VICARIOUS TRAUMA, COMPASSION FATIGUE AND MORAL INJURY AMONG CLINICAL PSYCHOLOGY INTERNS

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Dedication

To my parents, family, and friends: Your unwavering support and boundless love have been my anchor. Through every challenge and triumph, your belief in me has been my strength. I am profoundly grateful for your presence in my life.

To Sir Hanan: Your kindness and guidance have been a beacon of hope. You helped me find the courage to believe in myself and lifted me up every time I fell. Your unwavering support has been a cornerstone of my journey, and I am deeply thankful for your compassion and wisdom.

This thesis is dedicated to all the clinical psychology interns who are just beginning their journey. Clinical training is an important part of our development and a significant responsibility. It is crucial to be aware of the challenges we face during this time and to ensure that our growth does not come at the expense of our clients' well-being.

In this journey, the betterment of your clients and your own growth are deeply intertwined. Embrace the challenges as opportunities for profound personal and professional development. Understand that the struggles you face are not a reflection of your capabilities but a testament to the demanding nature of this work. Keep striving, keep learning, and keep caring—for your clients and for yourself. Your growth and your clients' well-being are both essential parts of this meaningful journey.

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ABSTRACT

This study was done to examine the relationship between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns. Correlational research design was used to conduct the study. A sample of 300 clinical psychology interns, both male *(n =111)* and females *(n= 189*) aged between 24-27 years (*M= 25.47, SD= 1.08*), were selected from different public and private institutes of Rawalpindi, Islamabad and Lahore, by using non-probability purposive sampling. Self-report measures of vicarious trauma scale (Vrklevski & Franklin, 2008), compassion fatigue short- scale (Figley et al., 2006), and the moral injury symptoms scale-health professionals (Litz et al., 2009) were used to assess the research variables. The results of pearson product moment correlation revealed a significant positive association between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out), moral injury and clinical cases per day, internship hours per day, while a significant negative relationship between age, clinical internship level, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out), and moral injury. The results of mediation analysis showed compassion fatigue to partially mediate the relationship between vicarious trauma and moral injury. Furthermore, there were significant differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury across diagnosis of clients and clinical internships. Similarly, significant differences were found in burn out across gender and marital status. However no significant differences were found between vicarious trauma, compassion fatigue (secondary traumatic stress) and moral injury across gender and marital status.

Keywords: Vicarious Trauma, Compassion Fatigue, Moral Injury, Clinical Psychology Interns

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LIST OF ABBREVIATIONS

CF-SS	Compassion Fatigue- Short Scale
CSDT	Constructivist Self-Development Theory
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
PSS	Perceived Stress Scale
PTSD	Post Traumatic Stress Disorder
SPSS	Statistical Package of Social Sciences
VTS	Vicarious Trauma Scale

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CHAPTER I

INTRODUCTION

Mental health professionals are constantly exposed to attending needs of their clients. Although this process is rewarding and fulfilling, it can become exhausting too. Due to their continuous client engagement, 30% of psychologists reported feeling emotionally exhausted in 2021; this number increased to 41% in 2022 and 46% in 2023 (Lin et al., 2023). Clinical Psychologists also belong to this category as they specialize in diagnosing and treating a range of mental illnesses to help people deal with psychological difficulties. They become deeply engaged with their clients, taking on their hardships and traumas, which can have a significant effect on their own life (Baker, 2023).

Research on seasoned professionals has revealed that working with trauma clients can change therapists' worldviews and impact how safe and trustworthy they feel (Curryer & Mawdsley, 2024). According to Tamarine et al. (2020), this deep engagement frequently makes it difficult to manage one's personal and professional lives. At times, the exposure to challenging clients causes psychologists to question the world's fairness and justice (Chaudhary et al., 2022). This effort to save their clients wears them out emotionally and causes them to doubt their ability to lessen their clients' suffering (Miller & Turluic, 2023). Clinical psychologists are required to continually reflect on their own mental health to maintain a careful balance between preventing burnout and engaging in compassionate engagement (Rasul et al., 2023). Effective client care and personal health both depend on their well-being as they negotiate the intricacies of client engagement, therapeutic approaches, and ethical issues (Choi, 2017).

Novice clinical psychology interns have similar difficulties as their more seasoned counterparts (Fernandez et al., 2022). Although the therapy process is rewarding, it involves

handling difficult instances where they may come across individuals who are suffering from various comorbidities, complex traumatic histories, or significant emotional anguish. These stressful instances may make it difficult for interns to control their emotional triggers, which may lead to emotional weariness (Berrios, 2020).

Vicarious trauma is a condition that develops over time because of the accumulation of experiences and traumatic histories. It happens when clinical psychology interns become immersed in the lives of clients, start identifying with their struggles, and ultimately experience a shift in perspective (Armes et al., 2020). Interns experience a disturbance of their basic ideas about the world, themselves, and other people because of hearing clients' distressing stories and experiences, which causes them to doubt their own sense of safety and faith in society (Leys et al., 2021).

This ongoing effort as well as an experience of emotional tiredness can result in compassion fatigue, which is a decreased level of empathy and care for clients because of an increasing emotional engagement, (McNeillie & Rose, 2021). The interns suffer emotional detachment because of greater emotional strain and an attempt to be present for the client. When they hear heartbreaking tales, they become depressed and hopeless for their clients because they are unable to provide them with any further support (Choi, 2017). It also manifests as amazement at what and how someone else was put through such an ordeal, as well as at how agonizing it must have been for them (Sweileh, 2020). Some interns may become numb and unable to respond to this, while others may shut down completely (Stevens & Abbadey, 2023).

Their prior levels of empathy and professional efficacy may be compromised by compassion fatigue, which may then result in guilt, shame and moral injury (Quinn et al., 2019). When someone believes that their behavior transgresses their moral and ethical standards, they

suffer moral injury. Clinical psychology interns may experience guilt and shame if they are unable to provide appropriate client care and are unable to cope with their feelings of exhaustion and emotional detachment (Chaudhary et al., 2022).

Due to their limited exposure, experience, skill set, or emotional tiredness after hearing about the challenges, they may encounter moral injury when working with challenging clients. In these situations, they may not know what to do or say and feel uncertain (Russo et al., 2020). Interns experience guilt and humiliation when they see a client needs assistance but are unable to offer it because of limitations. They question their abilities and hold themselves accountable for the situation. The client care they give may be jeopardized because of the combined effects of complicated emotions (Norman & Manguen, 2023).

Thus, the purpose of this study is to investigate whether clinical psychology interns experience vicarious trauma and compassion fatigue, as well as how these factors may contribute to moral injury. To improve comprehension for the research, this chapter aims to clarify each of these factors.

1.1 Vicarious Trauma

Literature has used a variety of definitions to define the word trauma. Trauma can include continuing, systematic occurrences and experiences that are difficult to integrate, even though many studies characterize it as discrete, solitary events (Wang et al., 2022). "Little T" trauma and "big T" trauma are the two categories into which it is often separated. Little t traumas are defined as non-fatal incidents that affect a person's ego and interfere with coping strategies, resulting in emotional dysfunction. These events, such as infidelity, financial distress, or interpersonal conflicts, may not initially be perceived as traumatic due to individuals' rationalizations (Isobel & Thomas, 2022).

Over time, though, the accumulation of these little stresses may lead to psychological deterioration. Big T traumas, on the other hand, are noteworthy, unique life occurrences connected to extreme stress and a sense of powerlessness. These incidents have a significant effect on a person's well-being and go beyond the dysfunctionality connected to minor traumas (Isobel & Thomas, 2022).

A thorough framework for comprehending the complicated nature of trauma is provided by the division of trauma into three categories (Kennedy & Booth, 2022). First, trauma includes occurrences that come as a surprise or in unusual ways, such startling or abrupt situations that take people by surprise. These circumstances depart from what is usually expected in day-to-day living (Kim et al., 2022).

Second, trauma surpasses a person's imagined capacity to handle its demands. This feature highlights the fact that trauma is characterised by people's perceptions of the incident as well as its actual nature. Trauma happens when people feel helpless and think they are incapable of handling the difficulties they face on a daily basis (Kennedy & Booth, 2022).

Thirdly, trauma throws off a person's other psychological requirements and schemas as well as their frame of reference. This feature emphasizes how trauma changes a person's whole worldview, including how they see reality, the outside world, and their sense of self. Trauma does not only cause momentary discomfort. Traumatic events upend an individual's fundamental psychological schemas, which are their conceptual frameworks for understanding the world. This has a significant influence on how people perceive and manage their environment (McNeillie & Rose, 2021).

The DSM-5TR adds a variable in psychological stress after exposure to traumatic events or stressful situations, further elucidating trauma by recognizing the individual's recurrent

exposure to unfavorable elements of traumatic experiences as a criteria for PTSD. This admission shows a greater comprehension of the complex effects of trauma. These modifications have led to the inclusion of PTSD symptoms on the vicarious trauma scale used by researchers. This more inclusive paradigm aids in capturing the variety of ways that people could encounter vicarious trauma, enabling a more thorough assessment and comprehension of its effects (American Psychiatric Association, 2022).

The definition of vicarious trauma varies throughout the study of literature. It entails alterations in a therapist's cognitive schemas about the world and oneself as a result of empathic involvement with clients' experiences, according to Leung et al. (2022). While McNeillie and Rose (2021) define it as the therapist's transformation because of an interaction with clients' traumatic experiences, Kim et al. (2022) defines it as the process of change resulting from sympathetic engagement with clients' experiences.

It is the loss of homeostasis and change in perspective that come from dealing with trauma survivors, according to Isobel and Thomas (2022). According to Kennedy and Booth (2022), it is the result of therapists' compassionate interaction with their clients' traumatic experiences, which causes changes inside them. Lastly, Gottfried and Bride (2018) characterize it as the metamorphosis of therapists' internal experiences that arises from their compassionate involvement with clients' traumatic encounters.

Furthermore, because therapists' contacts with clients who are upsetting have a direct impact on their feelings of safety and control, as well as their capacity to trust people, vicarious trauma is a phenomenon that may affect many parts of therapists' life (Malik et al., 2023). Therapists may experience cognitive mistakes as a result of this exposure, including catastrophizing, overgeneralizing, and all-or-none thinking, which they may then apply to both

them and their surroundings. These alterations may show up as tiredness, rage, disassociation from unpleasant emotions associated with trauma, sleep difficulties, and increased anxiety (Ball et al., 2022).

In addition, therapists' worldviews and spiritualities may change as a result of being exposed to upsetting client material. This can influence their interactions with others because they may begin to see important people through the prism of vicarious trauma (Choi, 2017). This change may also have an impact on their behavior and sense of self, possibly leading to the emergence of vicarious trauma symptoms (Mustafa & Iqbal, 2022). Vicarious trauma can also be explained by countertransference, in which therapists feel, albeit to differing degrees, the same feelings as their patients. According to McNeillie and Rose (2021), this idea offers a framework for comprehending the experience of vicarious trauma.

Comparably, working with clients involves coming into contact with traumatic information and the related ideas, feelings, and pictures that accompany it. These encounters can lead to vicarious trauma as well as countertransference. Mental health practitioners may experience mental tiredness due to the length and influence of these thoughts and feelings, which might ultimately result in compassion fatigue (Stevens & Abbadey, 2023).

1.2 Compassion Fatigue

Compassion fatigue is characterized by a condition of bodily, psychological, and social dysfunction brought on by extended exposure to compassion stress, according to Cavanagh et al. (2020). According to Russo et al. (2020), it's the severe physical and psychological damage brought on when carers are unable to replenish their energy and recuperate. According to Ozan and Polat (2024), it's a condition that affects people in helping professions and is typified by dysfunction and emotional tiredness as a result of absorbing trauma from clients.

Compassion fatigue, according to Storm and Chen (2021), is a state of physical, psychological, and emotional depletion brought on by a sustained exposure to the suffering of others while feeling helpless to end that suffering. Finally, Oktay and Ozturk (2022) consider compassion fatigue as the expense of providing care for those who are in mental distress.

A decreased ability to tolerate or cope with other people's pain is a sign of compassion fatigue (Campbell, 2020). It happens when people especially those who provide care for other become emotionally exhausted and find it difficult to sympathize with or absorb the pain and tragedy of others. This condition is characterized by an ongoing feeling of stress with the suffering of the people receiving care (Quinn et al., 2019).

In addition to these symptoms, people may feel emotionally and spiritually exhausted, which manifests as a lack of compassion. This weariness results from a strong sense of empathy for the pain and powerlessness of trauma survivors (Chaudhary et al., 2022).

To elaborate, there are two unique characteristics that define compassion fatigue: burnout and secondary traumatic stress (Storm & Chen, 2021). There is little study on the relationships between these characteristics, even though they are thought to be indicators of compassion fatigue and raise vulnerability to it (Bhattacharyya & Ushri, 2022).

First, it's critical to distinguish between secondary traumatic stress and compassion fatigue. Compassion fatigue, often referred to as secondary traumatic stress, is a condition marked by weariness and dysfunction in the bodily, psychological, and social domains that arises from extended exposure to compassion stress (Russo et al., 2020). Accordingly, the stressor that initiates the onset of compassion fatigue is secondary traumatic stress (Stevens & Abbadey, 2023).

The normal and anticipated behaviors and feelings that result from knowing about a catastrophic incident that a close or significant person has gone through are known as secondary traumatic stress (Clark & Lake, 2020). It basically describes the strain and emotional impact people feel when they know of someone else's terrible or upsetting experience and are driven to assist. This type of stress results from empathy for the individual who has experienced the trauma rather than from having experienced the event directly (Russo et al., 2020).

As a result, research makes a distinction between secondary trauma and compassion fatigue, with the latter acting as a catalyst for the former (Kercher & Gossage, 2023). Additionally, secondary trauma takes the form of a bodily response to the traumatic experience of another person, to the point that the affected person may exhibit symptoms that are similar to those of the victim (Aliza et al., 2020). Secondary traumatic stress symptoms might appear suddenly and even after only one session with a traumatized client. According to Kercher and Gossage (2023), compassion fatigue may be seen in this perspective as an emotional phenomenon resulting from intense emotional engagement and the ongoing desire to care for clients.

One's own well-being may be neglected as a result of this excessive emphasis on helping people in need. This emotional exhaustion is especially common among carers in helping professions, which highlights the significance of finding a balance between their caring duties and self-care. Notably, secondary traumatic stress disorder and compassion fatigue are closely related ideas that frequently co-occur. There are parallels and frequent overlaps between these intricate phenomena and vicarious trauma (Amsalem et al., 2021).

Other important aspect of compassion fatigue is burnout. Leiter and Maslach (2017) state that there are three main components of burnout. The first is overwhelming tiredness, which is

defined as an intense level of mental and physical weariness that leaves people emotionally and physically spent. The second category includes negative emotions and a disengagement from work or job-related circumstances, such as irritation, rage, and cynicism. The third is a sense of failure and ineffectiveness, which is the belief that their efforts are not producing significant outcomes, and which feeds emotions of powerlessness and inadequacy.

This causes a person to feel less confident in their talents and less successful personally, which strains their connection with their employment. The total well-being of the person is impacted by this tension, which presents both intrapersonally and interpersonally. However, because of their innate feeling of duty to their clients, therapists could find it difficult to identify their own burnout, which exacerbates emotional tiredness (Wang et al., 2022).

It's important to recognize that burnout can result from a variety of circumstances and causes and is not just connected to employment involving trauma. Burnout can be caused by a variety of circumstances, including demanding job positions, long-term workplace stress, organizational issues, and interpersonal relationships. Burnout is a more widespread condition that may impact professionals in a variety of industries, even if it may be more common in therapeutic settings for those working with challenging clients (Bayes et al., 2021).

Compassion fatigue, which can come from burnout and secondary traumatic stress, can cause mental tiredness that impairs therapists' capacity to offer proper care. This could lead to moral injury and ethical transgressions among mental health professionals (Griffen et al., 2023). Conflicts arise in deciding which should come first: patient care or personal well-being (Amsalem et al., 2021).

1.3 Moral Injury

Different researches have defined moral injury in different ways. According to Rischardson et al. (2020), it is defined as a severe psychological injury brought on by deeds or

inaction that go against one's moral or ethical principles. Moral Injury, according to Koenig and Al Zaben (2021), is the long-term psychological, bodily, spiritual, behavioral, and societal effects of actions that violate strongly held moral standards and beliefs.

It is defined by TerHeide and Olff (2023) as the upsetting behavioural, social, psychological, and even spiritual fallout from seeing actions that violate strongly held moral expectations and beliefs. Finally, Nash (2019) characterizes it as severe psychological discomfort brought on by deeds or omissions that compromise one's moral or ethical principles and betray basic beliefs.

Barnes et al. (2019) asserts that an individual's interpretation of a damaging occurrence determines the development of moral injury, highlighting the significance of the appraisal process. In this evaluation, the person determines if a certain incident seriously contradicts their worldview or causes them to experience cognitive dissonance. Essentially, one's perception and interpretation of an incident determines whether moral injury occurred or not. An incident might cause moral injury if it is interpreted in a way that is at odds with someone's values and beliefs. This emphasizes the subjective character of moral injury as it depends not only on the incident but also on how that incident is seen and evaluated by the victim considering their moral beliefs (Kercher & Gossage, 2023).

Norman and Maguen (2023) have identified seven dimensions in which moral injury manifests itself, with various implications on an individual's mental health. The act of commission and omission comes first in this list. A person commits an act of commission when they consciously choose to act against their firmly held moral convictions, and an act of omission is when they choose not to act in a way that is consistent with their moral principles (Boudreau, 2021).

Moral injury can come from both kinds of activities, including deliberately breaking the law and abstaining from morally righteous conduct (Norman & Manguen, 2023). People may also feel fooled, betrayed, hurt, or let down by someone they depend on for assistance or who they trust. There are many ways that this betrayal may occur, including betrayal by peers or coworkers, as well as betrayal by leaders or other powerful people in a social or organizational setting. Feelings of hurt and rage might be triggered by such betrayal experiences (Looi et al., 2022).

Exposure to traumatic situations that cause extreme dread, injury, or complicate a person's coping mechanisms falls within the second category (Norman & Manguen, 2023). According to Hall et al. (2022) such exposure may result in behavioural changes like avoidance and anger, psychological problems like anxiety and sadness, and social issues like disengagement and strained relationships.

According to Norman and Manguen (2023), moral injury might transpire in the third domain when a person watches others performing acts that go against their moral convictions or when they themselves engage in behaviours that go against their moral views. The crucial element in this situation is that the person's basic values are being violated by these actions, which causes emotional and psychological pain (Miller & Turliuc, 2023).

Shame and guilt are issues in domains four and five. According to Norman and Manguen (2023), guilt is the outcome of a deep sensation of regret or anguish stemming from the conviction that one has done something immoral. Feeling guilty prevents people from acting in a way that is consistent with their moral principles, even if they are nonetheless accountable for their actions. Remorse and the desire to make things right are frequently present along with this guilt (Miller & Turliuc, 2023).

Shame, on the other hand, is defined by a person's conviction that their acts have made them a horrible person overall. Shame, as opposed to guilt, is primarily about self-blame and self-condemnation, which makes people feel as though they are essentially defective or undeserving. Shame may have a significant impact on a person's identity and sense of self (McEwen et al., 2021).

The relationship experiences that a person has with a higher power and with one's own self are explored in domains six and seven. First, according to Mantri et al. (2020), the relational component is concerned with the ways in which moral injury affects a person's connection with oneself. Because of the perceived moral violations they have done, those who are impacted frequently find it difficult to forgive themselves.

A person's relationship with a higher power may also be impacted by moral injury, causing them to believe that they are essentially evil and unredeemable (McEwen et al., 2021). This view might show itself as self-blame, trust concerns, or a spiritual existential crisis. It may also lead to feelings of alienation and detachment from the outside world (Hossain & Clatty, 2021).

Studies reveal that incidents requiring personal accountability are linked to emotions of shame, remorse, and difficulty forgiving oneself (Looi et al., 2022). However, incidents involving other people's fault frequently result in negative feelings like rage, irritation, and trouble forgiving others. When both sides bear some of the blame, people may experience existential and spiritual crises and begin to doubt their morals and religion (Mantri et al., 2020).

Researchers have endeavored to differentiate ethically detrimental occurrences from other trauma-associated episodes by classifying them into three primary groups: omissions, transgressions, and betrayals. These experiences must have the capacity to seriously undermine

beliefs and lead to cognitive dissonance, which would damage relationships and self-worth (Wang et al., 2022).

This distinction is clear in situations where the results of one's actions are unpredictable; for instance, a military officer may suffer moral injury even though their gunshot does not injure a kid (Kercher & Gossage, 2023). Similarly, regardless of the patient's result, medical personnel may sustain moral injury if they are unable to administer proper care (Fatima et al., 2023). Furthermore, studies show that people who actively work to assist others, especially in the face of scarce resources, are more vulnerable to moral injury than people who just observe suffering without taking action (Stevenson et al., 2022).

1.4 Theoretical Framework

Clinical psychology interns are exposed to different experiences during their internship training that can lead to vicarious trauma, compassion fatigue and moral injury (Ball et al., 2022). Three different theoretical frameworks, named Constructivist Self-Development Theory, Compassion Stress and Fatigue Model and Social Cognitive Theory of Moral Injury, are discussed below to understand the phenomenon, and address the issue.

1.4.1 Constructivist Self-Development Theory

The Constructivist Self-Development Theory (CSDT), which was introduced by McCan and Pearlman in 1990, provides a framework for comprehending the behavioural symptoms of vicarious trauma. This idea, which was developed in the 1990s, is extensively utilized to comprehend how people create their reality, view the world, and come to understand themselves. The self, one's ego resources, self-capacities, psychological requirements, and encounters with cognitive schemas are important elements.

1.4.1.1 CSDT conceptualization of the self and self-capacities. Self-development, according to CSDT, starts at birth via interactions with people and the environment. One's self-concept is greatly influenced by the quality of their upbringing, particularly whether they experienced deprivation (Teri, 2016). Understanding how one handles the effects of these early developments later in life is made easier by the idea of self-capacities (Katie et al., 2020). These self-capacities include the capacity to control and endure strong emotions, find comfort in isolation, and effectively handle guilt and self-criticism (McCann & Pearlman, 1990).

1.4.1.2 The ego. An essential part of the self, the ego comprises self-awareness of psychological needs, empathy, and appropriate limits. It is the capacity to foresee outcomes, control risks, and form responsible bonds with others. These skills enable people to make well-informed decisions that protect their interpersonal and personal well-being while navigating the complexity of therapy and daily life (McCann & Pearlman, 1990).

1.4.1.3 Psychological needs. Certain requirements, including physical health and temperament, are innate and genetically fixed, whereas other needs are influenced by early encounters and carer reactions (Katie et al., 2020). A clear frame of reference, self-understanding, safety, and trust, as well as self-esteem and validation, independence and control, power and mastery, intimacy and connection with others, are all common human needs that are highlighted by CSDT (Choi, 2017).

These demands become apparent or contradictory in reaction to trauma, influenced by a person's ego resources and self-capacities (Malin et al., 2020). When these demands are not met, it can result in unfavorable assumptions and have an impact on a person's general psychological adjustment (Figley & Ludick, 2017).

1.4.1.4 Cognitive schemas. Schemas are flexible and ever-changing presumptions, expectations, and beliefs about oneself and the outside world (Marshman et al., 2022; McCann & Pearlman, 1990). On the other hand, trauma has a profound effect on a person's worldview, influencing how they perceive danger and safety and helping to create maladaptive behaviours (Victoria et al., 2023).

An interdependent system is formed by the interactions of self-capacities, ego resources, psychological needs, and cognitive schemas (McCann & Pearlman, 1990). Limited affect tolerance and poor self-soothing abilities might result in internal unrest due to low self-capacities, imbalanced psychological needs, and negative self-schemas (Ball et al., 2022).

1.4.2 Compassion Stress and Fatigue Model

This model describes how compassion fatigue develops and is based on the idea that developing a strong therapeutic bond with clients requires both empathy and emotional energy. But the same sympathetic involvement can also hasten the onset of compassion fatigue, which might hinder one's ability to function well in their professional capacity (Cavanagh et al., 2020).

As per Figley's theory, emotional contagion, in which an individual experiences another person's suffering, is the first step towards the development of compassion fatigue. Empathic concern follows, which inspires the therapist to attend to the client's needs (Russo et al., 2020). Consequently, the clinician's capacity for empathy enables them to sense their client's distress and respond in a way that is sympathetic to their plight. Empathetic disengagement, on the other hand, is required to avoid burnout and enable the assistance to remove oneself from the client's misery. Compassion fatigue is prevented by this disengagement in conjunction with a sense of accomplishment (Figley, 2002).

If left untreated, the buildup of residual stress, including compassion stress can eventually result in compassion fatigue. To avoid compassion fatigue and allow carers to emotionally recover and deliver better care, it is important to manage disengagement and promote a sense of fulfilment (Ozan & Polat, 2024). Compassion fatigue may arise from the persistence of leftover emotional energy from client encounters when coping strategies are dysfunctional and excessive engagement occurs (Figley, 2002).

This process is explained by the last three variables in Figley's model. A persistent sense of duty and emotional commitment to clients who are involved in prolonged suffering, can become overpowering (Storm & Chen, 2021). Clinicians may experience anxiety, despair, or other stress reactions because of traumatic memories (Rosso et al., 2020).

Dysfunction in both personal and professional domains is included in life disruption, which shows itself as adjustments to one's way of life, thought processes, feelings, and obligations (Campbell, 2020). The model's interactions between these stresses lead to compassion fatigue, which occurs when doctors find it difficult to step back or find fulfilment in their profession. All things considered, this model provides insight into the advantages and disadvantages of caring for others (Figley, 2002).

1.4.3 Social Cognitive Theory of Moral Injury

Dr. Brett Litz and his associates pioneered social cognitive theory, which focuses on military and combat environments. This theoretical framework explores the social and cognitive processes that lead to the formation of injury. Its main goals are to pinpoint the major risk factors, cognitive appraisal patterns, and maintenance variables that affect people's perceptions and comprehension of morally complex circumstances (Litz et al., 2017).

1.4.3.1 Key predisposing factors. Social cognitive theory holds that people are predisposed to morally harmful occurrences by their early experiences. These encounters mould expectations and beliefs on both an intra- and interpersonal level, affecting how people view circumstances (Ball et al., 2022). Moral injury may result when these expectations or beliefs are questioned or changed later in life (Amsalem et al., 2021).

The theory also emphasizes other aggravating circumstances that raise the possibility of moral injury, like a deficiency of social support or ongoing pressures like grief, which can intensify the effects of any traumatic incident (Ball et al., 2022). Furthermore, the importance of people's capacity to handle such situations is highlighted, implying that people who are psychologically ready and conscious of the possible outcomes may be better able to handle moral dilemmas (Litz et al., 2017).

1.4.3.2 Cognitive appraisal patterns. In the context of moral injury, this theory explores the cognitive evaluation processes people use to perceive and comprehend the world, others, and oneself (Litz et al., 2017). Cognitive assessments consider people's expectations and ideas about how they should have behaved in morally difficult situations as well as how they feel about how they should have treated other people (Wang et al., 2022). They frequently internalize the idea that they must uphold their moral code to the letter, which results in maladaptive views marked by guilt, humiliation, and rage (Maguire & Looi, 2022). People who have suffered moral injury may have a pessimistic view of the world, believing it to be morally devoid and essentially bad (Griffin et al., 2023).

1.4.3.3 Maintaining factors. Morally injured people frequently think about their problems and ruminate endlessly, which makes them feel even more distressed (Litz et al., 2017; Mantri et al., 2020). When subordinates observe injustice in their superiors, it can negatively

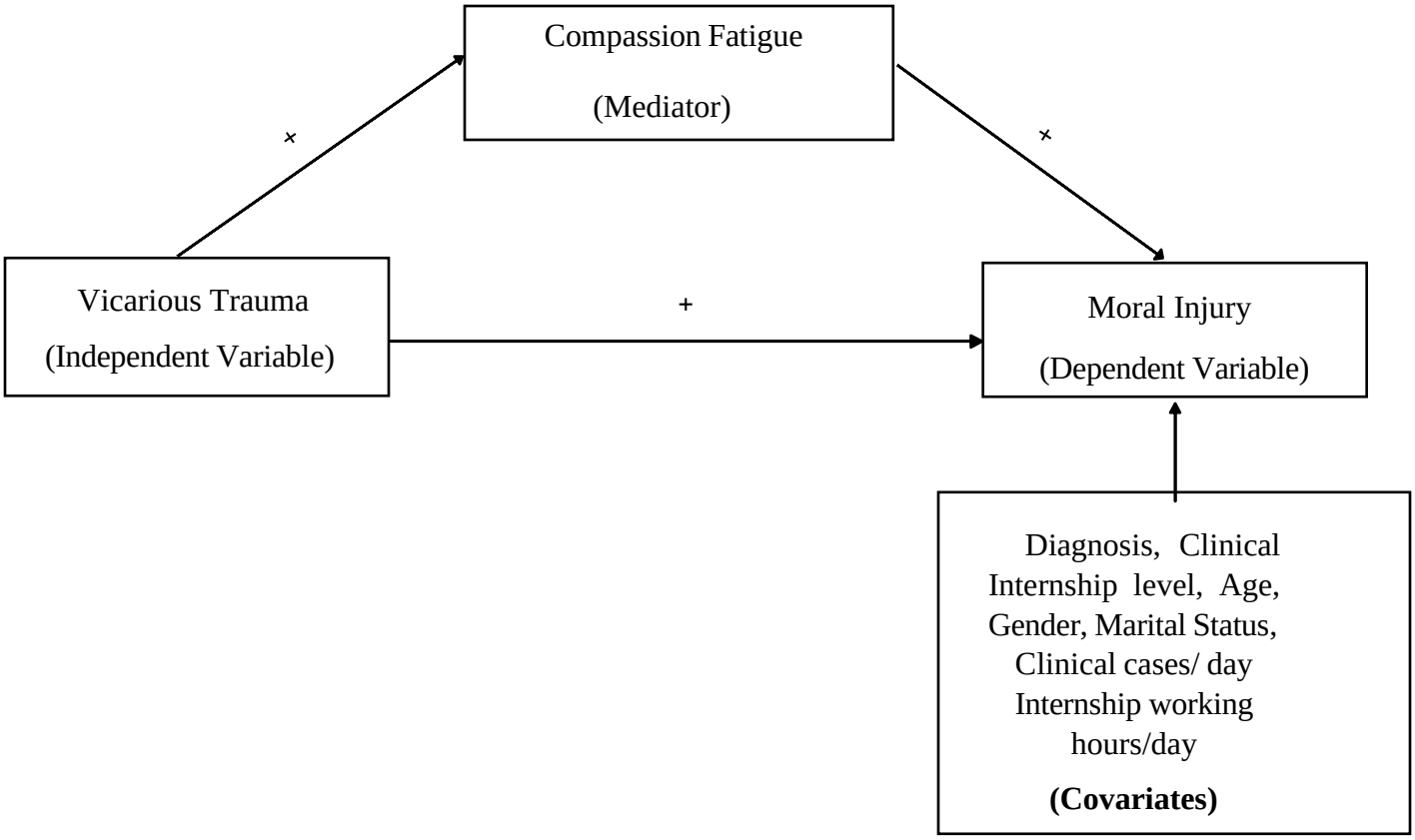
impact their behaviour at work and create a bad impression of authority leaders. This may affect how they interact with their family members, causing them to become resentful of them (Wang et al., 2022). As a result, people could feel worn out, have less empathy, and have strained relationships with others. According to Ball et al. (2022) these negative feedback loops have the potential to perpetuate emotions of inadequacy and unworthiness by reinforcing a self-fulfilling prophecy.

1.5 Conceptual Framework

The conceptual framework for the present study is mentioned below.

Figure 1.1

Conceptual framework of the study: Compassion Fatigue as a mediator between Vicarious Trauma and Moral Injury among Clinical Psychology Interns



1.6 Summary

Vicarious trauma, compassion fatigue, and moral injury can all play intricate roles in the experiences of mental health and other healthcare workers (Kercher & Gossage, 2023; Natalie, 2022; Quinn et al., 2019). Interns who are exposed to their clients' upsetting narratives may experience vicarious trauma, which can cause them to internalize their clients' suffering. This can have an impact on how they see reality and change how they see the world (Armes et al., 2020; Mustafa et al., 2020). While some interns might be able to handle this weariness well, others might become emotionally spent, which could lead to sentiments of moral compromise and professional inadequacy (Maguire & Looi, 2022; Natalie, 2022; Victoria et al., 2023). When caring for the client is compromised or they observe actions that violate their moral code of behavior, this can lead to moral injury in the form of feelings of betrayal, guilt, and humiliation (Amsalem et al., 2021; Fernandez et al., 2022; Kercher & Gossage, 2023).

The constructivist self-developmental theory, compassion stress and fatigue model and social cognitive theory of moral injury, offer a thorough explanation and perspective on the various difficulties that clinical psychology interns may encounter.

According to constructivist self-developmental theory, interns' perspectives of themselves, their surroundings, and other people might change as a result of various experiences including exposure to traumatic clients (Figley & Ludick, 2017; Malin et al., 2020; Quinn et al., 2019). The paradigm of compassion stress and fatigue provides additional insight into how interns' emotional reserves and energy might be depleted by their ongoing interactions with clients, ultimately resulting in burnout and a diminished ability to show compassion (Campbell, 2020; Russo et al., 2020; Storm & Chen, 2021).

Furthermore, the social cognitive theory of moral injury clarifies how experiencing additional stressors, such as compassion fatigue or vicarious trauma, can lead to a gap between

an individual's moral beliefs and behaviour, which can ultimately result in intense guilt and shame for interns (Ball et al., 2022; Litz et al., 2017; Wang et al., 2022).Together, these frameworks show how vicarious trauma, compassion fatigue, moral injury are related, and how managing them can be accomplished through a variety of useful techniques that need a comprehension of these ideas and their underlying causes (Stevenson et al., 2020).

CHAPTER II

LITERATURE REVIEW

The present study focused on exploring the relationship between vicarious trauma, compassion fatigue and moral injury in clinical psychology interns. Giving time to different clients and hearing their stories and issues can be fruitful, but at the same time they can make a clinical psychologist susceptible to fatigue, emotional exhaustion, which in turn can compromise the client care and treatment (Chen, 2021). Different research have been done on this issue and thus this chapter focuses on citing different findings that can help in conceptualizing each of these variables and how they manifest.

2.1 Vicarious Trauma

A study was conducted to investigate the influence of vicarious trauma on therapists working with preschool children, specifically how therapists' expertise of trauma-informed treatment, along with the chance of experiencing vicarious trauma, might lead to diminished self-efficacy. The Vicarious Trauma Scale and the Counsellor Self-Efficacy Scale were used to collect data from 101 therapists over the age of thirty. The study's findings indicated that therapists with less expertise and a less serious approach towards trauma-informed treatment reported greater levels of vicarious trauma, which was attributed to their lack of understanding of the impacts of countertransference and compassion fatigue. Therapists who were more conscious of preserving personal boundaries and controlling countertransference, on the other hand, were less likely to engage in over empathy and rescue behaviors, resulting in a better sense of self-efficacy. The study also found that age did not predict variations in trauma-informed care knowledge; nevertheless, females experienced more stress and vicarious trauma than males,

perhaps due to higher levels of sympathetic involvement and a need to rescue (Miller & Turliuc, 2023).

Given that vicarious trauma may lead to stress and exhaustion, a study examined the relationship between compassion fatigue and vicarious trauma in 200 psychologists, both male and female, between the ages of 45 and 70. Researchers found that psychologists who had experienced more vicarious trauma had greater degrees of weariness, frustration, emotional exhaustion, burnout, and secondary traumatic stress. The study employed the Compassion weariness Short Scale and the Vicarious Trauma Scale. The clients found it challenging to absorb these events within their routines because of the emotional toll that their stories took. Due to their exhaustion, they also neglected their clients, which frequently resulted in emotions of shame and remorse (Tujague & Ryan, 2023).

Research on the protective and risk variables that might lead to vicarious trauma among social workers will help one understand the many reasons one could be exposed to vicarious trauma. 373 Spanish social workers, both married and single, between the ages of 30 and 50 were the subjects of the cross-sectional study. The study aimed to determine the potential roles that protective variables such as organizational support and recovery processes may play in mitigating the effects of personal trauma and stress on vicarious trauma. The study showed that high workloads and traumatic experiences on a personal level raised the degree of vicarious trauma, which in turn caused emotional and psychological overload. All ages and genders experienced stress and emotional exhaustion, but marital status was a predictor, with married people reporting higher levels of emotional stress because of their greater obligations (Fernandez et al., 2022).

Research was conducted using open-ended interviews to investigate the experiences of 48 male and female social workers to obtain a deeper knowledge of numerous issues. The study's results demonstrated that the social workers had trouble comprehending and digesting extreme instances, which left them feeling overburdened and led them to doubt morality. They claimed to be tired and to be under a lot of stress and burnout, which negatively impacted on their work satisfaction and willingness to stay in the field. The results showed that there were no variations in the stress levels reported by male and female social workers based on age or marital status. Those who were seniors reported less vicarious trauma as compared to the junior social workers. Nonetheless, the study found that individual factors, such as the quantity of clients and lengthy work hours, may be more significant in one's experience of different types of trauma (Fox et al., 2021).

To gain a deeper understanding into various factors, a research looking at the effects of vicarious trauma on therapists working with children who have experienced sexual abuse found that the intensity of the instances can have varying effects on the therapists. The quantitative study focused on therapists who were between the ages of 30 and 50, had four to five years of experience, were married, single, or divorced, and were of both sexes. The study indicated a considerable incidence of vicarious trauma among therapists using the Professional Quality of Life Scale. Following therapy sessions, therapists reported experiencing negative cognitive shifts regarding children's safety and possible betrayal by loved ones, as well as negative emotional shifts including emotions of overload, betrayal, and despair. Because they had a tougher time expressing themselves, men reported higher levels of stress and emotional disengagement than women. Therapists who were older were better at handling their emotional states. Therapists who were married or single went through greater stress than those who were divorced or single

because they had compensating mechanisms in place. The study also discovered that therapists who had experienced trauma in the past themselves were more vulnerable to vicarious trauma, which is the experience of triggers that perpetuate a sense of unease in the environment. Professional and personal lines frequently become blurry, which made it harder to interact with others and made one feel disconnected (Tara & Shuman, 2021).

Therapists can employ many coping strategies to address stress and emotional vulnerability. A study looked at the coping mechanisms used by experienced trauma therapists and the incidence of vicarious trauma among them. It focused on male and female therapists between the ages of 40 and 60 who had at least ten years of experience. The Trauma and Attachment Belief Scale and Coping Strategies Inventory were used in the study to examine the effects of vicarious trauma on the psychological needs of therapists, with a focus on trust and control. The results showed that therapists' worldviews are profoundly changed when they engage with trauma clients, which has an impact on their cognitive functions and feelings of trust and safety. Extended exposure to the trauma experienced by their clients causes increased psychological stress, which shows up as symptoms that resemble those of their clients. Compared to younger and less experienced therapists, older and more experienced ones were better at handling stress. Because they were more emotionally invested in their clientele, women reported higher levels of stress than men. Furthermore, because they had less time for relaxation, therapists with heavier caseloads and longer workdays reported greater levels of stress (Shea, 2021).

According to a quantitative study conducted on 300 professionals, both male and female, aged 40–70, with at least six years of experience and a marital status of single or married, these guilt sentiments may have an influence on their worldview. The results showed that these

professionals frequently experienced vicarious trauma, which can cause overwhelming sentiments and make it difficult to regain balance. They frequently overidentify with the pain of their clients, which affects their identity and perspective. Professionals who were married reported less stress than those who were single, but there were no emotional differences according to age or gender. The study also brought attention to spiritual disengagement, a phenomenon in which carers lose faith in and attachment to loved ones because of questioning the existence or goodness of a higher force. Significant existential crises may be brought on by these encounters (Tamarine et al., 2020).

Similar research, including 240 male and female forensic mental health specialists aged 50 to 80, examined risk factors for and solutions to vicarious trauma. Using the Vicarious Trauma Scale and the Compassion Fatigue Short Scale, the study discovered a significant correlation between greater degrees of burnout and compassion fatigue and increased vicarious trauma, which further impacted job management. Older people experienced less vicarious trauma and compassion fatigue, indicating their ability to manage it with time and experience. Females reported higher stress and compassion fatigue than males, which was due to the greater emotional impact that client intake had on them (Pirelli et al., 2020).

According to research that looked at the effects of vicarious trauma on therapists during the pandemic, in addition to personal traits and work-related factors, extra emergency conditions can exacerbate vicarious trauma. The quantitative study concentrated on male and female therapists, aged 40–60, who had at least five years of experience and were conducting online sessions throughout the epidemic. Findings using the Professional Quality of Life Scale demonstrated that therapists suffer from vicarious trauma because of the difficulties in attending to clients' issues in the face of uncertainty. Men were more likely than women to report feeling

stressed, and married people were more likely to feel stressed because of their larger demands on their time and money. Age-related variations in stress levels, however, were not seen. Vicarious trauma was made worse by organizational culture and rising working demands, which resulted in excessive caseloads and little time for self-care. Stress was exacerbated by economic demands (Katie et al., 2020).

In a similar vein, another study examined the impact of vicarious trauma on healthcare workers during the epidemic. The sample of 121 male and female healthcare professionals, ages 35 to 50, were selected from an Italian emergency room. The study found a significant frequency of vicarious trauma among emergency healthcare workers using the Vicarious Trauma Scale, Coping Self-Efficacy Scale, and Emergency Stress Questionnaire. It was associated with a decrease in coping self-efficacy brought on by exposure to stressful situations in an uncertain environment. Male healthcare professionals showed more stress and emotional anguish than female colleagues, straining to express themselves while putting on a brave front. Younger healthcare workers reported higher levels of stress and uncertainty than older ones. On the other hand, there was no distinction between married and unmarried people. Vicarious trauma was also greatly influenced by longer workdays and a higher volume of cases (Vagni et al., 2020).

Research that looked at the effects of vicarious trauma on social workers and how it related to job satisfaction found that such situations and stress might eventually affect job satisfaction. 350 married and unmarried social workers, ages 30 to 50, from both Caucasian and Hispanic backgrounds participated in the study; Hispanic social workers often had greater experience. The study, which employed the Vicarious Trauma Scale, discovered that social workers belonging to both ethnic groups had internalized the feelings and experiences of their clients, resulting in a blurring of the lines between their personal and professional lives. Early in

their employment, they believed that the world was unfair and dishonest, which affected their job satisfaction because they were unable to ease their client's suffering. There were no differences in vicarious trauma levels between Caucasian and Hispanic social workers based on age or marital status. There were differences in in caseload and working hours, nevertheless, with a heavier workload affecting possibilities for self-care (Berrios, 2020).

In a similar vein, a different study that looked at how social workers' job satisfaction was affected by working with traumatized children brought this point to light. The study, which focused on clinical situations involving kids between the ages of 5 and 13, had 539 male and female volunteers in the 45–60 age range. It sought to investigate the ways in which interacting with the kids affected social workers' distress, vicarious trauma, and ability to do their jobs effectively. The results showed that social workers who experienced vicarious trauma experienced much higher levels of distress and were less able to do their jobs well. Having interactions with traumatized youngsters resulted in a pessimistic view and doubts about the safety of the outside world. Due to their expertise and less uncertainty, older social workers experienced less vicarious pain than younger ones. Men expressed more distress, citing emotional expression issues (Armes et al., 2020).

Apart from these results, studies have concentrated on examining the ways in which social workers' vicarious trauma is influenced by caseload, supervision, and pay. With a sample of 350 male and female therapists between the ages of 40 and 70, the study collected information on case load, income, and supervision arrangements in addition to measuring vicarious trauma levels using the Vicarious Trauma Scale. The development of vicarious trauma was positively correlated with these characteristics, according to the findings. Social workers with larger caseloads were exposed to more upsetting client stories, particularly if they were personally

involved. Gender and marital status had no effect on coping, while older therapists reported more vicarious trauma. Frequent supervision meetings reduced vicarious trauma by offering direction and support. Earnings was a key factor in job satisfaction; burnout and feelings of worthlessness resulted from low pay for emotional labour and effort (Quinn et al., 2019).

Subsequent research has demonstrated that emotional exhaustion and stress can affect an individual's self-esteem and self-confidence. This was demonstrated by a study that examined the prevalence of vicarious trauma in social workers' interactions with survivors of sexual and domestic abuse. The study used a quantitative method with an online vicarious trauma form, gathering data from 154 social workers, both male and female, connected with the National Association of Social Workers in the United States, ages 30 to 60. The results showed that social workers who worked with survivors had considerable levels of vicarious trauma; the trauma was more influenced by working hours and caseloads than by variations in age or gender. Social workers' conceptions of safety and family were put to the test when they interacted with survivors, making it more challenging to connect the savagery of sexual assault with violence that occurs within families. The study also revealed that social workers who had experienced vicarious trauma reported feeling less psychologically empowered, which raised questions regarding their suitability and efficacy in providing client care (Choi, 2017).

Research was conducted with 82 male and female counsellors, ages 35 to 60, who worked with traumatized clients and were married or single. The purpose of the study was to investigate the additional effects of vicarious trauma on counsellors' self-efficacy and treatment effectiveness. Using relevant measures, the study measured counsellors' self-efficacy and degrees of vicarious trauma using a quantitative approach. The results showed that counsellors who were exposed to upsetting client narratives had significant levels of vicarious trauma, which caused

cognitive changes and mental exhaustion. There were no gender or age disparities seen, however married people reported higher levels of vicarious trauma, which they attributed to their workload and marital duties. Counsellors' self-efficacy was severely damaged by vicarious trauma, which led to uncertainties about their abilities and efficacy in treatment. Counsellors were ignorant of the emotional effects of vicarious trauma, which resulted in self-doubt and internal questioning (Teri, 2016).

2.2 Compassion Fatigue

Ten newly hired psychologists, ages 27 to 30, were questioned for research that looked at what would make them more susceptible to compassion fatigue. The participants encountered difficulties in putting theoretical principles into practice, which resulted in feelings of inadequacy. In contrast to elder participants, younger psychologists expressed greater doubt. the younger junior psychologists also reported more fatigue as compared to senior psychologists. Married people also reported feeling more worn out, particularly burnt out, than single people did, maybe because of different stress management techniques. Therapist weariness and emotional exhaustion were partly caused by the challenge of adjusting session tempo to suit client demands and juggling a heavy caseload. Developing a relationship was extremely difficult, especially with difficult clients, which increased feelings of inadequacy. To build trust, some therapists turned to unethical self-disclosure, which caused shame over crossing boundaries (Stevens & Abbadey, 2023).

A research conducted in New Zealand contacted 149 certified psychologists between the ages of 40 and 70 to investigate potential risk factors for compassion fatigue. By using the Professional Quality of Life Scale, it was shown that compassion fatigue which can result in burnout and secondary traumatic stress was significantly more common. Because of their extended emotional involvement, women reported greater levels of burnout, secondary traumatic

stress, and compassion fatigue. These characteristics were also connected with age, with younger psychologists having difficulties controlling their emotions. the junior psychologists had difficulty understanding clients and managing emotions as compared to senior ones. Compassion fatigue was shown to be more likely in those with heavier caseloads and less work satisfaction, which left less time for emotional recovery and compromised empathy. Reduced compassion satisfaction had been connected to compassion fatigue, which influenced the quality of client services (Kercher & Gossage, 2023).

Given that a study focused on compassion fatigue, compassion satisfaction, and vicarious trauma in order to examine the effects of COVID-19 on nurses' mental health, low work satisfaction coupled with compassion fatigue may potentially be related to contextual variables. The research, which began with 774 male and female nurses, was eventually reduced to 512 participants over the course of four weeks between the autumn of 2019 and the spring of 2021. The study discovered significant levels of burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue among nurses using the Professional Quality of Life Scale and the Vicarious Trauma Scale. These findings suggest a positive association between these phenomena. When nurses were exposed to the upsetting COVID-19 reality, they suffered trauma from seeing fatalities and suffering, which altered their worldview and upset their cognitive schemas related to safety and control. Distress was not substantially influenced by gender, age, or marital status; coping was more closely linked to uncertainty. The epidemic made people feel even more powerless, since insufficient resources and tools made it difficult to provide patients with the best treatment possible and decreased their level of compassion (Peacock, 2023).

A study that looked at how empathy, countertransference, and compassion fatigue contribute to psychologist burnout found that personality traits might also influence one's level of

compassion fatigue in addition to environmental factors. The Maslach Burnout Inventory, NEO Five Factor Inventory, Questionnaire of Cognitive and Affective Empathy, and Compassion Fatigue Scale were used in this study, which involved 51 clinical psychologists, both male and female, ages 40 to 70. The results showed that burnout, secondary traumatic stress, and compassion fatigue were more common among psychologists who scored highly on agreeableness, neuroticism, and conscientiousness. These people had a propensity for over empathy, which made them more vulnerable to countertransference, which upset their cognitive schemas and made them less satisfied with their jobs. Contrary to preconceptions of emotional detachment, married men were shown to display these behaviors more frequently and to experience higher levels of stress and burnout (Bhattacharyya & Ushri, 2022).

A research that examined compassion fatigue in a variety of helping professions and its relationship to self-criticism revealed that, just as being neurotic and conscientious may cause compassion fatigue, so can one's own perspective on the world and self-talk. It included 607 participants, aged 40–70, who worked in fields like medicine, nursing, education, psychology, psychotherapy, and social work. The Compassion Fatigue Scale was employed. The emotional toll of helping others through difficult times is shown by the results, which showed consistently high levels of compassion fatigue across occupations. Compassion fatigue levels were not substantially influenced by characteristics such as gender, age, or marital status; instead, higher caseloads and working hours were important variables. People became more doubtful of themselves and critical of themselves as compassion fatigue worsened, which diminished their effectiveness and could have compromised client care (Julia and Natalia, 2022).

According to research on the effects of burnout and compassion fatigue on mental health professionals, everyone experiences fatigue and burnout differently, and so do their methods for

coping with it. Five psychologists, ages 40 to 50, took part and discussed their individual experiences. The emotional consequences included difficulties focusing, sleep disruptions, dread, and mistrust about other people, according to the results. Burnout affected both sexes, although it was more difficult for men to communicate, and it frequently showed up as a decrease in customer attentiveness. The degree of weariness and burnout depended more on an individual's ability to handle their own emotions than on their marital situation. Emotional tiredness was made worse by longer workdays and client sessions. Emotional distress and self-doubt may impair the quality of care and result in feelings of worthlessness and guilt (Natalie, 2022).

The degree of resilience and tolerance that an individual possesses can be connected to their self-criticism. Research conducted among 200 Hospice volunteers aged 25-30 examined the correlation between compassion fatigue, anxiety, depression, and resilience. Reduced anxiety and despair were linked to higher resilience levels, suggesting improved ability to handle stressful circumstances. Volunteers experienced stress regardless of age or gender, but they used different coping mechanisms. The association between anxiety/depression and resilience was largely mediated by compassion fatigue. Compassion fatigue sufferers may feel exhausted and overwhelmed, which can result in worry, despair, and self-criticism (Jo et al., 2020).

Comparably, another study that looked at how patient care and exposure to patient fatalities affected nurses' burnout and compassion fatigue during the pandemic also found that compassion fatigue had a mediating effect. The study, which involved 244 married nurses who were also parents, discovered that compassion fatigue was highly prevalent in both genders when it came to patient care and exposure to patient fatalities. There is a correlation between exhaustion and a higher likelihood of parental child neglect. High caseloads and long work hours made it difficult for nurses to control their burnout, which resulted in child abuse and neglect that

left victims feeling guilty and ashamed. Anger, alienation, and conflicting emotions were signs of compassion fatigue, which led to a disregard of parental duties (Stevenson et al., 2022).

Furthermore, another study examined compassion fatigue among Swedish clinical psychologists with the goal of concentrating on elements like workload, time between sessions, emotional strain, and personal issues. This was because contextual factors in earlier studies led to abuse and neglect. Eight psychologists who participated in interviews said they were emotionally exhausted by their heavy caseloads as a result of longer workdays. Fatigue was exacerbated by the need to give clients rapid relief, particularly in distressing circumstances. Emotional reactions were heightened when personal difficulties and treatment sessions overlapped. The participants also stated that because of their increased duties and management, married people were more likely to feel stress and burnout (Malin et al., 2020).

Various elements that may lead to compassion fatigue have been investigated thus far. Apart from that, the type of clientele one takes on might also matter. Research found that mental health practitioners experience emotional pressure, especially when working with trauma survivors. Using the Professional Quality of Life Scale, researchers evaluated compassion fatigue and vicarious trauma in male and female psychologists aged 30 to 50 who had worked with clients who had psychotic illnesses and had survived sexual assault. The psychologists' experience ranged from 7 years to 15 years. The results showed a significant degree of compassion fatigue, which highlights the challenge of processing situations with psychotic clients. Researchers found that emotional interest in clients welfare resulted in countertransference and a blurring of boundaries between the professional and personal domains (Figley & Ludick, 2017).

2.3 Moral Injury

During the COVID-19 pandemic, 12,900 healthcare professionals, aged 30 to 50, were included in the research to investigate moral damage. The study's use of the Moral Injury Symptom Scale and Psychological Well-Being Scale indicated a high rate of moral injury, which is defined by guilt and humiliation. These emotions were influenced by things like being in dangerous circumstances, seeing coworkers die, and having few resources. Increased effort and stress levels had a greater effect on moral injury than gender. However, the younger and junior health care professionals reported greater moral injury as compared to their senior ones and experienced more guilt and shame (Victoria et al., 2023).

Among 300 healthcare professionals aged 30 to 50, contextual factors that contribute to moral injury were explored. It was shown that varied facts might cause moral pain. It was shown that higher degrees of moral injury, driven by guilt and shame, were linked to more psychological and vocational disability. Heavy caseloads and long work hours were shown to be factors that restricted time for self-care and emotional processing. Because of their tendency towards caring, women experienced more moral hurt, and younger workers found it more difficult to handle complicated circumstances. Experts with experience handled ethical dilemmas more skillfully than less experienced peers overburdened with work. Similarly, the senior health care professionals with higher level of education experienced less moral injury as compared to junior counterparts (Weber et al., 2023).

Comparably, during the COVID-19 pandemic, different research looked at moral injury among 55 psychiatrists between the ages of 40 and 60 who worked in public community mental health services. The results showed emotional, behavioral, and psychological difficulties brought on by a lack of resources and a tight schedule. More injury and suffering were reported by female psychiatrists and those with family obligations; however, this was not correlated with

their marital status. Psychiatrists were aware of problems with care, but they felt helpless to solve them, which raised concerns about their moral conscientiousness. The psychiatrist who were senior helped the juniors manage their stress and moral injury experiences and reported lesser moral injury (Maguire & Looi, 2022).

Health practitioners may suffer moral injury presented with situations requiring quick decisions. Research that examined the difficulties experienced by trainees and psychiatrists during the COVID-19 epidemic provided insight on this. It was discovered that they suffered grave moral injury, as evidenced by sentiments of shame and remorse over the treatment of patients. Their already difficult work environment was made worse by the epidemic, which also exposed them to upsetting patient tales and made them more susceptible to vicarious trauma and compassion fatigue. Furthermore, the uncertainty surrounding the epidemic exacerbated their suffering, affecting their ability to think clearly and act empathically, although this was independent of their age, gender, or marital status. Further impeding their capacity to advocate for their mental health needs and deliver appropriate patient treatment were organizational restrictions (Looi et al., 2022).

A cross-sectional study that looked at the incidence of moral injury among healthcare professionals and its relationship to greater burnout revealed that higher mental stress might exacerbate burnout and unhappiness with one's employment. When 3,000 male and female doctors married and single were asked to rate their symptoms of moral injury, the results showed a significant degree of moral injury that was linked to heightened stress brought on by the epidemic. Increased workload-related burnout has been associated with behaviours that healthcare professionals may come to regret. Married and younger adults indicated higher levels of uncertainty and anxiety, despite the lack of discernible gender differences. Healthcare

professionals have poor self-esteem, high levels of anxiety, and sadness, which lowers their job satisfaction and self-doubt (Wang et al., 2022).

One's personal resilience can be important in times of misery, as demonstrated by a study that investigated moral injury among 300 healthcare workers married and single ages 30 to 50 during the pandemic. Using survey questionnaires, the study discovered that about 50% of the physicians and nurses said they had suffered moral injury, which is defined as remorse and self-doubt regarding patient care. There was a connection between workload and psychological discomfort as increased working hours positively connected with moral injury. On the other hand, moral injury and job experience negatively correlated with psychological resilience, suggesting that psychological resilience plays a role in coping with suffering. Perhaps because of the emotionally draining nature of psychiatric settings, married female healthcare professionals in psychiatry wards reported greater degrees of moral injury (Akhtar et al., 2022).

Mental health professionals may experience emotional exhaustion due to the psychological difficulties. In their investigation of the experiences of moral damage among psychiatrists employed in mental health facilities, Deborah et al. (2022) discovered that a significant number of psychiatrists, especially those with more demanding schedules, reported experiencing the moral injury-related emotions of guilt, shame, and detachment. It's interesting to note that the research showed compassion fatigue to rise with workload, making it more difficult for psychiatrists to emotionally distance themselves from the traumatic experiences of their patients. This psychological cost frequently resulted in worse treatment quality and, as a result, worse work satisfaction. Additionally, the study found that younger psychiatrists reported higher degrees of moral injury, and married psychiatrists tended to suffer more stress possibly as a result of extra duties.

Professionals in mental health may have varying experiences related to their moral injury. In-depth examinations of moral injury were conducted on trainee psychologists completing their master's degree in clinical psychology. The researchers investigated a few topics associated with these events using semi-structured interviews. The results showed that challenging clients, especially those with serious conditions like psychosis, frequently left trainee psychologists feeling overburdened. They described going through emotional pain, which included shame and remorse, particularly when their emotional states got in the way of their capacity to give proper care. The emotional upheaval permeated their personal lives, making it impossible for them to disengage from work-related issues and resulting in continual thinking about how to assist their clients in the most effective way (Ball et al., 2022).

A research on pandemic conditions was conducted with the intention of evaluating the influence of moral damage symptoms over time among 500 US healthcare professionals aged 35-60. Severe instances have the potential to cause psychologists to become detached and ruminate. By using measures such the Moral damage Symptoms Scale, Patient Health Questionnaire, Primary Care PTSD Screen, and Generalized Anxiety Disorder Scale, the study found that moral injury symptoms were highly prevalent, suggesting a considerable level of emotional distress. Healthcare staff experienced elevated levels of anxiety and sadness because of the complexity of COVID-19 and increased workload (Amsalem et al., 2021).

Indigenous Researches

A research looked into the psychological elements that influence healthcare practitioners' vicarious trauma. The Secondary Traumatic Stress Scale was used in a study including 170 participants from Rawalpindi and Islamabad, including psychologists, psychiatrists, nurses, and other medical professionals. Results indicated a high degree of vicarious trauma, which might

cause somatic symptoms including hypervigilance and nightmares. The greatest amounts were recorded by psychiatrists, who ascribed this to their caseloads and pharmaceutical duties. Vicarious trauma experiences were influenced by marital status and personal trauma history; married people had difficulties juggling work and personal obligations, and emotional vulnerability was impacted by prior trauma. Notably, there were no gender differences, emphasizing the importance of individual coping processes over gender in terms of vulnerability to vicarious trauma (Mustafa & Iqbal, 2022).

Research that examined the prevalence of vicarious trauma among 170 male and female MBBS graduates in Pakistan, aged 24 to 28, found similar results. The results of using the Vicarious Trauma Scale showed that individuals had a high prevalence of vicarious trauma, which was caused by exposure to upsetting patient situations. Even with medical knowledge, seeing injuries caused deep cognitive effects and shame about one's relative advantages. Adding to their sorrow, healthcare workers felt a great deal of obligation to relieve patients' suffering. Because of coping mechanisms, women may have experienced more vicarious trauma. Elevated stress levels related to increased exposure to trauma patients (Chaudhary et al., 2022).

This degree of vicarious trauma affects not only work roles but also family relationships. A study about family relationships and vicarious trauma in Pakistan included 170 participants, both married and single, aged 30 to 50, who were drawn from Rawalpindi and Islamabad. The participants included psychiatrists, psychologists, and nurses. The study sought to investigate how family connections and coping mechanisms were affected by vicarious trauma using the Vicarious Trauma Scale and Brief COPE Scale. Results showed that strained family relationships and vicarious trauma were positively correlated, and that emotional exhaustion and cognitive changes were experienced by medical professionals. Women, especially those who

were married, expressed more strained family relationships and greater levels of vicarious trauma, which is indicative of a heavy workload and stress. Traumatic event exposure caused emotional sensitivity and separation from loved ones. Nonetheless, the development of boundaries between one's personal and professional life and emotional control were made easier by productive coping mechanisms, such as a solution-focused mindset and optimistic attitude (Mustafa et al., 2020)

Research on compassion fatigue in Pakistan was conducted in connection to vicarious trauma, and it examined the associations between spiritual well-being, counsellor self-efficacy, and compassion fatigue among 55 psychiatrists and psychologists in Islamabad and Rawalpindi, Pakistan. The study discovered a favorable relationship between spiritual well-being and self-efficacy using the Daily Spiritual Experience Scale, Counsellor Activity Self-Efficacious Scale, and Professional Quality of Life Scale. Positive life attitudes were associated with greater levels of self-efficacy among mental health practitioners. However, compassion fatigue, secondary traumatic stress, and burnout were negatively correlated with spiritual well-being. This suggests that mental health practitioners may get weary and dissatisfied as a result of having their belief systems challenged by traumatic client experiences. Age and gender had no discernible effects on these factors, emphasizing the importance of personal coping strategies (Hawamdeh & Saleem, 2023).

In addition to self-efficacy, the function of coping strategies was also examined in a research including 153 male and female doctors between the ages of 40 and 70. The study looked at the relationship between empathy, coping mechanisms, and compassion fatigue. The research used the Professional Quality of Life scale, an empathy questionnaire, and a coping response inventory to determine the negative relationship between positive coping techniques and

clinicians who were suffering compassion fatigue. Furthermore, empathy and compassion fatigue were positively correlated with avoidance coping, suggesting a propensity to avoid patient encounters while feeling overwhelmed. Gender disparities were noted, with men reporting higher levels of burnout and compassion fatigue, possibly because of underlying emotional suffering that is not publicly acknowledged. Compared to their elder counterparts, younger doctors also had difficulty managing stress and workload, perhaps because of increased exposure and education (Aliza et al., 2020).

Everyone handles stress in a different manner, and coping mechanisms might differ as well. In light of this, research including 50 psychologists and 50 doctors, aged 40 to 60, examined the connections between hope, professional quality of life, and compassion fatigue. The research, which made use of the Hope Scale and Professional Quality of Life Scale, discovered a negative correlation between compassion fatigue and hope, suggesting that those who are suffering from compassion fatigue may find it difficult to remain optimistic. On the other hand, optimistic psychologists demonstrated favorable correlations with feelings of compassion and general job satisfaction, which promoted reasonable expectations and boundary upholding. In contrast, self-blame and skepticism about one's ability to perform well at work have been connected to compassion fatigue. While females indicated greater optimism despite stronger emotional expressiveness, men reported more compassion fatigue and lower hope scores. Age or marital status did not correlate with these changes (Batool & Akhtar, 2017).

A study that examined the link between burnout, compassion fatigue, and compassion satisfaction among 190 nurses aged 30-45 found that there is a negative correlation between compassion fatigue and one's sense of satisfaction. The study, which used convenience sampling at Liaqat Hospital Karachi, found that nurses, especially those working in intensive care units

(ICUs), had significant levels of burnout and compassion fatigue. High workloads and exposure to stressful events caused emotional difficulties that resulted in separation and conflict (Ahmed et al., 2019).

The quantitative cross-sectional study on moral injury among healthcare professionals. The purpose of the COVID-19 Pandemic study in Pakistan, which was carried out in Lahore, was to investigate the effects of moral injury on medical personnel, with a particular emphasis on doctors and clinical staff. The study evaluated moral damage symptoms in 420 doctors using the Moral damage Symptom Scale. The findings showed that throughout the epidemic, sentiments of guilt, humiliation, and moral concern were the main issues for healthcare personnel. According to the study, stress and moral injury caused significant dysfunction in 40% of doctors. Furthermore, compared to their male counterparts, female physicians reported greater levels of stress, possibly as a result of emotional expression disparities (Fatima et al., 2023).

A research conducted during the pandemic that looked at moral injury among 300 healthcare professionals, both married and single, aged 30 to 50, found that moral injury can result from increased vicarious stress and compassion fatigue. Using survey questionnaires, the study discovered that about 50% of the physicians and nurses said they had suffered moral injury, which is defined as remorse and self-doubt regarding patient care. There may be a connection between workload and psychological discomfort as increased working hours positively connected with moral injury. On the other hand, moral injury and job experience negatively correlated with psychological resilience, suggesting that psychological resilience plays a role in coping with suffering. Perhaps because of the emotionally draining nature of psychiatric settings, married female healthcare professionals in psychiatry wards reported greater degrees of moral injury (Akhtar et al., 2022).

2.4 Summary

The review of the literature looks at a number of aspects pertaining to, vicarious trauma, compassion fatigue, and moral injury among healthcare personnel, especially social workers and psychologists (Miller & Turluic, 2023; Natalia & Julia, 2022; Teri, 2016; Quinn et al., 2019). The text explores the impact of individuals' varied experiences on their psychological state and level of job satisfaction (Batool & Akhtar, 2017; Kercher & Gossage, 2023; Natalia & Julia, 2022; Peacock, 2023; Saleem & Hawamdeh, 2023; Quinn et al., 2019). According to research, a number of variables, including as caseload, workload, working hours, exposure to traumatic cases, and external circumstances like the COVID-19 epidemic, can lead to the emergence of vicarious trauma, compassion fatigue, and moral injury, (Akhtar et al., 2022; Griffin et al., 2023; Maguire & Looi, 2022; Malin et al., 2020; Quinn et al., 2019).

Moreover, it has been shown that the impact of these phenomena is influenced by people's unique stresses and coping strategies, such as resilience and self-efficacy (Fernandez et al., 2022; Figley & Ludick, 2017; Mustafa & Iqbal, 2022). Research has indicated a noteworthy association between moral injury and psychological distress, which is typified by feelings of self-doubt, remorse, and humiliation (Looi et al., 2022; Victoria et al., 2023; Weber et al., 2023). The interdependence of these elements emphasizes how critical it is to provide mental health assistance for healthcare professionals top priority in order to guarantee the provision of high-quality treatment and maintain work satisfaction (Amsalem et al., 2021; Ball et al., 2022).

2.5 Rationale

Investigating the relationship among clinical psychology interns with vicarious trauma, compassion fatigue, and moral injury is the main goal of the current study. The literature's citation of these variables' potential negative effects on the mental health of mental health professionals, particularly those who are just starting their careers justifies the study of them

(Julia and Natalia, 2022; Malin et al., 2020; Maguire & Looi, 2022). Managing an intricate clientele may lead to emotional fatigue and a decline in client's involvement. However, moral injury can also result from increasing emotional tiredness in certain people because of a higher workload and clientele.

An intern's professional efficacy and therapeutic efficacy may be negatively impacted by the interaction of these variables, potentially leading to a decrease in empathy. They could experience extreme guilt and humiliation and struggle to provide their clients with the care they need (Teri, 2016). Their perspective on their work, their clients, and their profession may become warped, and they may come to blame themselves for their experiences or get acclimated to the process and begin engaging in unethical behavior. In addition to increasing turnover, this emotional strain and a lack of knowledge can lead to interns quitting their internships early or opting not to pursue them as a career (Quinn et al., 2019).

Furthermore, based on the literature, there is a clear research need in the areas of vicarious trauma, compassion fatigue, and moral injury among clinical psychology interns. Previous research has largely ignored the vulnerabilities of novice clinical psychology interns in favour of concentrating on seasoned experts. Only vicarious trauma and compassion fatigue have been examined in a few studies including young practitioners, and even then, only on a small sample of 170 people (Chaudhary et al., 2022; Mustafa et al., 2020; Mustafa & Iqbal, 2022). In order to close this gap and ensure generalizability, the current study included a more diversified sample of 300 clinical psychology interns.

The current research attempts to target the young age range of 24-27, which has not been included in prior research (Ahmed et al., 2019; Batool & Akhtar, 2017). Therefore, there is a considerable age difference. Furthermore, most of the prior study has been on professionals who

work with children who have experienced physical and/or sexual abuse. By including interns who work with a more varied clinical population of clients with varying clinical diagnoses, our research seeks to expand this viewpoint. Research on psychiatrists in clinical populations has been conducted, but one of its shortcomings as mentioned in one of the study has been to examine the types of clinical clients that may increase the risk of moral injury and vicarious trauma for psychiatrists and psychologists (Looi et al., 2022). Considering the suggestion, this study covers that.

Furthermore, moral injury has been examined in Pakistan among health care providers, such as doctors and physicians, but research on clinical psychologists is lacking (Akhtar et al., 2022; Fatima et al., 2023). Research has employed compassion fatigue as a mediator in the past, but this study intends to explore the possible relationship that compassion fatigue may have between moral injury and vicarious trauma.

This study fills this research gap by highlighting the existence of vicarious trauma, compassion fatigue and moral injury among clinical psychology interns. It also aims to apply this knowledge practically by developing specific interventions for its management and prevention, in addition to adding it to academic knowledge.

2.6 Objectives

•To investigate the relationship between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.

•To find out the relationship between demographic variables, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.

•To investigate the predictive role of vicarious trauma and compassion fatigue for moral injury among clinical psychology interns.

•To determine the mediating role of compassion fatigue between vicarious trauma and moral injury among clinical psychology interns.

- To investigate the gender differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- To investigate the marital status differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- To investigate the differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their client diagnosis.
- To investigate the differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their clinical internship level.

2.7 Hypotheses

- There is likely to be a positive relationship between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- There is likely to be a relationship between demographic variables, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- Vicarious trauma and compassion fatigue are likely to predict moral injury among clinical psychology interns.

- Compassion fatigue is likely to mediate the relationship between vicarious trauma and moral injury among clinical psychology interns.
- There are likely to be differences between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns across their client diagnosis.
- There are likely to be gender differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- There are likely to be marital status differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- There are likely to be differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their clinical internship level.

CHAPTER III

METHOD

This study used the cross-sectional study design to explore the association between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns. In the current chapter, the methods that were chosen for the research are discussed which include the research design, sampling technique, the sample characteristics, operational definition of variables, different instruments used to collect data and the procedure and method of analysis.

3.1 Research Design

A correlational research design was used for the present study.

3.2 Sampling Technique and Sample

The sample was calculated using G power which resulted in data collection of *N=300* clinical psychology interns, including males *(n =111)* and females *(n= 189)* aged between 24-27 years (*M= 25.47, SD= 1.08*). The data were collected from different public and private institutes located in Rawalpindi, Islamabad, and Lahore. A non-probability, purposive sampling was used for data collection.

3.2.1 Inclusion Criteria

Those participants were included:

- who were currently engaged in clinical internships.
- who were working with clients having diagnosis of psychosis, substance use disorder, bipolar I and borderline personality disorder (as per brainstorming sessions findings).
- who scored low on perceived stress scale during screening.
- who were enrolled in their clinical internship II and III.

3.2.2 Exclusion Criteria

Those participants were excluded:

- who were engaged in additional jobs along with their internships.
- who were on leave or were on a semester freeze.

3.3 Operational Definitions

3.3.1 Vicarious Trauma

Vicarious Trauma is the profound shift in worldview that occurs in helpers when they work with clients who have experienced trauma. Helpers notice that their fundamental beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material (Vrklevski & Franklin, 2008). In the present study 43 or higher scores on vicarious trauma scale was considered high level of vicarious trauma.

3.3.2 Compassion Fatigue

Compassion Fatigue (CF) refers to the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate after repeated exposure to traumatic situations or stories. This exhaustion diminishes one's ability to feel empathy for their clients, loved ones and coworkers and in the present. In the current study 50 or higher scores obtained on compassion fatigue short scale was considered as high level of compassion fatigue (Figley et al., 2006).

3.3.2.1 Secondary Traumatic Stress. This is the stress that results from helping or wanting to help a traumatized or suffering person. It includes symptoms such as helplessness, a sense of isolation, difficulty concentrating or having flashbacks of client's problems. In the current study, 25 or higher score obtained on first 5 items of compassion fatigue short scale was considered as high level of secondary traumatic stress (Figley et al., 2006).

3.3.2.2 Burn Out. Burn out is a state of emotional, mental, and physical exhaustion that is caused by excessive and prolonged stress. It occurs due to being unable to meet constant work demands that result in feeling overwhelmed and emotionally drained. With time it leads to a loss of interest and motivation related to work activities causing decreased productivity and a lowered sense of personal accomplishment. In the current study, 40 or higher score obtained on last 8 items of compassion fatigue short scale were considered as high level of burn out (Figley et al., 2006).

3.3.3 Moral Injury

Moral injury in the current research referred to the long-lasting psychological, biological, spiritual, behavioral, and social impact on an individual after an exposure to morally injurious events, which entail "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. According to the moral injury symptom scale it included betrayal, guilt, shame, moral concerns, loss of trust, loss of meaning, difficulty forgiving oneself and others, self-condemnation, struggles with faith, and loss of religious faith (Litz et al., 2009). In the current study 25 or higher scores on moral injury symptom scale-health professionals was considered as high level of moral injury (MISS-HP).

3.4 Assessment Protocol

The following assessment measures were used including demographics, information sheet and perceived stress scale.

- Information sheet and Informed Consent
- Demographic Sheet
- Perceived Stress Scale (Cohen et al., 1994).
- Vicarious Trauma Scale (Vrklevski & Franklin, 2008).
- Compassion Fatigue Short- Scale (Figley et al., 2006).
- The Moral Injury Symptoms Scale-Health Professionals (Litz et al., 2009).

3.4.1 Information Sheet and Informed Consent

The purpose of an information sheet was to provide participants with knowledge about the research's objectives and its importance. Furthermore, participants were asked to sign an informed consent form, guaranteeing the protection of their identity and the confidentiality of the data. It was made clear to participants that their participation in the research was completely voluntary, and they had the option to withdraw at any point during or after the data collection process.

3.4.2 Demographic Sheet

A demographic questionnaire was used to gather information about the participants' demographic characteristics. It included age, gender, marital status, current internship level, diagnosis of client, number of clinical cases that interns take per day and their clinical internship working hours per day.

3.4.3 Perceived Stress Scale (PSS-10)

The perceived stress scale was used in the current study to screen out participants having moderate or high levels of stress as research has indicated that high personal stress levels among therapists or social workers impact the level of vicarious trauma, compassion fatigue and moral injury (Kercher & Gossage, 2023; Tamarine et al., 2020; Victoria et al., 2023). Perceived stress scale is a tool developed by Cohen et al. (1994). This scale measures and assesses how unpredictable, uncontrollable, and over loaded respondents find their lives in past 1 month. It has different version with 4, 10 and 14 items, however the one with 10 items is widely used. Each item is rated on a 5-point Likert scale ranging from 0 (never) to 4(very often). The positively rated items (4, 5,7 and 8) are reversed. The total score is produced by summing the whole items. The scores range from 0-40, with 0-13 indicating low stress, 14-26 indicating moderate stress and 27-40 indicating high perceived stress. A study on screening stress level of breast cancer patients indicated the scale reliability to be .82 and sufficient construct validity (Soria et al., 2023).

3.4.4 Vicarious Trauma Scale (VTS)

Vrklevski and Franklin developed the Vicarious Trauma Scale (VTS) as a measuring instrument in 2008. Its objective is to assess the subjective suffering that those who deal closely with survivors of traumatic events report experiencing. The VTS uses an eight-item survey with ratings on a Likert scale of seven, with "Strongly Disagree" to "Strongly Agree" as the extremes. The total of all the items is used to determine the score. Low levels of VT are indicated by a score between 8 and 28, while moderate levels of VT are indicated by a score between 9 and 42 (Vrklevski & Franklin, 2008). A score in the range of 43 to 56 indicates high levels of vicarious

Trauma (VT). A study assessing reliability and validity of vicarious trauma scale revealed its reliability to be .84 and its construct validity to be good (Jimenez et al., 2021).

3.4.5 Compassion Fatigue Short- Scale (CF-SS)

Compassion fatigue short scale is a condensed form of Figley's compassion fatigue self-test (2002). With five items related to secondary trauma and eight items related to job burnout, the compassion fatigue short scale assesses both conditions. Participants are asked to respond on a 10-point Likert scale, where 1 represents never or seldom and 10 represents very often, to identify the extent to which each item on the scale now reflects their own experience. Compassion fatigue is measured by adding together all of the scale's components that have a score between 13 and 130. A higher score corresponds to a higher level of compassion fatigue. According to a study, the compassion fatigue short scale has strong construct validity and a reliability of.90 (Baqeas et al., 2021).

3.4.6 The Moral Injury Symptoms Scale-Health Professionals (MISS-HP)

Litz et al. (2009) created the Moral Injury Symptoms Scale-Health Professionals (MISS-HP). It has ten components that include aspects of psychology and religion. Betrayal, guilt, shame, moral issues, loss of trust, meaninglessness, inability to forgive oneself and others, self-loathing, difficulties with religion, and loss of religious faith are some of these dimensions. Response options on the scale for each question range from 1 to 5 signifying the degree of agreement with claims. Each item is given a score ranging from 1 to 5, where 1 denotes "Strongly Disagree" and 5 denotes "Strongly Agree." The codes for items 5, 6, 7, and 10 are inverted. Higher scores indicate a greater severity of Moral Injury. The overall score is calculated by adding up all the elements on the scale. The total scale falls between 10 and 50. According to

a study evaluating the Moral Injury Symptoms Scale-Health Professionals (MISS-HP), it has strong convergent validity and a reliability of.82 (Hussain & Clatty, 2021).

3.5 Procedure

The initial step in the current research was to get the approval from the faculty at the Institute of Professional Psychology in Islamabad regarding the research and its applicability. Once approval was granted, an institutional request form was acquired from the department, which served as a permission letter to visit various institutes for the purpose of gathering data.

3.5.1 Brainstorming Sessions

To investigate the relationship between vicarious trauma, compassion fatigue and moral injury in clinical psychology interns, it was important to first identify the diagnosis of clients which cause these experiences among interns. As the literature has not precisely specified which clients tend to cause such experiences, four different brainstorming sessions were conducted in four different institutes of Islamabad and Rawalpindi with a group of 6-8 participants. The purpose was to determine the diagnosis of clients that specifically lead to symptoms of vicarious trauma, compassion fatigue and moral injury in clinical psychology interns.

This approach aligns with one of the study in which initially four brainstorming sessions were conducted to define the characteristics of clients that cause vicarious trauma among therapists and social workers. They were first briefed about vicarious trauma and then questions were asked about which clients in their experience have caused them symptoms like vicarious trauma. On the basis of this data was taken from therapists and social workers dealing with clients of sexual abuse (Kim et al., 2022).

Further the researches on qualities of brainstorming sessions have revealed that brainstorming sessions serve a function of helping in categorization of sample (Akyıldız & Ahmed, 2021; Hennink & Kaiser, 2022).

In addition to it, atleast four to five brainstorming sessions are an ideal approach to gather rich data,that too each brainstorming session based on ideally 6-8 participants as excessive participants can cause fatigue among participants (Casteel & Bridier, 2022; Conlon et al., 2020).

These brainstorming sessions further helped in selection of the current study's sample. Each brainstorming session lasted about 10-15 minutes. The participants were given informed consent prior to their participation and their confidentiality was assured. Participants who agreed to participate in the brainstorming sessions were included. All the participants were first briefed about the vicarious trauma, compassion fatigue and moral injury, their manifestations and their impact. Their understandingand misconceptions were clarified. The details of participants are given in Figure 1.

Further, in order to know the diagnosis of client, the following question was asked.

- Which diagnoses do you believe contribute most to these symptoms or signs of vicarious trauma, compassion fatigue or moral injury that you have experienced?

As per the analysis of the brainstorming sessions, four primary diagnoses were found that interns reportedto be associated with vicarious trauma, compassion fatigue and moral injury, as explained in Table 1.

Figure 3.1

Participants distribution in Brainstorming sessions

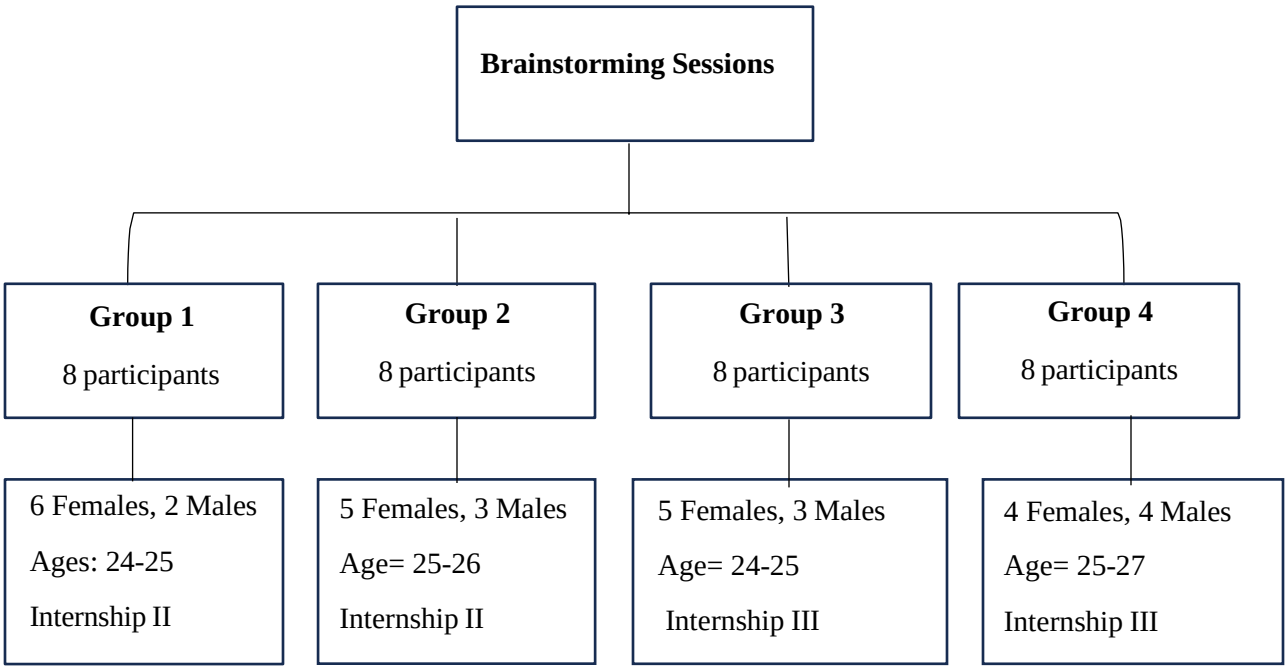


Figure 3.1 shows the distribution of participants across the brainstorming sessions. Each group consisted of 8 participants, including both males and females with ages ranging from 24-27. Participants in two groups were enrolled in their clinical internship II of masters' and advanced diploma in clinical psychology and the participants in other two groups were enrolled in their clinical internship III of masters. In addition to these, the marital status of clinical psychology interns varied across four groups; In group 1, 2 males and 3 females were single while 3 females were married. Group 2 consisted of 1 married male and 4 married females, with 1 male 2 femalesbeing single. in group 3, 2 males and 3 females were married, and 1 male and 2 females were single. Finally group 4 had 2 married males and 2 married females, as well as 2 single males and 2 single females.

Table 3.1

Frequency of the diagnosis of clients reported in the Brainstorming sessions

Diagnosis	Group 1 (*n=8*)	Group 2 *(n=8)*	Group 3 *(n=8)*	Group 4 *(n=8)*	*f (%)*
1. Psychosis related disorders	2	3	3	3	11(27.5 %)
2. Substance use Disorder	3	2	2	1	8 (20%)
3. Borderline Personality Disorder	1	2	1	3	7 (17.5 %)
4. Bipolar I	2	1	2	1	6(15%)

Note. f = frequency, %= percentage

The frequency of diagnoses reported by participants is displayed in Table 3.1. The majority of the participants stated that moral injury, compassion fatigue, and vicarious trauma were caused by clients with disorders having psychosis. The psychosis category was determined by the participants' responses; in total, two people in group 1 reported schizophrenia, two people in group 2 reported schizophrenia and one person reported depression with psychosis,one person in group 3 reported bipolar I disorder with psychosis, one person reported substance abuse with psychosis, and one person reported schizophrenia. One member of the fourth group reported schizophrenia, one reported depression with psychosis, and one reported bipolar disorder with psychosis. Thus, all these diagnoses were consolidated into a single psychosis

related disorders category. Similarly, other participants reported substance use disorder and borderline personality disorder. while the remaining reported bipolar I without psychotic symptoms.

The findings of the current brainstorming sessions align with the existing literature on trauma which says that individuals with psychosis have more history of going through trauma like childhood abuse, neglect or domestic violence that makes them susceptible to psychosis (Giannopoulou et al., 2023; Michel et al., 2020). With respect to substance use, 86.4% of the studies have indicatedthat substance use is linked with historical trauma while 84.7% of the studies have indicated it to be linked with lived trauma (Spillane et al.,2023; Ware et al., 2023). Bipolar disorder clients are found to have a history of trauma, social support and stressful environment and upbringing (Guillen et al., 2023; Wrobel et al., 2023). While studies have found emotional abuse and neglect to be prominent features in causing borderline symptoms (Zashchirinskaia, & Isagulova, 2023).

Therapists have reported getting impacted by this diagnosis too as its takes lot of emotional effort in assisting psychotic clients and not mentally getting effected by their experiences (Philllips et al., 2021; Wen & Mankiewicz, 2024). With substance users, therapists report feeling anger and a lack of empathy and detachment over time (Ishaq et al., 2023; Johnson, 2020). Challenges with bipolar I disorder include difficulty forming alliance causing fatigue and burnout due to having difficulty achieving any therapeutic outcome (Scherb & Kerman, 2023; Serbetci, 2024). In treating borderline personality disorder, therapists have reported experiencing intense burn out due to increased care that is required to be provided to these clients (Gracia, 2023). An increased suicidality and emotional dysregulation makes it

difficult for therapists to keep their empathetic engagement and they start feeling detachment and emotionally exhausted (Bell et al., 2024; Ukwuoma et al., 2024).

3.5.2 Final study

After conducting brainstorming sessions, a pilot study was conducted with 50 clinical psychology interns working in different private and public institutes of Islamabad and Rawalpindi and Lahore. These interns were enrolled in their clinical internship II and III of masters' and advanced diploma in clinical psychology. The informed consent and information sheet were shared with them, and they were briefed about the study's rationale and their ethical rights for participation. After providing all the information, consent was taken from the participants and questionnaires were given to them. Meanwhile, to rule out if the participants did not have any ongoing personal stressors that might impact their interactions with client, a perceived stress scale was applied on the clinical psychology interns as a screening tool, before collecting data, inpilot study (Choi, 2017). Initially 5 Participants who scored high on it were excluded from the pilot study, while the other 50 who scored low on it were included. This pilot study helped to identify any issues with the instruments, refining instructions, and ensuring clarity. As the reliability from pilot study was found to be sufficient, a further large sample was targeted for thefinal research.

The final sample of the current research included 300 clinical psychology interns, working in different public and private institutes of Rawalpindi, Islamabad and Lahore and enrolled in their clinical internship II and III of masters' and advanced diploma in clinical psychology. The informed consent and research details were shared with them. A perceived stress scale was applied on the clinical psychology interns as a screening tool, to screen out clinical interns with moderate and high levels of stress. In the current research, 15 interns, (10

females and 5 males) reported high on perceived stress scale and were excluded from further data collection while other 300 clinical psychology interns who scored low on it were included. Further statistical analysis was carried out and results were accurately reported.

3.6 Research Ethics

Following ethical considerations were followed.

- The synopsis was approved by the faculty of Institute of Professional Psychology, Bahria University Islamabad.
- Permission from the head of institutions was sought before data collection.
- Permission from authors of scales was sought.
- Before data collection, participants were briefed about the research and their permission was taken for the participation of research participants.
- The anonymity of the participants and confidentiality of the data was maintained.
- The results were accurately represented.

CHAPTER IV

RESULTS

The current research aimed to investigate the relationship between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns. The data was analyzed in five steps. In step I, descriptive statistics of demographic variables were computed. Additionally, the descriptive statistics and the reliability analysis were also calculated for vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury. In step II, pearson product moment correlation analysis had been executed in conjunction with demographic variables (age, clinical internship level, clients taken per day and internship hours per day), vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury. In step III, mediation analysis was employed to investigate the role of compassion fatigue as a mediator between vicarious trauma and moral injury. In step IV, one-way Anova analysis was used to explore the differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury across diagnosis (psychosis related disorders, substance use disorder, bipolar I and borderline personality disorder). In step V, an independent sample t test was used to explore the differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury across gender (women and men), marital status (single and married) and clinical internship level (clinical internship II and clinical internship III).

4.1 Descriptive Statistics

The descriptive statistics of demographic characteristics of the participants (age, number of clinical cases per day, internship hours per day, clinical internship level, gender, marital status and diagnosis) are presented. Also, the descriptive statistics and reliability analysis of perceived stress scale, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury are presented.

Table 4.1

Descriptive Statistics of the Demographic Characteristics of the Sample, (N=300).

Variables	*M (SD)*	*f (%)*
Age	25.47(1.08)	
Number of cases per day	4.77(1.89)	
Internship hours per day	5.83(1.09)	
Clinical Internship level		
Clinical Internship II		150 (50.0)
Clinical Internship III		150 (50.0)
Gender		
Male		111 (37.0)
Female		189 (63.0)
Marital Status		
Single		164 (54.7)
Married		136 (45.3)
Diagnosis		
Psychosis related disorders		141 (47.0)
Substance use disorder		77 (25.7)
Bipolar I		27 (9.0)
Borderline personality disorder		55 (18.3)

Note. M=mean, *SD*=standard deviation, *f*=frequency, *%*=percentage

Table 4.1 shows that that most of the participants belonged to the age group 25*(M=25.47, SD= 1.08).* On average, participants reported taking 4 cases per day *(M= 25.47, SD=1.89),* and having 5 hours of clinical internship per day *(M= 25.47, SD= 1.09).*

There was an equal distribution of participants with respect to their clinical internship level as 150 (50.0 %) were enrolled in their clinical internship II and 150 (50.0 %) were enrolled in their clinical internship III. There were 189 (63.0%) female participants and 111 (37.0%) males.

164 (54.7%) reported their marital status to be single, while 136 (45.3 %) reported their marital status to be married. Most of the participants had clients of psychosis related disorders (f= 141, %= 47.0), while 77 (25.7%) had clients of substance use disorder, 55 (18.3%) had borderline personality disorder, and 27 (9.0%) had bipolar I clients.

4.2 Descriptive Statistics and Reliability Analysis

Table 4.2

Descriptive Statistics and Cronbach's Alpha for Perceived Stress Scale, Vicarious Trauma Scale, Compassion Fatigue- Short Scale (Secondary Traumatic Stress, Burn Out), and The Moral Injury Symptoms Scale- Health Professionals among Clinical Psychology Interns, (N=300).

			Range		
Variables	*K*	*M (SD)*	*Actual*	*Potential*	α
Perceived Stress	10	7.5(3.5)	0-10	0-40	.81
Vicarious Trauma	8	32.5(9.77)	8-56	8-56	.84
Compassion Fatigue	13	38.1(14.3)	13-77	13-130	.90
Secondary Traumatic Stress	5	14.7(6.3)	5-28	5-50	.84
Burn out	8	23.4(9.07)	8-50	8-80	.87
Moral Injury	10	32.6(8.24)	10-25	10-50	.82

Note. K = number of items, *M* = mean, *SD* = standard deviation, *α* = Cronbach's Alpha.

Table 4.2 shows the descriptive statistics (mean, standard deviation, actual and potential ranges) and internal consistency using Cronbach's alpha reliability of perceived stress scale, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury. The reliability evaluation exhibited an excellent internal consistency ranging from .81-9.0 for the constructs.

4.3 Pearson Product Moment Correlation Analysis

It was hypothesized that there is likely to be a positive relationship between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury. It was also hypothesized that there is likely to be a relationship between demographic variables, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns. Pearson product-moment correlation was undertaken to explore the relationship between demographic variables and study variables, as well as vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.

Table 4.3

Bivariate correlation between Demographic Variables (Age, Clinical Internship Level, Clinical cases taken per day, Internship hours per day), Vicarious Trauma, Compassion Fatigue (Secondary Traumatic Stress, Burn Out) and Moral Injury among Clinical Psychology Interns, (N=300).

Variables	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1. Age	-	.11	-.678***	-.655**	-.555*	-.677**	-.510*	-.521*	-.512*
2. Clinical Internship level		-	.10	.14	-.555*	-.570*	-.550*	-.588*	-.610**
3. Clinical cases per day			-	850***	.824***	.710***	.520*	.535*	.824***
4. Internship hours per day				-	.836***	.710***	.520*	.535*	.824***
5. Vicarious Trauma					-	.660**	.607**	.574*	.765***
6. Compassion Fatigue						-	.838***	.926***	.694**
7. Secondary Traumatic Stress							-	.571*	.655**
8.Burn Out								-	.593*
9. Moral Injury									-

*Note. *p<.05. **p<.01. ***p<.001*

Table 4.3 shows the Pearson product moment correlation between age, clinical internship level, clinical cases per day, internship hours per day, vicarious trauma, compassion fatigue (secondary traumatic stress, burnout) and moral injury. The results of pearson product moment correlation showed that age was significantly negatively associated with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury.

Similarly, clinical internship level was found to be significantly negatively associated with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury.

Clinical cases per day were found to be significantly positively associated with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury. Internship hours per day also exhibited a significantly positive association with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury.

Furthermore, vicarious trauma was significantly positively associated with compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury. There was a significant positive association of compassion fatigue and its subdomains (secondary traumatic stress, burn out) with moral injury.

4.4 Mediation Analysis

It was hypothesized that vicarious trauma and compassion fatigue are likely to predict moral injury among clinical psychology interns. It was also hypothesized that compassion fatigue is likely to mediate the relationship between vicarious trauma and moral injury among clinical psychology interns. To explore this, mediation analysis was employed to examine the mediating role of compassion fatigue. Vicarious trauma and compassion fatigue were also investigated for predicting moral injury among clinical psychology interns.

Table 4.4

Standardized Estimates of Direct Effect for Vicarious Trauma, Compassion Fatigue and Moral Injury among Clinical Psychology Interns, (N=300).

Variables	Compassion Fatigue		Moral Injury	
	β	*SE*	β	*SE*
Vicarious Trauma	.28***	.06	.27***	.02
Compassion Fatigue			.11**	.02
Covariates				
Diagnosis			-.01**	.25
Clinical Internship level			-.34**	.25
Gender			.03	.36
Age			-.04*	.43
Marital Status			.04	.42
Clinical cases per day			.35**	.21
Internship hours per day			.26**	.39
R^2	.62	.	.81	
F	68.5		161.5	

*Note. *p<.05. **p<.01. ***p<.001*

Table 4.4 shows the results of mediation analysis. Results of direct effect showed that vicarious trauma was a significant positive predictor of compassion fatigue (62.1%) and moral injury (81%). Similarly compassion fatigue was a significant positive predictor of moral injury (81.6%). Covariates: clinical cases per day and internship hours per day were found to be significant positive predictors of moral injury. The covariate diagnosis, age and clinical

internship level were found to be significant negative predictors of moral injury. Meanwhile, the covariates gender and marital status were found to be non-significant predictors of moral injury.

Table 4.5

Standardized Estimates of Indirect Effects for Vicarious Trauma, Compassion Fatigue and Moral Injury among Clinical Psychology Interns, (N=300).

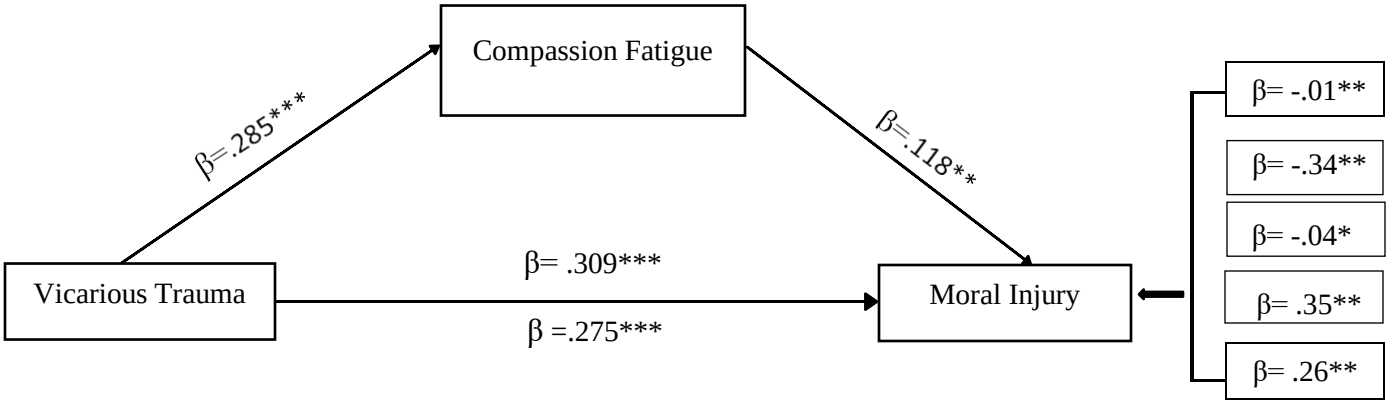
Variables	Moral Injury		95% Boot CI	
	β	*SE*	*Boot LL*	*Boot UL*
Compassion Fatigue	0.09	0.07	.008	0.61

Note. *CI*= Confidence Interval, *LL*= Lower Limit, *UL*= Upper Limit

Table 4.5 shows the results of Indirect effect. The indirect effect found that compassion fatigue was found to significantly positively mediate the relationship between vicarious trauma and moral injury which showed that an increase in vicarious trauma tends to increase compassion fatigue, and an increase in compassion fatigue tends to increase vicarious trauma.

Figure 4.1

Pathway model of mediation process for Vicarious Trauma and Moral Injury among Clinical Psychology Interns, (N=300).



The model depicts the mediating effect of compassion fatigue on the relationship between vicarious trauma and moral injury among clinical psychology interns. The model is depicting that vicarious trauma was significantly relating with moral injury both before and after introducing mediating variable which concluded that compassion fatigue was partially mediating the relationship between vicarious trauma and moral injury among clinical psychology interns.

4.5 One- Way Anova

It was hypothesized that there are likely to be differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their client diagnosis. To carry out the investigation, one-way anova analysis was conducted to compare the differences.

Table 4.6

Mean, Standard Deviation and One way Analysis of Variance on Vicarious Trauma, Compassion Fatigue (Secondary Traumatic Stress, Burn Out) and Moral Injury across client's diagnosis (Psychosis related disorder, Substance use disorder, Borderline personality disorder, Bipolar I), (N=300).

Variables	Psychosis related Disorders (*n*= 141)		Substance use Disorder (*n*= 77)		Borderline Personality Disorder (*n*= 55)		Bipolar I (*n*= 27)				
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(298)*	η^2	Post Hoc
Vicarious Trauma	38.01	7.75	27.50	5.91	27.50	8.14	19.55	7.84	93.70***	.42	1>2, 1>3, 1>4, 2>4, 3>4
Compassion Fatigue	46.09	10.10	27.18	3.86	27.18	6.01	17.74	4.91	153.34***	.60	1>2, 1>3, 1>4, 2>4, 3>4
Secondary Traumatic Stress	17.95	5.08	10.50	3.05	10.50	3.92	6.92	3.39	76.05***	.43	1>2, 1>3, 1>4, 2>4, 3>4
Burn Out	28.14	7.17	16.67	4.03	16.67	4.74	10.81	2.38	105.55***	.51	1>2, 1>3, 1>4, 2>4, 3>4
Moral Injury	38.02	6.81	30.93	3.77	28.6	5.93	19.77	5.10	93.78***	.48	1>2, 1>3, 1>4, 2>4, 3>4

Note. M=Mean, *SD*=Standard Deviation, η^2= eta square (effect size)

Table 4.6 shows results of one-way anova analysis that was carried out in terms of vicarious trauma, compassion fatigue, its subscales secondary traumatic stress, burn out and moral injury. The results depicted that there were significant differences found among vicarious trauma, compassion fatigue, secondary traumatic stress, burn out and moral injury, showing that vicarious trauma, compassion fatigue, secondary traumatic stress, burn out and moral injury were found to be higher among clinical psychology interns who dealt with psychosis related disorders, as compared to substance use disorder, borderline personality disorder and bipolar I. For further pairwise comparisons, a post hoc test (Gabriel) was applied.

For vicarious trauma scale, the results of the pairwise comparison on psychosis related disorders, substance use disorder, borderline personality disorder and bipolar I were found to be significantly different. This demonstrated that clinical psychology interns dealing with psychosis related disorders were likely to have higher vicarious trauma levels, as compared to substance use disorder, borderline personality disorder and bipolar I clients. The results of pairwise comparison of substance use disorder and bipolar I were found to be significantly different, indicating that clinical psychology interns dealing with substance use disorder clients were likely to have higher vicarious trauma levels, as compared to bipolar I. The results of pairwise comparison of borderline personality disorder and bipolar I were found to be significantly different, indicating that interns dealing with borderline personality disorder clients were likely to have higher vicarious trauma levels, as compared to bipolar I.

For compassion fatigue and its subscales, secondary traumatic stress and burn out, the results of the pairwise comparison on psychosis related disorders, substance use disorder, borderline personality disorder and bipolar I were found to be significantly different. This demonstrated that clinical psychology interns dealing with psychosis related disorders clients

were likely to have higher compassion fatigue secondary traumatic stress and burn out levels, as compared to substance use disorder, borderline personality disorder and bipolar I clients. The results of pairwise comparison of substance use disorder and bipolar I were found to be significantly different, indicating that clinical psychology interns dealing with substance use disorder clients were likely to have higher compassion fatigue, secondary traumatic stress and burn out levels, as compared to bipolar I. The results of pairwise comparison of borderline personality disorder and bipolar I were found to be significantly different, indicating that clinical psychology interns dealing with borderline personality disorder clients were likely to have higher compassion fatigue, secondary traumatic stress and burn out levels as compared to bipolar I.

For moral injury scale, the results of the pairwise comparison on psychosis related disorders, substance use disorder, borderline personality disorder and bipolar I were found to be significantly different. This demonstrated that interns dealing with psychosis related disorders were likely to have higher moral injury levels, as compared to substance use disorder, borderline personality disorder and bipolar I clients. The results of pairwise comparison of substance use disorder and bipolar I were found to be significantly different, indicating that clinical psychology interns dealing with substance use disorder clients were likely to have higher moral injury levels, as compared to bipolar I. The results of pairwise comparison of borderline personality disorder and bipolar I were found to be significantly different, indicating that clinical psychology interns dealing with borderline personality disorder clients were likely to have higher moral injury levels as compared to bipolar I.

4.6 Independent Sample t test

It was hypothesized that there are likely to be gender and marital status differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns. It was also hypothesized that there are likely to be differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their clinical internship level (clinical internship II, clinical internship III). To carry out the investigation, an independent sample t-test was conducted to compare the differences.

Table 4.7

Results of the Independent Sample t-test examining differences between Vicarious Trauma, Compassion Fatigue (Secondary Traumatic Stress, Burn Out), Moral Injury among Clinical Psychology Interns across gender (Men, Women), (N=300).

Variables	Men (*n*= 111)		Women (*n*= 189)				
	M	*SD*	*M*	*SD*	*t*(298)	*p*	Cohen's *d*
Vicarious Trauma	31.90	7.01	33.15	8.74	-1.36	.17	.15
Compassion Fatigue	39.20	11.3	36.60	13.05	1.85	.06	.21
Secondary Traumatic Stress	14.80	5.24	14.55	5.95	.46	.64	.05
Burn Out	24.30	7.44	22.04	8.38	2.43	.01	.28
Moral Injury	32.30	7.01	33.10	8.74	-.80	.42	.10

Note. M=Mean, *SD*=Standard Deviation

Table 4.7 shows the results of independent sample t test. The results depicted significant mean differences in burn out. The results showed that men exhibited higher scores in burn out as compared to women. The value of Cohen's d was .28 which showed small effect size.

Table 4.8

Results of the Independent Sample t-test examining differences between Vicarious Trauma, Compassion Fatigue (Secondary Traumatic Stress, Burn Out), Moral Injury among Clinical Psychology Interns across marital status (Single, Married), (N=300).

Variables	Single (*n*= 164)		Married (*n*= 136)				
	M	*SD*	*M*	*SD*	*t*(298)	*p*	Cohen's *d*
Vicarious Trauma	33.03	9.46	32.37	9.99	.58	.56	.06
Compassion Fatigue	36.50	12.73	38.90	12.09	-1.68	.09	.19
Secondary Traumatic Stress	14.66	5.82	14.72	5.55	-.09	.92	.01
Burn Out	21.84	8.35	24.20	7.64	-2.53	.01	.29
Moral Injury	32.80	8.40	32.70	7.83	.09	.92	.01

Note. M=Mean, *SD*=Standard Deviation

Table 4.8 shows the results of independent sample t test. The results of independent sample t test revealed significant mean differences in burn out. The results showed that married clinical psychology interns exhibited higher scores in burn out as compared to single clinical psychology interns. The value of Cohen's d was .29 which showed small effect size.

Table 4.9

Results of the Independent Sample t-test examining differences between Vicarious Trauma, Compassion Fatigue (Secondary Traumatic Stress, Burn Out) and Moral Injury among Clinical Psychology Interns across clinical internship level (Clinical Internship II, Clinical Internship III), (N=300).

Variables	Clinical Internship II (*n*= 150)		Clinical Internship III (*n*= 150)				
	M	*SD*	*M*	*SD*	*t*(298)	*p*	Cohen's *d*
Vicarious Trauma	34.00	3.44	32.50	3.33	3.84	.02	.41
Compassion Fatigue	40.03	3.11	37.90	3.00	6.03	.00	.69
Secondary Traumatic Stress	15.55	3.1	14.02	2.9	4.41	.01	.50
Burn Out	25.01	2.22	24.01	7.64	3.91	.01	.43
Moral Injury	35.61	3.91	32.70	4.0	6.37	.00	.73

Note. M=Mean, *SD*=Standard Deviation

Table 4.9 shows the results of independent sample t test. The results of the independent sample t-test revealed significant mean differences in vicarious trauma. The results showed that clinical psychology interns enrolled in clinical internship II exhibited higher scores in vicarious trauma as compared to those in clinical internship III. The value of Cohen's d was .41 which specified small effect size.

The findings uncovered that clinical psychology interns in clinical internship II also had greater compassion fatigue, than clinical psychology interns in clinical internship III. The value of Cohen's d was .69 which indicated a medium effect size. The results demonstrated significant mean differences in secondary traumatic stress, with higher degree of secondary

traumatic stress among clinical psychology interns in clinical internship II than clinical internship III. The Cohen's d value of .50 showed medium effect size.

The results demonstrated significant mean differences in burn out, with a higher degree of burn out among clinical psychology interns in clinical internship II than clinical internship III. The Cohen's d value of .43 showed small effect size. The results demonstrated significant mean differences in moral injury, with a higher degree of moral injury among clinical psychology interns in clinical internship II than clinical internship III. Cohen's d value of .73 showed large effect size.

4.7 Summary of Findings

- Pearson product moment correlation showed that age and clinical internship level were significantly negatively associated with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury among clinical psychology interns. Further clinical cases taken per day and internship hours were found to be significantly positively associated with vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- The Pearson product moment correlation also showed a significant positive association between vicarious trauma, compassion fatigue, its subdomains (secondary traumatic stress, burn out) and moral injury among clinical psychology interns.
- Mediation analysis was employed to examine the predicting outcome of moral injury by vicarious trauma and compassion fatigue among clinical psychology interns. The results of the mediation analysis showed that vicarious trauma and compassion fatigue significantly positively predicted moral injury. Further compassion fatigue was found to significantly positively mediate the relationship between vicarious trauma and compassion fatigue.
- One-way anova analysis carried out to examine differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across the client's diagnosis showed significant mean difference in vicarious trauma, compassion fatigue, its subdomain (secondary traumatic stress, burn out) and moral injury, indicating that interns taking psychosis related disorders clients experienced more vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury.

- Independent sample t-test carried out to examine differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across gender showed insignificant mean difference between vicarious trauma, compassion fatigue, its subdomain (secondary traumatic stress) and moral injury with weak effect size. However, the results showed significant mean difference in burn out with men scoring higher than women, with small effect size.
- Independent sample t-test carried out to examine differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across marital status showed insignificant mean difference between vicarious trauma, compassion fatigue, its subdomain (secondary traumatic stress) and moral injury with weak effect size. However, the results showed significant mean difference in burn out with married interns scoring higher than single interns, with small effect size.
- Independent sample t-test carried out to examine differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across clinical internship level showed significant mean difference in vicarious trauma, compassion fatigue, its subdomain (secondary traumatic stress, burn out) and moral injury with small effect size in vicarious trauma and burn out, medium effect size in compassion fatigue and secondary traumatic stress and large effect size in moral injury.

CHAPTER V

DISCUSSION

The study focused on exploring the association between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns. In this section, the findings of the present study are linked with existing literature about vicarious trauma, compassion fatigue and moral injury among clinical psychology interns.

It was hypothesized that there is likely to be a positive relationship between compassion fatigue (secondary traumatic stress, burn out), vicarious trauma, and moral injury among clinical psychology interns. The findings of the current study were that there is a significant positive relationship between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury. These findings are consistent with the previous literature which states that vicarious trauma has a positive association with compassion fatigue as exposure to distressing clients and hearing their stories can impact and alter a therapist's perception, which in turn can cause emotional exhaustion and fatigue among mental health professionals (Pirelli et al., 2020). Similarly, another study indicated that dealing with difficult clients can cause increased secondary traumatic stress and burn out among mental health professionals that impacts their energy and the services that they provide to the other people (Tujague & Ryan, 2023). The vicarious trauma causes an alteration in their perception of people and environment after dealing with complex clients, due to which they became unsatisfied with their job, which impacted their client's management (Armes et al., 2020). Further study reported that the increased vicarious trauma not only caused a detached behavior of therapists with their clients, but also with their families and children too (Mustafa et al., 2020).

Compassion fatigue can lead to frustration and moral injury among mental health professionals as dealing with distressing clients makes it difficult for mental health workers

to detach and they end up being overly emotionally engaged with them (Bhattacharyya & Ushri, 2022). This increases burn out at their end and an increased secondary traumatic stress making them think about their clients even outside of the therapy too, causing distress (Natalia & Julia, 2022). In this emotional engagement, novice psychologists indicated that they engaged in over disclosure to make client feel better, and other times being so emotionally overwhelmed that impacted the direction of therapy and the client was not well attended (Stevens & Abbadey, 2023). Often the need of rescuing the client makes the therapist too much worried and instead of making client independent they make client dependent on them, which interferes the therapeutic relationship negatively, later causing guilt and shame among therapists (Natalie, 2022).

It was hypothesized that there is likely to be a relationship between demographic variables, vicarious trauma, compassion fatigue (secondary traumatic stress, burn out), and moral injury among clinical psychology interns. The findings of the current study were that there is a significant negative association of age and clinical internship level, while a significant positive association of clinical cases per day, internship hours per day with vicarious trauma, compassion fatigue, its subscale; secondary traumatic stress, burn out and moral injury. These findings are consistent with the literature which states that as older psychologists have more experience and exposure, they deal with client's distress differently and manage it well as compared to younger psychologist who feel overwhelmed at times (Tara & Shuman, 2021). Similarly, another research showed older psychologists experiencing less cognitive changes and alterations in exposure to traumatic clients as compared to youngers ones (Shea, 2021). Older individuals might gain more experience in managing their occupational stress and may manage it better than the young individuals (Kercher & Gossage, 2023). Similarly younger psychologists report more uncertainty due to this burn out (Stevens & Abbadey, 2023). There is apprehension and distress as compared to older ones due to

exposure and experience (Aliza et al., 2020). Due to higher workload and lack of experience too, younger psychiatrists reported more moral injury as compared to older psychiatrists (Deborah et al., 2022). They felt more stressed and could not manage their emotional engagement with the client (Wang et al., 2022).

Similarly, research has indicated that junior therapists and social workers reported higher levels of vicarious trauma and found initial difficulty in managing their stress and emotional triggers (Shea, 2021; Tara & Shuman, 2021). They also report more compassion fatigue as research on health professionals indicated higher burn out and fatigue while dealing with patients (Stevenson et al., 2022). Their seniors reported less fatigue and burn out as with exposure and experience, they learned how to manage clients better and emotional exhaustion as compared to the junior health care professionals (Kercher & Gossage, 2023). As compassion fatigue and vicarious trauma levels are high in junior practitioners, this also increase the level of moral injury among them (Maguire & Looi, 2022). They try to navigate their client care and the increased fatigue and vicarious trauma resulting because of continuous interaction with clients (Victoria et al., 2023).

Further increased case load, increases the exposure to distressing content and experiences altering therapists' sense of world and perception too, making them unable to adequately process it (Fox et al., 2021). It made the psychologists doubt their own reality and safety and protection of those of their loved ones too (Katie et al., 2020). It also led to a feeling of worthlessness and inadequacy among professionals causing guilt and shame (Quinn et al., 2019). Back-to-back sessions make it difficult for mental health professionals to relax (Vagni et al., 2020). This interfered with their listening ability as the exhaustion caused them to become emotionally drained and unavailable to provide the warmth and empathy that the client really needed (Berrios, 2020). The high case load made it difficult to manage the session pace to meet client needs and handling a high caseload contributed to emotional drain

and therapist fatigue (Stevens & Abbadey, 2023). As cases increase and one becomes fatigued and exhausted, the caregiving ability and availability in turn compromises the services being provided to the client (Victoria et al., 2023). The emotional disengagement makes the client feel unattended and unheard (Maguire & Looi, 2022). This further exaggerated the decreased quality care and a sense of dissatisfaction with profession (Deborah et al., 2022).

Further as working hours increase, the responsibilities related to clients increase which in turn increase the level of exposure (Fernandez et al., 2022). With this increase in working hours, one spends more time in that environment (Fox et al., 2021), gathers less time to process and attend to one's own emotional stress (Shea, 2021). Therapists report more burn out and secondary traumatic stress, as the level of emotional engagement increases with clients, one becomes emotionally exhausted with time (Peacock, 2023). They do not get the time to recharge and often it results in not attending to client appropriately (Ushri, 2022). Other times it leads to psychologists and social workers being cold and detached from clients', making them feel unheard (Natalia & Julia, 2022). It also makes them not being able to understand their problems completely as they are distracted and overwhelmed with other occupational tasks too (Malin et al., 2020). Psychiatrists who have increased working hours experienced more emotional toll and were burdened with a lower job satisfaction (Deborah et al., 2022). They felt detached, which impacted their treatment plans (Looi et al., 2022). Other times they got so emotionally involved that in trying to rescue the client and build rapport they would cross the ethical lines and engage in more disclosure or personal interaction (Ball et al., 2022).

It was hypothesized that vicarious trauma and compassion fatigue are likely to predict moral injury among clinical psychology interns. The findings of the current study were that vicarious trauma and compassion fatigue significantly positively predicted vicarious trauma.

The findings are consistent with the literature which indicates that trainee psychologists exposed to clients having psychosis, experienced emotional distress and it impacted the care they provided to them (Ball et al., 2022). Similarly, psychiatrists reported experiencing intense changes in safety and certainty of world when due to exhaustion they were not able to help clients (Wang et al., 2022). Workload, and constant exposure to clients made the psychiatrists emotionally disconnect from clients and it decreased their quality of care which impacted their attention and satisfaction with their services (Deborah et. al, 2022). Another study reported the moral injury among health care workers in time of covid 19 due to extreme stress which compromised their compassion and empathy being provided to patients (Fatima et al., 2023). The emotional strain, case load, working hours impacted the health care workers emotional capacity and the presence of vicarious trauma and compassion fatigue together lead to moral injury in form of detachment, low empathy, guilt and feelings of shame (Akhtar et al., 2022).

It was hypothesized that compassion fatigue is likely to mediate the relationship between vicarious trauma and moral injury among clinical psychology interns. The findings of the current study showed that compassion fatigue partially mediated the relationship between vicarious trauma and moral injury among clinical psychology interns. The findings are consistent with the literature, which indicated that while dealing with clients, therapists must believe in one's own capabilities and emotional management. Therapists who got drained experienced more compassion fatigue which in turn lead to depression and anxiety in them (Jo et al., 2020). Another research indicated that health care professionals burn out lead to more constrained family relationships and neglect with clients as well as children, when they experienced more compassion fatigue and burn out (Stevenson et al., 2022).

It was hypothesized that there are likely to be differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical

psychology interns across their client diagnosis. The findings of the current research showed that there are significant mean differences between diagnosis of client, vicarious trauma, compassion fatigue, secondary traumatic stress, burn out and moral injury as clients who dealt with psychosis related disorder clients reported higher on the study variables, followed by substance use, then borderline personality disorders and lastly bipolar disorder. These findings are consistent with literature which suggests that therapists faced difficulties in forming therapeutic alliance with psychotic clients, as well as maintaining a sense of safety and trust (Knutsson et al., 2023). They reported putting emotional effort in assisting psychotic clients and difficulty not getting impacted by their experiences (Philllips et al., 2021; Wen & Mankiewicz, 2024).

While dealing with substance use disorder clients, therapists reported feeling anger and a lack of empathy and detachment over time (Johnson, 2020). They reported feeling empathy for their problems but at the same time detachment over their pattern of drug seeking and addiction (Ishaq et al., 2023). In treating borderline personality disorder, an increased suicidality and emotional dysregulation among clients made it difficult for therapists to keep their empathetic engagement, they started feeling detachment and emotionally exhausted (Bell et al., 2024; Ukwuoma et al., 2024). Challenges with bipolar I disorder included difficulty forming alliance, a lack of medicinal compliance at their end and a lack of receptivity (Scherb & Kerman, 2023; Serbetci, 2024). These factors along with their mania symptoms and clients' painful experiences made psychologists vulnerable to feeling and empathizing with them but at the same time being fatigued and burned out due to having difficulty achieving any therapeutic outcome (Jaffe et al., 2024; Kumar et al., 2022).

It was hypothesized that there are likely to be gender differences in vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns. The findings of the current study were that there is no significant

differences between vicarious trauma, compassion fatigue (secondary traumatic stress) and moral injury across gender. However, on burn out, there were significant gender differences as male interns scored higher than female interns. These findings are consistent with literature which indicated no gender differences between the level of vicarious trauma and one's own altered perception, considering it more to be linked with one's own emotional processing, way of handling stress (Fernandez et al., 2022). Similarly, another research indicated the level of vicarious trauma and compassion fatigue to be linked more with one's own personal characteristics self-efficacy and occupational factors as compared to gender only (Fox et al., 2021; Tamarine et al., 2020; Quinn et al., 2019). Other factors like one's own personality traits, experiences, learned behaviors and experience in dealing with different circumstances that influence more too in manifestation of emotional expression (Natalia & Julia, 2022; Peacock, 2023). Similarly, the experience of moral injury and its expression is not necessarily linked with gender of being a male or female (Wang et al., 2022). While yes, the emotional expression and dealing is influenced by gender norms and expectations, but how one processes it and deal with it can vary as per different factors too that can be client intake, workload, and the issue of the client, which can equally affect people regardless of gender (Victoria et al., 2023).

While compassion fatigue and moral injury can be different, research suggests a difference in case of burn out and indicate that even though males have a very controlled emotional expression and do not express much, but considering the number of responsibilities on them, they feel exhausted and experience the burn out more (Natalie, 2022). Also, as they do not engage in catharsis or venting and sharing as much as females do, so their burn out is more as compared to females (Aliza et al., 2020).

It was hypothesized that there are likely to be marital status differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury

among clinical psychology interns. The findings of the current study were that there are no significant differences between vicarious trauma, compassion fatigue (secondary traumatic stress) and moral injury across marital status. However, on burn out, there are significant marital status differences as married interns scored higher than single interns. The findings are consistent with the literature as research highlights that sometimes being married and single does not explain how one would process one's emotions (Fox et al., 2021). Other factors like how a person individually copes, what are one's own experiences and past traumas that can affect one's interaction with client and trigger one also greatly explain how one experiences vicarious trauma (Berrios, 2020; Quinn et al., 2019; Vagni et al., 2020). Regardless of being married or single, one can experience compassion fatigue and secondary traumatic stress differently too (Peacock, 2023). One's own personality factors and emotional processing impacts it (Natalia & Julia, 2022). At the same time the additional work environment factors like case load, working hours, emotional support and colleague relationships also greatly impact how much a person would experience compassion fatigue (Natalie, 2022). Studies on moral injury indicate that it can be experienced and expressed by either person regardless of their marital status (Maguire & Looi, 2022). The research states that there are additional factors experienced by practioners like occupational workload, caseloads, working hours and social relationships and environment that can make a person stressed and prone to doing anything unethical that can impact client and cause guilt in turn to practioners (Looi et al., 2022).

While there are no differences in compassion fatigue and moral injury, differences in burn out are indicated as married mental health practioners who deal with distressing clients reported more burn out due to additional emotional and financial responsibilities to them (Stevens & Abbadey, 2023). They did not get as much time to process and vent as much as a single individual did (Bhattacharyya & Ushri, 2022). Further additional factors like working

hours and client intake made married individuals experienced more burn out, as they had to manage other familial responsibilities too (Malin et al., 2020).

It was hypothesized that there are likely to be differences between vicarious trauma, compassion fatigue (secondary traumatic stress, burn out) and moral injury among clinical psychology interns across their clinical internship level. The findings showed that there are significant mean differences in clinical internship across vicarious trauma, compassion fatigue, secondary traumatic stress, and moral injury. These findings are consistent with the literature which suggest that senior social workers reported less vicarious trauma as compared to their junior social workers and were better able to manage their stress (Fox et al., 2021). Similarly, another study indicated junior psychologists facing more uncertainty and emotional reactivity in response to clients as compared to the senior psychologists (Shea, 2021; Tara & Shuman, 2021).

As vicarious trauma is more among junior psychologists, researchers have indicated a higher level of compassion fatigue among junior psychologists too (Kercher & Gossage, 2023; Stevens & Abbadey, 2023). Senior psychologists in response to their juniors experience less fatigue and burn out as they are exposed to the routine and get accustomed to client care (Jo et al., 2020). Further, junior psychologists with time develop an understanding of how to manage stressors and deal with clients differently, as compared to their senior psychologists (Stevenson et al., 2022).

With respect to moral injury, research has indicated senior health care professionals reporting lesser moral injury as compared to the junior health care professionals (Victoria et al., 2023). They had difficulty managing cases and managing the patient care. as they are new to gaining experience and interacting with patients, they take their time to understand the complexities along with their own triggers and emotional reactions (Maguire & Looi, 2022; Weber et al., 2023).

5.1 Conclusion

The present study was designed to explore the association between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns. The aim was to explore whether clinical psychology interns experience vicarious trauma, compassion fatigue and moral injury and how these variables are interrelated. Further the research also aimed to explore how compassion fatigue mediates the relationship between vicarious trauma and moral injury among clinical psychology interns. It has been concluded from the research that there is a positive association between vicarious trauma, compassion fatigue and moral injury among clinical psychology interns.

Clinical internships are important training programmes for clinical psychology interns as they get diverse exposure and learn to deal with different clients. During this experience, as they are building on their skills, they come across various clients and their distressing histories, that impacts their perception of world and safety too as hearing their stories and struggles makes them question their own perception of world and their subjectivity (Tujague & Ryan, 2023). It can get distressing for them as it gets overwhelming and triggers them. They might start thinking of themselves, the world and people around them in a negative way and start seeing everything from their clients' problems (Quinn et al., 2019).

As this gets overwhelming, it can lead to fatigue and emotional exhaustion among interns (Amsalem et al., 2021). Constantly listening to their clients' stories, without giving themselves the space to process their emotions and feelings, can cause increased client engagement, being very over empathetic and feeling emotionally drained as a result (Stevens & Abbadey, 2023). This emotional drain is due to various reasons of not having enough experience; being young in the field and an increased amount of client intake and clinical internship hours, that increase the fatigue (Jo et al., 2020).

This fatigue increases the chances of being detached from the client, not being able to give them the attention they need, impacting their therapeutic process (Maguire & Looi, 2022). Due to vicarious trauma and compassion fatigue, clinical psychology interns can act or say something that might hurt clients, or they may not be able to attend client as its required, causing moral injury among them (Akhtar et al., 2022). This makes them feel guilty, ashamed and feel that they are not good enough to help the clients. Thus, this research highlights the need to address the presence of vicarious trauma, compassion fatigue and moral injury in clinical psychology interns, in order to make interns aware of this process and how they can use the awareness to manage themselves as well as their clients better (Wang et al., 2022).

5.2 Implications

- The findings of the study can help to address the experiences of vicarious trauma, compassion fatigue and moral injury, that clinical interns go through during their training programs and how these experiences have the capacity to affect their mental health.
- Addressing the struggles associated with vicarious trauma, compassion fatigue and moral injury in supervision and navigating the challenges occurred during sessions can help clinical interns seek help and develop insight into their issues that impact them as well as the clients.
- A proper module and training programme can be incorporated into the curriculum to make clinical psychology interns aware of vicarious trauma, compassion fatigue and moral injury and how they can spot whenever they are experiencing it and then timely manage it.
- Further changes in organizational culture can make policies regarding the amount of client load and working hours. Policies to manage the number of clients taken daily, time allotted to them and self-care practices in between the sessions to keep oneself

mentally healthy can help not only clinical interns but other staff too to manage the workload and stress.

- A regular debriefing or peer groups sessions can be employed to help interns listen to each other struggles and maintain an accepting environment.

5.3 Limitations

- The current study was cross-sectional research which only provided an insight into relationship among variables, while a mixed method could have provided an in-depth understanding of the clinical interns experiences.
- The cultural norms and values may have impacted the respondents' responses that can be different from other countries and as a result findings cannot be generalized on a larger level.
- Also, data was collected from participants taking specific cases with certain diagnosis, thus the results are not applicable to every clinical psychology intern.

5.4 Recommendations

- Future research can do longitudinal research where they can explore how experiences of vicarious trauma, compassion fatigue and moral injury change over time and how clinical psychology interns learn to manage it with time.
- Further researchers can also focus on targeting an intervention plan that can help clinical psychology interns in their training level as how to cope with the stress and guilt associated with moral injury.
- Future research can focus on exploring the role of clinical supervision in managing vicarious trauma, compassion fatigue and moral injury among clinical psychology interns.
- Qualitative research can be done to dive deep into the personal experiences, coping styles and learnings that clinical psychologists develop with time.

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Appendices

Appendix A

Informed Consent

TITLE OF STUDY

Vicarious Trauma, Compassion Fatigue and Moral Injury among Clinical Psychology Interns

PRINCIPAL INVESTIGATOR

Ayesha Khan (ayeshaaa6810@gmail.com) Department of Professional Psychology

Bahria University, Shangrilla Rd, E-8/1 E 8/1 E-8, Islamabad, Islamabad Capital Territory

PURPOSE OF STUDY

You are being asked to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information. The purpose of this study is to investigate the challenges encountered by clinical psychology interns when working with difficult clients during the initial phases of their careers and the potential impact it can have on their emotional wellbeing.

STUDY PROCEDURES

1. If the individual provides consent, then a questionnaire will be handed to the participants who are suitable for this current study.
2. There will be no right or wrong answers. Participants will have to mark the items based on their personal experiences and subjectivity. The questionnaire will not take more than 5-10 minutes to fill in.
3. No participant will be harmed in the study and his/her information will be kept confidential.
4. No kinds of film procedures; audio or video taping will be done.
5. Results will be generated totally on the basis of participants' self-report regarding their experiences.
6. Conclusion will be deduced with the help of participants of the current study and previous research.
7. The complete study will be held out in six months ideally.
8. Identity of the participant will remain unknown.

RISKS

There will be no potential risks to you as a participant in this study but you still may decline to answer any or all questions and may terminate your involvement at any time if you choose.

BENEFITS

There will be no direct benefit to the researchers or university for your participation in this study. However, we hope that the information obtained from this study may help in advancing the literature regarding experiences of clinical psychology interns while dealing with difficult clients and its impact on their well-being.

CONFIDENTIALITY

Every effort will be made by the researchers to preserve your privacy, anonymity, and confidentiality.

CONTACT INFORMATION

If you have questions at any time about this study, or you experience adverse effects as the result of participating in this study, you may contact the researcher (contact information is provided on the first page).

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. My identifying information will be kept anonymous.

I voluntarily agree to take part in this study. YES/NO

Appendix B

Demographic sheet

Please provide the following details;

1. Gender: 1. Male 2. Female
2. Age: _____
3. Marital Status: 1. Single 2. Married
4. Current clinical internship level: _____
5. Diagnosis of your client: _____
6. Number of clinical cases that you take per day: _____
7. Your clinical internship working hours/day: _____

Appendix C

Perceived Stress Scale (PSS-10)

For each question choose from the following alternatives:

0- never 1 - almost never 2 - sometimes 3 - fairly often 4 - very often

1. _____In the last month, how often have you been upset because of something that happened unexpectedly?

2. _____In the last month, how often have you felt that you were unable to control the important things in your life?

3. _____In the last month, how often have you felt nervous and stressed?

4. _____In the last month, how often have you felt confident about your ability to handle your personal problems?

5. _____In the last month, how often have you felt that things were going your way?

6. _____In the last month, how often have you found that you could not cope with all the things that you had to do?

7. _____In the last month, how often have you been able to control irritations in your life?

8. _____In the last month, how often have you felt that you were on top of things?

9. _____In the last month, how often have you been angered because of things that happened that were outside of your control?

10. _____In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Appendix D

Vicarious Trauma Scale (VTS)

Please read the following statements and indicate on a scale of 1 (Strongly Disagree) to 7 (Strongly Agree) how much you agree with each statement. Please consider your clinical practicum or internship placement to be your job for the purposes of this questionnaire.

S#	Items	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	My job involves exposure to distressing material and experiences.	1	2	3	4	5	6	7
2	My job involves exposure to traumatized or distressed clients.	1	2	3	4	5	6	7
3	I find myself distressed by listening to my clients' stories and situations.	1	2	3	4	5	6	7
4	I find it difficult to deal with the content of my work.	1	2	3	4	5	6	7
5	I find myself thinking about distressing material at home.	1	2	3	4	5	6	7
6	Sometimes I feel helpless to assist my clients in the way I would like.	1	2	3	4	5	6	7
7	Sometimes I feel overwhelmed by the workload involved in my job	1	2	3	4	5	6	7
8	It is hard to stay positive and optimistic given some of the things I encounter in my work.	1	2	3	4	5	6	7

Appendix E

Compassion Fatigue Short- Scale (CF-SS)

Consider each of the following characteristics about you and your current situation. Write in the number for the best response. Use one of the following answers:

S#	Items	Never	Once a month	A few times a month	Once a week	A few times a week	Almost Everyday	Everyday	Several times a day	Almost all the time	All the time
1	I have felt trapped by my work.	1	2	3	4	5	6	7	8	9	10
2	I have thoughts that I am not succeeding in achieving my lifegoals.	1	2	3	4	5	6	7	8	9	10
3	I have had flashbacks connected to my clients.	1	2	3	4	5	6	7	8	9	10
4	I feel that I am a "failure" in my work.	1	2	3	4	5	6	7	8	9	10
5	I experience troubling dreams similar to those of a client of mine	1	2	3	4	5	6	7	8	9	10
6	I have felt a sense of hopelessness associated with working with clients/patients .	1	2	3	4	5	6	7	8	9	10
7	I have frequently felt weak, tired, or rundown as a result of my work as a caregiver	1	2	3	4	5	6	7	8	9	10
8	I have experienced intrusive thoughts after working with an especially difficult client/patient.	1	2	3	4	5	6	7	8	9	10
9	I have felt depressed as a result of my work	1	2	3	4	5	6	7	8	9	10
10	I have suddenly and involuntarily recalled a frightening experience while working with a client/patient	1	2	3	4	5	6	7	8	9	10
11	I feel I am unsuccessful at separating work from my personal Life	1	2	3	4	5	6	7	8	9	10

12	I am losing sleep over a client's traumatic experiences	1	2	3	4	5	6	7	8	9	10
13	I have a sense of worthlessness disillusionment, or resentment associated with my work	1	2	3	4	5	6	7	8	9	10

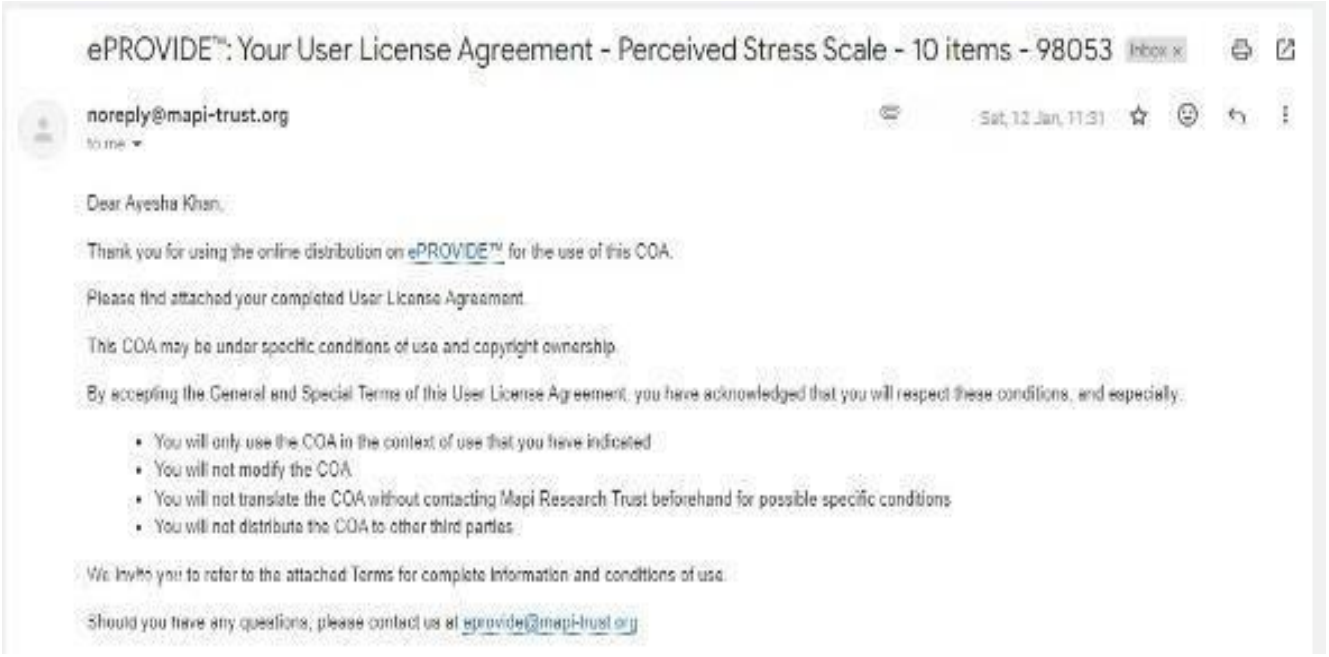
Appendix F

The Moral Injury Symptoms Scale-Health Professionals (MISS-HP)

The following questions may be difficult, but they are common experiences of busy healthcare professionals. They concern your experiences on your job as a health professional and how you are feeling now. Try to answer every question

S#	Items	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree
1	I feel betrayed by other health professionals whom I once trusted.					
2	I feel guilt over failing to save someone from being seriously injured or dying.					
3	feel ashamed about what I've done or not done when providing care to my patients.					
4	I am troubled by having acted in ways that violated my own morals or values					
5	Most people with whom I work as a health professional are trustworthy.					
6	I have a good sense of what makes my life meaningful as a health professional.					
7	I have forgiven myself for what's happened to me or toothers whom I have cared for.					
8	All in all, I am inclined to feel that I'm a failure in my work as a health professional.					
9	I sometimes feel God is punishing me forwhat I've done or not done while caring for patients.					
10	Compared to before I went through theseexperiences, my religious/spiritual faith has strengthened.					

Appendix G



ePROVIDE™: Your User License Agreement - Perceived Stress Scale - 10 items - 98053 Inbox x

noreply@mapi-trust.org
to me

Sat, 12 Jan, 11:31

Dear Ayesha Khan,

Thank you for using the online distribution on ePROVIDE™ for the use of this COA.

Please find attached your completed User License Agreement.

This COA may be under specific conditions of use and copyright ownership.

By accepting the General and Special Terms of this User License Agreement, you have acknowledged that you will respect these conditions, and especially:

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- You will not modify the COA
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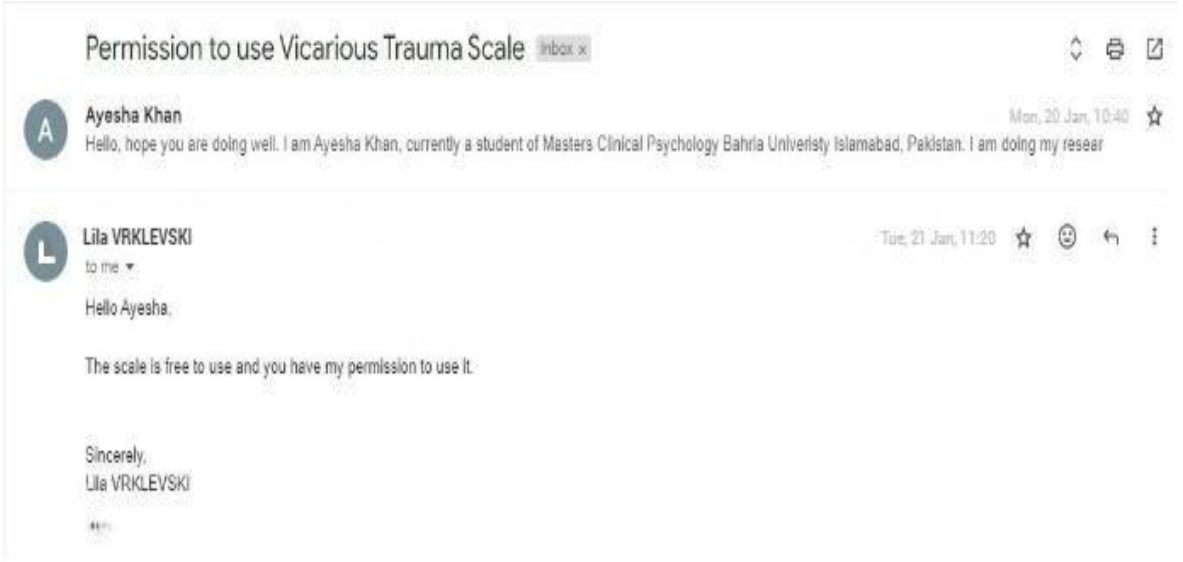
We invite you to refer to the attached Terms for complete information and conditions of use.

Should you have any questions, please contact us at eprovide@mapi-trust.org

Appendix H



Permission to use Vicarious Trauma Scale Inbox ×

Ayesha Khan Mon, 20 Jan, 10:40

Hello, hope you are doing well. I am Ayesha Khan, currently a student of Masters Clinical Psychology Bahria University Islamabad, Pakistan. I am doing my resear

Lila VRKLEVSKI Tue, 21 Jan, 11:20

to me

Hello Ayesha,

The scale is free to use and you have my permission to use it.

Sincerely,
Lila VRKLEVSKI

Appendix I

RE: EXT: Re: Permission to use compassion fatigue short scale Inbox ×

Adams, Richard <radams12@kent.edu> Sun, 2 Jan, 12:02

to Ph.D., me ▾

Hi Ayesha,

Our Compassion Fatigue scale is free to researchers for use in their studies. We are happy that you are interested in using it. I attach our articles related to the development and scoring of the Compassion Fatigue scale and it's two subscales, Burnout and Secondary Trauma. We only ask that you cite our work in your research. Please let me know if you have any questions about the scale or how to score it. I'm happy to help.

Thank you,

Richard E. Adams, Ph.D.
Professor
Department of Sociology and Criminology
204 Merrill Hall
Kent State University

Appendix J

Permission to use Moral Injury Symptom Scale: Healthcare Professionals Version (MISS-HF) Inbox ×

Ayesha Khan 25 Jan 2024, 15:00 (4 months ago)

Dear Sneha. Hope you are doing well. I am a student of Masters Clinical Psychology. Bahria University Islamabad, Pakistan and I want to do my final year researc

Sneha Mantri, M.D. 25 Jan 2024, 14:00 (4 months ago)

to me

I am the primary author; you have my permission to use the scale in your research. Please send a copy of your final manuscript when it is completed as we are building a repository here at Duke.

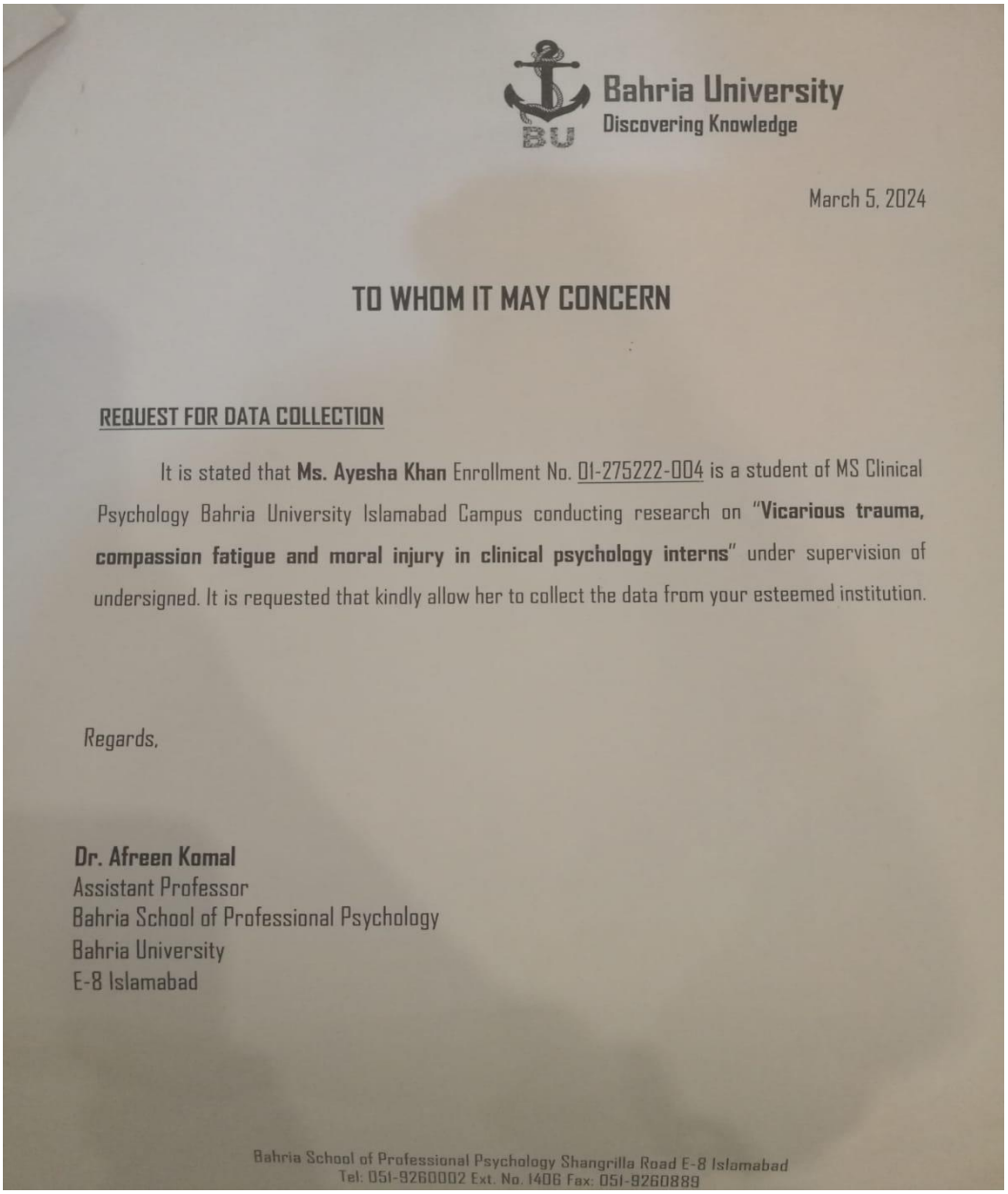
Dr Mantri

Sneha Mantri, MD MS

Associate Professor of Neurology, Duke Movement Disorders Center of Excellence

Director of Medical Humanities, Trent Center for Bioethics, Humanities, and History of Medicine

Appendix K



Bahria University
Discovering Knowledge

March 5, 2024

TO WHOM IT MAY CONCERN

REQUEST FOR DATA COLLECTION

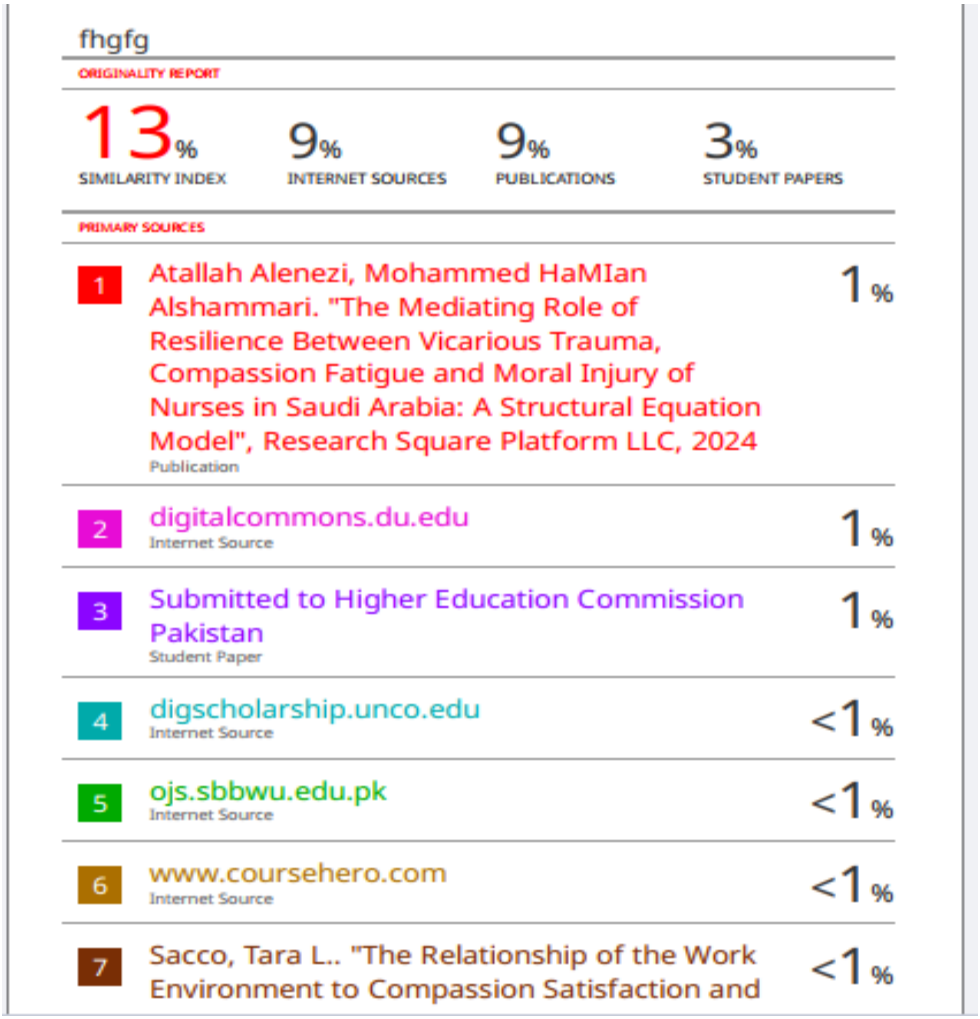
It is stated that **Ms. Ayesha Khan** Enrollment No. 01-275222-004 is a student of MS Clinical Psychology Bahria University Islamabad Campus conducting research on "**Vicarious trauma, compassion fatigue and moral injury in clinical psychology interns**" under supervision of undersigned. It is requested that kindly allow her to collect the data from your esteemed institution.

Regards,

Dr. Afreen Komal
Assistant Professor
Bahria School of Professional Psychology
Bahria University
E-8 Islamabad

Bahria School of Professional Psychology Shangrilla Road E-8 Islamabad
Tel: 051-9260002 Ext. No. 1406 Fax: 051-9260889

Appendix L



fhgfg

ORIGINALITY REPORT

13%	9%	9%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Atallah Alenezi, Mohammed HaMIan Alshammari. "The Mediating Role of Resilience Between Vicarious Trauma, Compassion Fatigue and Moral Injury of Nurses in Saudi Arabia: A Structural Equation Model", Research Square Platform LLC, 2024 Publication	1%
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