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The Impact of Trauma on Addiction Workers: An Exploration of Vicarious Trauma and Vicarious Post-traumatic Growth

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Abstract: Addiction workers play a crucial role in addressing the complex interplay between trauma and addiction, often navigating empathic connections with clients who have trauma histories. This study delves into the phenomena of vicarious trauma (VT) and vicarious post-traumatic growth (VPG) among addiction workers, exploring (counter)transference dynamics and the trauma–addiction nexus. Thematic analysis was conducted on narratives provided by six experienced addiction workers (mean age = 33 years, SD ≈ 5.86), comprising 33.33% men and 66.67% women. The analysis identified key themes including boundary dilemmas, therapeutic victories, defensive responses, and potential risk factors. The study highlights the detrimental effects of trauma on addiction workers while also revealing coping mechanisms and avenues for personal growth. Understanding the impact of trauma on addiction workers is vital for developing effective support strategies. By acknowledging both the risks of vicarious trauma and opportunities for vicarious post-traumatic growth, organizations can better support addiction workers and improve client care.

Keywords: addiction workers; vicarious trauma; vicarious post-traumatic growth; trauma–addiction nexus; coping mechanisms

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1. Introduction

The relationship between addiction workers and their clients is both deeply interactive and complex. Nevertheless, it serves as an essential foundation, vital for both the client's well-being and the overall health of the therapeutic relationship [1]. As a deep empathic connection is established, caregivers working with individuals who have experienced trauma are vicariously exposed to their patients' traumatic experiences themselves [2]. This phenomenon, termed Vicarious Trauma (VT), is defined as a transformative process experienced by professionals who assist trauma survivors, initially studied and defined by Pearlman and Saakvitne (1995) [3]. It entails shifts in the therapist's self-perception, interpersonal relationships, and worldview, resulting from exposure to their clients' trauma. While these changes are considered normal, predictable, and inevitable, failing to address this process can have significant negative effects on the therapist, both personally and professionally [3].

Symptoms of vicarious trauma mirror those of post-traumatic stress disorder (PTSD), including emotional numbing, low self-esteem, and cynicism [4], potentially impacting professional performance and leading to errors in judgment [5]. A wealth of studies has established a robust link between trauma and addiction [2,6,7]. For instance, in a previous study conducted by Bride et al. (2009), 75% of substance abuse counsellors experienced at least one symptom of PTSD in the previous week [8]. This suggests a high likelihood of coexisting trauma among individuals seeking addiction treatment in various settings. Indeed, studies show a high incidence of childhood trauma among people who suffer from substance abuse, often leading to post-traumatic stress disorder (PTSD) and subsequent substance abuse disorders [9]. Trauma, particularly sexual abuse, significantly increases

the risk of substance dependence in adulthood [10]. Research has consistently shown high prevalence rates of vicarious trauma among healthcare professionals, with between 40% and 85% reported as experiencing it [11]. As previously discussed, there is ample evidence linking trauma and addiction [12]. Consequently, individuals affected by addiction often constitute a highly traumatised population. This high prevalence of vicarious trauma among addiction workers is a direct result of this connection.

On the other end of the spectrum, Tedeschi and Calhoun proposed the concept of vicarious post-traumatic growth (VPTG), wherein addiction workers may experience positive outcomes and behavioural changes secondary to their patients' trauma [4]. Vicarious post-traumatic growth is defined as positive psychological changes experienced by healthcare professionals as a result of exposure to trauma in their clients [2]. This is thought to counteract the effects of VT and lead to more optimal outcomes like increased resilience, improved mental well-being, and greater satisfaction with life [13–15].

Indeed, recent studies suggest that a significant proportion of individuals in treatment experience traumatic events, with direct exposure correlating to higher rates of substance use disorder [16]. Childhood adverse experiences often lead to long-term physical and mental health issues, increasing the likelihood of substance abuse [17]. Various theories, including self-medication, negative reinforcement, emotional dysregulation, and neurophysiological factors, explain the link between childhood trauma and addiction.

Limited studies in Ireland explore addiction and trauma, with researchers attributing increased drug abuse to socio-economic crises. Studies indicate a high prevalence of trauma among addiction service users, particularly childhood trauma, significantly increasing the risk of substance abuse [17]. As such, the routine assessment of trauma or PTSD in addiction workers should be considered standard practice, especially because symptoms of VT often mirror PTSD [18]

Although considered normal and predictable in healthcare settings, unaddressed VT can have severe adverse effects on addiction treatment professionals, both personally and professionally. This phenomenon is particularly acute for professionals working with individuals exhibiting addictive behaviours, as they are more exposed to their patients' traumatic experiences, heightening the risk of developing VT or VPTG [2].

Despite the potential for both vicarious trauma and growth, addiction workers must actively engage in self-care activities to mitigate the negative impacts of trauma exposure. Strategies such as supervision, self-nurturing, and seeking connection have been shown to alleviate symptoms of vicarious trauma and promote vicarious post-traumatic growth [1]. Additionally, an awareness of individual factors such as trauma history, adequate training, and support availability are crucial in addressing and preventing vicarious trauma [19].

Various studies have highlighted a significant positive association between vicarious trauma and vicarious post-traumatic growth [20]. While numerous investigations have explored potential outcomes for healthcare workers engaging with trauma survivors, less attention has been paid to those working with individuals exhibiting addictive behaviours [21]. Given the interconnectedness of trauma and addiction, it is essential to understand how vicarious trauma and growth manifest in this context.

Overall, while healthcare professionals may experience both vicarious trauma and growth in their work with trauma survivors, fostering resilience and prioritizing self-care are essential in navigating the complexities of secondary trauma exposure.

Despite the variety of previous studies, the exact understanding of how some healthcare professionals experience PTG over VT is unclear. Therefore, this paper focuses on exploring the dynamics of vicarious trauma and post-traumatic growth among addiction treatment workers, assessing their vulnerability, coping mechanisms, and the impact on patient care in the context of trauma and addiction.

The aims of this research were the following:

- Explore the connection between vicarious trauma and vicarious post-traumatic growth in addiction treatment and addiction treatment workers.

- Investigate the vulnerability of addiction workers to VT and VPTG due to their patients' trauma history and addiction-related trauma.
- Examine the potential impact of VT and VPTG development on addiction workers' personal lives and the quality of care provided to patients.
- Investigate coping mechanisms employed by addiction workers in addiction treatment to prevent the onset of VT through qualitative research and literature review.

2. Materials and Methods

2.1. Rationale for Using Qualitative Methods

The utilization of qualitative research methods in this study is apt due to the intricate and multifaceted nature of the intersection between addiction and trauma. Qualitative methods are particularly suited for exploring such complexities because they prioritize depth over breadth, allowing for a detailed and nuanced examination of the participants' lived experiences. This approach is essential in understanding the subjective realities and diverse perspectives of addiction workers, whose roles and experiences are deeply personal and context-dependent [21].

Given the complexity and subjective experiences involved, qualitative methods offer a nuanced exploration that quantitative methods may not capture. Through open-ended interviews, we can gather rich, detailed narratives that reveal the inner workings of participants' thoughts, emotions, and behaviours [21]. This approach allows for an in-depth understanding of how addiction workers perceive and cope with vicarious trauma and vicarious post-traumatic growth, which are phenomena characterized by their deeply personal and often variable nature.

Qualitative research facilitates a comprehensive understanding of the dynamics of vicarious trauma, vicarious post-traumatic growth, and workers' responses in addiction treatment settings. It allows researchers to uncover the meanings and interpretations that participants attach to their experiences, providing valuable insights into their coping mechanisms and strategies. This method is particularly effective in capturing the complexity of human experiences, where numerical data might fall short in representing the full scope of participants' emotional and psychological landscapes.

Furthermore, qualitative methods enable the identification of patterns and themes that might not be immediately apparent through quantitative analysis. By engaging in a dialogic process with participants, this study probed deeper into specific areas of interest, clarified ambiguities, and explored unexpected findings. This iterative process helped to build a more holistic and empathetic understanding of the challenges and triumphs faced by addiction workers, thus contributing to a more comprehensive and empathetic body of knowledge.

2.2. Methods

Population and Sample

The participants were chosen from a group of professional workers who work in the addiction field in Ireland. The study recruited six professional workers from the addiction field in Ireland, chosen from a purposive sample (see Table 1). This study used the qualitative standard proposed by both Sandelowski and Morse [22], whereby sample sizes should be large enough to provide a richly textured understanding of the phenomenon but small enough to allow for deep, case-oriented analysis. Given the focused nature of this study, the quality of data collected, and the time and resource constraints typical of a master's thesis, it was determined that six interviews would be sufficient to achieve data saturation without overburdening the analytic process. The inclusion criteria for participation in this study were as follows:

- The sample included individuals with at least two years of working experience in the field of addiction. Curtis et al. (2009) highlighted that the average time spent in social work professions was estimated to be less than eight years (for work-related stress reasons), with no studies found on the average for addiction workers [23].

- Both male and female participants were included, as little information was found in the literature regarding differences in exposure to secondary trauma based on gender.
- Participants were required to be English-speaking addiction workers.
- Only consenting adults, who had signed ethical consent forms, were included in the study.

Table 1. Sample demographics.

Participant Number/Name	Gender	Age Range	Profession	Highest Education Level	Years of Experience in the Field	Regular Supervision?
Number 1: Peter	M	46/55	Mental health nurse	Degree	26	No
Number 2: Clark	M	30/45	Former addiction worker	Degree	12	No
Number 3: Carol	F	29/35	Nurse/nurse prescriber	BScN certificate in nurse prescribing	12	Yes
Number 4: Sonja	F	25/35	Case manager/team leader	Higher diploma	11	Yes
Number 5: Natasha	F	25/35	Project worker	Level 8	5	Yes
Number 6: Diana	F	25/35	Mental health nurse	Diploma	12	No

The exclusion criteria for participation in this study were as follows:

- Individuals known personally to the researcher or working colleagues, as their involvement could potentially raise ethical concerns and bias the data collection process due to existing personal relationships.
- Workers with less than two years of experience in the field were excluded.

Several people who worked in different treatment centres, or who were working in places who take care of people with addiction problems (methadone clinics, GP practice, accommodations for people experiencing homelessness, etc.), were contacted to participate via email. A total of 10 participants were interested in the study. After that, a list of people was drawn up, and 6 people out of the interested 10 were randomly selected so that the members of the list had an equal chance of being selected. All participants worked at the time with people with addictions except for one participant, who was a former addiction counsellor, but who had to stop because of the emotional involvement in working with people with addictions. Using 6 participants in this study was justified by the principle of data saturation, aiming to capture diverse perspectives until no new information emerged, while also balancing resource constraints and ensuring an in-depth exploration of individual experiences within the research context. In the sample, there were 3 nurses (50% of the participants), a project worker, a case manager, and a former addiction counsellor. Including a former addiction worker who experienced drug relapse but was in recovery at the time of the interview and no longer working in the addiction field added valuable insight into the challenges and emotional toll of working in addiction treatment, highlighting the need for support systems. The choice to include them enhances the diversity of perspectives within the study, contributing to a comprehensive understanding of the experiences and dynamics within the addiction treatment field. Four participants (66.6%) were between 25 and 36 years of age, one participant was in the age range of 46 to 55, and one was between 36 and 45 years of age. Four participants (66.6%) were female and two were male (33.2%). It was highlighted in the literature how supervision is an essential prerequisite for avoiding the development of vicarious trauma or negative emotions. But nevertheless, 50% of the interviewees did not receive regular supervision from their managers or their jobs, while the other half received regular supervision.

2.3. Materials and Data Analysis

2.3.1. Materials

Semi-structured face-to-face interviews were used to explore the pertinent topics of vicarious trauma and vicarious post-traumatic growth while allowing for flexibility and depth in participant responses. This methodological approach, as advocated by Wengraf (2001) [24], enables the researcher to navigate between predetermined questions and emergent themes, fostering a dynamic exchange of information. Before initiating the interviews, questions were developed and piloted by K.N.A and G.D. This collaborative process aimed to enhance the validity and reliability of the data collection instrument. Conducted in various locations across the Dublin area, the interviews prioritized participant comfort and convenience. The researcher adopted a flexible approach to scheduling, accommodating participants' preferences regarding time and venue. Such considerations are essential for establishing rapport and fostering open dialogue, as emphasized by the literature on qualitative research methodologies [21]. The interviews, ranging from 30 min to an hour and a half, were characterized by their open-ended nature and detailed exploration of topics. Participants were encouraged to share their experiences freely, contributing to the richness of the qualitative data. This approach aligns with recommendations for conducting semi-structured interviews, which emphasize the importance of eliciting in-depth responses while maintaining a conversational tone [22]. While a structured framework provided a foundation for each interview, the conversational flow was responsive to participants' narratives and unique contexts. This adaptive approach allowed the researcher to delve deeper into specific topics of interest, uncovering nuanced insights and perspectives.

2.3.2. Data Analysis

Thematic analysis, as outlined by Braun and Clarke (2006) [25], was employed to identify patterns and themes within the collected data. The transcription of the interviews was conducted verbatim, preserving not only the spoken words but also non-verbal cues and gestures. This meticulous approach to data management ensures the integrity and reliability of the qualitative findings [21]. Beyond textual scrutiny, considerable attention was devoted to deciphering non-verbal communication, recognized as a rich reservoir of information elucidating participants' emotional states and interpersonal dynamics. This incorporation of a multimodal analytical lens lent depth and richness to the research outcomes, uncovering both overt and covert dimensions of the participant experience [22]. This multimodal approach to data analysis enhances the comprehensiveness of the research findings, capturing both explicit and implicit dimensions of the participant experience. The analysis of the interviews was conducted iteratively, with themes and patterns identified through a systematic coding process managed by hand. This iterative approach, as recommended by Bagnasco et al. (2015), allows for the refinement and validation of emerging themes, ensuring the robustness of the qualitative analysis [26]. This process culminated in the identification of overarching themes, which were further distilled into specific categories, forming the basis of the findings chapter. By adhering to rigorous methodological practices, the study aimed to capture the depth and breadth of participant experiences, enriching our understanding of the phenomena under investigation.

2.4. Ethics Form and Consent

Ethical approval was given by the Dublin Business School Psychotherapy Research Ethics Committee REF: DBS03.18 in line with the Declaration of Helsinki, and all the participants gave informed consent to take part in the study. Detailed ethics forms were distributed, and consent was obtained prior to interviews. Participants were informed of their right to withdraw at any time, and anonymity was guaranteed.

3. Results

During the interviews, participants shared candidly about their experiences working with individuals facing substance misuse and trauma, yielding rich insights. Thematic

analysis unveiled four key themes: "Tough Love or Soft Love"—Boundary conflicts; "Small Wins"—Therapeutic success and relationships; "A System Built Up to Fail You"—Defence wall; and "The God Complex"—Risk factors. These themes were further explored through various subthemes, highlighting the complexities of addiction counselling and emphasizing the importance of anonymity for participant confidentiality (see Table 2). Each theme title was extracted directly from direct quotes from the participants.

Table 2. Themes and subthemes in findings.

Theme 1	Theme 2	Theme 3	Theme 4
"Tough Love or Soft Love"—Boundary Conflicts	**"Small Wins"—Therapeutic Success and Relationships**	**"A System Built Up to Fail You"—Defence Wall.**	**"The God Complex"—Risk Factors**
Individual personality and quality of care	Challenges to build and maintain relationships	Dehumanisation	Realistic expectations
Coping mechanisms	Clients' resilience	Trauma of the clients and personal trauma	"We are all humans."
	Reconnection	"Don't want to be seen weak" and reaching the limits	Right to self-determination

Theme 1: Boundary Conflicts

A recurrent theme among the participants was that of managing boundaries and their personal coping mechanisms in an attempt to keep a professional level of relationship with this particular group of clients. When Sonja, a young woman that worked 11 years in the field of addiction, talked about her relationships with clients, she stated that "*. . . I always trying to make it relaxed. Say. . . it's tough love or soft love. . . sometimes you have to balance it. . .*". Work in the field of addictions has always been highly analysed from the point of view of relations with the client and boundary management. Constructing a relationship with clients who have suffered different traumas has been considered by the participants to be difficult to obtain and maintain, often because the boundaries are too narrow or too soft. Many participants were very firm on the management of their boundaries, such that the clients did not even question the existence of strong boundary control:

Sonja: "*. . .but that's why you need to be confident with your boundaries. . . most of staff is scared of boundaries. . . because they think that boundaries is to put some rules in place. . . if you are confident. . . and the experience too (. . .) I know the boundaries and the clients know the boundaries. . . (. . .) I didn't have to go out shaking the keys and saying I am staff. . . do you know. . . and I much aware of my boundaries. . .*".

It can be noted, by this contribution, that this participant clearly has her own boundaries and does not question her own relationship of transference and countertransference with the clients.

One of the participants, Clark, who was an addiction counsellor but no longer worked on the front line with addictions as he suffered a severe "*burn out*" and had relapsed into addictions himself, expressed that the following:

Clark: "*as the years went on. . . I struggled to manage my relationships with the. . . the clients. . . um. . . in the beginning. . . um the boundaries (. . .) were set pretty tight. . . I had pretty good boundaries but then as the years went in. . . and there was a bit of burn out there as well. . . that. . . I kind found myself to give a bit more about myself. . . do you get me. . . to the clients. . . um. . . I suppose . . . that is what worked for me. . . I could identify with the staff. . . (. . .) so. . . to me retrospectively, looking at me. . . I started to give too much about myself and my professional boundaries. . . slipped. . .*".

Clark admitted during the interview that the main challenge of this field is "*(. . .) not the client himself. . . but your personal boundaries. . .*".

The participants were well aware of the risk of not maintaining boundaries and the consequences of "*. . . letting the boundaries slip*" (Clark). In this contribution, it can be clearly seen that undefined boundaries can put the professional at risk of developing vicarious trauma, being open to strong emotional empathy.

Diana, with 12 years working in mental health and addiction departments, explained the benefit of the limits for the clients themselves. Diana: "*you have to keep your boundaries. . . its important for the clients that you have boundaries. . . because they need them as well as you do. . . especially in recovery. . . humans always will try to push it and sometimes it's trying to maintain that. . .*".

Therefore, from what is reported by the participants, one of the reasons that working in the field of addictions can be considered difficult and of high risk for the development of vicarious trauma is because of boundaries and the challenges related to them.

Subthemes of Theme 1: Individual personality and quality of care and coping mechanisms

In this research, participants described the profile of addiction workers and emphasized the importance of qualities beyond professional boundaries for providing quality care. Peter, with 26 years of experience, attributed his longevity in the field to a blend of personality and training, maintaining professionalism throughout. Emotional qualities such as empathy were highlighted by Natasha and Clark, indicating its significance in forming connections with clients. However, empathy was also recognized as a potential precursor to vicarious trauma, emphasizing the need for establishing healthy boundaries. Participants suggested qualities like sincerity, relaxation, and self-worth as essential for fostering positive relationships with clients. Diana: "*I am just very relaxed about everything. . . (. . .) I am quite appreciable*". These qualities, coupled with self-care practices, were seen as vital for personal and professional growth.

Regarding coping mechanisms, participants discussed various strategies to mitigate the impact of work-related stressors. Natasha emphasized self-preservation and self-care: "*I have good bit of a walk on the way home so listen to my music and I don't talk to anyone. . . that's my time. . .*". This underscores the necessity for addiction treatment professionals to have personal debriefing sessions to alleviate the burdens of the day. Peter advocated for staying informed and participating in training to combat potential trauma. Although supervision was not universally available, those who received it praised its value in providing support and guidance. Natasha said that "*. . . We get it (supervision) every six weeks, which is great! And the manager is fantastic and very supportive. . . and that is so important. . .*" and "*I have an amazing support . . . my boss will text me. . . she text me one or twice a week anyway. . .*". However, Clark, who unfortunately had to step back from the field of addictions for reasons related to the job itself, stated that "*. . . (supervision) in the public sector. . . there is nothing. . . you know what I mean. . . (. . .) and that contributed towards my. . . decay. . .*".

Maintaining connections with family, friends, and colleagues was another common coping strategy mentioned by participants, highlighting the importance of strong social support networks. A significant aspect, moreover, was to switch off when the shift was over. This has been clearly stated by several participants such as Carol, who confirmed that "*(not bringing work at home) is really important. . . not to have a work phone on and things like that. . . leaving your work at work. . . and having people that you can hand things over to. . .*". However, excessive reliance on coping mechanisms, such as emotional dissociation, was acknowledged as potentially harmful, underscoring the delicate balance required for maintaining mental well-being in this demanding field. Overworking and taking work home has been considered a risk factor to develop vicarious trauma. The ability to detach completely from work, on the contrary, has shown a development in vicarious growth. Sometimes, the decisions of using a coping mechanism could perhaps be quite extensive, so much so that, for example, Diana explained that at times, the best way to protect herself was to forget about the horrific stories that she heard.

Diana "*. . . you (i.e., people in general) have no idea the reality of the actual fact of the stories. . . the horrendous. . . and I will ever. . . and I think I forgot quite of it. . . I forgot as a. . . like a defence mechanism. . . because I don't want to remember. . . what she did to her children (talking about a previous client) . . . it was horrific. . . as defence mechanism I just forgotten about it. . .*".

This defence apparently does not seem to be the healthiest mechanism for the well-being of the worker and the client, as sometimes the coping mechanisms used are not to be

considered the best escape routes, because too much detachment from the client and the emotions can lead to emotional dissociation. Clark's experience (*"I used to have… friends… that I used to go with… every week… I had my identity based on where I worked… and… I tried mindfulness… I have done early courses in mindfulness but I didn't really like them… felt into a rope and then it went bigger… I read for a long time and then it just stopped… everything just stopped."*) illustrated the challenges of relying solely on coping mechanisms, suggesting the need for comprehensive support systems to prevent burnout and vicarious trauma.

Theme 2: "Small Wins"—Therapeutic Success and Relationships

Participants emphasized the significance of "small wins" when discussing positive outcomes in their work with clients who suffer from addiction. They highlighted the importance of realistic expectations, focusing on incremental progress rather than the classical ideology of complete abstinence. Carol described positive outcomes as "*the small little thing… the small wins… um… seeing people doing well… that's always my favourite…*" or, as Sonja stated, "*… a small thing can be a positive outcome… I don't expect massively big things… for me positive outcome is like someone turning up to an appointment that he hasn't turned up in months… that is the success…*".

One of the most significant therapeutic successes identified by the participants was establishing a meaningful relationship with their clients. However, they also acknowledged the particular challenges inherent in forging such connections. The difficulty stemmed from the unique nature of relationships that individuals in dependency often have with others. Despite these challenges, participants actively contemplated methods to attain, sustain, and foster stable relationships, as revealed in their interviews. Sonja emphasized the importance of consistency in building these connections:

Sonja: "*(…) and the thing is that I am very consistent… I have built relationship with the clients because I brought consistency in the relationship with them… If you care about someone you find the way to help them in any capacity…*".

Carol expressed that what gives meaning to her work with clients in addiction is her affinity for working with individuals whom others find challenging to manage: "*I like making relationship with them (the clients).(…) those are the things that I hold dear and that gives me some kind of… I guess self-worth…*".

Subthemes of Theme 2: Challenges to build and maintain relationships, clients' resilience, and reconnection

Challenges in maintaining relationships were acknowledged, especially with clients exhibiting complex needs.

Carol: "*(…) there are obviously people that are more challenging to connect with… or if you have a particularly needy… client… he needs a lot of reassurances… or need a lot of support and at time there are people with challenges with unstable personality disorder… and they need that constant kind of reassurance… that can be very challenging…*".

The interviews revealed that relationships can also be compromised by continuous exposure to distressing stories and the concurrent presence of severe mental health issues among clients. Despite the difficulties, participants admired the resilience of their clients, who continue to strive for improvement despite adversity. Natasha*: "(…) and those people are trying. And they always try. It's phenomenal! It's great.*". Witnessing client resilience appears to have a positive impact on the participants. Carol further affirmed that despite the traumas they endure, individuals struggling with addiction can be perceived as remarkably resilient.

Carol: "*some of the women I worked with have experienced domestic abuse, sexual abuse… multiple sexual assault… very very traumatic sexual assault … under ages… you know… they have been through care system … have had their own children taken off them… and I don't know how they survived everything… really… they are such a completely fragile… but the same time they are so strong…*".

Some participants indicated that they have a certain esteem for people with a traumatic past and wondered whether if they were in the same position, they would be able to be as strong as their clients. Sonja "*I see it every day… every day I am at work… everyone talks*

about a trauma that they had. . . you know. . . and I think. . . if I had the trauma that they had. . . I wouldn't be surprised to be in the same position that they are. . .".

It is not surprising that individuals grappling with drug addiction often lose contact with family, friends, and loved ones. Another aspect highlighted by the research respondents, which they found meaningful in their work, is facilitating the reconnection of clients with their families and reintegrating them into society. Clark reported "*I loved when people got reconnected with the family*" as the main satisfaction in his work. The reconnections with families, friends, and society was, according to the participants, what could be considered one of the greatest results that can be obtained in the field of addictions.

For Sonja, reconnection is such an important factor that he repeated it several times in the interview: "*. . . and like I said just to see them back with their family. . . that's. . . that was the biggest part for me. . .*".

Clark: "*it's about that reconnection. People talk about recovery. . . which is important. . . but I think that most of it is from a social interaction. . . our emotional stuff. . . Reconnection with family. . . is essential*". Overall, participants recognized that therapeutic success often lies in the accumulation of small victories and the restoration of meaningful relationships and connections.

Theme 3: "A System Built Up to Fail You"—Defence Mechanisms

Another aspect that could be viewed as a defence mechanism against traumatic external factors is the metaphorical wall that professionals erect to shield themselves. Many participants discussed the "system" as a challenging factor and a major source of dislike in their field. Often, this barrier serves as a solid shield to conceal vulnerabilities and prevent others from exploiting them. Sonja shared that her approach to work has likely evolved since the beginning of her career. She acknowledged having a protective mechanism that she is aware of, which shields her and enhances her sense of safety.

Sonja: "*probably I have changed. . . my family would probably say that I changed. . . um. . . maybe it takes longer for people to know me. . . because I know there is a wall there now. . . and I much well aware of my wall, and is more a protection wall. . .*".

The bureaucratic system, seen as a barrier to client recovery, drew frustration for the majority of participants. Carol: "*(what I) dislike is around the gaps and the blocks and the gaps in the services. . . and I think every. . . every health system . . . and every social health system have spots. . . but if you could design a system to exclude the most vulnerable. . . that would be it.*". Another participant, Natasha, expressed the same frustration resulting from the blocks of the system, stating "*the system is giving. . . inappropriate resources for their needs. . . because the system is built up to fail them*".

Subthemes of Theme 3: Desensitization, trauma of the clients and personal trauma, "Don't want to be seen weak", and reaching limits.

Given the empathetic nature of this work, a significant theme emerged regarding the changes experienced by clinicians in managing their emotions and the continuous exposure to clients' traumas. An intriguing shift confirmed by many participants is the feeling of becoming more desensitized over time. This could be interpreted as an evolution of the emotional barrier that healthcare professionals often feel compelled to create as a means of protecting themselves from the traumatic narratives of their clients. Carol: "*I don't feel affected anymore. . . and it takes a long time. . . and I feel grateful that I don't get affected by it anymore*".

Participants highlighted the challenge of maintaining empathy while hearing traumatic stories, with Clark suggested that desensitization is inevitable. Clark: "*(. . .) whether you want it to admit it or not. . . you would become desensitized to it (the horrific stories of the client's trauma) . . . without. . . you get me. . . in the . . . in the dark humour of the addiction service. . . its forgotten about when. . . you go home. . .*".

For others, the impact of clients' trauma on workers was profound, leading some to hide their own struggles. Clark: "*. . .you lose the tools. . . it's very ego dripping. . . you know. . . the addiction service. . . you don't want to seem weak. . . you just want to be seen doing a great job. . . (pause) bull shit!*".

Sonja also shared her experience in the field of traumatic stories, and admitted that you get used to it:

Sonja: "*. . . I had a client that have been following me for the last 10 years. . . so I was very used to his story. . . I heard them and used to them. . . and every time that I hear him something else comes out even more horrific than I would have ever imagined. . . and I just get used that this is how is going to be every time. . . I see it every day. . . every day I am at work . . .*".

The type of desensitization of which the participants talked about was not the same as emotional dissociation. It was not considered by participants as a negative aspect but simply as a protective aspect. Carol explained her point of view:

Carol: "*I think I am desensitized. . . um. . . definitely. . . and I think that would be a word for lots of people that I would work with um. . . maybe. . . if you are desensitized that's ok because you can separate the emotions you know. . . the relationships. . . but you can be desensitized in really bad ways. . . you know where you are burned out. . . and you stop really to care about. . . you know. . . even trying with somebody. . . I think that that's specifically has been difficult. . . especially as a healthcare professional. . . I think you kinda have to accept things how they are. . . and move on. . .*".

In a field fraught with trauma, workers often encounter situations and emotions that defy conventional logic and language norms. Despite desensitization, participants shared the emotional toll of hearing clients' traumatic stories. Clark recounted the prevalence of trauma, attributing drug use to a cycle of repeated trauma. Constant exposure to such stories can lead to feelings of sadness and disillusionment, as expressed by Natasha, who questioned societal values.

Natasha: "*It makes me feel very sad. . . and hearing it over and over again. . . I didn't realize that each of those individual had experienced a trauma in their life, until I met each one of them and each one of them told me story. . . and they were so traumatic. . . each one of them. . . and it's really hard to hear. . . over and over again. . . it kind of crushing your faith in society. . . and it is hard to bring it home either. . . you know at some point you go like 'enough is enough'. . . you know when they talk about abuse. . . or whatever . . . is hard to hear it. . .*".

One participant, Diana, particularly emphasized the stark contrast between the harrowing reality of listening to traumas firsthand and the public fascination with such stories. While the firsthand experience of trauma can be deeply distressing, individuals outside the field often exhibit a curiosity for the most traumatic stories, readily consuming them through television, newspapers, and daily news reports: "*. . .I had to listen to the story of this particularly lady, who was in addiction, and she had three children who she abused in the most horrific ways. . . and I had to listen to that a lot. . . (. . .) They were pretty horrible. . . I mean if you are listening to it especially. . . but you know what make me struggle now? . . . you know in the newspaper when they write about murders. . . and stuff. . . people love it! They love to watch all that stuff. . .. Like. . . you have no idea the reality of the actual fact of the stories! the horrendous. . . (pause). . .*".

The direct exposure to clients' traumas can be overwhelming, leading to a struggle for workers who don't want to appear weak. Clark's admission that the job "*nearly killed me*" underscores the severity of the impact. Participants like Sonja and Diana felt pressure to maintain composure and resist showing vulnerability, even when facing personal struggles. Sonja mentioned that a traumatic event happened while at work, and she expressed the feeling of "*getting upset at work*" but that she felt that she could not say anything at work because "*I couldn't show the weakness at work. . . (. . .) I couldn't ask for support. . . (. . .) my boss has to move me if I can't (do my job)*". This persistence, driven by pride and dedication, reveals a complex interplay between professional expectations and personal well-being, raising questions about the true cost of resilience in this challenging field.

The pressure to appear strong despite internal struggles revealed a complex dynamic between personal pride and the well-being of both clients and workers.

Theme 4: "The God Complex"—Risk Factors

Two-thirds of participants identified the presence of a "God Complex" among health professionals as a prevalent issue. This complex, characterized by a sense of omnipotence and responsibility beyond one's role, often leads to burnout, especially in the early stages

of a career. Clark reflected on his own experience, admitting to feeling elevated above his duties:

Clark: "*I worked with people that unfortunately when they were working in the services their ego became too big. . . they went out. . . and they are dead now. . . staff members think at time that they are heroes. . . that can save people all the time. (. . .) For my own experience. . . I think . . . unconsciously I put myself up to a pedestal. . . and then when I felt. . . my God that was so hard to get back up. . .*".

This sense of power can lead to unrealistic expectations, with many participants admitting to initially believing they could "*save*" or "*fix*" clients. Natasha acknowledged her own naivety: "*. . . when I was younger and I was hearing those stories (i.e., problems and traumas) I was more like 'how can I fix this? I want to fix it right now'.*".

In the working experience of Diana, when she found herself facing three suicides by clients in a short period of time, she suffered what she calls "*a reaching of her limits*" and admitted that she felt in that period responsible for those dead, attaching to herself the God complex:

Diana: "*(. . .) 5 years ago. . . where we had three suicides in a short period of time. . . young. . . one was particularly young. . . she was only 31. . . and it was just like . . . 'I can't do this anymore. . .I can't. . . everyone is just fucking dying. . . I can't do this anymore'. And then I got the 'god complex' I was like 'I could have saved them! (. . .) I should have done something different!' but obviously I couldn't. That was very arrogant for me to think. . .*".

Subthemes of Theme 4: Realistic expectations, "We are all humans", and right to self-determination.

Maintaining realistic expectations emerged as a crucial strategy to mitigate the risk of the God Complex. Carol emphasized the importance of client-centred care and avoiding personal expectations:

Carol: "*(. . .) also I think one thing that you do need to learn is that it is not about you. It is about the service users. . . a lot of people can come in and say that is a client centred and. . . service users focused. . . you there to work with the person. . . not for the person. . . just not having expectation of people. . .*".

Participants also highlighted the need to recognize the humanity of both clients and workers, acknowledging that everyone is susceptible to addiction and trauma. Peter suggested that the field of addiction is a particular place to work in and that without realistic expectations, a worker would not be able to deliver the right care:

Peter: "*I was told years ago that. . . and I will always remember, when you are going to work in addiction, you have to go in knowing that it's a job where you get far more failure than successes. I want to help people but without being. . . without having unrealistic expectations*". At this juncture, he was asked why, despite experiencing at least an 80% failure rate among clients, he continued to work in the field of addictions. His response was poignant: "*Because that 20% are like diamonds.*".

Sonja emphasized the importance of breaking down barriers between staff and clients: "*I think you have to take that barrier off you of being staff. . . and clients. . . because they will see you as staff. . . because you are staff. . . you can't own that over them. . .*". This understanding fosters a non-judgmental approach, as expressed by Natasha: "*not to be judgmental of the person. . . but just see them the way they are. . .*".

One aspect that all participants agreed upon was the deep understanding that clients and workers were divided only by different life choices, past traumas, and addiction, and that, as Sonja expressed, "*they are all genuine good people that have been affected by some horrible instant in their life. . .*". From this theme derives a respect and a non-judgemental behaviour on the part of the worker. Peter, as well as other participants, expressed the following idea: "*Always make it crystal clear with addicts that people are all the same. Some people fall into addiction, some people don't.*".

Additionally, the right to self-determination is a theme that has been seized in setting the threshold of realistic expectations. Carol was the first participant who mentioned this right in a direct way:

Carol: "*the person rights to self-determination. . . . I think as healthcare professionals we need to respect that people are adults and they have the rights to choose what they want to do and. . . they have the right to drink themselves to death if they want to do that.*".

Sonja repeated the same thought, where forcing people to do anything is out of the control of the worker's scope: "*the clients have to be wanting to work with you. . .it's no point to set up work with a client that doesn't want to work with you. . . like there is just no point. . . if they don't want to be there. . . you can't force that. . .*".

Peter, with 26 years of experience in addiction, suggests how the worker should work to achieve success with their own well-being and that of clients: "*the smart addiction worker knows to work with them at the point where they are at, at that point. You may have aspiration that 'oh I would love to see him drug free', but that is not your call . . . your call is based on your assessment of where they are now and what they need now.*"

Overall, participants recognized the risks associated with the God Complex and stressed the importance of realistic expectations, empathy, and respect for client autonomy in maintaining a healthy therapeutic relationship.

4. Discussion

The primary aim of this research was to understand the impact of clients' trauma on addiction workers, particularly in relation to vicarious trauma and vicarious post-traumatic growth. Drawing from an extensive international literature, this study explored these concepts in depth. Through interviews with six participants, four main themes emerged, reflecting the research objectives. The analysis revealed a range of emotions and perspectives among the participants. One significant finding was the profound emotional involvement experienced by addiction workers, leading to shifts in perspective and cognitive patterns, which aligns with McCann and Pearlman's explanation of the negative changes experienced by those exposed to secondary trauma [27]. Participants acknowledged the importance of maintaining well-defined boundaries to prevent vicarious trauma and promote vicarious post-traumatic growth. Despite their dedication to client well-being, a majority expressed feelings of desensitization, highlighting the complex and challenging nature of therapeutic relationships [1].

The first theme, "Tough Love or Soft Love—Boundary Conflicts", revolved around the complexities of establishing and maintaining boundaries in the context of addiction work. Addiction workers often find themselves grappling with the balance between compassion and professionalism, navigating the fine line between offering support and maintaining appropriate boundaries. The literature highlights the importance of boundaries as essential for preventing the development of vicarious trauma [28]. Corey's (1996) delineation of therapeutic boundaries based on principles of beneficence, non-maleficence, autonomy, loyalty, and justice serves as a guiding framework for addiction workers [29]. However, participants in the study emphasized the nuanced nature of boundary-setting, recognizing the need for flexibility and adaptation in response to individual client needs and therapeutic contexts. Coping mechanisms such as supervision, self-care, and personal connections emerged as vital strategies for navigating boundary conflicts and mitigating the risk of vicarious trauma. This aligns with the literature, as early research by Pearlman and Saakvitne (1995) had already shown the importance of defence mechanisms for workers [3]. Other studies repeated that self-care strategies including processing with a supervisor, exercise, and spending time with family were also important mechanisms to decrease the chances of developing burn out, compassion fatigue, and vicarious trauma [13]. This theme underscores the intricate dance that addiction workers must perform in negotiating boundaries, balancing empathy and professionalism to ensure both client well-being and personal resilience.

The second theme, "Small Wins—Therapeutic Success and Relationships", explored the central role of relationships in addiction work and the profound impact of therapeutic success on both clients and addiction workers. Drawing from Freud's (1895) concept of transference and countertransference, this theme highlights the intricate dynamics at

play in client–worker relationships. Successful relationships not only facilitate therapeutic progress but also contribute to addiction workers' personal fulfilment and sense of accomplishment. However, the theme also underscores the challenges inherent in managing countertransference, with participants sharing experiences of feeling overwhelmed by clients' traumatic experiences [30]. Participants also reported positive outcomes, including developing healthy relationships with their clients, feeling gratified by their clients' resilience, and re-establishing connections between clients and their families and loved ones. This secondary gratification derived from clients' resilience has been documented in previous studies [31,32], highlighting its rewarding nature for addiction workers. Overall, the theme emphasizes the profound interplay between therapeutic success, relational dynamics, and personal fulfilment in addiction work.

The third theme, "A System Built Up to Fail You"—Defence Wall", delves into the defence mechanisms employed by addiction workers to cope with the emotional challenges of their work. Hochschild's (1983) concept of emotional labour is particularly relevant here, as addiction workers navigate the tension between authentic emotional expression and professional expectations [33]. Participants in this study shared experiences of feeling desensitized to clients' traumas, highlighting the emotional toll of addiction work. From the literature and studies, this refers to an excessive mode of detachment from others and cynicism. It usually occurs as a consequence of emotional exhaustion and, at least initially, can represent a form of defence [34,35]. Additionally, in alignment with the literature, the notion of "surface acting" emerged in this study as a coping strategy employed by some addiction workers to manage their emotions and present a facade of composure [36]. However, this theme also underscores the potential pitfalls of emotional inauthenticity, with participants acknowledging the toll of suppressing genuine feelings on their well-being. Overall, this theme highlights the complex interplay between defence mechanisms, emotional labour, and the risk of vicarious trauma in addiction work.

The fourth theme, "The God Complex—Risk Factors", delves into the psychological phenomenon of the "God Complex" among addiction workers, wherein they may unconsciously adopt overly grandiose expectations of their own abilities to save or cure clients. This complex, also referred to as delusion of omnipotence or superiority complex, can manifest as a belief that one possesses exceptional powers to intervene in clients' lives and overcome any obstacle [37]. Participants' narratives illustrated instances where they felt an overwhelming sense of responsibility for their clients' outcomes, expressing sentiments such as "I could have saved them!" (Diana). Such unrealistic expectations not only burden addiction workers with undue pressure but also set them up for disappointment and emotional distress when they inevitably fall short of these lofty goals. This phenomenon has also been highlighted in the literature. Pepper (1996) explained that when a healthcare worker practices outside their boundaries, believing themselves to be ethically superior to their clients, they jeopardize both the client relationship and their own well-being. This complex, regarded as countertransference, must be recognized as a potential danger for therapists [38]. The failure to meet overly high expectations can lead to emotional and professional decline for the healthcare worker [39].

The origins of the God Complex lie in the inherent desire to exert control and mastery over challenging situations, particularly in the context of healthcare professions [38]. Addiction workers, faced with the complexities of treating substance abuse and trauma, may succumb to this temptation to assert their authority and competence beyond reasonable limits. The consequences of this phenomenon can be profound, leading to emotional burnout, diminished job satisfaction, and compromised client care [39].

Furthermore, the God Complex poses a significant risk to the therapeutic relationship between addiction workers and their clients. When addiction workers perceive themselves as superior or all-powerful, they may overlook the importance of collaboration and mutual respect in the therapeutic process [39]. Clients may feel disempowered or alienated by the imposition of unrealistic expectations, undermining the trust and rapport essential for effective treatment outcomes [40]. Additionally, addiction workers who operate from

a place of superiority may be less inclined to seek supervision or support, believing themselves to be beyond the need for guidance or assistance [39].

5. Limitations

The study's findings may be limited by the self-awareness and self-care mechanisms exhibited by participants, suggesting that their reactions may be more unconscious than consciously driven by training. Additionally, the reliance on defence mechanisms and coping strategies reported by participants often occurs instinctively rather than as a result of deliberate training. Implementing training programs could potentially alleviate the emotional burden on workers and foster personal growth. However, the study's scope was restricted to six professionals in the Irish addiction field, and the limited time and number of participants may constrain the generalizability of the findings. Future research employing mixed methods and involving a broader sample across multiple countries is recommended to provide more comprehensive insights into the complex dynamics of vicarious trauma and vicarious post-traumatic growth in addiction workers.

6. Conclusions

In conclusion, this research sheds light on the intricate dynamics of addiction work, particularly regarding the impact of clients' trauma on addiction workers. Through in-depth interviews and a thorough review of the literature, this study has uncovered several significant themes that provide valuable insights into the experiences and challenges faced by addiction workers. The findings of this research have important practical implications for addiction professionals, policymakers, and organizations involved in providing support and care for individuals struggling with addiction and trauma. First, the identification of boundary conflicts as a prominent theme highlights the critical importance of establishing and maintaining clear boundaries in addiction work. Addiction workers must navigate the delicate balance between compassion and professionalism, recognizing the need for flexibility and adaptation while prioritizing both client well-being and personal resilience. Implementing strategies such as regular supervision, self-care practices, and seeking support from peers can help mitigate the risk of vicarious trauma and promote healthier therapeutic relationships.

Second, the emphasis on therapeutic success and relationships highlights the central role of relational dynamics in addiction work. Building strong, supportive relationships with clients not only facilitates therapeutic progress but also contributes to addiction workers' personal fulfilment and sense of accomplishment. However, it is essential to acknowledge and manage the challenges of countertransference effectively to prevent emotional overwhelm and burnout. By fostering empathy, establishing healthy boundaries, and prioritizing self-care, addiction professionals can enhance the quality of their therapeutic relationships and promote positive outcomes for clients.

Moreover, the exploration of defence mechanisms and the God Complex underscores the need for addiction workers to cultivate self-awareness and humility in their practice. Recognizing and addressing maladaptive defence mechanisms such as emotional detachment and the God Complex is crucial for maintaining emotional authenticity and preventing professional decline. Additionally, organizations should prioritize creating a supportive work environment that encourages open communication, ongoing training, and access to resources for self-care and professional development.

Overall, this research highlights the complexity and challenges inherent in addiction work while also offering practical recommendations for enhancing the well-being of addiction workers and improving the quality of care provided to clients. By addressing issues such as boundary conflicts, relational dynamics, defence mechanisms, and the God Complex, stakeholders can work towards creating a more supportive and sustainable framework for addiction treatment and support services.

Moving forward, future research could delve deeper into the specific strategies and interventions that effectively aid addiction workers in managing their emotional complexities.

This could involve exploring evidence-based practices for boundary setting and maintenance, such as role-playing exercises or mindfulness techniques tailored to the unique challenges faced by addiction workers. Furthermore, investigating the long-term impacts of vicarious trauma on addiction workers' well-being and job performance could provide valuable insights into the necessary support systems and resources needed to promote resilience and prevent burnout. Longitudinal studies tracking addiction workers over time could offer a nuanced understanding of how their emotional experiences evolve and the factors that contribute to their ability to cope effectively.

Moreover, assessing the impact of organizational support structures, such as access to counselling services, debriefing sessions, and peer support groups, on addiction workers' ability to cope with VT could provide valuable insights into best practices for workplace interventions. Understanding the barriers to seeking support for VT and identifying strategies to overcome them could inform organizational policies aimed at promoting addiction workers' well-being.

Additionally, investigating the potential for post-traumatic growth among addiction workers could offer a more holistic understanding of the psychological outcomes associated with this line of work. Identifying factors that contribute to post-traumatic growth, such as perceived social support, sense of meaning, and coping strategies, could inform interventions aimed at promoting positive psychological outcomes among addiction workers.

Overall, by integrating a focus on VT into research on addiction workers' emotional complexities, future studies have the potential to enhance our understanding of the unique challenges they face and inform the development of targeted interventions to support their well-being.

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