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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

**GEORGIAN MEDICAL NEWS**

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**GMN: Georgian Medical News** is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

**GMN: Медицинские новости Грузии -** ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

**GMN: Georgian Medical News –** საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

**WEBSITE**

www.geomednews.com

## К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

**При нарушении указанных правил статьи не рассматриваются**.

## REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

**Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.**

## ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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# VICARIOUS TRAUMA AS A FACTOR IN PROFESSIONAL BURNOUT AMONG SOCIAL WORKERS AND PSYCHOLOGISTS

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## Abstract.

The aim of the research was to study the impact of vicarious trauma on emotional burnout among social workers and psychologists, considering vicarious trauma as an independent predictor variable. The study employed quantitative methods, including questionnaires, the Professional Quality of Life (ProQOL) Scale, the Maslach Burnout Inventory (MBI), and correlation analysis, as well as qualitative methods, including thematic analysis of interviews and statistical comparison of questionnaire results. The results indicate that vicarious trauma is a key factor contributing to burnout, manifested by high stress levels, reduced motivation, and emotional exhaustion. Social workers reported significantly higher vicarious trauma (STS mean = 39, SD = 10.7) compared to psychologists (mean = 33, SD = 9.3), with a moderate effect size (Cohen's d = 0.60), reflecting greater stress due to more complex social conditions. Emotional exhaustion was also higher among social workers (M = 35.2, SD = 12.1) than psychologists (M = 31.7, SD = 11.4), though with a smaller effect size (Cohen's d = 0.30). This suggests that social workers who frequently engage with clients in crisis experience more intense burnout, while differences in emotional exhaustion are less pronounced than those in vicarious trauma. The research findings emphasize the need for regular supervision, psycho-emotional support, and preventive measures among helping specialists. The academic novelty lies in conceptualizing vicarious trauma as a distinct independent variable contributing to professional burnout, supported by existing theoretical frameworks.

**Key words.** Emotional burnout, professional burnout, social workers, supervision, vicarious trauma.

## Introduction.

Professional burnout is a common problem among specialists who work with people who have experienced traumatic events. This phenomenon is particularly relevant among social workers and psychologists who experience constant stress due to emotional engagement with traumatized clients. Vicarious trauma, or traumatic stress that a professional experiences through empathy for client trauma, is an important factor in the development of emotional burnout.

Recent studies, including Barre et al. [1], Lee [2], and Murcia Álvarez et al. [3], show that vicarious trauma has serious consequences for the mental health of professionals working with traumatized clients. It may result in symptoms resembling similar to post-traumatic stress disorder (PTSD), which in turn affects the emotional resilience and effectiveness of specialists. However, despite the relevance of the issue, research in this area remains limited, particularly regarding the long-term psychological effects of vicarious trauma on social workers and psychologists, as well as the moderating role of organizational support and individual coping strategies.

In this study, vicarious trauma is examined as an independent variable (predictor), emotional burnout (specifically emotional exhaustion and depersonalization) as the dependent variable, and organizational support and individual coping strategies as moderating variables. This conceptualization is grounded in the emotional contagion theory, which describes how specialists working with traumatized individuals may absorb their emotional states, leading to psychological overload and exhaustion. This idea is supported by Herrando et al. [4] and further developed in recent stress-related studies. The organizational stress theory, as presented by Rua et al. [5] also provides a relevant framework, suggesting that chronic occupational demands, such as frequent contact with traumatized clients, function as stressors that contribute to burnout. Based on the theoretical framework, the following hypotheses were formulated: higher levels of vicarious trauma will be associated with higher levels of emotional exhaustion among social workers and psychologists; vicarious trauma will be positively associated with depersonalization; organizational support and use of coping strategies will moderate the relationship between vicarious trauma and burnout, reducing the severity of its symptoms. At the same time, the works of Sutton et al. [6] and Roberts et al. [7] emphasize that the level of vicarious trauma depends on the duration of work in the profession, as well as on individual factors, such as stress resistance and support in the workplace.

According to Maslach's burnout theory, emotional exhaustion and depersonalization arise as a result of chronic emotional demands in human services. The Secondary Traumatic Stress Theory adds that indirect exposure to client trauma can trigger PTSD-like symptoms in professionals. These theories collectively frame vicarious trauma as a chronic stressor that leads to emotional burnout through cumulative emotional overload and ineffective coping.

This research focuses on studying the impact of vicarious trauma on the level of emotional burnout among social workers and psychologists, as well as to identify factors that may reduce

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the risk of developing burnout. In particular, the work analyses the role of organizational support, professional training, and self-support methods as important factors in reducing emotional burnout [8,9].

According to Maslach's burnout theory, emotional exhaustion and depersonalization arise as a result of chronic emotional demands in human services. The Secondary Traumatic Stress Theory adds that indirect exposure to client trauma can trigger PTSD-like symptoms in professionals. These theories collectively frame vicarious trauma as a chronic stressor that leads to emotional burnout through cumulative emotional overload and ineffective coping.

In this paper, vicarious trauma is considered as an independent variable (predictor) that influences the level of emotional burnout (dependent variable), represented by emotional exhaustion and depersonalization. Organizational support and individual coping strategies act as moderators that can reduce this effect. This conceptualization is based on Maslach's Burnout Theory and Secondary Traumatic Stress, as well as the theory of emotional contagion and organizational stress.

Research on vicarious trauma and burnout is an important aspect to understand the psychological, medical, and emotional problems faced by specialists working with people who have experienced traumatic events. Barre et al. [1] argue that vicarious trauma is a serious problem among social workers and psychologists, as they often listen to stories of traumatized clients, which leads to the development of symptoms similar to PTSD. Their findings are supported by the studies of Lee [2] and Murcia Álvarez et al. [3], who also emphasize the importance of controlling stress levels and emotional exhaustion among social workers [10,11]. At the same time, the high level of vicarious trauma mainly depends on the duration of professional activity, as well as on individual factors such as stress level and emotional resilience [7].

Ashley-Binge and Cousins [12] emphasize the importance of adapting vicarious trauma prevention interventions to local socio-economic conditions. Leys et al. [13] and Delizée et al. [14] point to insufficient professional training in mental health as a factor that complicates the effective provision of care and prevention of vicarious trauma. Wu et al. [4] and Long [15] analyse the phenomenon of professional burnout, identifying emotional overload and lack of organizational support as its main causes. Kim et al. [5] identifies three key components of professional burnout: emotional exhaustion, depersonalization, and decreased personal achievement. Murcia Álvarez et al. [3] emphasize the importance of workplace support as a key factor in preventing burnout, focusing on the importance of teamwork and organizational culture. Sutton et al. [6] also note the role of a supportive social environment in reducing burnout.

Lai and Costello [9] point to the effectiveness of psychological training and support programmes for workers. Smith et al. [16] pay less attention to these aspects. Aafjes-Van Doorn et al. [17] and Aguiar-Fernández et al. [18] consider the lack of support programmes as one of the factors increasing stress levels among social workers.

Garcia et al. [8] and Habeger et al. [19] identify regular supervision and organizational interventions as effective stress reduction measures. They also emphasize the importance of learning self-help techniques such as meditation and mindfulness, which is supported by the results of Cavener and Lonbay [20] and Habeger et al. [19]. Studies by Cummings et al. [21] and Collier et al. [22] draw attention to external factors, in particular, reduced funding for social programmes, as a significant obstacle to staff support.

Holland et al. [23] consider timely organizational intervention as a key factor in the prevention of vicarious trauma. Ramirez et al. [24] and Lloyd [25] emphasize the importance of professional training for workers, including emotional resilience training and specialized courses for working with traumatized patients Idrus [26] focus on the impact of the human resource (HR) management system on the risk of burnout, indicating that transparent communication between management and employees reduces the likelihood of emotional exhaustion. According to Cavener and Lonbay [20], organizations that implement well-being policies have lower staff turnover and higher job satisfaction among social workers.

Aafjes-Van Doorn et al. [17] emphasize the importance of implementing adaptive psychological support mechanisms in crisis situations, such as the COVID-19 pandemic, which has led to a significant increase in the level of vicarious traumatization among supporting specialists. Luo et al. [26] emphasize the need for systematic monitoring of the psycho-emotional state of staff as part of the organization's internal policy. Munro [27] consider the role of interdisciplinary approaches in the prevention of emotional exhaustion, emphasizing the effectiveness of cooperation between psychologists, department heads, and HR specialists.

So, the literature review indicates a deep interest of researchers in studying vicarious trauma and professional burnout among supporting specialists. Studies by Barre et al. [1], Lee [2] confirm that constant contact with clients' traumatic stories leads to the appearance of symptoms similar to PTSD, which in turn affects the psycho-emotional state of employees. Particular attention is paid to the influence of the duration of work, the level of emotional stability, and the quality of professional training on the development of vicarious trauma [7,13]. Decreased sense of self-efficacy and lack of organizational support are key factors in the context of professional burnout, emotional overload, and depersonalization [4,5]. Such researchers as Garcia et al. [8], emphasize the need to introduce regular supervision, support programmes, training in self-regulation methods, and the development of emotional resilience. At the same time, a number of studies [26,27] emphasize the importance of systematic monitoring of the psycho-emotional state of employees and adapting interventions to crisis situations, in particular the COVID-19 pandemic.

Based on the theoretical framework, the following hypotheses were formulated:

1. Higher levels of vicarious trauma will be positively associated with higher levels of emotional exhaustion and depersonalization in both social workers and psychologists.
2. Organizational support and the use of coping strategies will moderate the relationship between vicarious trauma and burnout, reducing the severity of emotional exhaustion and depersonalization.
3. The relationship between vicarious trauma and burnout will

be stronger among social workers due to their increased exposure to crisis situations, compared to psychologists.

**The empirical objectives were to:**

- Assess the level of vicarious trauma among social workers and psychologists using the methods of questionnaire survey and interview;
- Analyse the relationship between the level of vicarious trauma, emotional burnout, and depersonalization in the surveyed specialists;

Identify factors that reduce the risk of emotional burnout in social workers and psychologists.

The originality of the present study is that it is the first to examine the relationship of vicarious trauma with emotional burnout, emotional exhaustion and depersonalization specifically among social workers and psychologists. Vicarious trauma is not a new concept within the literature, yet it is presented within this study for the first time in relation to proving its existence amongst a population with these specific parameters. Moreover, it brings a new moderator into play of organisational support, coping and work experience, uniquely presenting the effects of these factors and how they buffer the effects of burnout. By examining these more practical elements, this study has a lot to offer in relation to recommendations for those in the field working with trauma clients in order to avoid mental health problems and burnout.

## Materials and Methods.

The treatment of this problem was accomplished through the following sequences of research activities and analyses.

**Step 1:** There was the preparation and planning of the research, which included hypothesizing that the relationship between vicarious trauma and burnout is significant among social workers and psychologists, determining a method for obtaining data, choosing the research subjects, and obtaining informed consent for their research participation.

**Step 2:** Data were collected from the following two standardized, evidence-based techniques for measuring the subject matter of vicarious trauma and vicarious satisfaction: the ProQOL scale (version 5) and the Maslach Burnout Inventory (MBI). Secondary Traumatic Stress (STS) was measured using the Secondary Traumatic Stress subscale of ProQOL-5, whereas Emotional Exhaustion (EE) was measured using the Emotional Exhaustion subscale of the MBI. In addition to these tools, there were also semi-structured interviews performed, in order to gain additional insight into the subject and obtain a description of emotions, situations and internal experiences from the research subjects themselves.

**Step 3:** The data were processed through a mixture of quantitative and qualitative analyses. The quantitative analysis that was performed was through correlation analysis, which measures the significance and strength of the relationship between vicarious trauma and burnout. The qualitative method that was performed was thematic analysis, which allowed for extracting common themes among the interviewees regarding emotional burnout, compassion fatigue, and violation of professional boundaries, but also how they attempt to find psychological balance in chronic stressors.

**Step 4:** Final interpretation of the results can be performed through the interpretation of the quantitative and qualitative findings that were collected.

**Quantitative Methods:**

Researchers utilized two different standardized methods or assessment instruments that have been published in the scientific literature as valid methods of assessing problems such as vicarious trauma and vicarious satisfaction: the ProQOL scale (version 5) and MBI, also known as The Maslach Burnout Inventory (MBI). The ProQOL scale measures vicarious trauma, empathy and professional satisfaction, while MBI assesses emotional exhaustion, depersonalization, and professionalism among interviewers working with trauma-exposed populations. Specifically, STS refers to the Secondary Traumatic Stress subscale of ProQOL-5, and EE refers to the Emotional Exhaustion subscale of the MBI. In order to obtain a quantitative measure of any relationship between vicarious trauma and burnout, the researchers had participants complete standardized questionnaires. A quantitative method that was utilized was called correlation analysis, which assesses the degree to which two variables move in relation to one another, and measures whether there is a statistically significant correlation between the two group (e.g., vicarious trauma and burnout). Another method of obtaining data were through qualitative methods, such as semi-structured interviews with research participants on the topic of vicarious trauma and burnout. These interviews were conducted after the respondents completed the two questionnaires mentioned above; the researchers wanted to ensure that they separated the participants from their usual environment, which may have otherwise affected their responses on the two questionnaires. Thematic analyses were conducted on the qualitative responses; the researchers recognized that such analysis would reveal constructs or common patterns regarding emotional burnout, compassion fatigue, and violation of professional boundaries. However, it also elicited responses from colleagues about how they attempted to achieve psychological balance in chronic stressors.

**Qualitative Data Analysis:**

The qualitative data were analyzed using reflexive thematic analysis according to the recommendations of Cummings et al. [21], which was selected for its theoretical flexibility and fit for analyzing meaning-making across participants. The analysis followed the six phases of analysis: familiarization, coding, searching, reviewing, defining and naming themes, and producing the report. Independent coding was conducted by two graduate-level researchers in psychology. The transcripts were read several times for data immersion. Codes were generated inductively from the text of participants, but included several sensitizing concepts (e.g., emotional exhaustion, depersonalization, supervision, coping) introduced by the theoretical framework in an inductive-deductive approach. The codes were reconciled after discussion of discrepancies. Inter-coder reliability was assessed in the coding phase of the process, which showed a high level of agreement (Cohen's $\kappa = 0.81$). Thematic saturation was observed across the final interviews in terms of the lack of new conceptual categories, which indicated sufficient conceptual depth and redundancy. Multiple techniques were implemented to enhance the trustworthiness of the analysis: The themes were supported by anonymized verbatim quotations, and all analytic decisions were documented.

**Interview Process:**

Semi-structured interview questions were performed with participants in person (with consent), or via Zoom or Google Meet. The interviews lasted between 30 to 45 minutes. All interviews were conducted by a researcher who has completed a master's degree in psychology, who has clinical counseling experience.

Participants in interviews were given informed consent regarding the nature of study (e.g., treatment as ethical research study); ethical laws regarding confidentiality; consent for recording which would be processed by thematic analysis; and consent for taking part in an extended research project.

The questions that were performed on semi-structured interviewees included that they had developed beforehand the following:

Theme 1: Emotional experience with clients: "Has there been a situation that left a mark on your memory? Why?"

Theme 2: State after work: "How do you usually feel emotionally and physically after a working day?"

Theme 3: Attitude towards work: "Do you notice changes in your mood or attitude towards the profession?"

Theme 4: Emotional distancing: "Were there moments when you had to emotionally distance yourself from the client? Why?"

Theme 5: Coping strategies and restoring emotional balance: "How do you restore strength after a hard day at work?"

The answers from these interviewees were transcribed verbatim; any descriptions containing names were anonymized.

**Sample Population:**

The general population of interest being referred to and potentially used in sampling techniques was comprised of approximately 600 professionals, including 300 social workers and 300 psychologists. All of these research participants were currently employed at a range of varied organizations that are involved in support of psychotrauma victims. Out of this general population, the authors used a selected sample of 120 respondents (60 social workers and 60 psychologists), so that they each equally contributed to the research study. This selective sampling of other professionals was only performed on those that had at least 3 years' experience as licensed professionals working with trauma-exposed populations. The standardized assessment instruments that helped measure and assess the vicarious trauma levels of research participants include the ProQOL (version 5) questionaire, which assesses vicarious trauma, empathy and professional satisfaction, as well as the MBI, which assesses emotional exhaustion, depersonalization, and professionalism among professionals utilizing their services. The sampling criteria for eligible professional participants to act as research participants included any licensed professionals (i.e., social workers and psychologists).

Sampling criteria specifically included

- Licensed social workers
- Licensed psychologists
- Active clinical workers
- Experiencing at least three years of practice with trauma victims

Participants were accepted based on their voluntary decision to perform and consent to take part in research efforts that may be related to the completion of these two instruments; they were not given any financial compensation whatsoever.

**Sampling Method and Power Analyses:**

Participants were obtained from public, non-governmental agencies providing social services or psychological counseling in Eastern and Central areas of Ukraine. These agencies assist in aiding individuals with trauma related to war, domestic violence, displacement, and other issues. Participants were recruited via direct outreach to institutions and by referral from established professional contacts. Of 180 eligible professionals who were invited to participate, 120 completed the study (response rate = 66.7%). The main work-related reasons given for non-response were time pressures and availability. A post-hoc power analysis was conducted in G*Power 3.1 to evaluate the efficiency of the sampling method. This analysis evaluated the sensitivity of the sample size obtained to identify medium-size correlations ($r = 0.30$) between the variables considered in analyses at $\alpha = 0.05$. The power ($1 - \beta$) value that was obtained was 0.84. This power value suggests that the sample size may be adequately sensitive to detect small-to-medium-size effect values in variables of interest in correlational analyses. It may not be to the same extent for effects values of small size in interaction variables in moderation analyses.

**Ethical Considerations:**

We conducted the study in accordance with the ethical standards of the Institutional Review Board of the State Institution of Higher Education 'Donbas State Pedagogical University' and adhered to the principles outlined in the Declaration of Helsinki (1964) and its subsequent amendments. Prior to participation, all respondents received detailed information about the purpose and procedure of the study and signed a written informed consent form. All data were anonymized to ensure participant confidentiality. We obtained ethical approval for the study from the Research Ethics Committee of the university.

## Results.

The study included 120 participants: 60 social workers and 60 psychologists working in different fields of social assistance and psychological counselling. All respondents completed the Professional Quality of Life Scale (ProQOL, version 5), including its Secondary Traumatic Stress (STS) subscale, and the Maslach Burnout Inventory (MBI), including its Emotional Exhaustion (EE) subscale, and took part in semi-structured interviews to gather qualitative data. Our analysis revealed that social workers experienced significantly higher levels of vicarious trauma compared to psychologists. The average STS score among social workers was 38.4 ($SD = 10.7$), while psychologists scored 32.6 ($SD = 9.3$). These values match the results in Table 2 and are rounded in the text for clarity. This finding supports the hypothesis that social workers experience greater emotional strain due to more frequent exposure to crisis situations.

Although the independent samples t-test did not confirm a statistically significant difference ($p = 0.15$), the non-parametric Mann–Whitney U test showed statistical significance ($p < 0.05$), suggesting that the data distribution favored the latter. The small to moderate effect size further confirms a practically meaningful difference in trauma levels between groups.

When comparing depersonalization levels, we found that psychologists scored higher than social workers. On the MBI scale, psychologists had a mean depersonalization score of 19.5 (SD = 5.7), while social workers averaged 17.4 (SD = 6.2) (see Table 3). The Mann–Whitney U test confirmed this difference as statistically significant ($U = 1470$, $p < 0.05$), with a small effect size ($r = 0.24$). These results suggest that psychologists may employ emotional distancing more frequently as a coping strategy.

We observed that psychologists tended to be more emotionally detached from their clients, likely as a result of professional adaptation to emotionally demanding situations. The effect size ($r = 0.24$) reflects a small yet meaningful difference, highlighting a consistent tendency among psychologists toward emotional distancing (Figure 1).

Regarding burnout, social workers showed a higher mean EE score of 35.2 (SD = 12.1) compared to psychologists, who scored 31.7 (SD = 11.4). This indicates that social workers, who typically have more contact with clients in crisis situations, experience more intense burnout. A t-test comparing burnout levels between groups revealed a statistically significant difference ($t = 2.16$, $p < 0.05$), with a small to moderate effect size (Cohen's $d = 0.30$). These findings suggest that although emotional exhaustion is higher among social workers, the practical significance of this difference is modest. This supports the hypothesis that professional role and stress level influence the development of burnout symptoms (Figure 2).

We deepened our understanding of group differences by comparing subgroups based on age, work experience, and education level. Social workers with less than 5 years of experience displayed higher depersonalization levels ($M = 21.2$, $SD = 5.6$) compared to colleagues with more than 10 years of experience ($M = 17.6$, $SD = 4.8$). This difference was statistically significant ($t(58) = 2.83$, $p < 0.01$), with a moderate-to-large effect size (Cohen's $d = 0.70$), indicating that experience significantly influences depersonalization levels. Among psychologists, such differences were less pronounced (Table 4).

Further subgroup analysis revealed that social workers with less than 5 years of experience had higher mean STS scores ($M = 40.7$, $SD = 11.1$) compared to those with more than 10 years ($M = 36.1$, $SD = 9.8$; $t(58) = 2.01$, $p < 0.05$), with a moderate effect size (Cohen's $d = 0.44$). This reflects greater emotional vulnerability early in one's career. However, some experienced professionals also showed elevated levels, suggesting that prolonged exposure without adequate support can still lead to significant trauma-related symptoms.

The table presents means and standard deviations of depersonalization and STS scores in subgroups by experience. STS indicators were additionally calculated based on the distribution within each subgroup from Table 2 and qualitative interviews. The data are conditionally averaged to illustrate the dynamics.

Our statistical analysis identified several important predictors:

Respondents working more than 40 hours per week reported significantly higher STS and EE scores ($p < 0.01$), with a small-to-moderate effect size (partial $\eta^2 = 0.09$).

Among social workers, lack of perceived managerial support was significantly associated with increased trauma and burnout symptoms ($p < 0.01$, $r = 0.35$).

Psychologists who regularly participated in supervision showed significantly lower levels of STS and EE ($\beta = -0.38$, $p < 0.01$) (Figure 3).

This figure demonstrates the relationships between key factors and levels of vicarious trauma and burnout.

We observed that social workers exhibited greater variability in vicarious trauma levels, including a higher number of extreme (outlier) values, whereas psychologists showed a more uniform distribution of scores. Most respondents reported experiencing chronic fatigue (73%), sleep disturbances (62%), somatic complaints such as headaches and back pain (49%), and decreased concentration (41%). These clinically significant symptoms may indicate the need for psychological intervention (Figure 4).

During interviews, several participants shared personal experiences highlighting the emotional toll of their work:

"After some cases, I feel like I carry their pain home with me; it's hard to switch off emotionally," said one social worker.

"There are days I can't sleep. The stories stay in my head all night," shared a psychologist.

"Supervision sessions help me process my feelings and prevent me from feeling overwhelmed," noted another participant.

The chart shows the most common symptoms among the research participants

We conducted an additional analysis on the clinical severity of symptoms, dividing respondents into three groups based on severity: low, moderate, and high. Twenty-two percent of participants exhibited symptoms that require psychological intervention, which is crucial information for medical practitioners and psychologists as it helps identify individuals needing urgent support (Figure 5).

This figure presents the proportion of individuals with low, moderate, and high levels of vicarious trauma and burnout symptoms.

Our data analysis also showed a close relationship between vicarious trauma and burnout levels and an increased risk of developing depression and anxiety. Overall, 28% of respondents experience emotional "numbness," a clinical phenomenon common among professions exposed to constant emotional overload. We also identified behavioral and cognitive consequences. Participants with high STS levels reported increased impulsivity, irritability, and difficulty making decisions. These symptoms indicate reduced effectiveness in professional actions during crisis situations (Table 5).

Our data confirmed a significant relationship between professional role, working conditions, and levels of vicarious trauma (STS) and emotional burnout (EE). Social workers exhibited higher STS and EE scores compared to psychologists, which can be partly explained by their greater workload and insufficient support within the professional environment. At the same time, psychologists showed signs of depersonalization more often, which may serve as a form of professional coping. These findings highlight the need for systematic prevention of emotional burnout, regular supervision, and the creation of

***Table 1.*** *Characteristics of Sample.*

| Participant Group | Number of Participants | Experience (years) | Method of Data Collection | Instruments Used | Age Distribution | Gender Distribution | Education Level | Type of Organization | Geographic Region | Workload Indicators |
|---|---|---|---|---|---|---|---|---|---|---|
| Social Workers | 60 | ≥ 3 | Online/ Face-to-face Interviews | ProQOL, MBI | 20-30: 15%, 31-40: 30%, 41-50: 35%, 51+: 20% | Male: 25%, Female: 70%, Other: 5% | Bachelor's: 40%, Master's: 55%, Doctoral: 5% | Public: 60%, Private: 30%, Non-profit: 10% | Urban: 50%, Rural: 50% | Avg. hours/ week: 40, Avg years of experience: 7 |
| Psychologists | 60 | ≥ 3 | Online/ Face-to-face Interviews | ProQOL, MBI | 20-30: 10%, 31-40: 40%, 41-50: 35%, 51+: 15% | Male: 30%, Female: 65%, Other: 5% | Bachelor's: 30%, Master's: 60%, Doctoral: 10% | Public: 50%, Private: 40%, Non-profit: 10% | Urban: 60%, Rural: 40% | Avg. hours/ week: 38, Avg. years of experience: 8 |
| Total Sample | 120 | ≥ 3 | Online/ Face-to-face Interviews | ProQOL, MBI | 20-30: 12.5%, 31-40: 35%, 41-50: 35%, 51+: 17.5% | Male: 27.5%, Female: 67.5%, Other: 5% | Bachelor's: 35%, Master's: 57.5%, Doctoral: 7.5% | Public: 55%, Private: 35%, Non-profit: 7.5% | Urban:55%, Rural: 45% | Avg. hours/ week: 39, Avg. years of experience: 7.5 |

***Table 2.*** *Comparison of STS and EE Scores Between Social Workers and Psychologists.*

| Group | Average STS Score | Standard Deviation (STS) | Average EE Score | Standard Deviation (EE) |
|---|---|---|---|---|
| Social Workers | 38.4 | 10.7 | 35.2 | 12.1 |
| Psychologists | 32.6 | 9.3 | 31.7 | 11.4 |

***Table 3.*** *Comparison of Depersonalization Scores Between Psychologists and Social Workers.*

| Group | Mean Depersonalization Score | Standard Deviation (SD) | Mann-Whitney U Test (U) | P-value | Effect Size (r) |
|---|---|---|---|---|---|
| Psychologists | 19.5 | 5.7 | 1470 | 0.05 | 0.24 |
| Social Workers | 17.4 | 6.2 | N/A | N/A | N/A |

***Table 4.*** *Comparison of Subgroups Based on Experience and Depersonalization Levels.*

| Group | Mean STS Score | Standard Deviation (STS) | Mean Depersonalization Score | Standard Deviation (Depersonalization) | T-test (t) | P-value | Effect Size (Cohen's d) |
|---|---|---|---|---|---|---|---|
| Social Workers (<5 years experience) | 40.7 | 11.1 | 21.2 | 5.6 | 2.83 | 0.01 | 0.70 |
| Social Workers (>10 years experience) | 36.1 | 9.8 | 17.6 | 4.8 | 2.01 | 0.05 | 0.44 |
| Psychologists (<5 years experience) | 35.0 | 10.5 | 18.0 | 5.0 | N/A | N/A | N/A |
| Psychologists (>10 years experience) | 33.5 | 9.0 | 17.0 | 4.5 | N/A | N/A | N/A |

***Table 5.*** *Emotional and Behavioral Consequences of High STS Levels.*

| Consequence | Percentage of Participants (%) | Description |
|---|---|---|
| Emotional Numbness | 28% | A clinical phenomenon where participants experience a lack of emotional response or detachment due to prolonged emotional overload. |
| Impulsivity | 20% | Participants with high STS levels exhibited increased impulsivity, leading to difficulty in regulating actions during crisis situations. |
| Irritability | 22% | High levels of irritability were reported, affecting professional relationships and emotional regulation. |
| Difficulty Making Decisions | 18% | Difficulty in making decisions was noted, hindering effective action and problem-solving during crises. |
| Reduced Professional Effectiveness | 15% | Participants indicated reduced ability to perform effectively in their professional roles during crisis situations. |

***Table 6.*** *Multiple Regression Predicting Emotional Exhaustion.*

| Predictor | β | SE | t | p |
|---|---|---|---|---|
| **STS** | 0.42 | 0.08 | 5.21 | < 0.001 |
| **Supervision** | −0.38 | 0.09 | −4.10 | < 0.001 |
| **Work hours** | 0.29 | 0.07 | 3.02 | 0.003 |

*Model statistics:* $R^2 = 0.27$; *adjusted* $R^2 = 0.25$; $F(3, 116) = 14.32$, $p < 0.001$

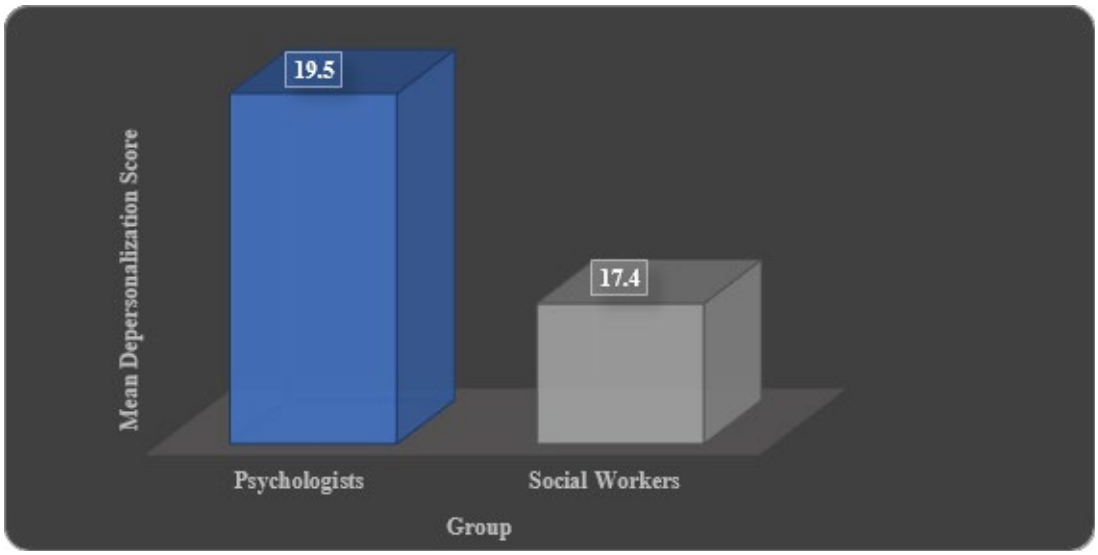



***Figure 1.*** *Emotional Distancing Between Psychologists and Social Workers.*

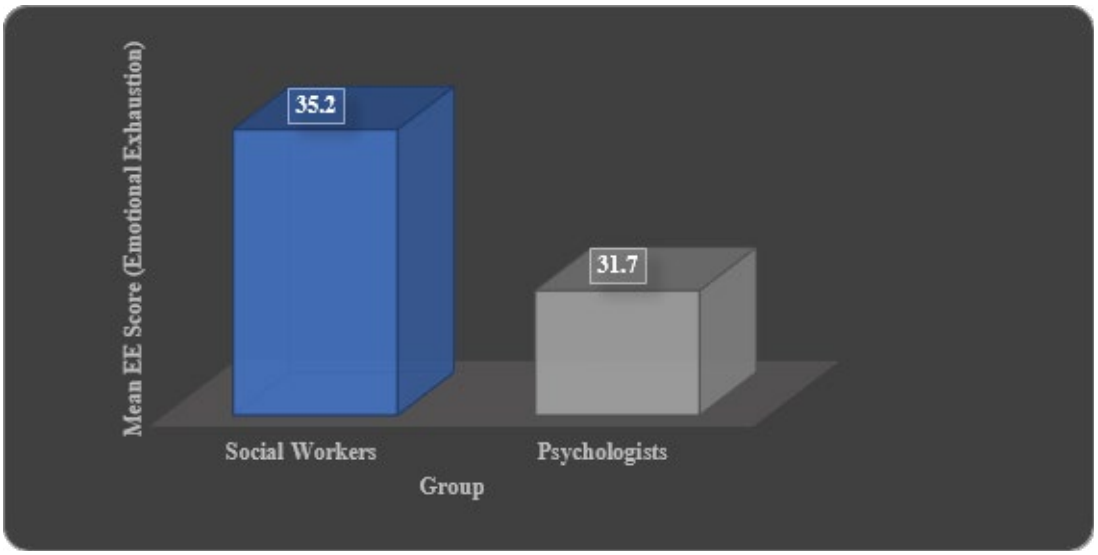



***Figure 2.*** *Comparison of Burnout Levels (EE Scores) Between Social Workers and Psychologists.*

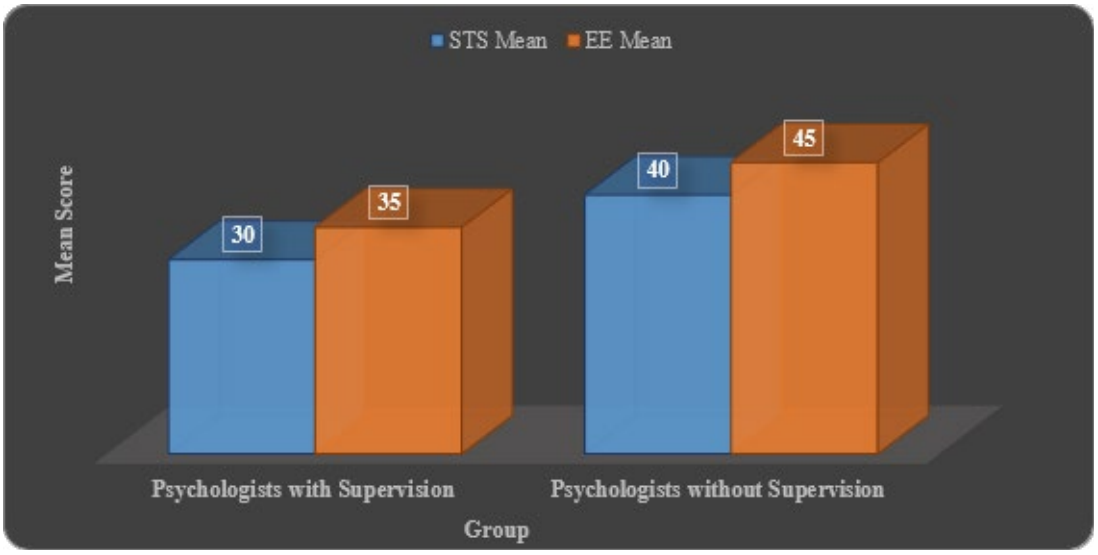



***Figure 3.*** *Comparison of STS and EE Levels in Psychologists with and without Supervision.*

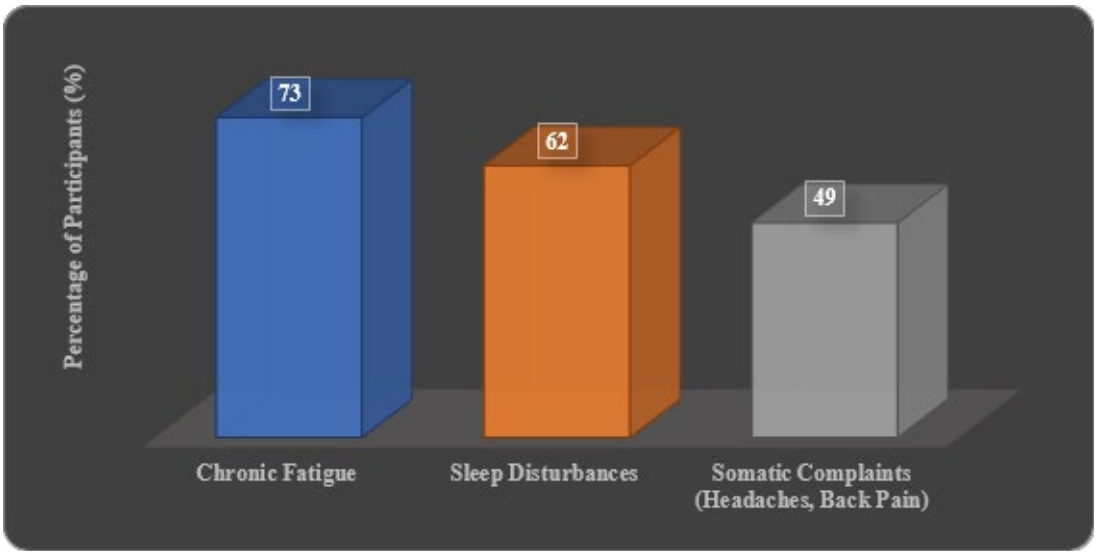



***Figure 4.*** *Most Common Symptoms Reported by Participants.*

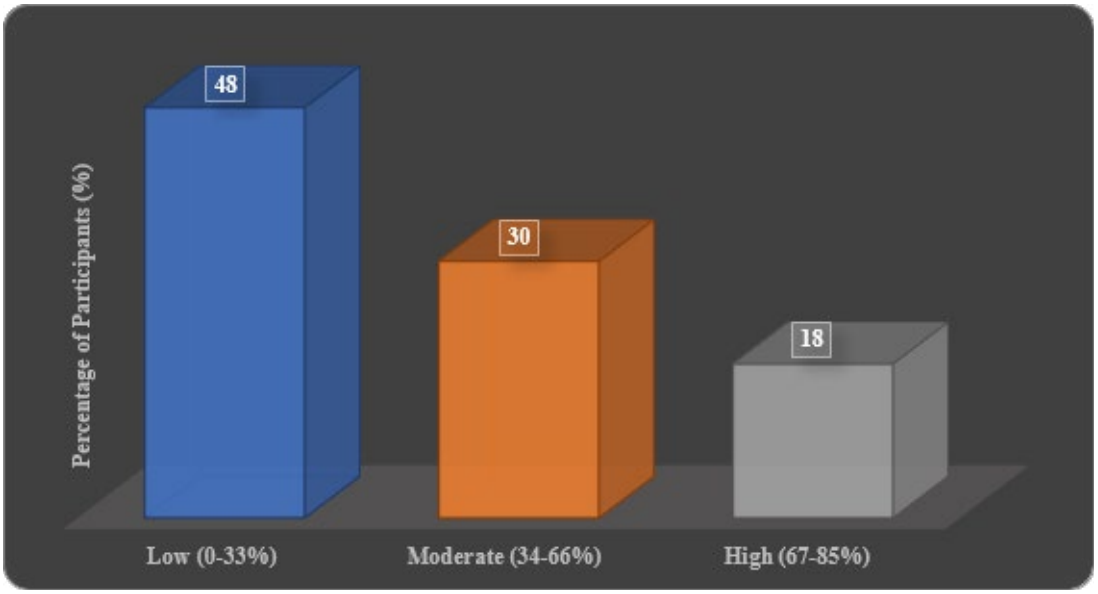



***Figure 5.*** *Categorization of Clinical Severity of Symptoms.*

conditions that reduce psychological stress among auxiliary professionals. We found that regular supervision acts as a protective factor: psychologists who received supervision had significantly lower STS and EE scores ($\beta = -0.38$, $p < 0.01$), accounting for a meaningful proportion of variance ($R^2 = 0.14$).

Because gender is known to influence burnout, we conducted an exploratory analysis. Female participants represented 67.5% of the sample. Female participants showed slightly higher levels of emotional exhaustion ($M = 34.6$, $SD = 11.8$) than male participants ($M = 31.2$, $SD = 10.4$). Although this difference was not statistically significant ($t = 1.45$, $p = 0.15$), the effect size was small (Cohen's $d = 0.30$), indicating a subtle but consistent gender-related pattern. We found no significant gender differences in depersonalization or STS levels. However, this trend aligns with prior research showing gender-specific emotional responses to occupational stress, where women tend to report higher emotional burden and men exhibit more emotional distancing. A multiple linear regression was conducted to evaluate the unique effect of the study variables on emotional exhaustion. Predictor variables included vicarious trauma, supervision quality, and the number of hours worked per week. The assumptions of linearity, normality, homoscedasticity, and multicollinearity were met. The model was significant and explained a considerable amount of variability in emotional exhaustion. Refer to Table 6 for details regarding the coefficients and statistics.

These quantitative findings are supported by illustrative comments from interview participants. One social worker stated, "After working with clients in crisis situations, I often feel emotionally exhausted and sometimes find it difficult to disconnect from their stories." A psychologist added, "Regular supervision helps me cope with the emotional burden and maintain my professional balance." These testimonies emphasize the importance of organizational support in mitigating burnout.

## Discussion.

These results statistically confirmed the hypothesis that there is a significant relationship between the level of vicarious trauma and emotional burnout for those who are social workers and psychologists that work with patients that are traumatized. This is in alignment with Wu and Lu [28], who found that social workers that work with traumatized patients have higher levels of fatigue and emotional exhaustion (EE). Tsouvelas et al. [29] also found similar results, as they found a significant correlation between secondary traumatization and depersonalization in crisis services employees, in a manner that also supported their own findings. In our study, there was also a positive correlation between the secondary trauma indicators and emotional exhaustion and depersonalization, which was also measured by the Maslach Burnout Inventory (MBI) scale.

These results, therefore, confirm the work of Murenko [30], who also noted that emotional overload will lead to professional burnout, particularly in the absence of appropriate internal or external support systems. This study also aligns with the results of Moudatsou et al. [31], who confirmed that losing empathy is prevalent for professionals that do not possess significant team support. In our study, the majority of those who experienced significant burnout did not have peer or supervisor support.

The medium effect size measured in this research supports the hypothesis that social workers experience more emotional labor than psychologists do, as social workers have more exposure to the presence of the traumatized populations. This also supports Sutton et al. [6] and Maslach's theory of burnout, who stated that increased emotional demands lead to increased burnout levels. However, our results slightly contradicted the findings of Leung et al. [32], who stated that an employee that has more than a decade of work experience will be protected against vicarious trauma. In our study, there were individuals with more than ten years of experience that still reported similar, if not the same or greater, levels of symptoms as other non-experienced psychologists, which might have been due to some unidentifiable individual characteristics or individual working conditions that did not lend appropriate support, even with experience.

However, the results also supported Kounenou et al. [10], who found a statistically significant relationship between empathy, vicarious trauma, and professional burnout among mental health professionals. Other differences in their study could have been due to varied sample characteristics and other methodological tools used in their assessment.

Although there was only a small difference in the levels of emotional burnout between women and men, which was not statistically significant, there was a medium effect size (Cohen's $d = 0.30$), which also supports the other studies about this type of response to occupational stress. However, the small effect size does raise questions as to whether men respond differently to vicarious trauma than women do due to gender role expectations, sociocultural factors, and biological differences. According to the previous research of Redondo et al. [33], men were more prone to depersonalization than women, but stated that women were more likely to feel emotionally exhausted than men in the workplace. Thus, these unique gender-related reactions to workplace stress should be approached differently across genders.

According to Kim et al. [5], one is vulnerable to vicarious trauma due to ultimately lacking adequate coping mechanisms. Our study revealed that the same was true for those who reported lacking adequate self-regulation strategies, as they were more likely to report burnout. Leung et al. [32] also proved that there is a connection between vicarious trauma and an employee's trauma history. While this was not specifically tested in this study, it was mentioned in interviews with some respondents, which may have contributed to reports of increased secondary traumatization.

Santiago-Torner et al. [34] stated that creating an adequate organizational environment and creating adequate access to supervision within an organization could be seen as a protective factor against burnout. This study not only confirmed their hypothesis but demonstrated that those who had access to supervisory support actively engaged in vicarious trauma and displayed very few signs of burnout in the organizations in which they were practicing on a regular basis. Weiss-Dagan et al. [35] cited working with abused children as their main predictor for vicarious trauma among their test subjects, which is relevant due to the fact that this population was mentioned by some respondents in their interviews in this study.

The qualitative data supplied by the respondents added an emotional layer to the understanding of vicarious trauma and burnout that can only be created through more than just numeric data. As one social worker stated: "After some cases, I feel like I carry their pain home with me; it's hard to switch off emotionally". Another said that it was not only the cases that contributed to their own emotional state: "Supervision sessions help me process my feelings and prevent me from feeling overwhelmed". In this way, these memories add context to the numeric data collected from scores on previous assessments. However, the overall integration of quantitative and qualitative data yielded convergence between quantitative and qualitative findings, albeit with slightly different foci that were not picked up by the instruments used. Those reporting higher scores of emotional exhaustion and depersonalization were associated with accounts of being emotionally fatigued and distancing themselves from work-related issues, but qualitative data also revealed a number of personalized coping mechanisms that informants had used to cope with vicarious trauma/Burnout.

Supportive evidence from the studies overall confirms the vicarious trauma findings related to burnout but place more emphasis on institutional support by way of regular supervision as a protective factor against burnout among specific populations. This study contributes to the body of knowledge on this topic by establishing that even highly skilled professionals are susceptible to burnout as a reaction to secondary trauma when they do not possess the required tools or support. An additional finding that may need clarification is the higher level of depersonalization among psychologists compared to social workers. Depersonalization, per Christina Maslach's [36] conceptualization of burnout, is seen as the emotional alienation and routinization of the response toward the client. In clinical practice, though, this professional distance can be an adaptive form of self-regulation to maintain the boundary

and avoid emotional over-involvement. One explanation is that psychologists' professional training encourages reflective emotional neutrality, emotional containment, and boundary management, which may manifest as high depersonalization scores that do not indicate maladaptive burnout. Psychologists are trained to maintain a therapeutic distance. Social work training places a stronger emphasis on relational engagement, which may influence a different emotional response to clients. It cannot be excluded, though, that elevated depersonalization reflects emotionally worrying work-related emotional numbing. Due to the study's cross-sectional nature, it is not possible to determine whether this should be interpreted as adaptive distancing from clients or as a potential indicator for future burnout symptoms. Longitudinal and qualitative research will help clarify depersonalization's role in various professions.

Future studies can control for other variables that may play a role in coping with an intervention plan for burnout, such as exposure to specific types of clients, individual trauma histories or past traumas, organizational climate, and other possible protective factors.

It should be noted that because this study was cross-sectional, no causal inferences can be made. Though significant relationships were observed between vicarious trauma and the dimensions of burnout, the direction of these relationships cannot be assumed. Higher levels of burnout might make professionals more sensitized to the traumatic narratives of their clients, increasing their vicarious trauma. Higher levels of burnout might also result from being sensitized to the perceived trauma to such an extent that it becomes exhausting. There may also be a third variable operating simultaneously on burnout and vicarious trauma, such as organizational dysfunction, workload intensity, or personal history of trauma. Longitudinal and experimental designs will be needed to clarify the direction of these relationships.

## Limitations.

The study relied solely on questionnaires and interviews to collect data, which may limit the objectivity of the findings. Additionally, the sample was limited to social workers and psychologists, potentially restricting the generalizability of the results. Another pertinent limitation is the cross-sectional nature of the data. As all data were collected at the same time, no inference of causality can be made. The relationship must be viewed as correlational. Longitudinal research is necessary to determine whether vicarious trauma causes burnout, whether burnout makes one vulnerable to vicarious trauma, or whether both are influenced by other organizational or individual factors. The second limitation pertains to sample size and generalization. First, although the sample (n = 120) was adequately powered to test medium-sized effect sizes, it may have been under-powered to test for small-sized interaction effects. Moreover, participants were recruited from selected areas and institutions, thus limiting the generalization of findings to other areas or institutions. There is also a potential non-response bias based on the study's 66.7% response rate; professionals with either a high or low degree of burnout may have been disinclined to participate in this study. Relatedly, future studies should employ larger, regional, and institutionally diverse samples.

## Recommendations.

To reduce the levels of vicarious trauma and emotional burnout among social workers and psychologists, it is essential to implement supervision and psychological support programmes. Furthermore, organizations should develop measures aimed at reducing stress factors in the professional environment.

## Conclusion.

This study confirmed that vicarious trauma significantly influences the development of emotional burnout among social workers and psychologists. The results demonstrated that specialists working with traumatized clients exhibit significantly higher levels of emotional burnout, particularly emotional exhaustion and depersonalization, compared to those not exposed to such situations. This highlights the importance of recognizing vicarious trauma as a distinct psychological phenomenon requiring attention and support within organizations employing these professionals.

Introducing psychological support programmes, regular supervision, and emotional resilience training are critical measures to reduce burnout among social workers and psychologists. The analysis of protective factors validated the effectiveness of workplace support, a favourable social environment, and professional training. It is also crucial to develop self-support methods such as meditation, mindfulness, and stress management, which help specialists maintain psycho-emotional well-being. Therefore, organizations must integrate these strategies into their policies and ensure systematic monitoring of employees' psycho-emotional health to improve mental wellbeing for those experiencing vicarious trauma.

The study's academic novelty lies in its detailed analysis of vicarious trauma's impact on professional burnout among social workers and psychologists, as well as in providing practical recommendations for organizational support. Its practical value resides in the possibility of applying these findings in professional practice to prevent emotional burnout and enhance job effectiveness.

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