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When Empathy Becomes a Risk: Psychotherapists' Vulnerability in the Aftermath of Collective Trauma

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Dear Editor,

Psychotherapists play an important role in the aftermath of collective trauma, such as devastating wars, terrorist attacks, natural disasters including massive earthquakes, and other large-scale violent events (1). They provide essential emotional and supportive scaffolding for survivors and establish a safe space that enables traumatized individuals to process the horrors they have experienced, rebuild the shattered meaning of their lives, and regain emotional agency (2). However, although a vast body of scientific research has thoroughly examined the psychological vulnerabilities, symptoms, and treatment needs of direct survivors and even first responders, the substantial psychological toll imposed on psychotherapists themselves frequently remains underestimated in policymaking (2-4).

Emerging evidence from recent years indicates that the primary tool of healing and recovery within the therapeutic space, namely empathy, can also function as a major vector of risk (5, 6). During periods of collective trauma, intense empathic engagement, driven by exposure to graphic and deeply painful traumatic narratives, places therapists at risk of secondary traumatic stress (STS), secondary trauma, compassion fatigue, and professional burnout (4, 7, 8).

A growing body of quantitative, qualitative, and review-based research now points to the dual nature of empathy. Although empathy is the foundation of the therapeutic alliance and effective treatment, it may also increase clinicians' emotional permeability and vulnerability to trauma-related distress (5, 8). Despite addressing various nuances, complexities, and mediating variables, recent literature consistently emphasizes that, although most psychotherapists do not develop full-blown posttraumatic stress disorder (PTSD), a significant minority experience STS symptoms, secondary stress, compassion fatigue, or intrusive thoughts following mass traumatic events (1, 4). This risk peaks when therapists' empathic exposure to clients is intense, repetitive, and prolonged and is accompanied by a shared lived experience in a crisis context. Numerous clinical studies, such as those conducted by Velasco (1) and Shamai-Leshem (5), have empirically validated this pattern of vulnerability.

Clinical and field evidence indicates that these psychological injuries are not merely theoretical or academic concerns but real and tangible consequences of professional work after collective violence (2). For example, a study of 81 mental health workers who provided services during the September 11 attacks found that higher therapist stress was associated with heavier workloads, less clinical experience, younger age, longer deployments, work with vulnerable populations such as children and firefighters, and exposure to highly painful narratives (9). These stress patterns are also supported by broader research. A systematic review by Velasco and colleagues (1), covering 52 studies and more than 10000 mental health professionals, found that, although most psychologists and counselors do not develop severe or lasting psychological impairment, a meaningful proportion experience PTSD symptoms related to professional exposure. Similarly, Pellegrini and colleague (4) reported that trauma-focused psychologists experience more frequent, deeper, and more persistent mental health difficulties than general practitioners. The strongest predictors of distress were a

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high number of traumatized clients, a heavy workload, and negative cognitive appraisals of indirect trauma exposure, factors that become even more pronounced under conditions of collective trauma and war. These findings are particularly important in mass-trauma settings, where clinicians face continuous exposure to traumatic material while working under surge conditions with limited time for recovery. When the volume and emotional intensity of trauma narratives exceed a clinician's capacity for regulation and processing, secondary exposure may begin to resemble a primary psychological injury.

The prevalence of secondary trauma symptoms among helping professionals varies considerably, with rates ranging from 19% to 70%; these figures are often exacerbated by recent global crises. Such disparities arise from inconsistent terminology, including compassion fatigue, burnout, and secondary PTSD, as well as the use of diverse measurement methods. Consequently, prevalence estimates across studies cannot be directly compared without accounting for differing conceptual frameworks (10).

To better understand how empathy contributes to this pathological process, its different dimensions must be considered. Empathy is both central to trauma therapy and a major source of therapist vulnerability. Two dimensions of empathy, empathic concern and fantasy, appear to intensify the relationship between therapeutic exposure and STS symptoms. Therapists who strongly resonate with clients' suffering or imagine themselves within the traumatic experience report higher levels of reexperiencing, avoidance, and hyperarousal. This vulnerability is also observed in other helping professions. Key pathways include excessive empathic involvement, emotional contagion, repeated exposure to horrific material, and negative cognitive appraisals of indirect trauma exposure. The phenomenon of stress contagion, in which a client's distress is transmitted to the therapist's nervous and psychological systems, provides a biological explanation for how traumatic affect may be absorbed during clinical sessions. Nevertheless, the relationship between empathy and secondary stress is not simple; moderate empathy may be more protective than either very high or very low empathy. In addition, qualitative studies suggest that empathic exposure can also promote vicarious posttraumatic growth, stronger meaning in life, occupational satisfaction, and secondary resilience. Even so, the evidence suggests a gradual process of professional erosion among therapists with heavy trauma caseloads, marked by emotional exhaustion, helplessness, sadness, compassion fatigue, and reduced empathic presence.

A collective trauma environment complicates the therapeutic process through dual exposure and a shared traumatic reality. In this context, therapists live through the same crises as their clients, such as war, disasters, and instability, blurring professional boundaries and making emotional containment difficult. Studies have shown that therapists face additional stress from continuous media exposure and personal safety concerns. Predictors of distress include younger age, less experience, a personal trauma history, and heavy workloads. Conversely, resilience, social support, and high-quality supervision serve as protective shields (10). Recent reviews confirm a strong link between therapists' prior vulnerabilities and their susceptibility to secondary stress (7, 8). Furthermore, an organizational culture that recognizes secondary stress as a natural occupational hazard rather than a personal deficit is a powerful protective factor.

Despite the identification of these risks, intervention research remains less developed. However, more recent evidence suggests that cognitive behavioral therapy-based programs provide sustainable symptom reduction, whereas traditional single-session debriefing has limited efficacy. Mindfulness and self-care appear beneficial but require more rigorous long-term study. Crucially, therapists often experience moral injury due to feelings of ineffectiveness or institutional failure during disasters, indicating that purely individualistic psychological interventions are insufficient; structural and ethical dimensions must also be addressed.

Operationally, training in empathy regulation and boundary management should be mandatory. Essential structural measures should include clinical supervision, peer support networks, active caseload management, and the destigmatization of vulnerability. Although psychotherapy is often idealized as a profession of infinite emotional endurance, evidence demonstrates that even seasoned clinicians are vulnerable to shared trauma. Therefore, mental health systems must transition from individual self-care mandates to preventive, structural models of support. The fundamental question is no longer whether trauma work poses a risk but which specific systemic structures can best protect therapists without compromising empathy, their most vital tool for healing.

Footnotes

AI Use Disclosure: For the purpose of Text Editing, the Chatgpt was used Minor in the Etc section.

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