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Beyond the couch: A Comparative Lens of Therapist Fatigue in Addiction vs. Non-Addiction Settings Across Delhi NCR.

Aishna Chaudhry[1] Simran Bagga[2] Dr. Aanchal Chaudhary[3]

[1]Student, Department of Psychology, IILM University, Gurugram, India
[2]Student, Department of Psychology, IILM University, Gurugram, India
[3]Assistant Professor, Department of Psychology, IILM University, Gurugram, India

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ABSTRACT

Therapists frequently experience emotional burnout and psychological distress due to prolonged exposure to client suffering. In India, where mental health care is under-resourced and highly stigmatized, therapists' emotional well-being remains underexplored, particularly across different clinical contexts. Treating clients with substance use disorders is often viewed as especially demanding given relapse patterns and resistance, yet therapists in non-addiction clinical settings also navigate complex and taxing issues. The present study examined differences in compassion fatigue, burnout, and compassion satisfaction among therapists working in addiction specialty settings compared to those in non-addiction clinical settings in Delhi NCR. Using purposive sampling, 50 therapists (25 from addiction settings and 25 from non-addiction settings) completed the Professional Quality of Life Scale (ProQOL-5; Stamm, 2010) along with a demographic survey. Independent-samples t-tests were conducted to assess group differences, and correlational analyses explored relationships among the three constructs. It was hypothesized that addiction therapists would report higher compassion fatigue and burnout, and lower compassion satisfaction than non-addiction therapists. Findings highlight the pervasive psychological costs of therapeutic work across clinical settings and underscore the need for context-sensitive emotional support, supervision, and wellness interventions for mental health professionals in India.

Introduction

Mental Health System in India

India faces an overwhelming mental health treatment gap, and mental health professionals in India are significantly under- resourced. The World Health Organization (WHO) estimates that nearly one in every eight people live with a mental health disorder, in low- and – middle-income countries like India, up to 70% of these individuals do not receive treatment at all (WHO,2022). The National Health Survey of India (2016) reported something similar that nearly 83% of individuals with mental health conditions did not have access to adequate services, mainly due to shortages of trained professionals, stigma, and weak health infrastructure. According to the Indian Journal of Psychiatry, India has 0.75 psychiatrists per 1000,000 people, whereas WHO recommends at least 3 per 100,000 (Press Information Bureau [PIB],2025). As per information provided by Rehabilitation Council of India (RCI), there are 3,372 Clinical Psychologists registered with RCI as on July, 2023. These figures not only reflect a quantitative shortage but also an uneven distribution, urban cities like Delhi or Bangalore may have relatively higher number of mental health professionals, while rural and semi-urban regions have lesser number of professionals (Sinha et al.,2025).

The Emotional Demands of the Therapist's Role

Within this infrastructure that is fragile, mental health professionals carry an extraordinary emotional burden. Mental Health Professionals serve as emotional anchors for clients to help them navigate through distress, trauma and life disruptions. The demand of the therapist's role is unique, simultaneous empathy, objectivity, and resilience. This demand put therapist to risks of emotional depletion.

Conceptualization of Therapist's Role

Therapists provide a secure base for individuals navigating complex psychological challenges, often absorbing the weight of human suffering while striving to remain objective, empathetic, and effective. Over time, however, the cumulative emotional toll of clinical work can manifest as therapist fatigue, an umbrella term encompassing burnout, compassion fatigue, and vicarious trauma (Figley, 2002; Maslach & Leiter, 2016). Burnout, classically defined by Maslach (1982), refers to emotional exhaustion, depersonalization, and reduced personal accomplishments, often resulting from chronic occupational stress. Compassion fatigue, a concept elaborated by Figley (2002), denotes the gradual decline in a therapist's ability to empathize, often described as the "cost of caring" for others in emotional pain. Meanwhile, vicarious trauma refers to the profound cognitive and emotional shifts that occur when therapists internalize their clients' traumatic narratives (Pearlman & Saakvitne, 1995). All of these components, together represent a continuum of professional strain of a therapist well- being.

Although this phenomena of therapist fatigue have been widely acknowledged across mental health professions, its intensity and nature vary substantially across different contexts. While all therapeutic domains involve exposure to client distress, addiction therapy often presents a unique set of challenges like chronic relapse cycles, high client mortality risk, societal stigma, and the emotional toll of navigating resistance. In contrast to the addiction settings, non – addiction settings may be marked by chronicity of other forms like long term trauma, personality dynamics and socio-cultural barriers, often with different emotional and systemic pressures.

Differential Stressors Across Clinical Settings

Addiction treatment environments impose a distinctive set of challenges that intensify therapist fatigue. Empirical studies of addiction therapist highlight structural pressures like low pay, high turnover, unstable funding, and mandated client populations, that increase emotional strain (Vilardaga et al., 2011; Knudsen, Ducharme, & Roman, 2006). Beyond the clinical stressors addiction therapist also have to deal with stigma: - both societal and within health systems, that can deepen cognitive and emotional strain among therapists (Hayes et al., 2004; Vilardaga et al., 2011). Stigma-related cognitive fusion (rigid stigmatizing thoughts) toward clients may sometimes erode empathy and contribute to compassion fatigue unless specifically addressed (Luoma et al., 2008; Vilardaga et al., 2011). Non-addiction clinical contexts on the other hand (e.g., PTSD, anxiety, depression etc.) produce therapist fatigue through somewhat

different pathways. Chronic nature of client conditions, prolonged therapeutic relationships, and high emotional intensity (as in trauma work) lead to cumulative empathic strain, vicarious trauma, and secondary traumatic stress (Pearlman & Saakvitne, 1995; Craig & Sprang, 2010). Whereas working with addiction often involves crisis cycles and relapse-related frustration, working with non-addiction can produce deep, long-term involvement that blurs boundaries and heightens over-involvement, both risk factors for emotional exhaustion and reduced efficacy (Skovholt & Trotter-Mathison, 2014; Vivolo et al., 2022).

Gaps and Need for the Study

Direct head-to-head comparisons of therapist fatigue across addiction vs. non-addiction settings are surprisingly less. Much of the available evidence treats burnout in a single domain (e.g., addiction counsellors or trauma therapists), limiting cross-context inference (Knudsen et al., 2006; Vivolo et al., 2022). The lack of rigorous comparative studies, quantitative or qualitative in India specifically in Delhi NCR, constitutes a clear empirical gap and the rationale for the present research.

The Indian setting adds further complexity. Addiction treatment in India is shaped by cultural stigma, uneven resources, and limited integration with mainstream health systems. Families in India even perceive as a moral failing, leading to both client and therapist stigma (Sinha et al.,2025). Non-addiction settings, by contrast, contend with stigma of a different kind, psychiatric diagnoses such as depression or schizophrenia are often hidden due to fears of social exclusion or marital prospects, producing chronic delays in treatment and compounding therapeutic challenges.

The literature suggests three implications for research and practice. First, multi-level measurement (individual psychological processes, clinical demands, and organizational factors) is needed to capture setting-specific burnout dynamics (Vilardaga et al., 2011; Schaufeli & Bakker, 2004). Second, intervention strategies should be tailored: process-based approaches (e.g., ACT, mindfulness) show promise in addiction contexts, while trauma-informed supervision and workload control may be more salient in some non-addiction settings (Hayes et al., 2004; Craig & Sprang, 2010). Third, there is a clear shortage of comparative empirical work in low-resource, culturally diverse settings (including Delhi NCR), especially studies that combine quantitative prevalence estimates with qualitative accounts of lived experience — the exact gap this study aims to fill (Vivolo et al., 2022; Sinha et al., 2025).

Given the escalating demand for addiction recovery services and the high turnover among mental health professionals in Delhi NCR, this comparative research is urgently needed to inform evidence-based policy, design targeted therapist training programs, and implement workplace practices that not only safeguard practitioner well-being but also enhance patient outcomes across addiction and non-addiction settings.

Review of literature

The Emotional Demands and Conceptualization of Therapist Fatigue

In recent years, the concept of therapist fatigue has gained a lot of attention in the field of psychological research. It offers a

backdrop for understanding the pressure of the occupation that the mental health professionals have working in different settings. Contemporary research since 2010 has reframed therapist fatigue as a multidimensional construct, which includes burnout, compassion fatigue (CF), secondary traumatic stress (STS), and vicarious trauma (VT). Burnout still continues to be characterized by emotional exhaustion, depersonalization, and reduced professional accomplishment, but scholars have highlighted its interdependence with other constructs as well, particularly in professions like mental health, where high empathetic engagement is required (Craig & Sprang, 2010; Vivolo et al.,2022). Reviews of trauma- focused clinicians show consistently elevated levels of Secondary Traumatic Stress, Vicarious Trauma and burnout, along with risk factors like those of heavy caseloads, large exposure to traumatic narratives and inadequate supervision (Vivolo et al.,2022). These findings are also mirrored in India, where therapist being in an under-resourced system amplifies the strain on them. Kumar et al. (2020), examined helpline counsellors across 6 states of India, the studies showed a result of high levels of personal, client- related, and organizational burnout with the strongest predictor being long hours, emotional labour and limited emotional support. Protective factors appear equally robust across studies – resilience and self-efficacy buffer fatigue (Liu et al.,2024), while poor supervision and role ambiguity exacerbate it (Wohlford, 2025). However, practices such as mindfulness along with self-care and participation in peer support networks are shown to reduce emotional exhaustion and also sustain professional engagement (Paulson et al.,2024). These papers act as evidence and highlights the importance of examining therapists for fatigue not only on individual level but also at systematic level, which can either aggravate or reduce the risk of therapist fatigue.

The Under- resourced and Fragile Mental Healthcare System in India

Recent epidemiological mapping of substance uses and mental health of India, offers a backdrop for understanding the pressure of occupation on mental health professionals working with addiction. The National Drug Dependence Treatment Centre at AIIMS estimated the 2019 national burden of alcohol and drug use with state-wise resolution, underscoring both the size of the treatment-need population and scale of service gaps across the country (Ambekar et al., 2019). National data from the 2015-2016 National Mental Health Survey showed that nearly 15% of Indian adults require active mental-health help or interventions along with pronounced treatment gaps and limited availability of therapists, especially in rural areas (Gururaj et al.,2016).

These reports when combined imply that a large proportion of individuals with complex, high-need conditions are directed into a system that is already overburdened and under-resourced mental health and addiction workforce. Circumstances like these create conditions that are strongly associated with increased risks of burnout, secondary traumatic stress and compassion fatigue among professionals in these settings.

A study conducted across diverse Indian mental- health professionals (psychiatrists, psychologists, social workers, and

therapist) found that burnout compromises emotional regulation, depleted empathy, and erodes perceived therapeutic effectiveness, the participants of the study also talked about system level factors such as excessive work load, limited supervision and organisational constraints, that added to the emotional exhaustion and cynicism (Bhattacharya et al., 2025). These clinicians related experiences align with the data of earlier Indian Helpline, among health-information helpline counsellors across six states, 16.9% reported work- related burnout, 15.5% client- related burnout, and 25.3% personal burnout, with substantial psychological distress measured by GHQ-28 (Suri et al., 2020). These findings contribute to a cumulative stress model for human service roles, in which high emotional labour, continuous exposure to client crisis, and limited recovery time coalesce into measurable burnout and distress.

Differential Stressors Across Addiction and Non- Addiction Settings

Burnout in therapy settings does not usually occur in isolation due to trauma exposure. Researches in India are now increasingly examining and studying the vicarious trauma and secondary trauma stress in clinicians who regularly process client's traumatic materials. A qualitative study on psychotherapists' experiences treating trauma highlighted the permeable boundary between clients' narratives and therapists' inner worlds, showing intrusive imagery, empathetic strain, and shifts in worldview consistent with STS and vicarious traumatization (Kaur & Sharma, 2024). Similarly, an Indian focused study of clinical psychologists described vicarious-trauma sequel, emotional numbing, disrupted meaning-making and altered self-appraisals, particularly in early career practitioners without proper and continuous supervision (Joesph & Thomas, 2023). Another study conducted by Bhagwagar in 2022, show the co-occurrence of burnout, STS, and compassion fatigue in Indian mental- health professionals, with resilience and compassion satisfaction acting as partial buffers. When all these studies taken together, suggest that in Indian context, trauma- proximal roles (crisis, de-addiction, and intensive psychotherapy) carry elevated risks that are magnified by systemic resource constraints.

Systemic and Individual Factors Influencing Therapist Fatigue in India

While the studies in India on addiction counsellor's burnout remain limited, international data provides relevant comparison. An analysis conducted over the period of 2024-2025 in Alcohol and Alcoholism reported that 62% of addiction therapists experienced exhaustion and 50% disengagement, underscoring the field's vulnerability to chronic job strain even in well- resourced systems (Hobfoll et al.,2024-2025). Even though these findings are not India – only findings but they do map onto the Indian qualitative evidence that individual- level coping and meaning making mediate the impact of heavy caseloads and trauma exposure (Bhattacharya et al.,2025; Kaur & Sharma, 2024).

Stigma around substance use acts as an another corrosive layer for both the client as well as the practitioner. Indian reviews document that stigma reduces help seeking behaviours and shape provider's attitude, factors that can boomerang back onto the counsellors as moral distress, when the

system fails to meet the client's needs (Pattnaik & Sagar, 2020). An analysis done on the media portrayal in India further suggests that online coverage often reinforces stereotypes of people who use drugs, which may entrench public stigma and complicate therapeutic engagement (Narayan et al.,2022). Multinational synthesis confirms stigma as a negative driver for recovery trajectories and service utilization (Livingston et al., 2023).

In summary to the researches, the ongoing Indian literature collectively paints a picture of addiction and trauma- proximal counselling roles are the mid- point of high emotional labour, repeated exposure to client's traumatic narratives, systemic stigma, and organisational constraints. Studies conducted in India capture the measurable burnout and psychological distress among the mental health professionals along with the accounts that richly describe the mechanisms of emotional numbing, empathy strain and meaning disruption. The international findings also reinforce the scale of the risk and point to modifiable targets, supervision, workload governance, trauma- informed organizational practices and therapists psychological flexibility. Addressing to counsellor well-being is not ancillary to client outcomes but now has become a core quality- of- care imperative.

RESEARCH METHODS AND MATERIALS

Research Design

The study adopted a comparative, cross-sectional design to investigate therapist fatigue across two different contexts: - addiction treatment settings and non-addiction treatment settings. The aim of this study was to identify group differences in burnout. Compassion fatigue, and secondary traumatic stress using standardized quantitative measures.

Sample

The sample comprised of 50 participants, mental health professionals working in Delhi NCR. Of these 50 MHP'S, 25 were employed in addiction treatment settings, such as de-addiction centres, rehabilitation units, and hospital-based substance use clinics, while 25 participants were employed in non-addiction settings such as counselling centres, hospitals etc.

Inclusion criteria for this study required participants to have (a) had at least one year of experience in working with clients, (b) are currently practicing, (c) are currently practising in Delhi NCR and, (d) provided informed consent.

A purposive sampling strategy was used, along with snowball referrals.

Measurement of Variables

Compassion fatigue, Burnout and Secondary Traumatic Stress are measured using an appropriate scale available in works of literature, measurement scales are finalised and shown in Table 1.

Table 1. Scales.

Variables	*Name of the Scale*	*Author & Year*	*Items*

Compassion Fatigue Burnout Secondary Traumatic Stress	Professional Quality of Life Scale (ProQOL)	Stamm, 2010	30

Demographic and professional background data was collected through a structured questionnaire.

Procedure

Ethical clearance was obtained prior to data collection. Recruitment of the participants was conducted through professional contacts and referrals. Participants were provided with all the information detailing the purpose, voluntary nature and the confidentiality of the study. After the participants provided with the informed consent, they completed the ProQOL and the demographic questionnaire through online platforms.

All responses were coded and analysed using SPSS. Descriptive statistics were computed for demographic and scale variables. Group differences (addiction vs. non – addiction) on the ProQOL subscales were examined using independent sample t-tests. Pearson's correlation analyses were conducted to explore the association between therapist fatigue related variables (burnout, compassion fatigue and secondary traumatic stress) and professional background factor such as years of experience.

Group	***Mean***	***SD***	***Range***
Addiction (n = 25)	99.96	8.07	79-112
Non Addiction (n =25)	97.28	7.4	79-112
Total (n=50)	98.62	7.78	79-112

Table 2. Descriptive Statistics

Result

Initially descriptive statistics were examined to provide an overview of fatigue scores across the sample (N=50). Fatigue scores, that were measured using the ProQOL, ranged from 79 to 112, with an overall mean of 98.62 and standard deviation of 7.78. These scores indicate a moderate level of fatigue among mental health professionals in the sample, suggesting that therapist fatigue is present across both addiction and non-addiction settings. Group means indicated that participants in addiction treatment settings (n=25) reported slightly higher fatigue levels (M= 99.96, SD = 8.07) compared to their counter-parts in non-addiction treatment settings (M= 97.28, SD =7.40).

After the descriptive statistics were done, an independent –samples t-test was conducted to determine whether these mean differences were statistically significant. Results of the t-test showed that the difference between addiction and non-addiction settings was not significant, t (48) = 1.22, p= .227. The 95% confidence interval of the difference (-1.72 to 7.08) crossed zero, further confirming the lack of

statistical significance. However, effect size analyses indicated a small practical difference, with Cohen's $d = 0.35$, Hedges' correction = 0.34, and Glass's $\Delta = 0.36$. Although the difference is small, these effect sizes suggest that clinicians in addiction settings may experience marginally greater fatigue, though this difference was not strong enough to be considered conclusive.

Table 3. Independent Samples t- test: Group

Group	*Mean*	*SD*
Addiction	99.96	8.07
Non- addiction	97.28	7.4

Table 3 (cont.) Independent Samples t – Test : Test Summary

t	*df*	*p*	*Cohen'd*	*95% Cl*
1.22	48	0.227	0.35	-1.72, 7.08

A multiple regression analysis was also conducted to examine the extent to which work setting (addiction vs. non-addiction) and years of professional experience predicted overall therapist fatigue. The regression model was not significant, $F(2,47) = 1.05$, $p = .375$, and explained only 4.3% of the variance ($R^2 = .043$). The adjusted R^2 was close to zero (.002), indicating that the model had little explanatory power. Within the model, both predictors were non – significant: experience (($\beta = –.12$, $t = –0.79$, $p = .436$) and work setting ($\beta = –.21$, $t = –1.41$, $p = .165$). These results suggest that neither the number of years spent in practice nor the type of clinical setting substantially accounted for differences in fatigue scores.

Table 4. Multiple Regression Coefficients Predicting Fatigue .

Predictor	*B*	*SE B*	*β*	*t*	*p*
Work setting	-2.68	1.9	-0.21	-1.41	0.165
Years of experience	-0.12	0.15	-0.12	-0.79	0.436

Table 4. (Cont.) Regression Model Summary

F	*df*	*p*	*R^2*	*Adjusted R^2*
1.05	2, 47	0.357	0.043	0.002

Correlation analysis was also done to further explore the relationship between years of professional experience and fatigue levels. Results showed no significant

association, *r = -.05, p = .739.* This indicates that, within the current sample, greater years of professional practice did not correspond to lower or higher levels of therapist fatigue. The absence of a relationship supports the regression results, reinforcing that professional tenure was not a protective or risk factor for fatigue in this research data.

Table 5. Correlation Between Years of Experience and Fatigue

Variables	***r***	***p***
Years of experience & Fatigue	-0.05	0.739

All of these analyses taken together, findings indicate that while fatigue is prevalent among therapists in both addiction and non-addiction contexts, there are no statistically significant differences between groups, nor is fatigue significantly associated with years of professional experience.

Discussion

The primary aim of this research was to compare the levels of therapist fatigue among mental health professionals working in addiction versus non-addiction treatment settings in Delhi NCR, and to examine whether professional experience predicted fatigue. Contrary to the initial hypothesis and expectations, results indicated no significant differences between groups, nor did years of experience predict fatigue. While addiction therapists reported marginally higher fatigue scores, this difference was not statistically significant. These findings carry several important implications when considered alongside existing literature.

The absence of significant group differences suggests that therapists fatigue is not confined to a single treatment context but may be pervasive across both addiction and non-addiction settings. Early researches have consistently demonstrated that addiction therapists face unique pressures such as relapse cycles, client resistance, societal stigma, and high mortality risk (Vilardaga et al.,2011; Hayes et al.,2004). These factors are often associated with elevated levels of burnout and compassion fatigue. However, non-addiction therapists are similarly exposed to cumulative emotional demands. For example, clinicians working with trauma, anxiety, and depression are often engaged in long –term therapeutic relationships that can blur professional boundaries and foster vicarious trauma (Craig & Sprang, 2010; Pearlman & Saakvitne,1995). The current results suggest that both the groups encounter sufficiently high emotional strain such that their fatigue levels converge, even if the sources of strain differ in nature.

Also the lack of association between years of professional experience and therapists fatigue is also notable. Some studies suggest that early- career practitioners are more vulnerable to vicarious trauma and burnout due to less-developed coping strategies and inadequate supervision (Joseph & Thomas, 2023; Kaur & Sharma, 2024). At the same time, longitudinal exposure to client suffering may accumulate into fatigue even among

experienced practitioners if protective systems are absent (Bhattacharya et al., 2025). When talking about the Indian context, systemic issues such as understaffing, lack of structured supervision, and high caseloads (Suri et al.,2020; Sinha et al.,2025) may neutralize any protective effects of experience. Thus, the current findings reinforce the idea that experience alone does not safeguard against fatigue, echoing resilience models that emphasize the importance of organizational support and individual coping resources (Paulson et al., 2024).

The findings of the study also resonate strongly with the Job Demands- Resources (JD-R) model (Bakker & Demerouti, 2007; Schaufeli & Bakker, 2004). Both the therapist, those working in addiction settings and those working in non-addiction settings in Delhi NCR operate in high-demand, low – resource environments. The Indian mental health system is marked by an overwhelming treatment gap, scarcity of professionals, and uneven distribution of resources (WHO, 2022; Sinha et al., 2025). In such a setting, high job demands such as heavy caseloads, prolonged exposure to distress, and stigma are not offset by sufficient job resources like supervision, manageable workloads or even institutional support. This systemic imbalance may explain why contextual differences (addiction vs. non-addiction) did not yield statistically significant variance in fatigue levels.

However, the practical implications of these findings are significant. Intervention that cater to reducing therapist fatigue should be applied broadly across mental health settings, rather than targeting one domain exclusively. Organisational strategies such as regular supervisions, caseload monitoring, peer support groups, and stigma-reduction programs are likely to be beneficial across both addiction and non-addiction contexts (Westwood et al., 2022; Livingston et al., 2023). Training programs that foster psychological flexibility and resilience may help therapists sustain engagement despite ongoing demands (Hayes et al., 2004; Vilardaga et al., 2011). Finally, policy efforts must address structural barriers, including the shortage of trained professionals and limited integration of mental health into broader healthcare systems (WHO, 2022; Sinha et al., 2025). Without systemic reforms, individual-level coping strategies are unlikely to fully mitigate fatigue.

Future research should build on these findings by employing larger, more diverse samples to capture potential subgroup variations. Mixed-methods approaches that integrate quantitative prevalence estimates with qualitative accounts of therapists' lived experiences (as suggested by Kaur & Sharma, 2024) would also yield richer insights into the mechanisms of fatigue. Additionally, longitudinal designs could clarify whether fatigue accumulates or fluctuates across the career span, and whether protective interventions such as mindfulness or trauma-informed supervision produce measurable benefits over time.

Conflict of Interest

The authors have no conflict of interests to declare.

Ethics Approval

The authors received the consent of the institution and the therapists to administer the questionnaire and use it in this study.

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