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SILENT STRUGGLES OF THE HEALERS: THE UNSEEN PSYCHOLOGICAL COSTS AND VICARIOUS TRAUMA IN MENTAL HEALTH PROFESSIONALS

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ABSTRACT

Mental health professionals work in very close contact with psychological distress, trauma narratives, and emotional suffering. Although they play a crucial role in the welfare of both individuals and communities, the psychological costs of their labour are frequently hidden. The present study explores the unseen psychological costs of therapeutic practice and with a specific focus on vicarious trauma among mental health professionals. Using a quantitative correlational design, The study included 32 practicing mental health professionals from hospitals, private practice, and non-governmental organizations in India.. Findings from this study indicates that although overt trauma symptoms may remain subtle, cumulative exposure to clients' traumatic material produces meaningful cognitive and emotional shifts that influence professional functioning and personal worldviews. The study highlights the need to recognize vicarious trauma as a distinct occupational hazard and calls for systemic, culturally responsive support mechanisms within mental health settings.

Keywords: Mental health professionals, vicarious trauma, psychological costs, therapist well-being

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1. INTRODUCTION

Mental health practitioners regularly deal with the individuals who are facing trauma, abuse, loss, and severe psychological pain and listen to the detailed stories of suffering while maintaining emotional presence and professional responsibility through consistent empathic engagement (Cieslak et al., 2014). Research often highlights that long-term exposure to trauma narratives can create a significant psychological burden for clinicians. This burden is often overlooked in workplace cultures (Molnar et al., 2017).

One important but underexplored effect of trauma-focused clinical work is vicarious trauma (VT). McCann and Pearlman were the first to articulate this idea (1990). They defined vicarious trauma as the gradual emotional and cognitive alterations that therapists undergo as a result of sympathizing with the terrible experiences of their clients. Vicarious trauma, as opposed to typical occupational stress, causes long-lasting alterations in therapists' fundamental beliefs, particularly with regard to safety, intimacy, control, trust, and meaning (Pearlman & Saakvitne, 1995). Vicarious trauma is mainly inconspicuous in work settings since these changes typically occur gradually and may go unrecognized. Over time, studies have distinguished vicarious trauma from similar ideas such as secondary traumatic stress disorder and burnout. Workplace stress, emotional tiredness, and separation brought on by excessive workloads and a lack of support are the main causes of burnout (Maslach & Leiter, 2016).

Instead of referring to temporary emotional exhaustion or symptom-based reactions, vicarious trauma denotes cumulative, long-term changes in cognitive frameworks and worldviews (Pearlman & Mac Ian, 1995). Mental health practitioners who engage with survivors of violence, abuse, natural disasters, and chronic trauma are especially vulnerable to vicarious trauma, according to studies done in Western environments. Emotional numbness, increased alertness, cynicism, helplessness, and altered perspectives on one's own safety and trust in others are typical symptoms (Hernandez et al., 2007). Risk is further increased by elements such as a history of personal trauma, a lack of reflective supervision, a heavy caseload, and inadequate peer support (Trippany et al., 2004).

Notably, vicarious trauma can occur in practitioners who do not experience burnout, indicating that it may develop independently of overall professional stress (Figley, 1995). Research on vicarious trauma within non-Western and collectivist societies remains limited, despite increasing global recognition of its impact (Trippany et al., 2004) In countries such as India, mental health professionals are often expected to demonstrate emotional fortitude, self-control, and resilience, which may discourage the open expression of vulnerability or psychological distress (Patel et al., 2018). This cultural expectation can contribute to a pervasive silence surrounding therapists' emotional challenges. Consequently, vicarious trauma may remain unrecognized and intensify over time, as the cumulative effects of repeated exposure to clients' trauma narratives are neither sufficiently acknowledged nor addressed (Pearlman & Saakvitne, 1995).

The majority of research within Indian mental health literature has primarily focused on stress, burnout, and job satisfaction (Maslach et al., 2001) with comparatively limited attention given to the deeper existential and cognitive shifts associated with prolonged exposure to trauma narratives (McCann & Pearlman, 1990). As a result, the full psychological cost of mental health practice in India remains inadequately understood. By examining vicarious trauma as a subtle yet significant psychological consequence of mental health work among Indian professionals, the present study seeks to address this gap. Furthermore, by clearly distinguishing vicarious trauma from burnout and compassion fatigue (Stamm, 2010), the study aims to highlight the often unspoken emotional and cognitive transformations experienced by therapists, while emphasizing the need for culturally responsive supervision, training, and institutional support systems.

2. Methodology

2.1. Research Design

A quantitative, correlational research design was employed to examine the psychological impact of therapeutic work, with a primary focus on vicarious trauma.

2.2. Sample

The sample comprised 32 mental health professionals, including counsellors, clinical psychologists, and therapists working in hospitals, private practice, and non-governmental organizations.

2.3. Inclusion Criteria

1. Minimum of one year of professional experience in mental health practice
2. Active involvement in direct client-based therapeutic work

2.4. Tools

2.4.1. Maslach Burnout Inventory (MBI)

The MBI is a 22 item self report scale which was developed by Maslach and Jackson (1981), which measures three dimensions of burnout: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Responses are recorded on a 7-point Likert scale ranging from never *to* every day.

2.4.2. Compassion Fatigue Self-Test

The Compassion fatigue self test was given by Figley (2002) and Stamm (2010). This is a self-report Likert-type scale assessing compassion fatigue and secondary traumatic stress among helping professionals. Higher scores indicate greater compassion-related distress.

2.4.3. Vicarious Trauma Scale (VTS)

The Vicarious Trauma Scale was Developed by McCann and Pearlman (1990), the VTS is a self-report Likert-type scale that measures cognitive and psychological changes related to vicarious trauma, particularly disruptions in safety, trust, control, esteem, and intimacy.

2.5. Procedure

Participants for this study was approached through professional networks and online platforms. Prior to data collection, informed consent was obtained from all participants. The questionnaires were administered in person, ensuring clarity of instructions and voluntary participation. Participants were assured that their responses would remain anonymous and confidential, and no identifying information was collected.

2.6. Data Analysis

Data was analyzed using Statistical Package for the Social Sciences (SPSS). Descriptive statistics was computed to assess levels of burnout, compassion fatigue, and vicarious trauma and Pearson's correlation was employed to examine the relationships among the study variables.

2.7. Ethical Considerations

The study adhered to the APA Ethical Guidelines (2017). Participation was voluntary, and participants had the right to withdraw at any stage. Confidentiality and anonymity were strictly maintained, and the data were used solely for research purposes.

3. RESULTS & DISCUSSION

This section presents the descriptive statistical findings, highlighting patterns of emotional exhaustion, professional efficacy, empathic distress, and trauma-related impact observed within the sample, followed by correlation analyses exploring the relationships among these psychological constructs.

Table 1: Descriptive statistics for burnout, compassion fatigue, and vicarious trauma (N = 32)

Variable	Minimum	Maximum	Mean	Standard Deviation
Emotional Exhaustion (EE)	12	34	25.72	5.53
Depersonalization (D)	3	22	14.38	4.51
Personal Accomplishment (PA)	14	38	22.91	5.94
Total Burnout Score (TBS)	36	92	63.00	12.19
Total Compassion Fatigue Score (TCS)	29	65	43.31	9.14
Total Vicarious Trauma Score (TVT)	27	48	38.06	5.12

The above table shows the overall levels of burnout, compassion fatigue, and vicarious trauma among mental-health practitioners. The findings show the moderate levels of burnout among participants, with Emotional Exhaustion (M = 25.72) and Depersonalization (M = 14.38) indicating a notable degree of work-related strain in them Personal Accomplishment (M = 22.91) reflects a mid-range sense of professional efficacy and the Total Burnout Score (M = 63.00) suggests overall moderate burnout intensity.

Scores for compassion fatigue (M = 43.31) fall within the moderate range, which indicates that respondents experience emotional depletion and empathic distress which results from prolonged exposure to clients' suffering. In contrast, vicarious trauma levels (M = 38.06) were relatively lower, implying that direct trauma-related cognitive disruptions are less pronounced within this group.

These findings align with prior studies indicating

mental-health practitioners frequently highlight moderate burnout and compassion fatigue, rather than extreme scores (Cieslak et al., 2014). According to global data, vicarious trauma typically manifests in clinicians who have had prolonged exposure to severe client trauma, but emotional tiredness continues to be

a significant aspect of practitioner discomfort (Baird & Kracen, 2006).

Table 2: Correlations among burnout, compassion fatigue, and vicarious trauma (N = 32)

Variables	1	2	3	4	5	6
1. Emotional Exhaustion (EE)	1					
2. Depersonalization (D)	.619**	1				
3. Personal Accomplishment (PA)	.556**	.661**	1			
4. Total Burnout Score (TBS)	.802**	.883**	.826**	1		
5. Total Compassion Fatigue Score (TCS)	.296	.256	.464**	.383*	1	
6. Total Vicarious Trauma Score (TVT)	.047	.030	.006	.034	.036	1

Table 2 presents Pearson's correlation coefficients among burnout, compassion fatigue, and vicarious trauma. Strong positive correlations were observed among the burnout subscales and the Total Burnout Score (EE ↔ TBS, $r = .802$, $p < .001$; D ↔ TBS, $r = .883$, $p < .001$; PA ↔ TBS, $r = .826$, $p < .001$), indicating internal consistency within the burnout construct.

A moderate positive correlation was found between Total Burnout Score and Compassion Fatigue ($r = .383$, $p < .05$), suggesting that higher levels of burnout are associated with increased compassion-related distress. Additionally, Personal Accomplishment demonstrated a significant positive association with Compassion Fatigue ($r = .464$, $p < .01$), indicating a complex relationship between professional efficacy and empathic strain.

Notably, Total Vicarious Trauma Score did not show significant correlations with burnout or compassion fatigue variables. This lack of association suggests that trauma-related cognitive shifts may operate independently from general emotional exhaustion within this sample.

These correlations mirror previous research linking burnout and compassion fatigue as overlapping yet distinct phenomena (Stamm, 2010). Studies by Cieslak et al. (2014) also reported moderate-to-strong associations between emotional exhaustion and compassion fatigue among therapists. The absence of a strong correlation between burnout and vicarious trauma corresponds with findings that Vicarious trauma is conceptually separate, often mediated by personal trauma history and organizational support (Baird & Kracen, 2006).

4. DISCUSSION

The present study examined the relationships among burnout, compassion fatigue, and vicarious trauma among Indian mental health professionals. The findings indicates that burnout and compassion fatigue are moderately associated yet remain conceptually distinct constructs. Strong intercorrelations among the burnout dimensions, Emotional Exhaustion, Depersonalization, and Personal Accomplishment support the multidimensional conceptualization of burnout, wherein emotional exhaustion and depersonalization form its core components.

The moderate positive association between total burnout and compassion fatigue suggests that sustained empathic engagement with distressed clients may increase vulnerability to secondary emotional strain. This relationship reflects the emotional demands inherent in therapeutic work, where repeated exposure to clients' suffering may gradually intensify psychological fatigue. These findings align with existing literature indicating overlap between emotional exhaustion and compassion-related distress among helping professionals.

Vicarious trauma did not show significant correlations with burnout or compassion fatigue in the present sample. This absence of association reinforces the theoretical distinction between affective strain and cognitive schema disruption. While burnout and compassion fatigue primarily represent emotional exhaustion and stress reactions, vicarious trauma reflects deeper, cumulative changes in cognitive frameworks related to safety, trust, control, esteem, and intimacy. The findings suggest that clinicians may experience emotional fatigue without necessarily undergoing profound shifts in core belief systems.

Within the Indian socio-cultural context, these results carry particular relevance. Cultural norms emphasizing emotional resilience, professional responsibility, and self-regulation may contribute to the under-recognition of trauma-related cognitive shifts. Practitioners may continue to function effectively in their professional roles even as subtle internal transformations occur gradually over time. This highlights the importance of

creating institutional spaces that allow reflective processing and open discussion of secondary exposure to trauma.

Given the pilot nature of the study and the modest sample size, the findings should be interpreted cautiously. The results contribute to emerging Indian research on therapist well-being by distinguishing emotional exhaustion from cognitive trauma-related changes. Recognizing vicarious trauma as distinct from burnout and compassion fatigue is essential for developing culturally responsive supervision practices and systemic support mechanisms for mental health professionals.

5. CONCLUSION

The study highlights that vicarious trauma as often unacknowledged psychological cost of mental health practice. While burnout and compassion fatigue are more readily recognized, vicarious trauma operates silently, reshaping clinicians' internal belief systems over time. Addressing therapist well-being therefore requires moving beyond surface-level stress management toward trauma-informed organizational cultures that validate and respond to the hidden psychological burdens of healing work.

These findings emphasize the importance of institutional support, effective supervision, workload regulation, and reflective practices to safeguard the psychological health of mental-health professionals. The results contribute to the growing body of Indian research on occupational stress and compassion satisfaction, adding culturally relevant insights into how practitioners experience and manage secondary exposure to trauma.

6. FUTURE IMPLICATIONS

1. Future research should design and evaluate organizational well-being programs such as supervision models, peer-support groups, and mindfulness-based interventions specifically tailored for Indian clinical settings.
2. Longitudinal studies can examine how burnout, compassion fatigue, and vicarious trauma evolve over time and identify protective factors (e.g., resilience, emotional intelligence, professional autonomy).
3. Cross-cultural comparisons could explore how collectivistic coping styles, spirituality, and stigma influence secondary traumatic stress among Indian practitioners.
4. Findings can inform mental-health policy and institutional guidelines, advocating for counsellor wellness programs and mandatory debriefing sessions in clinical agencies.

7. LIMITATIONS

- The relatively small sample size (N = 32) limits statistical power and reduces the generalizability of the findings to the broader population of Indian mental health professionals.
- The cross-sectional research design restricts the ability to draw causal inferences among burnout, compassion fatigue, and vicarious trauma.
- Participants were recruited through professional networks and online platforms, which may introduce sampling bias and limit representativeness.
- The pilot nature of the study necessitates replication with larger and more diverse samples across different clinical settings.

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