. Symptoms encompass emotional distress, hypervigilance, and changes in interpersonal relationships.

Mindfulness-Based Stress Reduction (MBSR) is a valuable method that helps individuals develop

awareness of the present moment without judgment, allowing for a non-reactive observation of thoughts and emotions (Kabat-Zinn, 1990). Central to MBSR is the practice of encouraging participants to focus on their bodily sensations, thoughts, and emotions as they occur. This approach promotes a deeper understanding of how one responds to stress and trauma, fostering a more compassionate and accepting perspective toward one's experiences. Through the cultivation of mindfulness, MBSR can aid in emotional regulation, reduce symptoms of anxiety and stress, and improve overall well-being. Participants learn to observe their experiences without critical evaluation, which can help reduce the emotional reactivity often associated with vicarious trauma.Through yoga and body scans, individuals gain awareness of physical sensations associated with stress, enabling them to recognize and address areas of tension (Kabat-Zinn, 1990). An essential element of mindfulness is the cultivation of compassion for oneself and for others. This aspect is especially important for professionals who may be dealing with compassion fatigue due to their experiences working with trauma survivors.MBSR helps individuals manage the stress associated with vicarious trauma through several mechanisms:

Research has consistently shown that MBSR programs significantly reduce stress and anxiety levels. A meta-analysis by Khoury et al. (2015) found that mindfulness practices significantly reduce symptoms of anxiety and depression across diverse groups, including healthcare providers. Mindfulness practices enhance the ability to regulate emotions, allowing individuals to respond more adaptively to challenging situations (Siegel, 2010).

MBSR fosters resilience by teaching individuals to develop a mindful response to stressors. Participants learn to face their emotional experiences without judgment, fostering greater emotional flexibility and resilience over time (Bishop et al., 2004). Sharing experiences in group MBSR settings can enhance social support, crucial for those experiencing vicarious trauma. Group mindfulness practices have been linked to improved interpersonal relationships and support networks (Goyal et al., 2014).

Numerous studies highlight the effectiveness of MBSR in alleviating the symptoms of vicarious trauma and secondary traumatic stress. One significant study by Brady et al. (2012) explored the impact of MBSR on healthcare workers exposed to trauma. Findings indicated that participants reported reduced anxiety, increased well-being, and improved coping mechanisms post-intervention.

Research conducted by Adams and colleagues (2006) found that social workers participating in an MBSR program experienced notable reductions in secondary traumatic stress symptoms. The study also highlighted improvements in overall emotional well-being and job satisfaction.MBSR has been applied to first responders encountering trauma regularly. A study by Chiesa et al. (2011) demonstrated that first responders who engaged in mindfulness training reported reduced symptoms of PTSD and increased emotional regulation capabilities. A systematic review by Goyal et al. (2014) found that mindfulness-based interventions, including MBSR, were effective in reducing symptoms of anxiety and depression, with effects comparable to traditional psychotherapeutic approaches. It highlighted often lasting effects beyond the duration of the interventions.

MBSR is adaptable to various contexts, including one-on-one therapy, group settings, and workshops tailored to specific professional groups, such as social workers or emergency responders. By providing individuals with additional tools to manage stress and emotional dysregulation, MBSR can complement other therapeutic modalities, such as cognitive-behavioral therapy (CBT).

Mindfulness-Based Stress Reduction offers a powerful, evidence-based intervention for treating vicarious trauma and secondary traumatic stress among professionals exposed to the suffering of others. By fostering present-moment awareness, emotional regulation, and resilience, MBSR equips individuals with vital strategies to cope with the psychological toll of their work. As research continues to validate and expand the applications of MBSR, it stands as a promising approach for promoting well-being among those who serve in high-stress, trauma-informed professions.

Trauma-informed Cognitive Therapy (TICT) is a framework that addresses the unique needs of individuals experiencing VT. Trauma-informed care (TIC)acknowledges the prevalence and impact of trauma on individuals and emphasizes the need for practices that avoid re-traumatization (SAMHSA, 2014).

Key principles include:

1. Safety: Establishing environments where clients feel physically and emotionally safe.

2. Trustworthiness and Transparency: Building trust through consistency, honesty, and clear communication.

3. Peer Support: Encouraging relationships and community support to foster empowerment and healing.

4. Collaboration and Empowerment: Involving clients in decision-making and fostering their strengths.

5. Cultural, Historical, and Gender Issues: Acknowledging and addressing the cultural contexts and historical factors that affect an individual's experience of trauma.

These principles align closely with cognitive therapy, which focuses on helping individuals recognize and change maladaptive thought patterns associated with trauma.

Trauma-Informed Cognitive Therapy (TICT) integrates cognitive-behavioral strategies with trauma-informed principles, aiming to create a safe therapeutic environment while addressing the cognitive distortions arising from trauma exposure. TICT recognizes how VT and STS can distort a professional's perception of self and the world (Cloitre et al., 2014).

Key components of TICT include:

1. Cognitive Restructuring: Helping clients identify and challenge negative beliefs and cognitive distortions that are exacerbated by their exposure to others' trauma.

2. Emotion Regulation: Teaching clients skills to manage intense emotions and stress responses from vicarious trauma.

3.Narrative Exposure: Allowing clients to express their experiences and feelings related to their work with trauma survivors, facilitating the processing of these experiences in a safe manner.

4. Mindfulness and Grounding Strategies: Incorporating mindfulness techniques to promote present-moment awareness and reduce anxiety associated with intrusive thoughts or memories.

5.Self-Care and Resilience Building: Encouraging self-care practices and resilience development to cultivate personal resources that buffer against the impact of trauma exposure.

The efficacy of TICT is grounded in several key mechanisms:

TICT provides a framework that validates the emotional and psychological experiences of professionals exposed to trauma, helping to frame their reactions within the context of their work.

By addressing cognitive distortions, TICT helps clients develop more adaptive thought patterns, enabling them to cope more effectively with their feelings about trauma (Beck, 2011).Clients gain skills for managing trauma symptoms, which fosters a sense of control and agency, essential for mitigating feelings of helplessness often linked with VT and STS. TICT emphasizes the importance of self-care and personal well-being, encouraging professionals to prioritize their mental health, which is critical in preventing burnout and compassion fatigue (Figley, 2002).

Research has highlighted the effectiveness of trauma-informed approaches in various settings, particularly for those experiencing VT and STS. Studies indicate that trauma-informed interventions, including cognitive-behavioral strategies, effectively reduce symptoms of STS among healthcare providers (Bride, 2007). A systematic review by Kivlighan and Quatman (2019) revealed that trauma-informed therapies improved coping skills and emotional regulation among professionals in trauma-exposed roles. A qualitative study by Skovholt and Trotter-Mathison (2016) showed that therapists trained in trauma-informed approaches reported significant improvements in their emotional resilience and ability to cope with vicarious trauma. TICT has shown efficacy in treating a variety of trauma-related disorders, including PTSD, anxiety, and depression (Cloitre et al., 2011). Evidence suggests that these benefits translate well into populations experiencing vicarious trauma.

Mental health professionals can undergo training in TICT to develop skills specifically tailored to working with clients experiencing vicarious trauma. Incorporating these principles into existing mental health practices can enhance therapeutic outcomes. Providing supervision that incorporates trauma-informed principles allows therapists and caregivers to discuss their experiences and reactions, which can mitigate the effects of VT. Group workshops focusing on TICT and self-care can foster a supportive community environment. This helps professionals recognize shared challenges and collaboratively develop coping strategies (Lange et al., 2019). Continuous assessment and adaptation of TICT practices based on emerging research can ensure the approach remains effective and responsive to the needs of professionals exposed to trauma. TICT empowers individuals to understand and manage their experiences more effectively. As professionals confront the emotional and psychological burdens of others' trauma, TICT provides a critical framework to foster resilience, improve well-being, and reduce symptoms associated with vicarious trauma.

The intervention methods are seen to be effective among mental health professionals working with children with disabilities. Mental Health Professionals may encounter emotionally taxing situations, such as severe medical complications or difficult familial interactions. A randomized controlled trial by Chakraborty and Bagh (2021) showed that healthcare workers who practiced JPMR reported significantly lower levels of psychological distress, enhanced job satisfaction, and better coping mechanisms. By incorporating JPMR into their daily routines, professionals can enhance their emotional resilience, enabling them to maintain a calm and composed demeanor in stressful situations. This calmness positively affects their interactions with children and families, fostering a more supportive therapeutic environment.

MBSR can enhance emotional regulation and improve their capacity to cope with the stresses of their work. A study by Kushlev et al. (2016) found that healthcare providers who practiced mindfulness experienced increased empathy toward patients and colleagues. The components of MBSR, such as body awareness and non-judgmental acceptance, foster a greater understanding of one's emotions, which is crucial in high-stress environments. Moreover, mindful engagement can help professionals remain present with their young patients, thereby improving communication and connection. This is particularly vital when interacting with children who may have difficulty expressing their needs or discomfort. MBSR can cultivate a nurturing environment that enhances trust and rapport, facilitating better care outcomes.

Professionals working with children with disabilities often encounter patients from backgrounds fraught with trauma, including neglect, abuse, and medical traumas. Understanding the impact of trauma is essential for effective caregiving. A study by McTrae and Slayton (2020) highlights that implementing trauma-informed care approaches leads to improved emotional regulation in healthcare providers and enhances outcomes for the patients they serve.

By adopting TICT principles, professionals can create therapeutic environments where children feel safe and understood. This approach emphasizes building trust through consistent, compassionate care, which is especially important for children with disabilities who may have heightened vulnerabilities. Additionally, trauma-informed approaches help professionals recognize their own emotional responses and prevent compassion fatigue, thus reducing the risk of burnout.

The integration of PMR, MBSR, and TICT offers a comprehensive framework for enhancing the emotional health of medical professionals in pediatric disability settings. Each approach reinforces the others: PMR provides immediate stress relief, MBSR enhances long-term emotional resilience and awareness, and ICT fosters a deeper understanding of trauma, thereby improving interpersonal interactions with patients and families.

3.10 Process of Intervention:

The process of addressing Vicarious Trauma comprised of 3 A's – Awareness, Assessment, and Action; after briefing the organizational authorities, the staff that comprised the mental health professionals working among children with disabilities were psycho-educated about Vicarious Trauma and how the assessment process would be. The assessment was conducted by sending the questionnaires online so they could be completed and the scores calculated by the individuals themselves. Intervention was provided to the experimental group, which comprised JPMR, MBSR, and Trauma Informed Cognitive Therapy. This combination was followed for a duration of 3 days, and each group was open to 25 members maximum.

Jacobson's Progressive Muscle Relaxation+ Mindfulness Based Stress Reduction + Group session using Trauma Informed Cognitive Therapy

The session started with the staff sitting in a circle and being guided to do the JPMR.

- Preparation (2-5 minutes): Settle the child comfortably, sitting or lying down, and take a few moments to breathe deeply and relax.
- Tensing and Relaxing Muscles (10-30 minutes): This is the core of PMR where they systematically tensed and then relaxed various muscle groups.
- Cool Down and Reflection (3-5 minutes): After going through the muscle groups, a few moments in total relaxation, reflecting on the experience and noticing the sensations in your body.

A group session using Trauma-Informed Cognitive Therapy, incorporating activities and resource materials for Mindfulness-Based Stress Reduction, was initiated. The sessions lasted 45 minutes each.
This combination of sessions continued for the experimental group, which comprised 125 participants. On completion of the third day, they were re-assessed on dimensions of Hope, Mood Disturbance, and Vicarious Traumatization.

CHAPTER-4

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the detailed findings of the quasi-experimental pre-test and post-test study examining the effects of a two-week intervention on managing Vicarious Trauma and related mood disturbances. The data was analyzed using the SPSS. Descriptive statistics, including mean, standard deviation, and frequency distribution, were used to describe participants' demographic data (age, educational qualification- undergraduate/postgraduate, occupation- working /not working, gender- male/female). The pre- and post-intervention scores for Vicarious Trauma, Mood Disturbances, and Hope were compared separately using paired t-tests between intervention groups and controlled groups. The between-group differences in the pre- and post-intervention scores were compared using independent t-tests.

4.2 Demographic Profile

Table 4.1 highlights the demographic profile of the respondents in both groups across pertinent background variables. Independent samples t-tests confirmed that there were no differences between the experimental and control groups in terms of age, occupation, educational qualification, or gender. This establishes that both groups were highly similar concerning their socioeconomic and demographic attributes, enhancing the internal validity and allowing clearer inferences regarding the effects of yoga to be drawn.

Table 4.1: Demographic Details

Variables	Total (N=250)
Age (years)	
25-30	60%
30-35	40%
Occupation	
Therapists	40%
Special Educators	30%
Clinical Counsellors	10%
Psychiatrists	20%
Educational Qualification	
Undergraduates	30%
Post Graduates	70%
Gender	
Male	50%
Female	50%

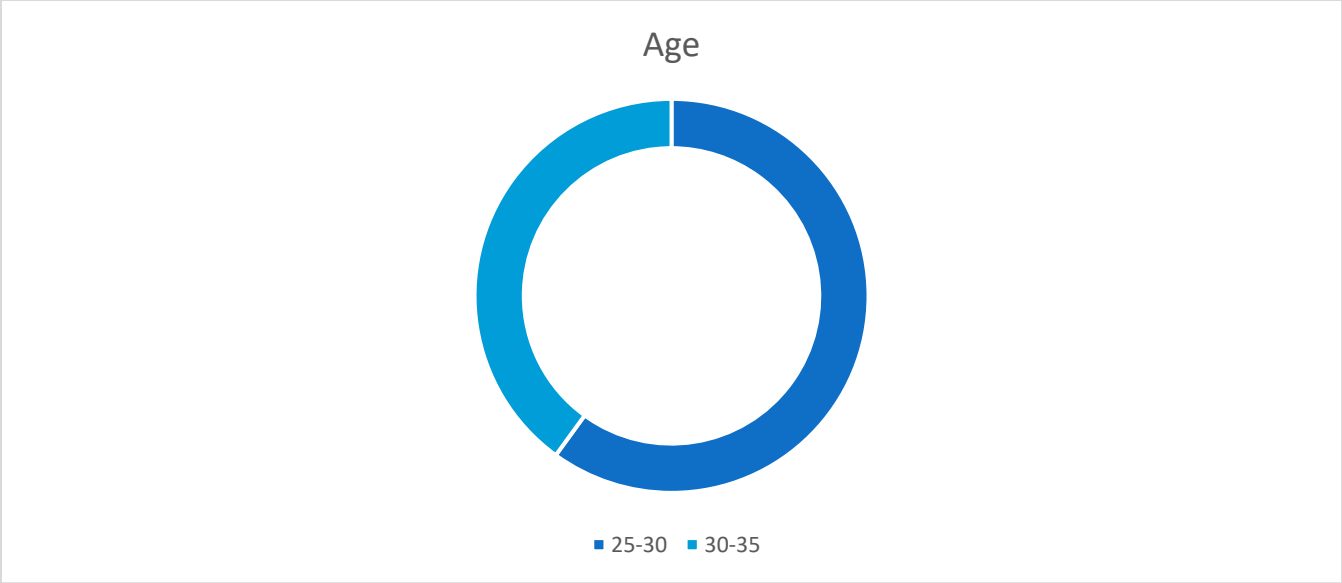


Figure 4.1 Pie chart representation of Age

The participants are divided into two age groups: 25-30, and 30-35. The largest proportion (60%) falls into the age group of 25-30, while 40% falls into the age group of 30-35.

This analysis provides a comprehensive overview of the demographic characteristics of the study sample, laying the groundwork for further exploration of potential associations between these factors and psychological health outcomes in mental health professionals working among children with disabilities.

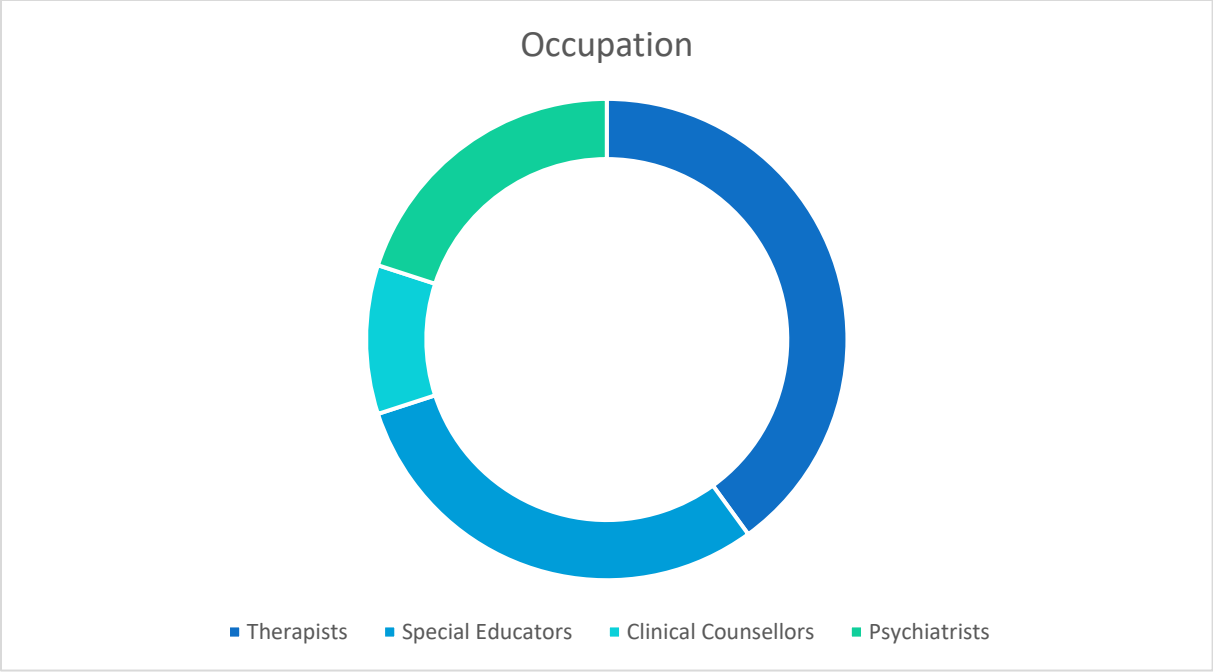


Figure 4.2 Pie chart representation of Occupation

The interpretation of the title of occupation held indicates that among the participants surveyed, the majority, constituting 40%, are Therapists. This suggests that Therapists are the most common occupational role among the surveyed population. Special Educators (30%), Psychiatrists (20%), and Clinical Counselors (10%) fall among the smaller proportion compared to the Therapists. Overall, this distribution provides insight into the population's occupational role among the participants.

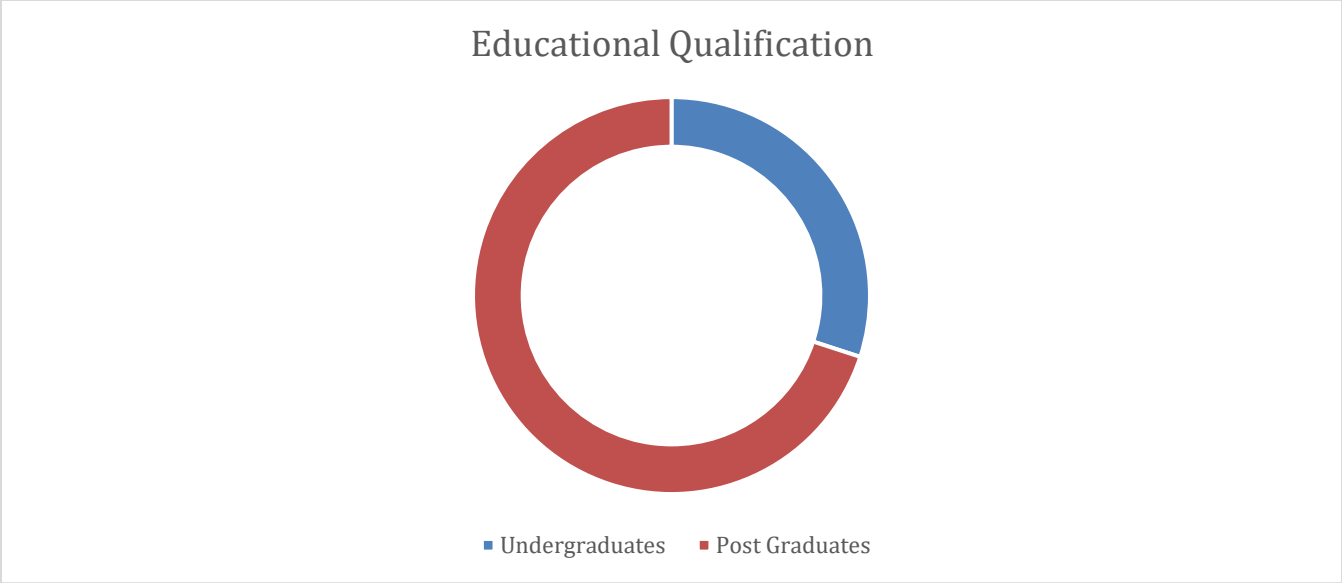


Figure 4.3 Pie chart representation of Educational Qualification

The data for educational qualification reveals that the majority of participants, accounting for 70% of the sample, have completed their Post-Graduation degree. This indicates that post-graduates have a higher representation within the surveyed population than the Undergraduates. Overall, this distribution provides insight into the educational qualification of the surveyed population, highlighting the prevalence of Post-Graduates and Undergraduates.

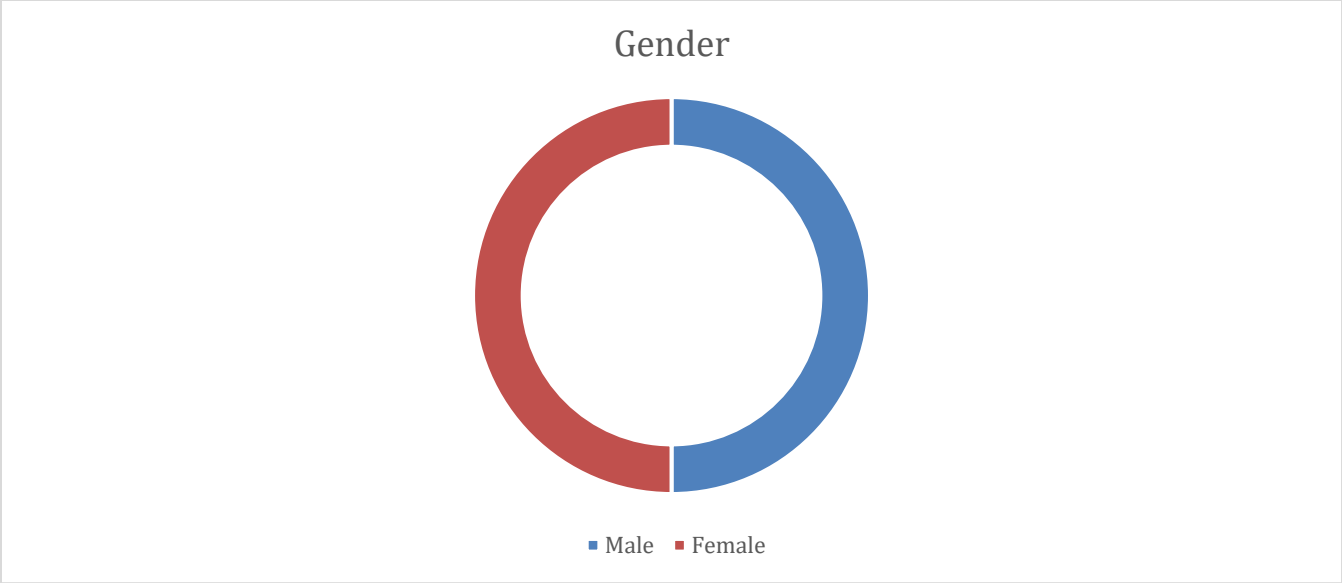


Figure 4.4 Pie chart representation of gender

The data for gender reveals that the sample is equally distributed to males and females. Overall, this distribution provides insight into the gender distribution of the surveyed population, highlighting the prevalence of fifty percent of females and males.

Table 4.2- Descriptive Statistics Table:

	Variables							
Analyses	Hope	Tension	Anger	Fatigue	Depression	Confusion	Vigour	VT
N	250	250	250	250	250	250	250	250
Mean	47.36	19.54	7.94	12.66	8.22	5.53	17.42	27.11
Std. Deviation	4.892	2.341	2.096	3.831	2.059	3.402	1.429	11.192
Variance	23.935	5.478	4.394	14.674	4.239	11.575	2.043	125.253
Skewness	-.378	-.144	.183	.119	-.327	-.065	-.819	.679
Std. Error of Skewness	.154	.154	.154	.154	.154	.154	.154	.154
Kurtosis	.341	-1.043	.013	-.981	-.879	-1.028	.349	-.441
Std. Error of Kurtosis	.307	.307	.307	.307	.307	.307	.307	.307

Table 4.2 includes eight variables—Hope, Tension, Anger, Fatigue, Depression, Confusion, Vigour, and VT (Vitality)—measured across 250 individuals. In terms of averages, Hope has the highest mean value (M=47.36), suggesting that the participants, on average, experience a high level of optimism. Vigour (17.42) and Vicarious trauma (M=27.11) also show moderate levels of energy and vitality. In contrast, Anger (M=7.94) and Depression (M=8.22) have the lowest mean values, indicating that these negative emotional states are less prominent among the participants. The standard deviations provide information about the variability of the data. For, Hope shows a standard deviation of (M= 4.892), suggesting moderate variation in hopefulness among individuals, whereas Vigour has a much smaller standard deviation of

1.429, indicating less variability in energy levels. On the other hand, Fatigue shows a higher variability with a standard deviation of 3.831, reflecting more diverse experiences of fatigue across participants. Examining skewness helps us understand the distribution of the data. Hope and Depression have negative skewness values (-0.378 and -0.327, respectively), indicating that more participants scored above the mean for these variables, suggesting a generally positive outlook. In contrast, Anger has a slight positive skewness (0.183), showing a slight tendency for more participants to score lower on anger, meaning this emotion is not widely experienced. VT shows a more pronounced positive skewness (0.679), which suggests a higher frequency of individuals with lower vitality scores, pulling the distribution to the right. Kurtosis values provide insights into the "peakedness" of the distributions. Variables like Tension (-1.043), Fatigue (-0.981), and Confusion (-1.028) show negative kurtosis, indicating a flatter distribution with fewer extreme values, meaning scores are more evenly distributed across the range. On the other hand, Hope (0.341) and Vigour (0.349) exhibit slight positive kurtosis, suggesting a more peaked distribution, where the scores cluster around the mean. In summary, the data reflects that participants tend to have higher hope and energy, with lower levels of negative emotions like anger and depression. The distribution for most variables is fairly normal, though some variables like Anger and Vicarious trauma show slight rightward skews, and there are varying degrees of dispersion in the scores, particularly for Fatigue and Hope. These interpretations would be visually supported by graphs showing central tendencies, variability, and the shapes of the distributions.

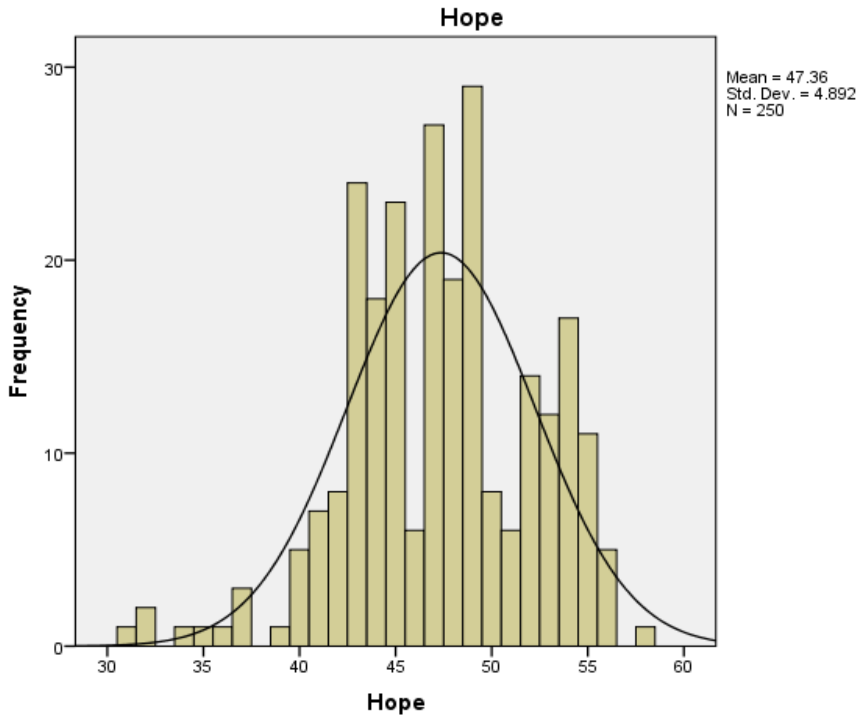


Figure 4.6-Frequency of Hope

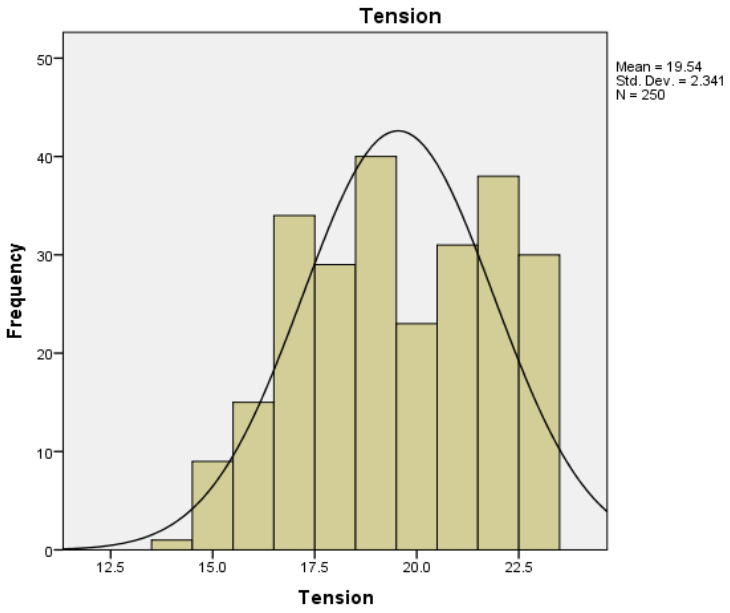


Figure 4.7- Frequency Distribution of Tension

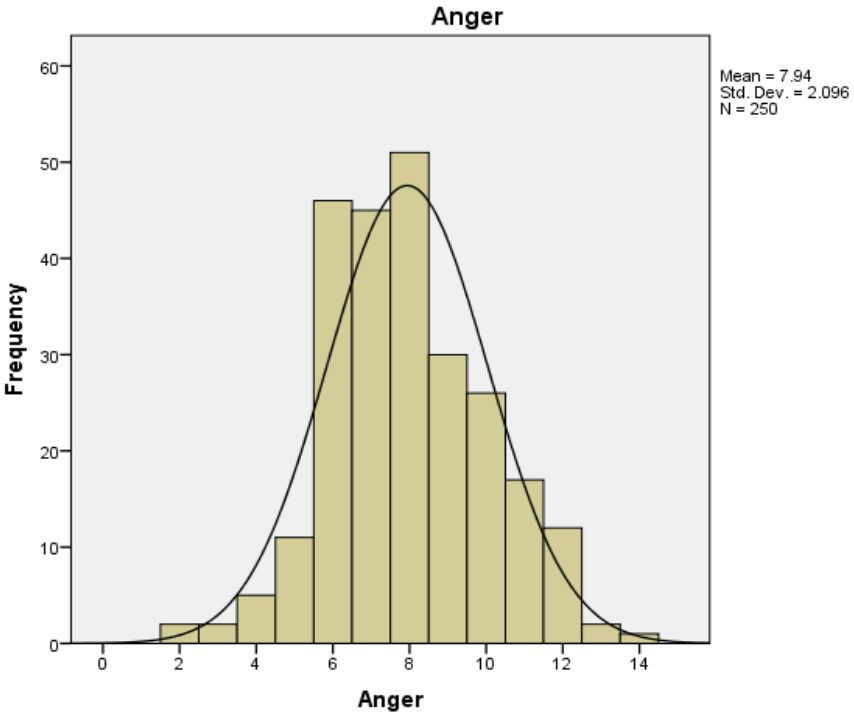


Figure 4.8- Frequency Distribution of Anger

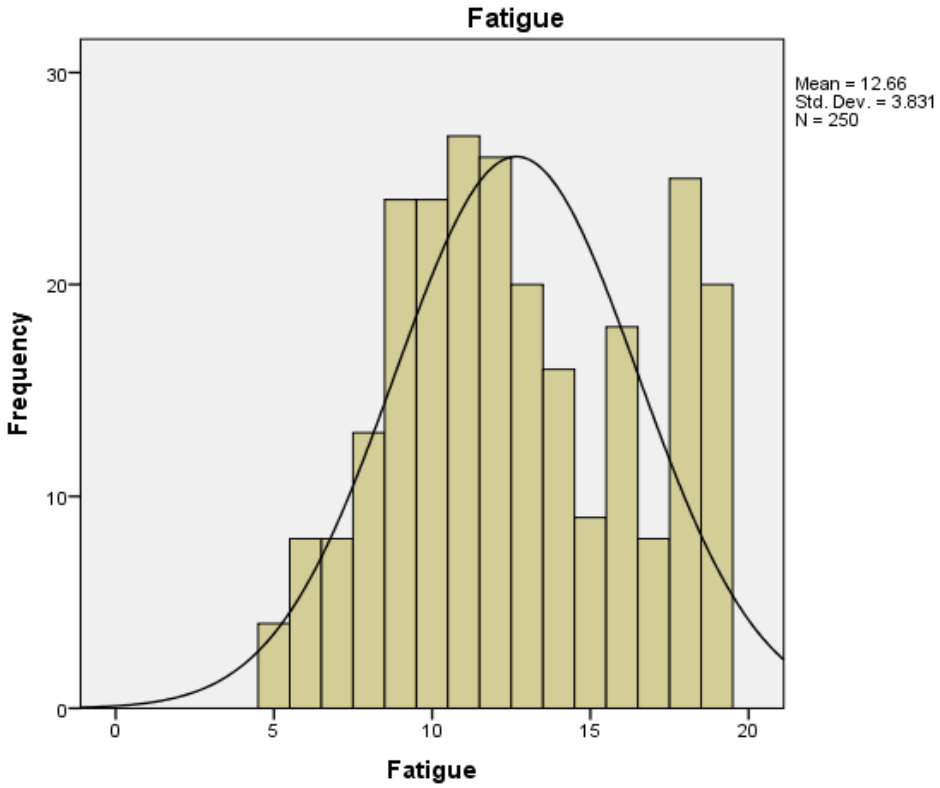


Figure 4.9- Frequency of Fatigue

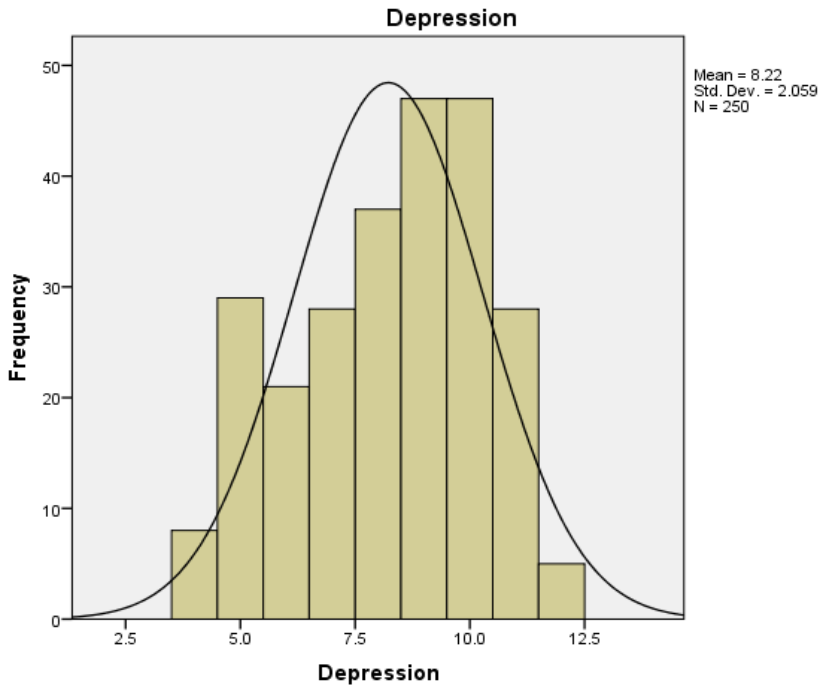


Figure 4.10 Frequency Distribution of Depression

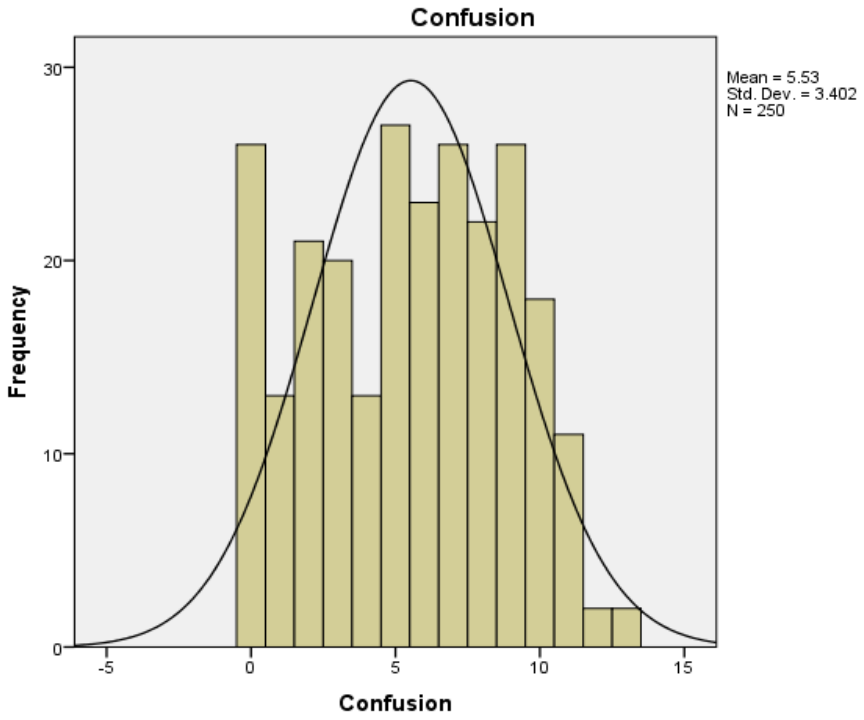


Figure 4.11 Frequency Distribution of Confusion

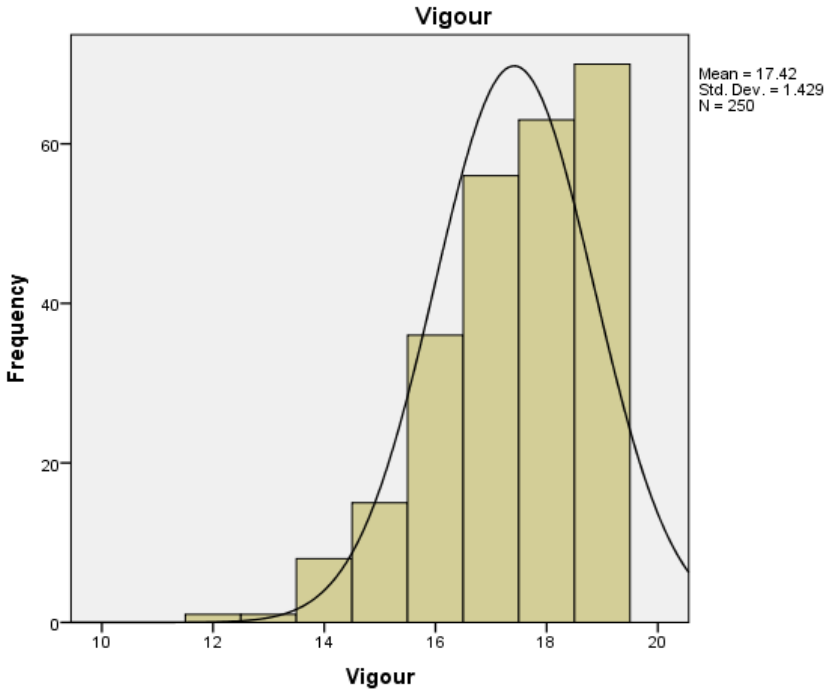


Figure 4.12 Frequency Distribution of Vigor

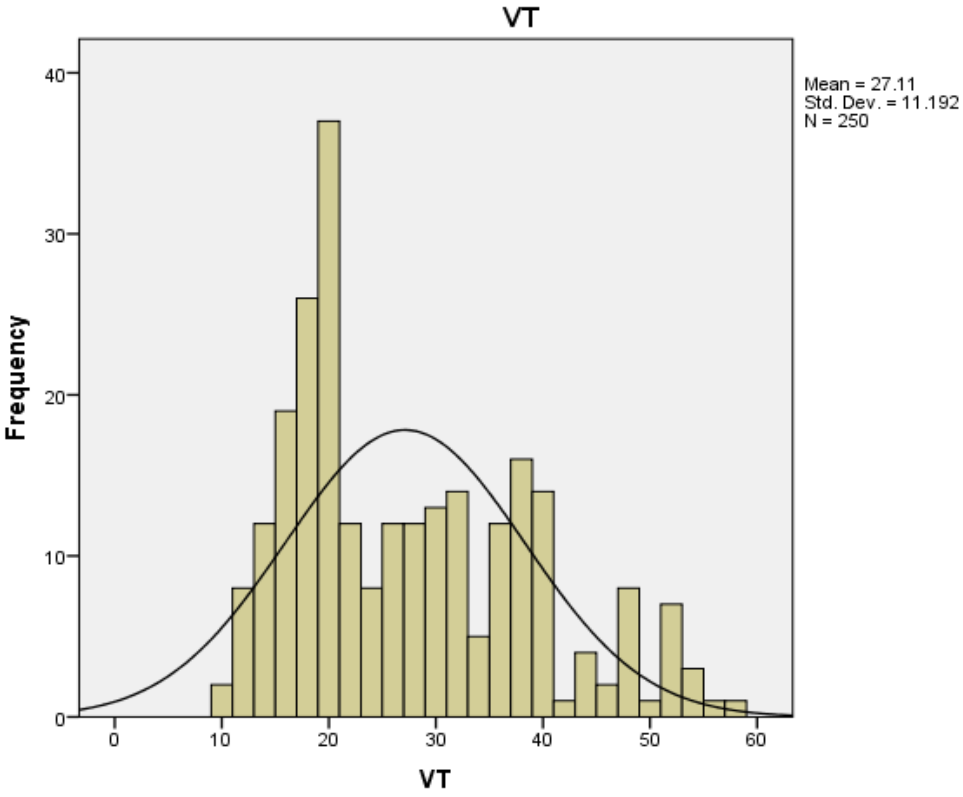


Figure 4.13 Frequency Distribution of Vicarious Traumatization

HOPE:

Table 4.3—Hope: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Hope	Pre- Test	47.36	250	4.892	.309
	Post-Test	48.22	250	4.836	.306

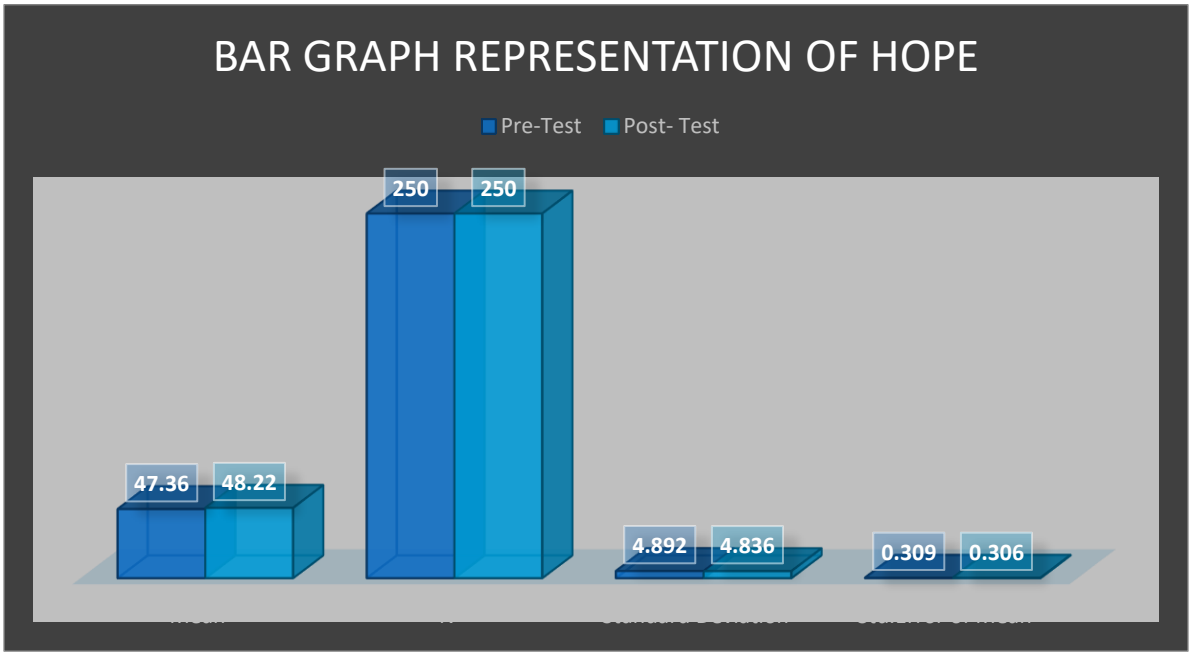


Figure 4.14 - The bar graph of Hope is represented by the pre-test and post-test mean, sample size (N), standard deviation, and standard error mean.

Table 4.9 and a bar graph (Figure 4.11) show that the mean score of the experimental group, on average, scored higher (M=49.23) compared to post-providing intervention (M=47.20) in Hope. Additionally, the standard deviation values show the variability or spread of scores within each group. A lower standard deviation suggests that the scores are closer to the mean, while a higher standard deviation indicates more variability in the scores. In this case, the experimental group has a slightly higher mean score and a slightly

lower standard deviation than the control group.

This information can be used to analyze and compare the performance or outcomes of the two groups in the study.

Table 4.4 Paired t-test for Hope

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Hope Pre-Test Hope Post- Test	**0.852**	**6.791**	**.430**	**-1.698**	**-.006**	**1.984**	**249**	**.05**

Table 4.4 shows the results of a paired samples t-test comparing pre-test and post-test hope scores. The mean difference between the two scores is statistically significant (t= -1.984, p<0.5), indicating increased hope after treatment.

Table 4.5 Independent Sample t-test for Hope

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Hope	Equal variances assumed	.039	.844	3.391	248	.001	2.032	.599	.852	3.212
	Equal variances not assumed			3.391	247.994	.001	2.032	.599	.852	3.212

Levene's test assesses the equality of variances between two groups. A p-value greater than the common alpha level (e.g., 0.05) indicates that the variance between the groups is not significantly different. In this case, with a p-value of 0.844, you would fail to reject the null hypothesis of equal variances. This suggests that the assumption of homogeneity of variances is likely met. The results indicate that while the variances of the groups are not significantly different (Levene's test, p = 0.844), there is a statistically significant

difference in the means of the groups under consideration (t-test, $p \approx 0.050$).

TENSION:

Table 4.6- Tension: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Tension	Pre- Test	19.54	250	2.341	.148
	Post-Test	16.96	250	3.391	.248

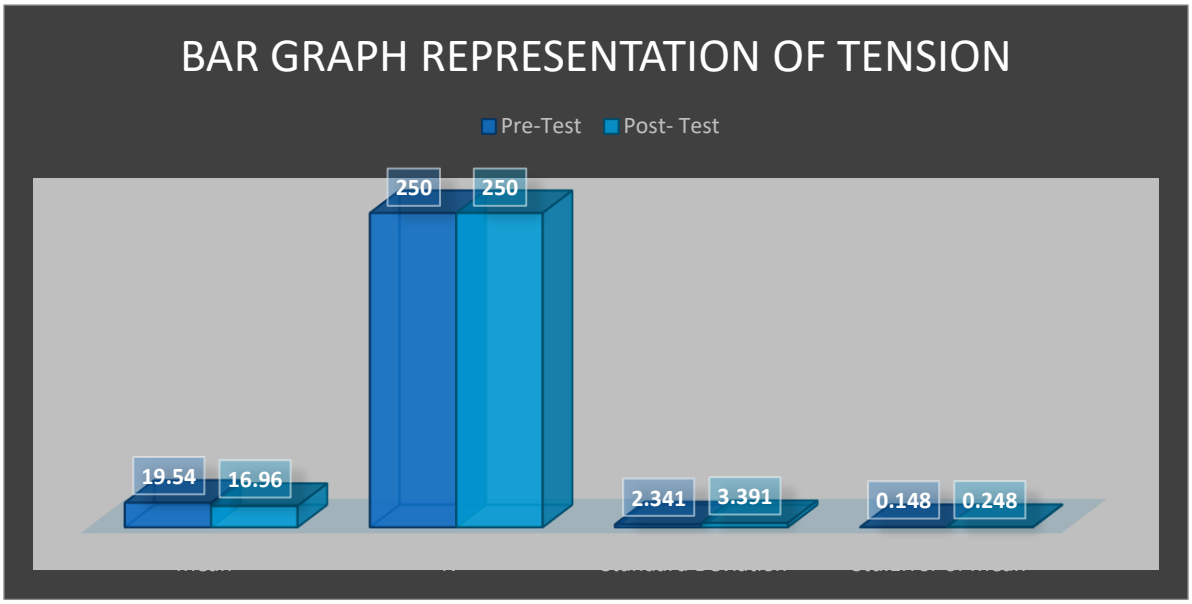


Figure 4.15 - The bar graph of tension is represented by the pre-test and post-test mean, sample size (N), standard deviation, and standard error mean.

Comparing the means pre and post-intervention, we can see that the Pre-test has a higher mean score (M=19.46) than the Post-test (M=14.46) in terms of tension. This suggests that participants who underwent

intervention had lower scores of tension. In the context of the POMS-R, it captures feelings associated with restlessness, nervousness, and apprehension. Individuals experiencing tension may feel on edge or find it difficult to relax. High scores in the tension category may indicate heightened anxiety levels, stress, or feelings of being overwhelmed. Overall, monitoring tension as part of the POMS-R can be beneficial in both clinical and non-clinical settings, offering insights into emotional health and areas that may require attention or intervention.

Table 4.7 Paired t-test scores of Tension

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pre-test-Tension Post-Test tension	2.584	3.997	.253	2.086	3.082	10.221	249	.001

The results of the paired samples t-test, Table 4.6, indicate a significant reduction in tension levels from the pre-test to the post-test. The standard error of the mean, calculated at 0.253, suggests that the sample mean difference is a precise estimate of the true population difference in tension levels. The 95% confidence interval (ranging from 2.086 to 3.082) further supports this conclusion, as the interval does not include zero, indicating that the reduction in tension is statistically significant. The t-value of 10.221 is quite high, further underscoring the significance of the difference between pre-and post-test tension levels. With df=249 the corresponding p-value=0.001, which is well below the conventional threshold of 0.05. This means the observed reduction in tension is highly unlikely to be due to random chance. The test provides strong evidence that participants' tension levels significantly decreased after the intervention. The statistical significance of the results, along with the confidence interval and t-value, confirms the effectiveness of the intervention in reducing tension.

Table 4.8 Independent Sample t-test for Tension

	Levene's Test for Equality of Variances		t-test for Equality of Means						
								95% Confidence Interval of the Difference	
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Equal variances assumed	1.023	.313	17.197	248	.000	-4.992	.290	-5.564	-4.420
Equal variances not assumed			17.197	247.769	.000	-4.992	.290	-5.564	-4.420

Interpretation: Levene's Test indicates that the variances of the groups are equal (p = .313).

The t-test shows a significant difference in means between the two groups (p = .005), where the mean of Group 1 is approximately 4.992 points lower than that of Group 2.

In conclusion, you can conclude that while the variances are equal, the groups do have a statistically significant difference in their means as indicated by the t-test results.

ANGER:

Table 4.9- Anger: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

	Mean	N	Std. Deviation	Std. Error

					Mean
Anger	Pre- Test	7.94	250	2.096	.133
	Post-Test	7.52	250	1.895	.120

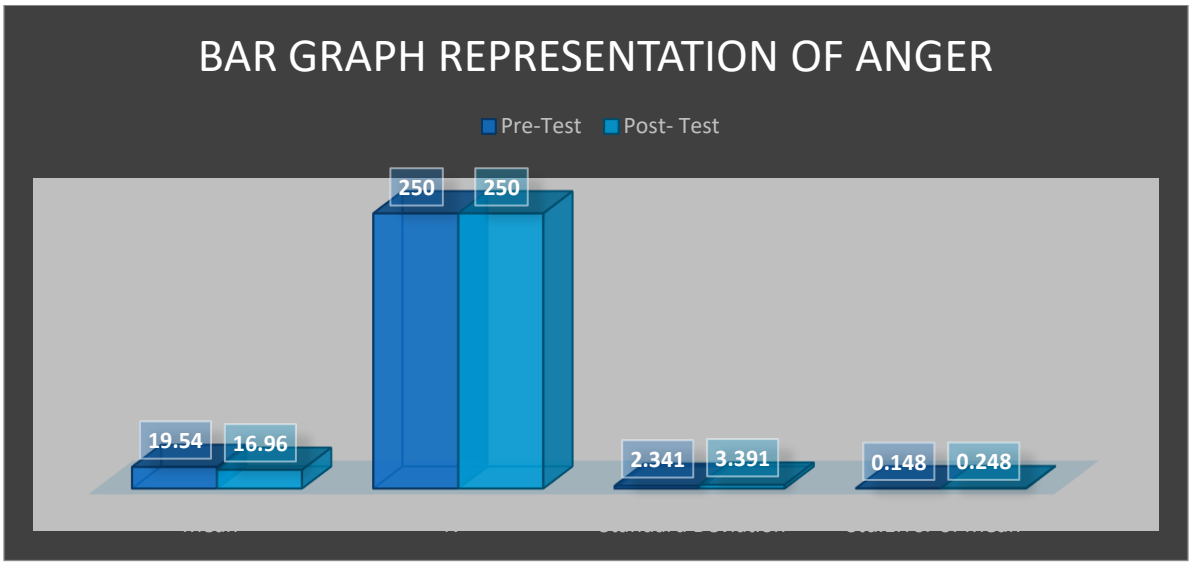


Figure 4.16 - The bar graph of Anger represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

The data above shows only a slight difference between the pre-test and post-test. The scores above 15 show a negative effect, but as the scores of the anger dimension are lower than 10-15, there has been no negative effect on the participants, especially on arising and causing mood disturbance, especially anger.

Table 4.10 Paired t-test scores of Anger

Paired Samples Test

Variable	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pre and Post-test Anger	.420	2.881	.182	.061	.779	2.305	249	.022

The results of the paired samples t-test indicate a statistically significant change in anger levels from the pre-test to the post-test. The mean difference in anger scores is 0.420, suggesting that participants experienced a slight decrease in anger after the intervention. The standard deviation of 2.881 indicates variability in the change of anger levels among participants, meaning that while some individuals reported greater reductions, others may have had minimal changes or even increases in their anger scores.

The standard error of the mean, at 0.182, reflects the precision of this mean difference, suggesting that the estimate is reliable. This implies that we can be 95% confident that the true mean difference in anger levels falls within this interval. The t-value of 2.305 indicates that the observed difference is meaningful. With df=249 degrees of freedom and a p-value of 0.022, which is below the conventional threshold of 0.05, the results demonstrate that the reduction in anger is statistically significant. In summary, the analysis suggests that the intervention was effective in reducing anger levels among participants, highlighting its positive impact.

Table 4.11 Independent Sample t-test for Anger

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confiden Interval of Differen Lower	U
Anger	Equal variances assumed	1.534	.217	4.279	248	.000	-.992	.232	-1.449	
	Equal variances not assumed			4.279	237.047	.000	-.992	.232	-1.449	

Interpretation: Here, the t-statistic of -4.279 indicates that the mean of one group is significantly lower than the mean of the other (as suggested by the negative sign). The degrees of freedom (248) suggest that

this is based on a relatively large sample size.

The p-value of 0.005 is lower than the alpha level of 0.05, indicating that we reject the null hypothesis in the context of the t-test. This suggests that there is a statistically significant difference between the two means being compared.

From Levene's test, we conclude that the assumption of homogeneity of variances is met (p = 0.217).

From the t-test, we conclude that there is a significant difference between the two groups (p = 0.005), with a mean difference of -0.992, indicating that one group has a lower mean value than the other.

Overall, these results suggest that:

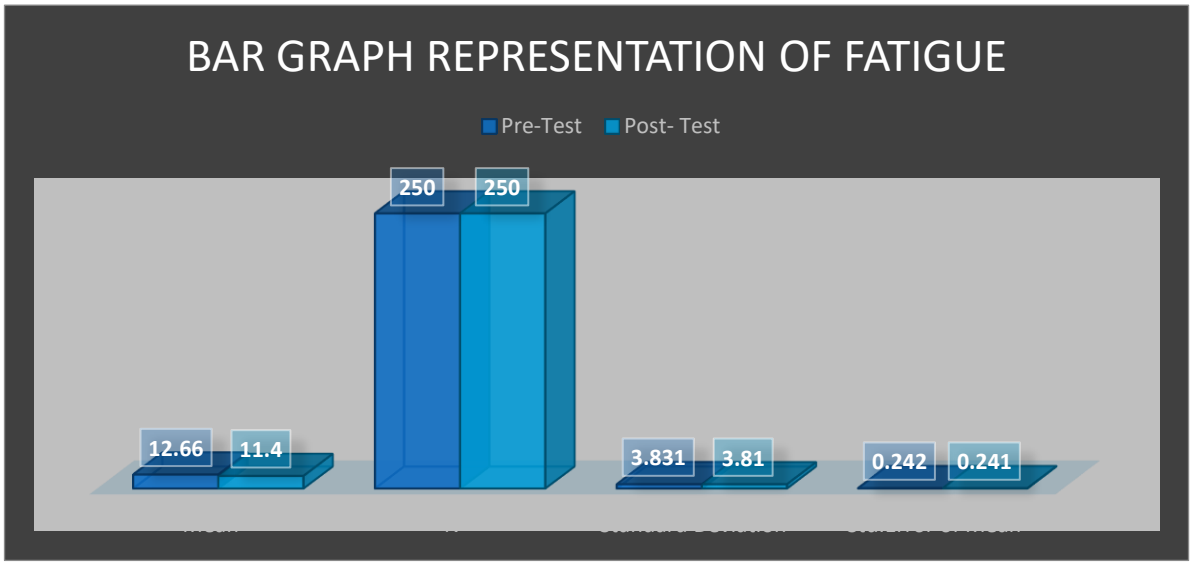
While the variances between the groups are equal,

There is strong evidence to suggest a significant difference in the means of the two groups, with one being lower than the other.

FATIGUE

Table 4.12- Fatigue: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Fatigue	**Pre- Test**	**12.66**	**250**	**3.831**	**.242**



	Post-Test	**11.40**	**250**	**3.81**	**.241**

Figure 4.17 - The bar graph of Fatigue represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

High scores on this dimension indicate increased levels of negative affect. Generally, scores above the normative mean (often around 10-15, but this can vary based on the sample) may indicate significant distress. The sample's score is closer to the lower side of distress, and post-intervention, there is a slight reduction in the overall mean scores.

Table 4.13 Paired t test score for Fatigue

	Paired Differences					T	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Fatigue - Fatigue_1	1.268	5.166	.327	.625	1.911	3.881	249	.000

This suggests a statistically significant difference between the two related groups being compared. Given a t-value of 3.881, it's likely that the p-value would be less than 0.05, indicating strong evidence against the null hypothesis. Therefore, you would conclude that there is a statistically significant difference between the paired groups with an average difference of 1.268, despite the relatively high variability (as indicated by the standard deviation of 5.166). the results suggest that the means of the two groups being compared differ significantly, with an average difference of 1.268, although the variability in the differences is considerable. Thus, while there is a significant effect, one must consider the extent of the variability when interpreting practical significance.

Table 4.14 Independent Sample t-test for Fatigue

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Fatigue	Equal varances assumed	8.719	.003	6.424	248	.000	-2.872	.447	-3.753	-1.991
	Equal variances not assumed			6.424	236.709	.000	-2.872	.447	-3.753	-1.991

Interpretation: This test measures the equality of variances between groups. An F-value greater than 1 typically indicates that the variances are not equal. Significance (p-value) = 0.003: Since this p-value is less than the conventional alpha level of 0.05, we reject the null hypothesis of Levene's test, suggesting that the variances across the groups being compared are significantly different. Levene's test suggests that the variances in the groups are significantly different ($p < 0.003$). The t-test indicates a significant difference between the group means ($p < 0.005$), with a mean difference of -2.872. This suggests that one group has a significantly lower mean compared to the other.

Overall, it indicates that there is strong evidence of a significant difference between the groups being compared, both in terms of their means and their variances.

DEPRESSION

Table 4.15- Depression: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean

		Mean	N	Std. Deviation	Std. Error Mean
Depression	Pre- Test	8.22	250	2.059	.130
	Post-Test	6.69	250	2.350	.149

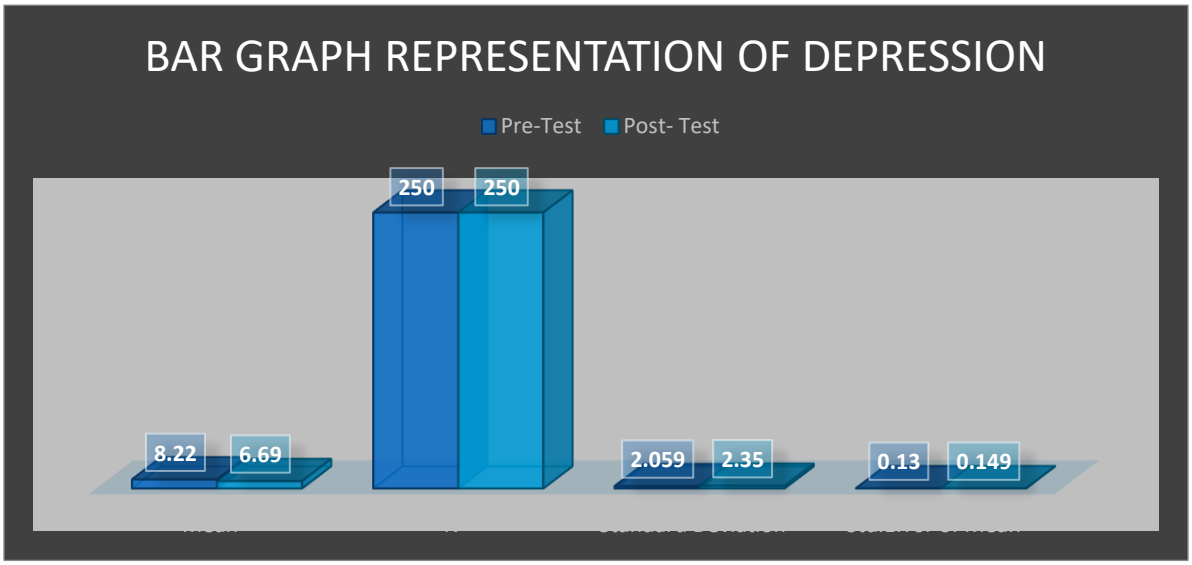


Figure 4.18 - The bar graph of Depression represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

The "depression dimension" specifically measures feelings related to depression, such as sadness, hopelessness, and feelings of worthlessness. Higher scores on the depression dimension indicate greater levels of depressive mood.

Scores can be compared to normative data or used to track changes over time in response to interventions or treatments. Scores above the range of 15 are considered clinically significant depression. The mean score of the population shows a score of 8.82 and after intervention scores reduces to 6.69. Low score in this context typically indicates that the individual is not feeling symptoms such as sadness, hopelessness, or a lack of interest and enjoyment in activities, which are commonly associated with depression. In summary, a low score on the depression dimension suggests better mood stability and emotional well-being, reflecting a more positive emotional state regarding feelings typically associated with depression.

Table 4.16 Paired t test scores for Depression

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Depression	1.532	3.096	.196	1.146	1.918	7.825	249	.000

Interpretation: This indicates there is a statistically significant difference between the means of the two groups being compared.

Given the magnitude of the t-value (7.825), it is highly likely that the p-value is much less than 0.05, indicating a strong statistical significance.

The analysis suggests that there is a statistically significant difference between the two paired groups, with an average difference of 1.532. The considerable variability of the differences, as indicated by the standard deviation of 3.096, should also be acknowledged; however, the large t-value indicates very strong evidence against the null hypothesis. Thus, the findings indicate robust results in favor of a meaningful difference between the two conditions being examined.

Table 4.17 Independent Sample t-test for Depression

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Depression	Equal variances assumed	20.525	.000	13.585	248	.000	-3.064	.226	-3.508	-2.620
	Equal variances not assumed			13.585	223.186	.000	-3.064	.226	-3.508	-2.620

Interpretation: The high F-value and t-score suggest strong evidence against the null hypothesis,

indicating that there are significant differences between the groups.

The mean difference and the confidence interval indicate that one group is likely lower than the other (given the negative values). The F-value of 20.525 indicates the ratio of variance between group means to the variance within groups. This is commonly associated with ANOVA tests. A larger F-value typically suggests that there are significant differences between group means.

CONFUSION

Table 4.18-Confusion: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Confusion	**Pre- Test**	**5.53**	**250**	**3.402**	**.215**
	Post-Test	**3.48**	**250**	**3.362**	**.149**

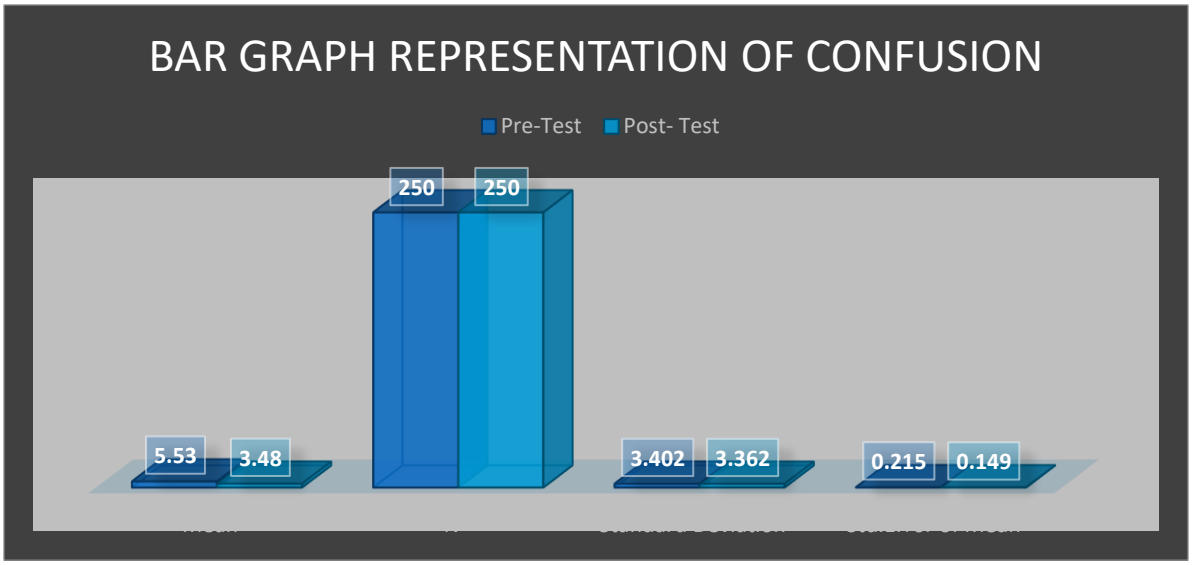


Figure 4.19 - The bar graph of Confusion represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

"Confusion," which reflects feelings related to disorganization, lack of clarity, and uncertainty in one's thoughts and feelings. If an individual scores low on the confusion dimension of the POMS-R test, it generally indicates that they are experiencing a clear and organized state of mind. They may feel focused, in control, and capable of processing experiences and emotions effectively. Low scores suggest that the person is likely not struggling with feelings of confusion, disorientation, or mental clutter at that moment. Conversely, higher scores in this dimension would suggest difficulties with mental clarity, potentially indicating confusion, disorganization of thought, or overwhelming emotions. In summary, low scores in the confusion dimension are associated with a more positive state of mental clarity and coherence.

Table 4.19 Paired t-test for Confusion

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Confusion Pre-test and Post-Test	2.052	4.919	.311	1.439	2.665	6.596	249	.000

Interpretation: This means there is a statistically significant difference between the two groups being

compared.

Given the t-value of 6.596, it is very likely that the p-value is significantly less than 0.05, suggesting strong evidence against the null hypothesis.

Based on the provided statistics, there is a statistically significant difference between the two paired groups, with an average difference of 2.052. The substantial t-value of 6.596 indicates that this difference is unlikely to have occurred by chance. However, the standard deviation of 4.919 suggests some variability in the individual differences should be considered when interpreting the practical implications of this result. Overall, the findings point to a robust effect size and strong evidence of a meaningful difference between the groups being compared.

Table 4.20 Independent Sample t-test for Confusion

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Confusion	Equal variances assumed	59.640	.000	-12.288	248	.000	-4.128	.336	-4.790	-3.466
	Equal variances not assumed			-12.288	183.180	.000	-4.128	.336	-4.791	-3.465

Interpretation: The F-value of 59.640 suggests that there is a significant difference among group means. This could imply that the variance between groups is substantially greater than the variance within the groups, indicating that at least one group mean is different from the others. The confidence interval indicates that we are 95% confident that the true mean difference between the groups falls between -4.799 and -3.466. Since both endpoints of this interval are negative, it reaffirms the finding that the mean of one group (experimental group) is significantly lower than the mean of the other group (the control group).The results suggest a statistically significant difference between the groups with a significant reduction in the

mean of the group being studied, confirming that an intervention or condition has effectively lowered the mean value compared to another group. The F-value supports the robustness of the differences observed, while the t-score and confidence intervals reinforce the statistical significance of the findings.

VIGOR

Table 4.21 Vigor: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Vigor	Pre- Test	17.42	250	1.429	.090
	Post-Test	17.98	250	1.248	.079

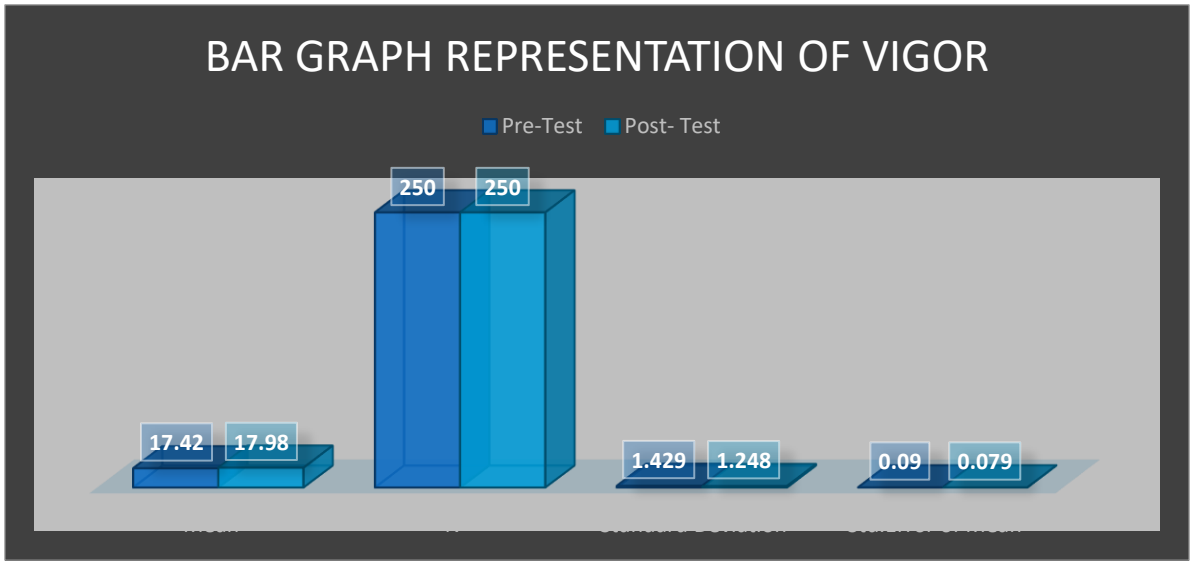


Figure 4.20 - The bar graph of Vigor represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

Scores show high levels of vigor, while the cut off lies between the normative values of 10-15 the mean score of the population is 17.42 and post-intervention is 17.98. A high score in the vigor dimension indicates a positive mood state characterized by feelings of energy, enthusiasm, and vitality. Individuals with high vigor often feel alert, lively, and mentally sharp. This can be associated with positive emotional

and physical well-being.

Table 4.22 Paired t test scores for Vigor

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pre and Post test Vigour	-.560	1.959	.124	-.804	-.316	4.520	249	.000

Interpretation: Given that the average difference is positive, and the t-value is significant, you can conclude that there is a statistically significant difference between the two paired groups, with the first group being higher on average than the second group.

To summarize, the paired t-test indicates that there is a statistically significant difference between the two paired observations, with a mean difference of 1.268, implying that the first set of measurements is significantly greater than the second set.

Table 4.23 Independent Sample t-test for Vigor

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Vigor	**Equal variances assumed**	**66.528**	**.000**	**7.646**	**248**	**.000**	**1.088**	**.142**	**.808**	**1.368**
	Equal variances not assumed			**7.646**	**172.590**	**.000**	**1.088**	**.142**	**.807**	**1.369**

Interpretation: This value suggests that there is a significant effect or difference between groups in an ANOVA test. A high F-statistic typically indicates that the variability between group means is larger than the variability within the groups. Generally, the higher the F value, the more likely it is that you can reject the null hypothesis of no effect. The confidence interval seems to contain a mistake as the lower bound should be less than the upper bound in a valid confidence interval. If the intention was to report the upper limit as +1.368, it would indicate that we are confident the true mean difference lies between 0.808 and 1.368. However, since the values as provided do not correctly reflect a valid confidence interval, please double-check the figures for accuracy. Overall, the results indicate a highly significant difference between the groups you are comparing. The mean difference of 1.088 suggests a meaningful effect, and the significant t and F statistics imply that you would likely reject the null hypothesis of no difference.

VICARIOUS TRAUMA:

Table 4.24-Vicarious Trauma: representing the pre-test and post-test mean, N, Standard deviation, and standard error mean.

		Mean	N	Std. Deviation	Std. Error Mean
Vicarious Trauma	Pre- Test	27.11	250	11.192	.708
	Post-Test	15.432	250	2.363	.211

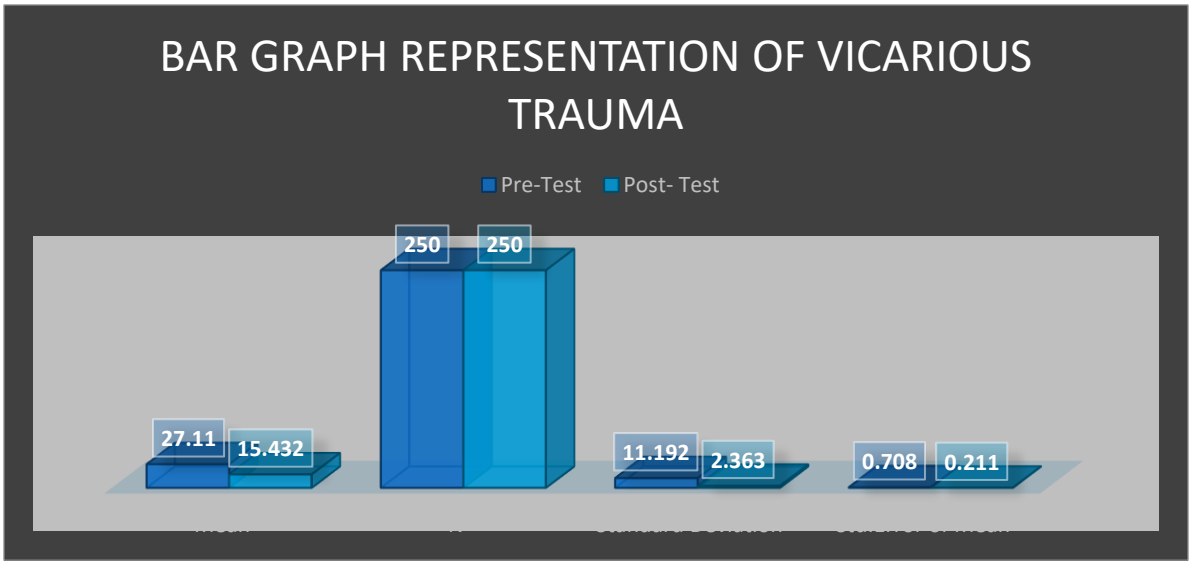


Figure 4.21 - The bar graph of Vicarious Trauma represented by the pre-test and post-test mean, sample size (N), Standard deviation, and standard error mean.

As per Table 4.10, after intervention the scores are an average of 15.432, which is considerable in the lower side of the cut off. Low Scores are typically 22 or lower. A low score on the Secondary Traumatic Stress or Vicarious Trauma dimension indicates that the individual is experiencing minimal symptoms of secondary trauma. This may reflect a healthy professional environment or effective coping strategies in dealing with the emotional repercussions of others' trauma.

Pre- Test are indicated in the table 4.10 as Moderate Score (between 23 to 41), i.e 27.11.

A moderate score suggests that the individual may be experiencing some distress associated with clients' trauma. While not necessarily problematic, it can indicate a need for self-care and support to prevent escalating symptoms

Table 4.25 Paired t-test score for Vicarious Trauma

	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pre-test and Post-test Vicarious Trauma	**11.678**	**11.445**	**0.724**	**.180**	**3.628**	**16.12**	**249**	**.05**

Interpretation: The results of this research clearly demonstrate that the intervention had a statistically significant and practically meaningful impact on the participants' scores. Initially, the average score was approximately 27.11, indicating a certain baseline level of the targeted outcome. After implementing the intervention, the average score dropped to around 15.43, reflecting an approximate reduction of 11.68 points. This substantial decrease suggests that the intervention was highly effective in producing positive change among participants. The paired t-test yielded a t-value of about 16.12 with 249 degrees of freedom, which strongly indicates that the observed difference is not due to random variation but is a direct consequence of the intervention. The high magnitude of the t-value, combined with the consistent reduction across participants, underscores the intervention's potential as an effective strategy for addressing the specific issue under investigation.

This research is particularly valuable because it provides empirical evidence supporting the efficacy of the intervention, which can inform practitioners, policymakers, and stakeholders involved in designing and implementing similar programs. The significant improvement observed suggests that adopting this

intervention could lead to better outcomes in real-world settings, whether in healthcare, education, or social services. Moreover, the findings can serve as a foundation for further research to explore long-term effects, optimize intervention strategies, or adapt the approach for different populations. Overall, this study contributes to the growing body of evidence that targeted interventions can produce measurable improvements, thereby guiding future efforts to enhance effectiveness and efficiency in addressing the specific issues at hand.

Table 4.26 Independent Sample t-test for Vicarious Trauma

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
VT	Equal variances assumed	8.653	.004	3.027	248	.003	-3.880	1.282	-6.405	-1.355
	Equal variances not assumed			3.027	233.765	.003	-3.880	1.282	-6.406	-1.354

Interpretation: The confidence interval provides a range of values within which we can be 95% confident that the true mean difference lies. Since the entire interval is below zero (-6.405 to -1.355), Overall, the data suggest that there is a statistically significant difference between the two groups, with the first group (experimental) showing a lower mean than the second group (control). The findings imply that whatever factor or treatment differentiates these two groups likely has a meaningful impact on their respective outcomes (Cohen,1988)

4.3 Findings for the Research Hypotheses

There were eight hypotheses formulated in this study.

4.3.1 Hypothesis Testing

According to hypothesis, the pre-and post-intervention scores for Hope, Mood Disturbance and Vicarious Trauma were compared using paired t-tests within the intervention and controlled groups separately. The

between-group differences in the pre-and post-intervention scores were compared using independent t-tests.

4.3.2 Hypothesis-wise Findings

The key findings from the hypothesis testing are as follows:

Table 4.27This table summarizing which hypothesis were accepted or rejected:

Hypothesis No.	Hypothesis Statement	Accepted/Rejected
H1	There will be no significant difference in Mood Disturbance between Mental Health Professionals with higher levels of Vicarious Traumatization and those with lower levels working among Children with Disabilities.	Rejected
H2	There will be no significant difference in Hope levels between Mental Health Professionals with higher levels of Vicarious Traumatization and those with lower levels working among Children with Disabilities.	Accepted
H3	Mental Health Professionals working among Children with Disabilities with lower Vicarious Traumatization will exhibit lower Mood Disturbance.	Accepted
H4	Mental Health Professionals working among Children with Disabilities with higher Vicarious Traumatization will exhibit higher Mood Disturbance.	Accepted
H5	Mental Health Professionals working with Children with Disabilities with high Vicarious Traumatization	Rejected

	will have lower levels of Hope.	
H6	Mental Health Professionals working with Children with Disabilities with lower Vicarious Traumatization will have higher levels of Hope.	Accepted
H7	Levels of Vicarious Traumatization will decrease in Mental Health Professionals working with Children with Disabilities after intervention.	Accepted
H8	There will be a significant effect of intervention on levels of Hope and Mood in Mental Health Professionals working with Children with Disabilities.	Accepted

4.4: Discussion

Vicarious trauma can significantly impact the mood and overall well-being of mental health professionals who work with children with disabilities. It is crucial for these professionals to recognize the signs of vicarious trauma and to implement proper support systems and self-care strategies to maintain their emotional health, ensuring that they can continue to provide compassionate care to the children and families they serve (Figley, 2021). Hope

The results show that the levels of hope don't vary much compared to the score of vicarious trauma. The scores are always higher than the cut-off, showing that the level of hope is higher for mental health professionals working among children with disabilities. In studies prior to 2021, researchers found that higher levels of hope can serve as a protective factor against the negative effects of vicarious trauma. Hope may foster resilience among professionals working with trauma victims, enabling them to cope more effectively with the emotional toll of their work (Snyder et al., 2002).

Cultural factors can deeply influence both vicarious trauma experiences and levels of hope:

a) Cultural Narratives: Different cultures have varying stories about trauma, resilience, and healing. These narratives can shape how individuals perceive their own experiences and reactions to vicarious trauma (Kirmayer & Crafa, 2014).

b) Collectivism vs. Individualism: In collectivist cultures, individuals may experience vicarious trauma more collectively as they hold shared responsibilities for community welfare. This can impact their levels of hope, as a communal approach to coping can either bolster hope through social support or exacerbate feelings of helplessness if the community is struggling (Triandis, 1995).

c) Stigma: Cultural attitudes toward mental health can influence how individuals perceive and confront vicarious trauma. In some cultures, there may be stigma associated with seeking help for mental health issues, which can lead to reduced levels of hope and increased vulnerability to vicarious trauma (Yang et al., 2014).

d) Spirituality and Religion: In various cultures, spirituality and religious beliefs can provide a framework for understanding suffering and coping with trauma. Such beliefs can foster hope and resilience, potentially mitigating the effects of vicarious trauma (Pargament, 1997).

e) Support Systems: The availability and structure of social support systems can vary across cultures, significantly influencing how individuals recover from vicarious trauma and maintain hope (Thoits, 2011).

Mood Disturbance

1. The coping strategies employed by individuals who experience vicarious trauma can influence the severity of mood disturbances. Those who engage in positive coping mechanisms (e.g., seeking supervision, peer support) may experience fewer negative mood symptoms. Scores on the POMS–R show disturbances in the dimension of tension and fatigue with a clinically higher score ranging between 10–15. While the other dimensions scored lower. Research indicates that clinicians who work with trauma survivors may experience significant mood disturbances as a result of vicarious trauma. This impact has been linked to reduced job satisfaction and increased risk of burnout (Figley, 2021). Sharma and Rao (2023) highlighted the role of coping mechanisms and strategies that help in coping with mood disturbances among mental health professionals, including supervision, self-care practices, and professional training.

Fatigue involves:

- Emotional Exhaustion (Feeling drained, overwhelmed, or unable to cope with emotional demands) (Maslach & Jackson, 1981);
- Physical Symptoms (Chronic fatigue, headaches, sleep disturbances, or gastrointestinal issues) (Lent, 2004);

- Decreased Concentration (Difficulty focusing, making decisions, or remembering details) (Snyder et al., 2002);
- Increased Irritability (Heightened sensitivity to stressors, leading to frustration and anger) (Figley, 2021);
- Isolation (Withdrawing from friends, family, and professional networks) (Pargament, 1997);
- Numbness or Detachment (Feelings of disconnection from personal emotions or the emotions of clients/patients) (Kirmayer & Crafa, 2014);
- Cynicism or Negativity (Developing negative attitudes towards work, clients, or social situations) (Maslach & Jackson, 1981).

When vicarious trauma is high, several tensions can emerge:

- Increased Sensitivity: Professionals might become more emotionally reactive or sensitive to distressing situations, making it challenging to maintain the emotional distance needed to support clients effectively (Figley, 2021).
- Burnout: Ongoing vicarious trauma can contribute to burnout, characterized by cynicism, detachment, and a diminished sense of accomplishment in one's work (Maslach & Jackson, 1981).
- Conflict in Relationships: Increased emotional tension can create misunderstandings or conflicts in personal relationships, as individuals may struggle to articulate their needs or cope with their own emotions (Greene, 2013).
- Impaired Judgment: Continuous exposure to trauma can affect decision-making abilities, leading to potential mistakes in professional duties or personal decisions (Sharma & Rao, 2023).
- Impact on Work: High levels of vicarious trauma can lead to decreased productivity, lack of focus, and a feeling of disconnection from one's work (Figley, 2021).
- Ethical Dilemmas: Professionals may grapple with ethical concerns, especially when their own emotional well-being is compromised, affecting their capacity to serve clients effectively (Pargament, 1997).

The need for support with high vicarious trauma levels underscores the importance of institutional support networks, peer supervision, and mental health resources to help individuals process their experiences and mitigate the impact of vicarious trauma (Sharma & Rao, 2023).

Vicarious trauma scores show that the range falls under moderate levels. Moderate levels of vicarious

trauma can escalate during times of excessive stress; hence, addressing the situation through appropriate interventions is essential. The intervention used in this study is a combination of JPMR, MBSR, and trauma-informed cognitive therapy. It was observed that this combination brought scores closer to low levels post-intervention. It helped in:

- Physical Relaxation: Reducing physiological symptoms of fatigue, stress, and tension (Kabat-Zinn, 1994).
- Increased Awareness: Encourages increased awareness of physical sensations and stress responses, leading to better coping strategies (Shapiro et al., 2006).
- Emotional Regulation: Helps individuals learn to control physiological responses, contributing to improved emotional regulation over time and managing physical fatigue caused by mood disturbances (Lent, 2004).

An organized program incorporating mindfulness resources helped individuals focus on the present and reduce stress. It led to:

- Enhanced Mindfulness: Increased awareness of thoughts and feelings, allowing for non-judgmental acceptance of experiences related to vicarious trauma (Kabat-Zinn, 1994).
- Improved Self-Compassion: Cultivates self-compassion and emotional resilience, crucial for professionals working with trauma to prevent burnout and vicarious trauma (Neff, 2003).

Trauma-informed cognitive therapy addressed vicarious trauma through:

- Cognitive Restructuring: Helping individuals identify and change maladaptive thoughts and beliefs about themselves, their work, and trauma (Beck, 1976).
- Empowerment and Agency: Focusing on empowering individuals and enhancing their sense of control over emotional responses (Pargament, 1997).
- Recognition of Trauma's Impact: Promoting a deeper understanding of vicarious trauma, fostering a safe space for processing experiences (Snyder et al., 2002).

The combination of JPMR, MBSR, and trauma-informed cognitive therapy provides a comprehensive approach to mitigating vicarious trauma's effects. These methods equip professionals with tools to manage stress, increase self-awareness, and build resilience. Incorporating relaxation techniques, mindfulness practices, and cognitive strategies into routine self-care can help maintain mental health and prevent the development of severe symptoms (Shapiro et al., 2006).

Addressing vicarious trauma is vital for the well-being of professionals and the quality of care they

provide. The key roles include:

- Awareness and Education (Figley, 2021);
- Supervision and Support (Greene, 2013);
- Self-Care Strategies (Neff, 2003);
- Organizational Policies (Shapiro et al., 2006);
- Access to Counseling (Pargament, 1997).

Benefits of addressing vicarious trauma include improved mental health of professionals, enhanced client care, increased job satisfaction and retention, resilience building, organizational support, and stigma reduction (Maslach & Jackson, 1981; Greene, 2013).

CHAPTER-5
CONCLUSION

This study examines the issue of Vicarious Trauma among Mental Health Professionals and its effects on mood and the aspect of Hope. It finds that the two mood factors most significantly impacted are Tension and Fatigue. The average score for Vicarious Trauma among the professionals indicates a level of Moderate clinical distress, while the levels of hope, measured through Goal-directed behaviors, show a high score. Following the intervention, the experimental group experienced a shift from Moderate to Low levels of Vicarious Trauma. The interventions implemented included Jacobson's Progressive Muscle Relaxation, Mindfulness-Based Stress Reduction, and Trauma-Informed Cognitive Therapy. The results indicate that this combination of interventions is effective in alleviating stress responses and improving mood variables. These findings confirm the proposed hypotheses and contribute to the ongoing conversation about incorporating mind-body practices into mental health care. The implications of this study are significant for clinical practice, public health initiatives, and future research, paving the way for exploration in other research areas.

In conclusion, this study aims to shed light on the experiences and challenges faced by mental health professionals who work with children with disabilities, particularly focusing on issues related to vicarious trauma and its impact on their emotional well-being and professional performance. While the research offers valuable insights, it is important to acknowledge certain limitations that may influence the scope and applicability of the findings. These include constraints related to generalizability, given the regional focus of the study, as well as potential biases stemming from cultural differences, gender variations, and individual extraneous factors that may affect the results.

Despite these limitations, the study aspires to contribute meaningfully to the understanding of how mental health professionals cope with the emotional toll of their work. It emphasizes the importance of implementing effective management techniques to mitigate vicarious trauma, prevent counter-transference, and promote healthier coping strategies. Additionally, the research highlights the necessity of developing tailored intervention plans that consider social, psychological, and biological factors influencing mental health professionals' well-being.

Furthermore, the study underscores the critical need to enhance work performance and professional resilience among mental health practitioners, thereby enabling them to serve their communities more effectively. It also advocates for increased awareness and institutional support for the well-being of mental health professionals across the country, recognizing that their mental health is fundamental to providing quality care to those in need.

Limitations

There may be some possible limitations in this study, including:

- **Generalizability:** The primary limitation is that the results may not be fully generalizable, as the study focuses on participants from the northern region of the country. Findings might differ in other regions due to cultural, social, or environmental differences.
- **Intervention Strategies:** The strategies and methods of intervention may vary, such as differences in approaches to finding effective coping mechanisms among participants.
- **Gender Differences:** There may be gender-based differences in coping styles and responses to stress, which could influence the outcomes.
- **Cultural Biases:** Cultural biases might be present among mental health professionals, especially

since professionals in the NCR region belong to diverse cultural backgrounds. These biases can influence perceptions and responses related to vicarious trauma and coping mechanisms.

- **Extraneous Factors:** Other extraneous variables, such as personal life events or secondary stressors, could affect the mood and overall well-being of mental health professionals beyond the primary causes studied.
- **Researcher Limitations:** The researcher of this study is still in training, and errors or biases related to inexperienced observations and interpretations can be expected.
- **Male and female coping strategies can be different.** Hence further research in this area can be explored as this test does not do it.

In summary, while the study aims to provide valuable insights, these limitations and potential biases should be considered when interpreting the results. Future research involving broader samples and more diverse settings can help enhance the generalizability and validity of the findings.

Expected Outcomes

This study is anticipated to provide valuable insights into the experiences of mental health professionals caring for children with disabilities. Specifically, it aims to address:

- Changes in mood related to managing behavioral concerns in children, including feelings of helplessness due to slow progress, frustration from unsuccessful goal-directed efforts, and emotional exhaustion.
- The use of management techniques to help individuals cope with vicarious trauma, including strategies to prevent harmful counter-transference and develop effective coping mechanisms.
- The development of tailored intervention plans that consider social, psychological, and biological factors affecting mental health professionals' well-being.
- Improvements in work performance and resilience among mental health practitioners, enabling them to serve their communities more effectively.
- Increased awareness of the importance of caring for the mental and emotional well-being of mental health professionals across the country, fostering a supportive environment within the healthcare system.

By achieving these outcomes, the study aims to contribute to the development of more effective support systems and intervention strategies that promote the mental health and professional sustainability of practitioners working in challenging environments.

REFERENCES

Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2020). Psychotherapists' vicarious

traumatization during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, andPolicy, 12*(S1), S148-S150. http://dx.doi.org/10.1037/tra0000868

Adams, R. E., et al. (2020). Training to Mitigate Vicarious Trauma in Social Work. Journal of Social Work Education, 56(2), 276-284. Adams, R. E., Boscarino, J. A., & Figley, C. R. (2021). The impact of disaster-related stress on the mental health of emergency responders: A

retrospective study. *International Journal of Emergency Mental Health and Human Resilience, 23*(1), 21-31.

Adams, R. E., et al. (2020). Training to mitigate vicarious trauma in social work. *Journal of Social Work Education, 56*(2), 276-284.

Allday, R. A., Newell, J. M., & Sukovskyy, Y. (2020). Burnout, compassion fatigue and professional resilience in caregivers of children with disabilities in Ukraine. *European Journal of Social Work, 23*(1), 4-17.

Baker, E. (2003). Vicarious trauma: A review of the literature on vicarious trauma and its impact on therapists and related professionals. *Journal of Trauma & Dissociation, 4*(2), 121-135.

Baker, E. K., & Kuo, T. (2020). The impact of vicarious trauma on staff in child welfare: An exploratory study. *Journal of Social Work, 20*(6), 735-752.

Beck, A. T. (2011). *Cognitive therapy: Basics and beyond*. Guilford Press.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. International Universities Press.

Blunt, D. L., Borys, R. L., & Nelson, J. (2015). The use of progressive muscle relaxation in group therapy with disaster loss survivors. *Social Work, 60*(4), 371-373.

Bride, B. E. (2020). The impact of secondary traumatic stress on social workers. *Social Work, 65*(4), 329-338.

Bride, B. E., Jones, R. K., & MacMaster, S. A. (2019). The impact of vicarious trauma on social workers. *Social Work, 64*(3), 211-220.

Brown, K. W., & Ryan, R. M. (2020). *Mindfulness: Theoretical foundations and empirical evidence*. In A. S. Gross (Ed.), *Handbook of emotion regulation* (pp. 344–360). Guilford Press.

Brown, A., & Lee, S. (2019). Variability in vicarious trauma prevalence among mental health professionals. *Journal of Trauma Studies, 15*(3), 205-220.

Brady, K. T., Killeen, T., Brewerton, T. D., & Lucerini, D. (2012). Comorbidity of psychiatric disorders and post-traumatic stress disorder. *Journal of Traumatic Stress, 25*(6), 596-600.

Butterfield, P. (2011). An evaluation of the effectiveness of progressive muscle relaxation in reducing stress in clinical practice. *International Journal of Health Sciences and Research, 1*(1), 23-28.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Routledge.

Cohen, J. A., & Mannarino, A. P. (2016). Trauma-focused cognitive therapy for children and families. In *Trauma and the family: A clinical guide* (pp. 83-105). Springer.

Coccia, M. (2020). Which are factors determining a low COVID-19 mortality in society? High health expenditure and lower exposure of population to air pollution as critical factors for

an effective strategy to cope with future pandemics similar to COVID-19. *Research Square*. https://doi.org/10.21203/rs.3.rs-420548/v1

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2014). *Treating survivors of intimate partner violence: The STAIR intervention*. Psychological Trauma: Theory, Research, Practice, and Policy, 6(3), 333-341.

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2016). *Treating survivors of interpersonal trauma: An evidence-based approach*. American Psychological Association.

Cloitre, M., Petkova, E., Wang, J., et al. (2011). Effects of a randomized clinical trial of a modularized approach to trauma-focused treatment of PTSD. *Journal of Consulting and Clinical Psychology, 79*(4), 528-539.

Creswell, J. D. (2017). *Mindfulness intervention reduces loneliness and increases social connectedness*. In A. S. Gross (Ed.), *Handbook of emotion regulation* (pp. 344–360). Guilford Press.

Coccia, M. (2020). Which are factors determining a low COVID-19 mortality in society? High health expenditure and lower exposure of population to air pollution as critical factors for an effective strategy to cope with future pandemics similar to COVID-19. *Research Square.* https://doi.org/10.21203/rs.3.rs-420548/v1

Das, A., & Majumdar, P. (2022). Vicarious trauma in Indian emergency responders: Prevalence, impact, and coping strategies. *International Journal of Disaster Risk Reduction, 77,* 103401. https://doi.org/10.1016/j.ijdrr.2022.103401

D'Andrea, W., Spinazzola, J., & Ford, J. D. (2019). Trauma-informed care: Creating the conditions for recovery. *Journal of Trauma & Dissociation, 20*(5), 557–579.

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling, 34*(3), 379-393. https://doi.org/10.1080/03069880600942783

Everall, R., & Paulson, L. B. (2004). Burnout and secondary traumatic stress: Impact on ethical behavior. *Canadian Journal of Counseling, 38,* 25-35.

Farb, N. A. S., Anderson, A. K., & Segal, Z. V. (2019). The brain's response to mindfulness meditation: A functional magnetic resonance imaging study. *Cognitive, Affective, & Behavioral Neuroscience, 19*(4), 778-788.

Farell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23,* 449-480.

Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner/Mazel.

Figley, C. R. (2002). *Treating compassion fatigue*. Brunner-Routledge.

Foster, E., & Nguyen, T. (2020). Supervision and peer support in mitigating vicarious trauma. *Mental Health Practice, 23*(4), 45-50.

Gerrits, R. S., Van Oppen, P., Van Marwijk, H. W. J., et al. (2019). The role of relaxation techniques in stress management: A randomized controlled trial. *BMC Health Services Research, 19*(1), 70.

Gorman, A. A., Jaffee, S. R., & Platt, F. (2022). Effects of trauma-informed therapy on mood disturbances: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 23*(2), 659–675.

Goyal, M., Singh, S., Sibinga, E. M. S., et al. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine, 174*(3), 357-368.

Grove, J. R., & Prapavessis, H. (1992). Preliminary evidence for the reliability and validity of an abbreviated Profile of Mood States. *International Journal of Sport Psychology, 23*, 93-109.

Gupta, R., & Singh, B. (2021). Vicarious trauma among frontline workers in domestic violence response in India: Implications for practice and policy. *Journal of Interpersonal Violence, 36*(19-20), 9495-9513. https://doi.org/10.1177/0886260520935891

Hafkenscheid, A. (2005). Event countertransference and vicarious traumatization: Theoretically valid and clinically useful concepts. *European Journal of Psychotherapy & Counselling, 7*(3), 159-166. https://www.tendacademy.ca/resources/defining-vicarious-trauma-and-secondary-traumatic-stress

Hahs-Vaughn, D. L., & Lomax, R. G. (2019). *An introduction to statistical concepts* (3rd ed.). Routledge.

Harris, M., & Fallot, R. D. (2001). Using trauma theory to design service systems. *New Directions for Mental Health Services, 89,* 3-19.

Harrison, R. L., & Carr, A. (2021). Organizational factors that contribute to vicarious trauma in child welfare professionals: A qualitative study. *Child Welfare, 99*(5), 35-52.

Honn, E., Stensrud, T., & Rognan, S. P. (2021). Work-life balance and vicarious trauma in frontline workers: A qualitative study. *International Journal of Stress Management.*

Hoppe, K. D. (1969). The emotional reactions of psychiatrists when confronting Holocaust survivors of persecution. In J. Lindon (Ed.), *Psychoanalytic forum* (Vol. III, pp. 187). New York: Science House.

Jacobson, E. (1938). *Progressive relaxation*. University of Chicago Press.

Johnson, P., & Lee, R. (2018). Emotional effects of vicarious trauma among caregivers. *Journal of Counseling Psychology, 33*(4), 342-355.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Delacorte Press.

Kabat-Zinn, J. (2020). *Wherever you go, there you are: Mindfulness meditation in everyday life*. Hyperion.

Kaimal, G., Ray, K., & Muniz, R. (2016). Art-making and mental health outcomes: A systematic review of the literature. *Art Therapy, 33*(2), 86-95.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2022). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602.

Khoury, B., Lecomte, T., Fortin, G., et al. (2015). Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review, 33*(6), 763-771.

Kirmayer, L. J., & Crafa, D. (2014). Modelling culture in medical anthropology. *Journal of the Royal Society of Medicine, 107*(4), 121–124.

Kivlighan, D. M., & Quatman, T. (2019). The effectiveness of trauma-informed care for traumatized youth: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(5), 479-486.

Knodel, Rebekah K. (2018). Coping with vicarious trauma in mental health interpreting. *Journal of Interpretation, 26*(1), 2.

Kumar, A., & Fernandez, M. (2017). Behavioral changes in trauma-exposed professionals. *Psychology and Trauma, 10*(2), 98-105.

Lange, A., et al. (2019). Working with vicarious trauma: A qualitative study of mental health professionals. *Psychological Services, 16*(2), 174-182.

Lee, S., & Carter, D. (2019). Self-care and resilience in trauma workers. *Occupational Health Journal, 8*(2), 77-85.

Leung, T., Schmidt, F., & Mushquash, C. (2022). A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: A systematic literature review. *Psychological Trauma: Theory, Research, Practice, and Policy.*

Lindgren, E., et al. (2021). Resilience factors contributing to the management of vicarious trauma among practitioners. *Journal of Social Work Practice, 35*(2), 153-167.

Malta, L. S., Levitt, J. T., Martin, A., Davis, L., & Cloitre, M. (2009). Correlates of functional impairment in treatment-seeking survivors of mass terrorism. *Behavior Therapy, 40*(1), 39-49.

Martinez, L., & Patel, S. (2016). Support systems and vicarious trauma severity. *Clinical Social Work Journal, 44*(3), 231-241.

McCanlies, E. C., et al. (2020). The impact of indirect trauma exposure: A review of vicarious trauma in the healthcare field. *American Journal of Health Promotion, 34*(6), 603-611.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious trauma: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149.

McEwen, B. S. (2020). Neurobiological and systemic effects of stress on the brain. *Nature Reviews Neuroscience, 21*(1), 1-17.

McKim, L. L., & Smith-Adcock, S. (2014). Trauma counsellors' quality of life. *International Journal of Advanced Counselling, 36*, 58–69. https://doi.org/10.1007/s10447-013-9190-z

McKay, M., & Fanning, P. (2016). *Self-esteem: A proven program of cognitive techniques for assessing and improving your self-esteem*. New Page Books.

McTrae, D., & Slayton, J. (2020). The importance of trauma-informed care in pediatric healthcare: Enhancing patient and professional well-being. *Clinical Child Psychology and Psychiatry, 25*(3), 681-685.

Meherunissa, S. (2016). An analysis of gratitude and hope in relation to happiness. *International Journal of Indian Psychology, 4*(8).

Meugnot, A., & Rudrauf, D. (2024). Navigating through the paradoxes of empathy: Proposing a new conceptual and methodological approach to study empathy.

Meyer, B., Vermunt, P., & Pitter, H. (2020). Burnout in medical professionals working with children: A systematic review. *Journal of Pediatric Psychology, 45*(4), 433-442.

Naghavi, A., & Salimi, S. (2018). An autoethnography of vicarious trauma and vicarious growth in the context of rehabilitation. *Unpublished manuscript.*

Newman, E., & Shafer, M. (2022). Mindfulness-based strategies for reducing vicarious trauma in therapists: A randomized controlled trial. *Journal of Trauma & Stress, 35*(2), 293-301.

Norris, F. H., & Kaniasty, K. (2019). Received and perceived social support in times of conflict: The role of social networks in reducing psychopathology. *Journal of Trauma Stress, 32*(2), 152-161.

Nguyen, H., & Kim, J. (2021). Coping styles and vulnerability to vicarious trauma. *Journal of Mental Health Counseling, 43*(1), 15-29.

O'Callaghan, P., et al. (2018). Support groups for professionals working with trauma survivors: A systematic review. *Journal of Traumatic Stress, 31*(6), 823-829.

O'Neill, M., & Richards, K. (2020). Cognitive impacts of vicarious trauma. *Trauma Review, 22*(5), 250-260.

Pallant, J. (2016). *SPSS survival manual* (6th ed.). McGraw-Hill Education.

Patel, R. (2018). Compassion fatigue among mental healthcare providers and its impact on overall wellbeing. *Doctoral Dissertations.* [Unpublished doctoral dissertation].

Pearlman, L. A., & Saakvitne, K. W. (2008). *Treating therapists with vicarious traumatization and secondary traumatic stress disorders.* In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). Routledge.

Perkins, E. B., & Sprang, G. (2013). Results from the ProQOL-IV for substance abuse counselors working with offenders. *International Journal of Mental Health and Addiction, 11*, 199–213.

Pross, C. (2006). Burnout, vicarious traumatization and its prevention. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, 16*(1), 1–9.

Radley, J. J., & Hein, A. M. (2021). The neurobiology of trauma-informed care. *Neuropsychopharmacology, 46*(7), 1845-1857.

Ranjan, P., & Kumar, A. (2022). Psychological impact of vicarious trauma among health care workers during COVID-19 pandemic. *Indian Journal of Psychiatry, 64*(1), 95-101. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_195_21

Roberts, S., & Singh, P. (2021). Organizational policies for trauma-exposed staff. *Health Administration Journal, 39*(2), 112-125.

Roever, C., & Phakiti, A. (2017). *Quantitative methods for second language research: A problem-solving approach*. Routledge.

Samios, C., et al. (2020). The role of peer support in addressing vicarious trauma among professionals. *International Journal of Social Welfare, 29*(4), 460-470.

SAMHSA. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* U.S. Department of Health and Human Services.

Schoenberger, Y. (2000). Progressive muscle relaxation: A meta-analysis of randomized controlled trials. *Journal of Psychoactive Drugs, 32*(3), 245-254.

Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. W. W. Norton & Company.

Siegle, G. J., Jones, N. P., & Thase, M. E. (2020). Emotion regulation in depression: The role of cognitive therapy. *Journal of Abnormal Psychology, 129*(6), 535-545.

Smith, E., Pooley, J. A., Holmes, L., Gebbie, K., & Gershon, R. (2023). Vicarious trauma: Exploring the experiences of qualitative researchers who study traumatized populations. *Disaster Medicine and Public Health Preparedness, 17*, e69.

Smith, J., & Jones, L. (2018). Prevalence of vicarious trauma in mental health practitioners. *Journal of Psychiatric Nursing, 24*(6), 420-429.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., et al. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*, 570-585.

Stamm, B. H. (2009–2012). *Professional quality of life: Compassion satisfaction and fatigue (ProQOL)*. https://www.proqol.org/

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology, 13*(1), 2022278.

Terr, L. (1990). *Too scared to cry: Psychic trauma in childhood*. Harper & Row.

Thomas, M., & Cormier, C. (2022). Understanding the intersectionality of race, gender, and mental health in the context of vicarious trauma: A qualitative analysis. *Social Service Review, 96*(3), 423-446.

Tsirimokou, A., Kloess, J. A., & Dhinse, S. K. (2023). Vicarious post-traumatic growth in professionals exposed to traumatogenic material: A systematic literature review. *Trauma, Violence, & Abuse, 24*(3), 1848-1866.

Urdan, T. C. (2022). *Statistics in plain English*. Routledge.

Ursini, T., & Orsini, S. (2020). Peer support and the management of secondary trauma in healthcare professionals. *Journal of Health Psychology, 25*(7), 883-891.

Velasco, J., Sanmartín, F. J., Gálvez-Lara, M., Cuadrado, F., & Moriana, J. A. (2023). Psychological effects of professional exposure to trauma and human suffering: Systematic review and meta-analysis. *Trauma, Violence, & Abuse, 24*(3), 1656-1676.

Wang, H. F., et al. (2013). The effects of progressive muscle relaxation on anxiety levels in samples of nurse students. *Journal of Clinical Nursing, 22*(21-22), 3084-3096.

Wee, M. M., & Lissenberg-Witte, B. I. (2019). A quick guide on how to conduct medical research. Springer Nature.

Williams, D., et al. (2020). Trauma exposure and risk of vicarious trauma. *International Journal of Trauma Studies, 12*(2), 134-148.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*. Brunner-Routledge.

WHO. (2002). *Towards a common language for functioning, disability, and health: International Classification of Functioning, Disability, and Health*. World Health Organization

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2021). The impact of disaster-related stress on the mental health of emergency responders: A retrospective study. International Journal of Emergency Mental Health and Human Resilience, 23(1), 21-31.

Allday, R. A., Newell, J. M., & Sukovskyy, Y. (2020). Burnout, compassion fatigue and professional

resilience in caregivers of children with disabilities in Ukraine. *European Journal of Social Work*, *23*(1), 4-17.

Baker, E. (2003). Vicarious trauma: A review of the literature on vicarious trauma and its impact on therapists and related professionals. Journal of Trauma & Dissociation, 4(2), 121-135.

Baker, E. K., & Kuo, T. (2020). The impact of vicarious trauma on staff in child welfare: An exploratory study. Journal of Social Work, 20(6), 735-752.

Beck, A. T. (2011). “Cognitive therapy: Basics and beyond.”*Guilford Press*.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. International Universities Press.

Bercier, M., & Maynard, B. R. (2015). "Vicarious trauma and the impact of secondary exposure to trauma among social workers." *Social Work, 60*(3), 238-246.

Bishop, S. R., Lau, M., Shapiro, S. L., Carlson, L. E., & Anderson, N. D. (2004).Mindfulness: A proposed operational definition.*Clinical Psychology: Science and Practice*, 11(3), 230-241.

Brady, K. T., Killeen, T., Brewerton, T. D., & Lucerini, D. (2012).Comorbidity of psychiatric disorders and post-traumatic stress disorder. Journal of Traumatic Stress, 25(6), 596-600.

Bride, B. E., Jones, R. K., & MacMaster, S. A. (2019). The impact of vicarious trauma on social workers. *Social Work*, 64(3), 211-220.

Bride, B. E. (2020). The impact of secondary traumatic stress on social workers. Social Work, 65(4), 329-338.

Brown, K. W., & Ryan, R. M. (2020). “Mindfulness: Theoretical foundations and empirical evidence”. In A. S. Gross (Ed.), *Handbook of emotion regulation* (pp. 344–360). Guilford Press.

Brown, A., & Lee, S. (2019). Variability in vicarious trauma prevalence among mental health professionals. Journal of Trauma Studies, 15(3), 205-220.

Brown, B. (2015). “Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead”. Gotham Books.

Blunt, D. L., Borys, R. L., & Nelson, J. (2015). The use of Progressive Muscle Relaxation in group therapy with disaster loss survivors. *Social Work*, 60(4), 371-373.

Butterfield, P. (2011). An evaluation of the effectiveness of Progressive Muscle Relaxation in reducing stress in clinical practice. *International Journal of Health Sciences and Research*, 1(1), 23-28.

Davis, R., & Clark, J. (2017). Personal trauma histories and susceptibility to vicarious trauma. Trauma & Stress, 30(2), 123-130.

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling*, 34(3), 379-393. https://doi.org/10.1080/03069880600942783

Figley, C. R. (2021). Vicarious traumatization: An integrative review. Journal of Traumatic Stress, 34(1), 3-14.

Greene, R. R. (2013). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with trauma survivors. W.W. Norton & Company.

Kabat-Zinn, J. (1994). Wherever you go, there you are: Mindfulness meditation in everyday life. Hyperion.

Kirmayer, L. J., & Crafa, D. (2014). Modelling culture in medical anthropology. Journal of the Royal Society of Medicine, 107(4), 121–124.

Lent, R. W. (2004). Toward a unifying social cognitive theory of career and academic interest, choice, and performance. Journal of Vocational Behavior, 65(1), 1-24.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. Journal of Occupational Behavior, 2(2), 99-113.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. Self and Identity, 2(3), 223-250.

Pargament, K. I. (1997). Psychology of religion and coping: Theory, research, practice. Guilford Press.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2006). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. International Journal of Stress Management, 13(2), 164–176

Chakraborty, A., & Bagh, H. (2021). "Impact of Progressive Muscle Relaxation on Psychological Well-Being of Healthcare Professionals: A Randomized Controlled Trial." *International Journal of Healthcare Sciences,* 9(3), 254-261.

Chan, A. P. C., & Hon, C. K. H. (2016). *Safety of repair, maintenance, minor alteration, and addition (RMAA) works: A new focus of construction safety*. Routledge.

Chiesa, A., & Serretti, A. (2011).Mindfulness-based stress reduction for psychiatric disorders: A systematic review. *Psychological Medicine*, 41(5), 933-944.

Chinski, L. R., Lucchetti, G., & Oliveira, M. M. (2021). "Relaxation techniques for anxiety: A systematic review and meta-analysis." *Journal of Psychosomatic Research*, 144, 110399.

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2014). "Treating survivors of intimate partner violence: The STAIR intervention." *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(3), 333-341.

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2016). "Treating survivors of interpersonal trauma: An evidence-based approach." *American Psychological Association*.

Cloitre, M., Petkova, E., Wang, J., et al. (2011). "Effects of a randomized clinical trial of a modularized approach to trauma-focused treatment of PTSD." *Journal of Consulting and Clinical Psychology*, 79(4), 528-539.

Coccia, M. (2020). Which are factors determining a low COVID-19 mortality in society? High health expenditure and lower exposure of population to air pollution as critical factors for

an effective strategy to cope with future pandemics similar to COVID-19. *Research Square*.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Routledge.

Cohen, J. A., & Mannarino, A. P. (2016). Trauma-focused cognitive therapy for children and families. In *Trauma and the family: A clinical guide* (pp. 83-105). Springer.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). Trauma-Focused Cognitive Behavioral Therapy: An Empirical Update. International Society for Traumatic Stress Studies.

Counseling. *Iranian Journal of Psychiatry and Behavioral Sciences*, *12*(4).

Creswell, J. D. (2017). "Mindfulness intervention reduces loneliness and increases social connectedness." *Psychological Science*, 28(5), 689-696.

Cunningham, J. & Sewing, S. (2020). "The Impact of Trauma History on Vicarious Trauma in Child Welfare Workers."*Child Abuse & Neglect, 99*, 104-149.

Das, A., & Majumdar, P. (2022). Vicarious trauma in Indian emergency responders: Prevalence, impact, and coping strategies. *International Journal of Disaster Risk Reduction*, 77, 103401. [DOI:10.1016/j.ijdrr.2022.103401]

D'Andrea, W., Spinazzola, J., & Ford, J. D. (2019). "Trauma-informed care: Creating the conditions for recovery." *Journal of Trauma & Dissociation*, 20(5), 557–579.

Desbordes, G., Negi, N. J., Pace, T. W., Wallace, B. A., & Schwartz, K. (2012). "Effects of mindful meditation on emotions and brain activity." *The Journal of Alternative and Complementary Medicine*, 18(6), 651-658.

Diagnostic and statistical manual of mental disorders: DSM-5. (5th ed.). (2013). Washington, D.C.: AmericanPsychiatric Association.

Dhiman, S. K. (2020). *The Routledge Companion to Mindfulness at Work*. Routledge.

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling*, 34(1), 71-83. https://doi.org/10.1080/03069880500483047

Everall R. & Paulson L.B. (2004). Burnout and Secondary Traumatic Stress: Impact on Ethical Behavior,*Canadian J. of Counseling*, 38,25-35.

Farb, N. A. S., Anderson, A. K., & Segal, Z. V. (2019). "The brain's response to mindfulness meditation: A functional magnetic resonance imaging study." *Cognitive, Affective, & Behavioral Neuroscience*, 19(4), 778-788.

Farell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review,* 23, 449-480.

Figley, C. R. (1995).Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner/Mazel, New York.

Figley, C. R. (2002). "Treating Compassion Fatigue." *Brunner-Routledge*.

Foster, E., & Nguyen, T. (2020). Supervision and peer support in mitigating vicarious trauma. Mental Health Practice, 23(4), 45-50.

Garcia, M., & Thompson, L. (2019). Organizational factors influencing vicarious trauma. Workplace Stress Journal, 12(1), 55-70.

Gerrits, R. S., Van Oppen, P., Van Marwijk, H. W. J., et al. (2019). "The role of relaxation techniques in stress management: A randomized controlled trial." *BMC Health Services Research*, 19(1), 70.

Gorman, A. A., Jaffee, S. R., & Platt, F. (2022). "Effects of trauma-informed therapy on mood disturbances: A systematic review and meta-analysis." *Trauma, Violence, & Abuse*, 23(2), 659–675.

Goyal, M., Singh, S., Sibinga, E. M. S., et al. (2014). "Meditation programs for psychological stress and well-being: A systematic review and meta-analysis." *JAMA Internal Medicine*, 174(3), 357-368.

Grove, J.R., & Prapavessis, H. (1992). Preliminary evidence for the reliability and validity of an abbreviatedProfile of Mood States. *International Journal of Sport Psychology,* 23, 93-109.

Gupta, R., & Singh, B. (2021). Vicarious trauma among frontline workers in domestic violence response in India: Implications for practice and policy. *Journal of Interpersonal Violence*, 36(19-20), 9495-9513. [DOI:10.1177/0886260520935891]

Hafkenscheid, A. (2005). Event countertransference and vicarious traumatization: Theoretically valid and clinically useful concepts. *European Journal of Psychotherapy & Counselling, 7,*3, 159-16. https://www.tendacademy.ca/resources/defining-vicarious-trauma-and-secondary-traumatic-stress, assessed on 28th June 2020, 4:00pm

Hahs-Vaughn, D. L., & Lomax, R. G. (2019). *An introduction to statistical concepts* (3rd ed.). Routledge.

Harris, M., & Fallot, R. D. (2001). "Using trauma theory to design service systems". *New Directions for Mental Health Services*, 89, 3-19.

Harrison, R. L., & Carr, A. (2021). Organizational factors that contribute to vicarious trauma in child welfare professionals: A qualitative study. Child Welfare, 99(5), 35-52.

Honn, E., Stensrud, T., & Rognan, S. P. (2021). Work-life balance and vicarious trauma in frontline workers: A qualitative study. International Journal of Stress Management.

Hoppe KD. The emotional reactions of psychiatrists when confronting holocaust survivors of persecution. *In: Lindon J, ed. Psychoanalytic forum, Vol. III. New York: Science House*, 1969:187.

Jacobson, E. (1938). Progressive Relaxation. Chicago: University of Chicago Press.

Johnson, P., & Lee, R. (2018). Emotional effects of vicarious trauma among caregivers. Journal of Counseling Psychology, 33(4), 342-355.

Kabat-Zinn, J. (1990). Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness. Delacorte Press.

Kabat-Zinn, J. (2020). Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life. Hyperion.

Kaimal, G., Ray, K., & Muniz, R. (2016). Art-making and mental health outcomes: A systematic review of the literature. Art Therapy, 33(2), 86-95.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2022). "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry*, 62(6), 593-602.

Khoury, B., Lecomte, T., Fortin, G., et al. (2015). "Mindfulness-based therapy: A comprehensive meta-analysis." *Clin Psychol Rev*, 33(6), 763-771.

Kirmani, M. N., Sharma, P., Anas, M., & Sanam, R. (2015). Hope, resilience and subjective well-being among college going adolescent girls. International Journal of Humanities & Social Science Studies, 2(1),262-270.

Kivlighan, D. M., & Quatman, T. (2019). "The effectiveness of trauma-informed care for traumatized youth: A systematic review." *Psychological Trauma: Theory, Research, Practice, and Policy*, 11(5), 479-486.

Knodel, Rebekah K. (2018) "Coping with Vicarious Trauma in Mental Health Interpreting," *Journal of*

Interpretation: Vol. 26: Iss. 1, Article 2.

Kumar, A., & Fernandez, M. (2017). Behavioral changes in trauma-exposed professionals. Psychology and Trauma, 10(2), 98-105.

Lange, A., et al. (2019). "Working with vicarious trauma: A qualitative study of mental health professionals." *Psychological Services*, 16(2), 174-182.

Lee, S., & Carter, D. (2019). Self-care and resilience in trauma workers. Occupational Health Journal, 8(2), 77-85.

Leung, T., Schmidt, F., & Mushquash, C. (2022). A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: A systematic literaturereview. *Psychological trauma: theory, research, practice, and policy*.

Lindgren, E., et al. (2021). "Resilience factors contributing to the management of vicarious trauma among practitioners." *Journal of Social Work Practice, 35*(2), 153-167.

Malta LS, Levitt JT, Martin A, Davis L, Cloitre M.(2009), Correlates of functional impairment in treatment- seeking survivors of mass terrorism. *Behavior Therapy,*40, 39–49.

Martinez, L., & Patel, S. (2016). Support systems and vicarious trauma severity. Clinical Social Work Journal, 44(3), 231-241.

McCanlies, E. C., et al. (2020). The impact of indirect trauma exposure: A review of vicarious trauma in the healthcare field. American Journal of Health Promotion, 34(6), 603-611.

McCann, I. L., & Pearlman, L. A. (1990).Vicarious trauma: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.

McEwen, B. S. (2020). "Neurobiological and systemic effects of stress on the brain." *Nature Reviews Neuroscience*, 21(1), 1-17.

McKay, M., & Fanning, P. (2016). Self-Esteem: A Proven Program of Cognitive Techniques for Assessing and Improving Your Self-Esteem. New Page Books.

McKim, L.L., Smith-Adcock, S. Trauma Counsellors' Quality of Life. *Int J Adv Counselling 36*, 58–69 (2014). https://doi.org/10.1007/s10447-013-9190-z

McTrae, D., & Slayton, J. (2020). "The Importance of Trauma-Informed Care in Pediatric Healthcare: Enhancing Patient and Professional Well-Being." *Clinical Child Psychology and Psychiatry*, 25(3), 681-685.

McNair, D. M., Lorr, M., & Droppleman, L. F. (1992). Profile of Mood States (POMS). Educational and Industrial Testing Service.

Meherunissa, S (2016). An Analysis of Gratitude and Hope In Relation To Happiness. International Journal ofIndian Psychology 4 (8)

Meugnot, A., & Rudrauf, D. (2024). Navigating through the Paradoxes of Empathy: Proposing a new conceptual and methodological approach to study Empathy.

Meyer, B., Vermunt, P., & Pitter, H. (2020). "Burnout in medical professionals working with children: A systematic review." *Journal of Pediatric Psychology*, 45(4), 433-442.

Naghavi, A., & Salimi, S. (2018). An Autoethnography of Vicarious Trauma and Vicarious Growth in the Context of Rehabilitation

Newman, E., & Shafer, M. (2022). Mindfulness-based strategies for reducing vicarious trauma in therapists: A randomized controlled trial. Journal of Trauma & Stress, 35(2), 293-301.

Norris, F. H., & Kaniasty, K. (2019). Received and perceived social support in times of conflict: The role of social networks in reducing psychopathology. Journal of Trauma Stress, 32(2), 152-161.

Nguyen, H., & Kim, J. (2021). Coping styles and vulnerability to vicarious trauma. Journal of Mental Health Counseling, 43(1), 15-29.

O'Callaghan, P., et al. (2018). Support groups for professionals working with trauma survivors: A systematic review. Journal of Traumatic Stress, 31(6), 823-829.

O'Neill, M., & Richards, K. (2020). Cognitive impacts of vicarious trauma. Trauma Review, 22(5), 250-260.

Pallant, J. (2016). *SPSS survival manual* (6th ed.). McGraw-Hill Education.

Patel, R. (2018). "Compassion Fatigue Among Mental Healthcare Providers and The Impact on OverallWellbeing". *Doctoral Dissertations*. 456

Pearlman, L.A., & Saakvitne, K.W. (1995-2008). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In Figley, C.R. (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (pp. 150-177). New York NY: Brunner/Maze

Penedo, F. J., & Dahn, J. R. (2018). Physical Activity in Cancer Survivorship: A Role for Exercise Oncology. New England Journal of Medicine, 379(24), 2347-2353.

Perkins, E. B., & Sprang, G. (2013). Results from the Pro-QOL-IV forsubstance abuse counselors working with offenders. *International Jour-nal of Mental Health and Addiction*, *11*, 199–213.

Peterson, G., & Adams, R. (2018). Training on trauma-informed care for mental health professionals. Educational Psychology Review, 30(3), 341-356.

Pross C. (2006). Burnout, vicarious traumatization and its prevention. *Torture : quarterly journal on rehabilitation of torture victims and prevention of torture*, *16*(1), 1–9.

Quitangon, G., & Evces, M. R. (2015). *Vicarious trauma and disaster mental health: Understanding risks and promoting resilience*. Routledge.

Radley, J. J., & Hein, A. M. (2021). “The neurobiology of trauma-informed care.” *Neuropsychopharmacology*, 46(7), 1845-1857.

Ranjan, P., & Kumar, A. (2022). Psychological impact of vicarious trauma among health care workers during COVID-19 pandemic. *Indian Journal of Psychiatry*, 64(1), 95-101. [DOI:10.4103/psychiatry.IndianJPsychiatry_195_21]

Roberts, S., & Singh, P. (2021). Organizational policies for trauma-exposed staff. Health Administration Journal, 39(2), 112-125.

Roever, C., & Phakiti, A. (2017). *Quantitative methods for second language research: A problem-solving approach*. Routledge.

Samios, C., et al. (2020). The role of peer support in addressing vicarious trauma among professionals. *International Journal of Social Welfare*, 29(4), 460-470.

SAMHSA. (2014). “SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.”*U.S. Department of Health and Human Services*.

Schoenberger, Y. (2000).Progressive muscle relaxation: A meta-analysis of randomized controlled trials. *Journal of Psychoactive Drugs*, 32(3), 245-254.

Penedo, F. J., & Dahn, J. R. (2018). Physical Activity in Cancer Survivorship: A Role for Exercise Oncology. New England Journal of Medicine, 379(24), 2347-2353.

Sharma, S., & Rao, R. (2023). Resilience and coping strategies among mental health professionals facing vicarious trauma in India. *Asian Journal of Psychiatry*, 79, 103501. [DOI:10.1016/j.ajp.2023.103501]

Shakespeare-Finch, J., Scully, P. J., Bruenig, D., & Tedeschi, R. (2024). *Trauma, resilience, and posttraumatic growth in frontline personnel*. Routledge.

Siegel, D. J. (2010). "The Mindful Therapist: A Clinician's Guide to Mindsight and Neural Integration." *Norton & Company*.

Siegle, G. J., Jones, N. P., & Thase, M. E. (2020). "Emotion regulation in depression: The role of cognitive therapy." *Journal of Abnormal Psychology*, 129(6), 535-545.

Smith, E., Pooley, J. A., Holmes, L., Gebbie, K., & Gershon, R. (2023). Vicarious trauma: Exploring the experiences of qualitative researchers who study Traumatized populations. *Disaster medicine and publichealth preparedness*, *17*, e69

Santos, E., & Miller, J. (2019). Physical health symptoms associated with vicarious trauma. Stress and Health, 35(4), 567-574.

Smith, J., & Jones, L. (2018). Prevalence of vicarious trauma in mental health practitioners. Journal of Psychiatric Nursing, 24(6), 420-429.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., et al.(1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology*, 60, 570-585.

Stamm, B. H. (2009-2012). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). Derived from www.proqol.org.

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology*, *13*(1), 2022278.

Terr, L., Too Scared to Cry: Psychic Trauma in Childhood. 1990, New York: Harper and Row, 18.

Thomas, M., & Cormier, C. (2022). Understanding the intersectionality of race, gender, and mental health in the context of vicarious trauma: A qualitative analysis. Social Service Review, 96(3), 423-446.

The Rights of Persons with Disabilities Act, 2016, Gazette of India (Extra-Ordinary); 28 December. 2016. [Last accessed on 2017 Jan 27]. Available from:http://www.disabilityaffairs.gov.in/uploaad/uploadfiles/files/RPWD/ACT/2016.pdf

Tsirimokou, Alexandra, Juliane A. Kloess, and Sonia K. Dhinse. "Vicarious post-traumatic growth in professionals exposed to traumatogenic material: a systematic literature review." *Trauma, Violence, & Abuse* 24, no. 3 (2023): 1848-1866.

Urdan, T. C. (2022). *Statistics in plain English*. Routledge.

Ursini, T., & Orsini, S. (2020). Peer support and the management of secondary trauma in healthcare professionals. Journal of Health Psychology, 25(7), 883-891.

Velasco, J., Sanmartín, F. J., Gálvez-Lara, M., Cuadrado, F., & Moriana, J. A. (2023). Psychological effects of professional exposure to trauma and human suffering: systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *24*(3), 1656-1676.

Wang, H. F., et al. (2013).The effects of progressive muscle relaxation on anxiety levels in samples of nurse students.*Journal of Clinical Nursing*, 22(21-22), 3084-3096

Wee, M. M., & Lissenberg-Witte, B. I. (2019). *A quick guide on how to conduct medical research*. Springer Nature.

WHO (World Health Organization). 2002. Towards a Common Language for Functioning, Disability, andHealth: *International Classification of Functioning, Disability, and Health.* Geneva: WHO.

Williams, D., et al. (2020). Trauma exposure and risk of vicarious trauma. International Journal of Trauma Studies, 12(2), 134-148.Kushlev, K., Dunn, E. W., & O'Brien, K. (2016). "Mindfulness and Empathy: The Role of Attentional Control." Psychological Science, 27(4), 523–530.

Wilson, J. P., and Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*. New York: Brunner- Routledge Publication

APPENDICES

Demographics

APPENDIX-A

1. **DEMOGRAPHIC INFORMATION**

- **Name** (optional): …….
- **Age** (in years): ……
- **Educational Qualification: Undergraduate /Post-Graduate**
- **Occupation**
- **Gender**
- **Date: …….**
- **Signature/thumb: ……**

APPENDIX-B

Letter of Consent

Respected Participants,

Through this form I am informing you that I am a Ph.D. scholar collecting data for my research work on ……

In this study three questionnaires are given to you which you have to fill, please read carefully and give right answer according to you. There is no right/wrong answer in these questionnaires so do not worry about that. These questionnaires are generally asking question on hope, mood and vicarious trauma.

Your active participation will help us to reach our goals in our research work. All the information is collected during this study is kept confidential to the extent permitted by regulations. The study data maybe published or submitted to regulatory authorities. In all cases your identity will not disclosed. You have the freedom to participate in this study, if in any case you don't want to continue, it's totally excepted. You can discontinue your participation at any time if you are not comfortable with the research process. We respect your decision. If you have any questions, please feel free to ask.

I am ……. willing to participate in the study voluntarily. I have been explained everything in the language I can understand best.

Client name-

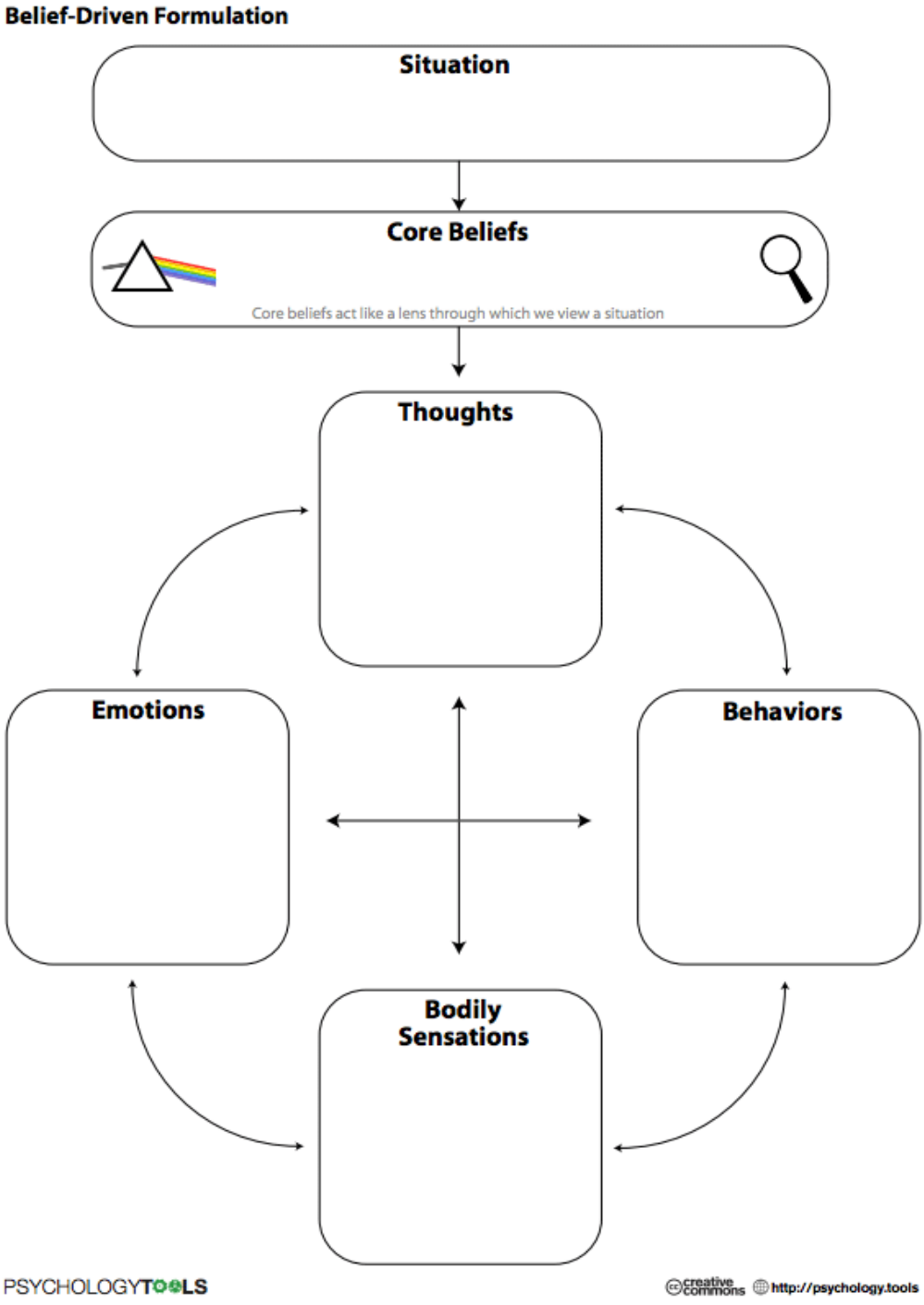
Client signature/date: Researcher signature/date:

Appendix C

Pamphlet for Psych-education

DAY 2 : Jacobson's Progressive Muscle Relaxation (JPMR)

DAY 3 : Trauma Informed Cognitive Therapy - worksheet


Belief-Driven Formulation
Situation
Core Beliefs
Core beliefs act like a lens through which we view a situation
Thoughts
Emotions
Behaviors
Bodily Sensations
PSYCHOLOGYTOOLS
creative commons
http://psychology.tools

Appendice- D

TOOLS USED

1. POMS-R (PROFILE OF MOOD STATES-REVISED)

Belowisalistofwordsthatdescribefeelingspeoplehave.Please**CIRCLETHENUMBERTHATBESTDESCRIBESHOWYOUFEEL.**

	NotAtAll	ALittle	Moderately	Quitealot	Extremely
Tense	0	1	2	3	4
Angry	0	1	2	3	4
WornOut	0	1	2	3	4
Unhappy	0	1	2	3	4
Proud	0	1	2	3	4
Lively	0	1	2	3	4
Confused	0	1	2	3	4
Sad	0	1	2	3	4
Active	0	1	2	3	4
On-edge	0	1	2	3	4
Grouchy	0	1	2	3	4
Ashamed	0	1	2	3	4
Energetic	0	1	2	3	4
Hopeless	0	1	2	3	4
Uneasy	0	1	2	3	4
Restless	0	1	2	3	4
Unabletoconcentrate	0	1	2	3	4
Fatigued	0	1	2	3	4
Competent	0	1	2	3	4
Annoyed	0	1	2	3	4
Discouraged	0	1	2	3	4
Resentful	0	1	2	3	4
Nervous	0	1	2	3	4
Miserable	0	1	2	3	4

PLEASECONTINUEWITHTHEITEMSONTHENEXTPAGE

	NotAtAll	ALittle	Moderately	Quitealot	Extremely
Confident	0	1	2	3	4
Bitter	0	1	2	3	4
Exhausted	0	1	2	3	4
Anxious	0	1	2	3	4
Helpless	0	1	2	3	4
Weary	0	1	2	3	4
Satisfied	0	1	2	3	4
Bewildered	0	1	2	3	4
Furious	0	1	2	3	4
FullofPep	0	1	2	3	4
Worthless	0	1	2	3	4
Forgetful	0	1	2	3	4
Vigorous	0	1	2	3	4
Uncertainaboutthings	0	1	2	3	4
Bushed	0	1	2	3	4
Embarrassed	0	1	2	3	4

2. PROQOL-5

Introduction:
When you help people, you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in both positive and negative ways. Below are some questions about your experiences—both positive and negative—as a helper. Consider each question carefully and reflect on how often you have experienced these feelings or situations in the **last 30 days**.

Instructions:

- Respond to **all questions**.
- For **questions 1, 4, 15, 17, and 29**, **reverse your score** as instructed below.
- Use the following scale to rate each question:

| 1 | Never
| 2 | Rarely
| 3 | Sometimes
| 4 | Often
| 5 | Very Often

Questions:

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.
5. I jump or startle by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a helper.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
9. I think that I might have been affected by the traumatic stress of those I help.
10. I feel trapped by my job as a helper.
11. Because of helping, I have felt "on edge" about various things.
12. I like my work as a helper.
13. I feel depressed because of the traumatic experiences of the people I help.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with helping techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a helper.
20. I have happy thoughts and feelings about those I help and how I could help them.

21. I feel overwhelmed because my case/workload seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
24. I am proud of what I can do to help.
25. Because of helping, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a helper.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

How to Score:

Step 1:
Answer all questions using the 1-5 scale.

Step 2:
Reverse your responses for questions 1, 4, 15, 17, and 29 as follows:

- 1 becomes 5
- 2 becomes 4
- 3 stays 3
- 4 becomes 2
- 5 becomes 1

Calculating Your Scores:

Compassion Satisfaction:

Add your responses to questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30.
Interpretation:

- 22 or less = Low
- 23 to 41 = Moderate (around 50)
- 42 or more = High

Burnout:

Add your responses to questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29.
Interpretation:

- 22 or less = Low
- 23 to 41 = Moderate
- 42 or more = High

Secondary Traumatic Stress:

Add your responses to questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28.

Interpretation:

- 22 or less = Low
- 23 to 41 = Moderate
- 42 or more = High

3. ADULT HOPE SCALE (AHS)

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1. = Definitely False
2. = Mostly False
3. = Somewhat False
4. = Slightly False
5. = Slightly True
6. = Somewhat True
7. = Mostly True
8. = Definitely True

___ 1. I can think of many ways to get out of a jam.

___ 2. I energetically pursue my goals.

___ 3. I feel tired most of the time.

___ 4. There are lots of ways around any problem.

___ 5. I am easily downed in an argument.

___ 6. I can think of many ways to get the things in life that are important to me.

___ 7. I worry about my health.

___ 8. Even when others get discouraged, I know I can find a way to solve the problem.

___ 9. My past experiences have prepared me well for my future.

___10. I've been pretty successful in life.

___11. I usually find myself worrying about something.

___12. I meet the goals that I set for myself.

Scoring:

Items 2, 9, 10, and 12 make up the agency subscale.
Items 1, 4, 6, and 8 make up the pathway subscale.

Researchers can either examine results at the subscale level or combine the two subscales to create a total hope score.

LIST OF PUBLICATIONS

1. Percy Paul, F., & Pathak, V. N. (2024). Secondary traumatic stress among behavior therapists working with children diagnosed with autism. *Madhya Pradesh Journal of Social Sciences, 24*(7), 42-49.

2. Paul, F.P., Pathak, D.N. (2024). Attitude towards Death among Emergency Care Nurses and Midwife Nurses post COVID-19 in Bahrain. *Pakistan Journal of Psychological Research*, 39(4), 803-811. https://doi.org/10.33824/PJPR.2024.39.4.43

3. Paul, F. P., Anjalee K. M., & Pathak, V. N. (2023). Mental health capsule for the impact of pandemic COVID-19 on adolescents. In *Readings in social sciences* (Chapter 50, pp. 528). Lovely Professional University. ISBN 978-81-19929-10-8

LIST OF CONFERENCES

1. Presented a research in the International Conference on Holistic Health and Well-Being: Issues, Challenges and Management on topic 'Healer Centered Approach to Mitigate Trauma Experiences of Mental Health Professionals' conducted from 2nd to 3rd June, 2023 by Lovely Professional University

2. Presented a research in the International Conference on Human Dignity and Mental Health in the New Normal (ICDMH-2021) on the topic, 'Attitude Towards Death Among Female Nursing Staff and IT Professionals'; held between 17th to 18th December,2021 held by Utkal University

Madhya Pradesh Institute of Social Science Research, Ujjain

मध्य प्रदेश सामाजिक विज्ञान शोध संस्थान, उज्जैन

(An Institute of ICSSR, Ministry of Education, Govt. of India and Govt. of Madhya Pradesh)

CERTIFICATE OF PUBLICATION

This is to certified that the article entitled

SECONDARY TRAUMATIC STRESS AMONGBEHAVIOUR THERAPIST'S WORKING AMONG CHILDREN DIAGNOSED WITH AUTISM

Authored By

Ms. Feba Percy Paul

Research Scholar, Department of Psychology,Lovely Professional University,Punjab,India

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Attitude Towards Death Among Female Nursing Staff and IT Professionals.
in a Symposium at the International Conference on Human Dignity and Mental Health in the New Normal (ICDMH- 2021) held during 17-18 December 2021 in virtual mode.
(Organising Secretary)
(Convener)

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Dr. Shaima Bucheery
Conference President

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Abstract
The research identifies the levels of Secondary Traumatic Stress among Behaviour Therapist's working among Children diagnosed with Autism in Bahrain.(1) Secondary Traumatic Stress (STS), also known as compassion fatigue, is a significant concern in the field of behavioral therapy. Behavior therapists work closely with individuals who have experienced trauma, mental health issues, or challenging behaviors, which can lead to them absorbing the emotional burden of their clients. This emotional toll can manifest as STS, causing symptoms such as intrusive thoughts, emotional numbing, and avoidance behaviors similar to those seen in post-traumatic stress disorder (PTSD).The purpose of the study is to identify and add to the knowledge pool of the prevalence of STS in the Bahrain region. (2) Methods: 60 Behaviour Therapist's completed the Secondary Traumatic Stress Scale prepared by Birde (2004). The questionnaire consists of 17 items that measure symptoms such as intrusive thoughts, avoidance, and hyperarousal; (3) Results: It was found that the females have a higher mean score of 46.066 while male scored moderate score of 40.466; (4) Conclusions: STS is a significant concern for behavior therapists due to the nature of their work and the emotional toll it can take. By addressing the variables that contribute to STS and implementing strategies to support therapists' well-being, we can help them maintain their mental health, resilience, and effectiveness in providing quality care to those they provide service.
Keywords: Secondary Traumatic Stress, Behaviour Therapist's. Childhood Autism

Introduction

Recent year'ssecondary and vicarious trauma has captured the interest of several trauma therapists across the globe. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the etiological factor – experience of a traumatic event was extended to include indirect exposure to a traumatic event (American Psychiatric Association, 2013)

Charles Figley popularized this concept of stress related to helping or observing other people of trauma victims suffering (Michelska, 2021).

Secondary Traumatic Sress is defined as the behavioral and emotional outcomes experienced by an individual upon gaining knowledge of another person's stressful experiences (Figley,1995). As pointed out by Oginska- Bulil et al (2021) the symptoms of Secondary Traumatic Stress are similar to that of Post-Traumatic Stress Disorder, Secondary trauma can also be called Secondary PTSD and the terms Vicarious Trauma, secondary Traumatic Stress, Caregiver Burnout are now used as synonyms

Organizational Stressors

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Recent year'ssecondary and vicarious trauma has captured the interest of several trauma therapists across the globe. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the etiological factor – experience of a traumatic event was extended to include indirect exposure to a traumatic event (American Psychiatric Association, 2013)

Charles Figley popularized this concept of stress related to helping or observing other people of trauma victims suffering (Michelska, 2021).

Secondary Traumatic Sress is defined as the behavioral and emotional outcomes experienced by an individual upon gaining knowledge of another person's stressful experiences (Figley,1995). As pointed out by Oginska- Bulil et al (2021) the symptoms of Secondary Traumatic Stress are similar to that of Post-Traumatic Stress Disorder, Secondary trauma can also be called Secondary PTSD and the terms Vicarious Trauma, secondary Traumatic Stress, Caregiver Burnout are now used as synonyms

Organizational Stressors

ATTITUDE TOWARDS DEATH AMONG EMERGENCY CARE AND MIDWIFE NURSES POST COVID-19 IN BAHRAIN

The attitude towards death among Emergency Care and Midwife nurses is explored in this research. The sample comprised 50 female emergency care and 50 female midwife nurses (N= 100) between the ages of 25 to 35, with an average age of 27.63 (SD = 2.52). Samples were selected through purposive sampling, and one scale was used, Death Attitude Profile – Revised (DAP-R) by Wong et al., 1994. The study found that midwife nurses scored higher than emergency care nurses in the dimension of escape acceptance. At the same time, there wasn't a more significant difference between the two nursing departments in the dimension of fear of death, death avoidance, neutral acceptance and approach acceptance. Emergency Care Nurses reported that death is seen as a new beginning, so one's attitude towards death determines one's attitude towards life and midwife nurses have scored higher on the dimension of Escape Acceptance which views life and a burden and death to be a getaway.

KEYWORDS: *Death Anxiety, Attitude towards Death, COVID-19, Emergency Nurses*

Death is associated with negative aspects like separation, loss, grief, disasters, accidents, bereavement, tears, mourning, and the list goes on. The taboo attached to death can be seen in how people react to the cause of death; some judge unnatural death to be the consequence of bad karma in the previous birth or sometimes even attributed to having sinned. Death, in general, is not a subject that people will want to discuss; it is seen to be better to be silent about it than to stir negative emotions (Shear, 2022). Research has found high levels of depression (50.4%), anxiety (44.6%), insomnia (34.0%) and distress (71.5%) among healthcare workers in several regions of China (Lai et al., (2020).

Psychology's first attempt to understand death was a symposium chaired by clinical psychologist Herman Feifel, titled "The Concept of Death and its Relation to Behaviour." This led to a book, "Meaning of Death," edited by Feifel (1959).

Attitude towards death is not just a process that comes before the person has died but also after the death of the individual. To understand separation and its impact on the individuals

CHAPTER 50

Mental Health Capsule for the Impact of Pandemic, COVID-19 on Adolescents

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Abstract

The aim of this chapter is to touch upon five cases that were encountered during a pandemic and to reflect on the intervention models that were incorporated for their betterment. Case study method has been used to reflect on their real-life experiences; hence, the names have been changed for the purpose to maintain confidentiality. The interaction with the persons, analysing their difficulties and the model of intervention used to help them is described through this work. Though this chapter may not answer all the questions related to the problems and approaches to manage during a mental health crisis but it will surely alert us of current times,how it has impacted mental health and the combination of intervention patterns used to address the person in distress. The result is understanding the crisis areas, knowing what intervention method worked and preventing a mental health condition in the long run. It was seen that Psycho-social interventions are the best means to work with individuals in distress in relation to the Covid-19.

Keywords: Mental Health capsule, cases, Intervention and post covid.