

**PERSONAL AND CONTEXTUAL FACTORS THAT MAY INFLUENCE  
COMPASSION FATIGUE AS EXPERIENCED BY COUNSELLORS  
PRACTICING IN NAIROBI, KENYA**

**BY**

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## DECLARATION

I, the undersigned, declare that this is my original work and that it has not been submitted to any other college, institution or university other than the United States International University in Nairobi for academic credit.

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## ABSTRACT

Compassion fatigue occurs when counsellors among other health professionals begin to experience the pain and suffering of the people whom they serve. Although there is substantial literature supporting that, people who work with trauma clients are impacted positively and negatively, most of the studies have focused on the positive impact of work and the qualitative evidence is inconsistent. Further, most research has been conducted outside Kenya and most of the research has been carried out immediately after a traumatic event.

This research study sought to investigate the presence of compassion fatigue and identify the personal and contextual factors that may influence compassion fatigue as experienced by a group of counsellors working in different environments in Nairobi, Kenya. A sample of 106 counsellors with different levels of training and working in diverse settings participated voluntarily. The research used the professional quality of life (Proqol) model to provide a theoretical understanding of the development of compassion fatigue. A self-administered questionnaire developed using The Professional Quality of Life Scale (version 5) to assess compassion fatigue, collect demographics and other pertinent information was used.

The results show that 50.2 % of the counsellors surveyed were satisfied with their work, while 25.5 % had compassion fatigue. Female counsellors had slightly elevated levels of compassion fatigue compared to the males. This study therefore, shows that it is normal for counsellors to have negative feelings towards their clients but it does not in any way minimize the satisfaction they also experience from helping.

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## **DEDICATION**

To my parents, Mirera and Wanjugu, they are my link with the past.

AND

My husband and children, Mwangi, Nyawira, Njeri and Kabacho, they are my present and link with the future.

## TABLE OF CONTENTS

TITLE PAGE.....	
DECLARATION .....	iii
COPY RIGHT PAGE .....	iv
ABSTRACT.....	v
ACKNOWLEDGEMENT .....	vii
DEDICATION .....	vii
CHAPTER 1: INTRODUCTION AND BACKGROUND .....	1
1.0 Introduction.....	1
1.1 Background of the study .....	2
1.2 Statement of the Problem.....	4
1.3 The Purpose of the Research Study .....	6
1.4 Objectives of the study.....	6
1.5 Significance of the Study .....	7
1.6 Scope of the Study .....	7
1.7 Operational Definitions of Terms .....	8
1.8 Summary .....	9
CHAPTER 2: LITERATURE REVIEW .....	10
2.1 Introduction.....	10
2.2:1 Prevalence of Compassion Fatigue .....	11
2.2:2 Compassion Fatigue among Health Care Workers .....	13
2.2:3 Compassion Fatigue among Aid Workers.....	14
2.2:4 Clinical Implications of Compassion Fatigue .....	15
2.2:5 Personal Factors that may Precipitate Compassion Fatigue.....	16
2.2:6 Contextual Factors that may Influence Compassion Fatigue .....	19
2.2:7 Conceptual Framework .....	21
2.2:8 Biological Dimension.....	23
2.2:9 Psychological Dimension .....	24
2.2:10 Social-Cultural Dimension .....	25
2.2:11 Spiritual Dimension.....	26
2.3 Summary .....	27
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY .....	28
3.1 Introduction.....	28
3.2 Research Design.....	28

3.3 Study Population and Sampling Design. ....	28
3.4 Data Collection .....	30
3.5 Data Analysis Strategies .....	31
3.6 Ethical Issues .....	31
CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION .....	34
4.0 Introduction.....	34
4.1:1 Response rate.....	34
4.1:2 Scoring the Scales .....	34
4.1:3 Reliability .....	35
4.2 Personal Factors (Socio-Demographic Characteristics of the Respondents).....	35
4.3 Contextual Factors .....	37
4.3:1 Place of counselling practice.....	37
4.3:2 Registration with a professional body .....	38
4.3:3 Volunteering for Counselling Services in Response to Disasters .....	39
4.3:1 Frequency of Receiving Counselling Supervision .....	39
4.4 Levels of Compassion Fatigue among the Psychological Counsellors .....	40
4.5 Do Personal Factors Predict The Levels of Compassion Fatigue? .....	41
4.6 Extent to Which Contextual Factors Predict Compassion Fatigue.....	43
4.7 Summary .....	46
CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS .....	47
5.1 Introduction.....	47
5.2 Summary of the Key Findings .....	47
5.4 Discussions .....	49
5.4 Conclusion .....	50
5.5 Recommendations.....	50
REFERENCES .....	52
APPENDIX A: Respondent Questionnaire .....	57
APPENDIX B: Professional Quality Of Life Scale (ProQOL) Approval.....	61
APPENDIX C: Respondent Consent Form.....	63
APPENDIX D: Confidentiality Agreement for the Principal Investigator .....	65
APPENDIX E: Confidentiality Agreement for Other Researchers.....	66
APPENDIX F: Respondent Debrief Form .....	67

## **CHAPTER 1: INTRODUCTION AND BACKGROUND**

### **1.0 Introduction**

Counselling as a profession has evolved over the years from different disciplines such as Philosophy, Anthropology, Education, Ethics, Sociology and Medical Sciences (Smith, 2001). In the United States, the counselling profession began as a vocational guidance movement at the beginning of the 20<sup>th</sup> century and grew rapidly in the next 10 years to be part of all progressive schools. It emphasized personal, social and moral development of the individual (Perusse, Goodnough & Noel 2001). Like the United States, in Turkey (Dogan, 2000) and Malaysia (See & Mg, 2011) the counselling profession began in schools in an effort to improve the education system and it is organized around identifiable historical periods which clearly record the progression of counselling to the present day where counsellors are now assigned to schools. In South Africa it emerged as a result of the intellectual testing during the class ordering in the then New South African Union in the 1920's. Since then there has been great change in the character of the psychology landscape in South Africa to include indigenous African oriented counselling (Maree & Westhuizen, 2011).

In Kenya, the need for professional counselling emerged as a response to the HIV/AIDS epidemic, emerging mental health needs created by political and community based violence and increasing students' unrest in most public institutions of learning (Okech & Kimemia, 2012). This may have brought on some stigma on both the counsellors and the counselees as it is viewed as reactive rather than proactive.

Counselling is a structured conversation aimed at facilitating a client's quality of life in the face of adversity (McLeod, 2009). It is therefore, a purposeful encounter that reflects meaningful engagement between counsellors and clients that in the end leads to qualitative shifts of a transformative nature (Semenya & Modutla, 2010). Counselling, as

a helping process, uses safety to help individuals access a greater part of their personal resources as a means of responding to life's challenges (McLeod, 2009). Counselling therefore, pays special attention to emotional, social, developmental and health-related concerns of individuals.

The counselling relationship is driven by the core value of empathy (Egan, 2010) which centres on attending, observing and listening in order to develop an understanding of the clients' world. The level of intimacy is deep and professional counsellors have a personal responsibility (Corey et al., 2007) for self-knowledge as integrated people in order to avoid being overly involved with the clients. In addition to knowing their motivation to nurture others, they should ensure they receive professional counsellor training that is holistic in approach.

### **1.1 Background of the study**

Professional Counselling in Kenya is still in its formative years and growth and development is associated with evolution of traditional structures caused by multiple social and economic factors (Otieno & Kimemia, 2012). Gichinga (2007) posits that in Kenya, it was not available to ordinary people until the early eighties, though the concept of counselling has always been part of society's lives. In Kenya and most other African countries it was offered by traditional healers (Gichinga, 2007) who treated the same problems that counsellors are expected to treat today but according to the customs and the traditions of the people. The individual was treated in the context of his family and community, unlike today when the emphasis is on individual empowerment.

The first (Meck, 2004) and the oldest institution to offer counsellor education in Kenya is Amani Counselling and Training Institute (ACCTI). Amani was registered on 12<sup>th</sup> September, as a society in the spirit of ecumenism by the Catholic Church with

international organizations such as Mary Knoll fathers and brothers, Missio and Miser or, (Meck, 2004) as the development partners. Its main objective was to provide counselling services to individuals and their families regardless of sex, race, gender or personal beliefs. The counsellors who were mostly volunteers were expected to help those who sought counselling services improve their emotional health through understanding their attitudes, behaviours and emotions. Naturally, this type of counselling focussed on the individual's personal development. In a predominantly traditional society like Kenya and other developing countries models which are not embedded in a framework of community and cultural integration may not adequately address issues relating to conflict with self and community (Wango, 2015).

In addition to offering counselling services, the first generation of counsellors also introduced counsellor training at the levels of certificate and diploma to the local community. Since then, other tertiary institutions have continued to offer similar courses. However, in the absence of a Legal framework to regulate the curriculum, the courses offered by these institutions are not harmonized and it is common to find people trained in sociology and theology offering counselling services. True some counsellors have received their education from outside the country where the approach may be different, and some local Universities predominantly offer guidance and counselling training which may not address the issues adequately. The exception is United States International University- Africa which has offered the Bachelor of Psychology and Master of Arts in counselling degrees since the 1980's. Local public Universities have since established Counselling Psychology at both undergraduate and graduate levels (Gichinga, 2007). In almost all these programs, the African perspective to psychopathology is often neglected even though the majority of the clients are Africans with very strong roots in their customs and traditions (Meyer et al, 2005).

These groups of counsellors have been present to offer support to Kenyans as the country experienced several natural and manmade disasters as volunteers. Starting with the terrorist bombing of the American Embassy in Nairobi (1998), the post-election violence (2007/2008) which left over one thousand dead and six hundred thousand displaced (Amir et al.2015), the recent terrorist attacks at Westgate (2013) and Garissa University college (2015).It is natural to assume that there is a large number of Kenyans who need psychological support and that these statistics must have a great emotional impact on the counsellors offering these services.

It is against this background that the researcher's interest in the emotional wellbeing of the counsellors developed as they consistently listen to recurrent trauma stories of the clients they serve.

## **1.2 Statement of the Problem**

Traumatic events occur globally and affect people of all cultures and societies. Governments and corporate bodies spent substantial amount of resources in treatment of survivors and reconstruction of infrastructure (Nettie et al, 2007). Kenya, as a nation has in recent time's experienced mass bereavement from road and ferry accidents, fire tragedies, terrorists attacks and natural disasters such as floods and droughts (Mwiti, 2013) (Kiima, 2013). Nairobi City alone has experienced several grenade attacks; major among them is the terrorist attack of the Westgate shopping mall. Other traumatic events include the Mathare land slide, Sinai Village petrol tragedy, the Nakumatt fire tragedy and the Uhuru park prayer bombing in addition to the terrorist bombing of the American Embassy in 1998 and the post-election violence of 2007/2008 whose survivors still need psychological support (Mwiti, 2011).

On all these occasions counsellors are called upon to offer trauma counselling. They listen to recurrent trauma stories as they observe their clients struggle with feelings of fear, helplessness, hopelessness, anger and horror. Whatever the situation, counsellors are expected to be empathic, understanding and compassionate and control their emotions while consulting with clients. Empathy as a desirable attribute for counsellors is often defined as an ability to connect with another person at such a deep level that one almost experiences what the other person is experiencing and is able to communicate that back. Counsellors therefore, have a way of knowing what the clients are going through. A study carried out on mental health workers responding to the September 11, 2001 terrorist attack in New York City by Cleaver & Liddle (2005) found that the workers had elevated levels of secondary trauma symptoms. An earlier study on mental health worker who responded to the Oklahoma City bombing found that 20.6% had moderate to severe levels of PTSD and 53.5% had moderate to extremely high risk of compassion fatigue (Wee & Myers, 2002). Studies done in South Africa are consistent with the above study. One study that explored (MaCrichtie, 2006) the psychological impact of trauma workers who worked with survivors of violent crime indicated that 30% of the respondents had clinical levels of secondary traumatic stress.

Counsellors practicing in Kenya are not limited to disaster related trauma but also deal with issues of domestic abuse, child abuse and neglect, alcohol and substance abuse as well as emerging issues like working with internally displaced people (IDPs) after terrorists attacks. In addition most of the trauma literature is from countries in Europe and America whose cultures are different and more individualized. The research findings are expected to provide evidence and theoretical basis for developing different ways to improve the quality of life for counsellors and other helpers. This study takes into account that the Kenyan people have strong family and community values that may

influence how difficulties that require counselling are perceived by both the counsellors and those they help.

### **1.3 The Purpose of the Research Study**

The purpose of this study is to contribute to the existing body of knowledge on existence of compassion fatigue among counsellors in general and those practicing in Nairobi, Kenya in particular, by investigating the personal and contextual factors that may influence compassion fatigue. It is intended to gather and document trauma literature that is both current and relevant. The research's major aim is to analyse the term compassion fatigue through an appreciation of social construction application perspective, and compare the lay interpretation with a professional explanation.

### **1.4 Objectives of the study**

- i. To evaluate levels of compassion fatigue among counsellors practicing in Nairobi County.
- ii. To assess whether counsellor personal factors of gender, marital status, length of time spent in the field and level of training are predictors of compassion fatigue.
- iii. To assess whether contextual factors of working environment influence compassion fatigue.
- iv. To establish what personal resources mitigate against compassion fatigue among counsellors.

## **1.5 Significance of the Study**

Compassion fatigue is a feeling of deep sympathy and sorrow for another person who is experiencing pain or misfortune accompanied by a strong desire to alleviate that person's suffering. It is experienced by professionals in health care-systems where the patients' outcomes are expected and little emphasis has been placed on the potential consequences of the helpers (Fahy, 2007). Learning to recognize the signs and symptoms of compassion fatigue among counsellors serves as an important check-in process for helpers who unable to explain their feelings of unhappiness or dissatisfaction when it happens .

This research study sought to analyse the term compassion fatigue through an appreciation of social construction application perspective, and compare the lay interpretation with a professional explanation. The research findings are expected to provide evidence and theoretical basis for developing different ways to improve the quality of life for counsellors. This is relevant for Kenya, as the country transits from a subsistence to market economy as research (McKee and Leon, 2005; Paula, 2011) has shown that such changes are linked to many negative and mental health problems (Walt et al, 2013).

## **1.6 Scope of the Study**

This study was carried out in Nairobi, the capital city of Kenya. The respondents of this study were drawn from three counselling institutions namely; Amani Counselling Centre, Embulbul Counselling Centre and Tangaza University College. Ninety four (106) respondents were recruited using a purposeful sampling technique. The rationale behind the choice of the sites was that, in addition to having full time counsellor employees the three institutions also out- source visiting counsellors who are engaged in other

counselling activities in different parts of Nairobi. The three institutions are also strategically positioned such that they are most likely to serve diverse populations.

According to the Kenya National Bureau of Statistics, Nairobi County occupies an area of 691 km<sup>2</sup> and has an estimated population close to 4 million (Statistical Abstract, 2015) given that it was 3.138 million when the last population census was carried out in 2009. Its neighbours are; Kiambu to the north, Kajiado to the south and Machakos to the east. Several international bodies have set up offices here so that the city population is highly heterogeneous. Nairobi is also home to some of the biggest informal settlements in Sub-Saharan Africa, (Kibera and Mathare) and Kenyatta National Hospital which is one of the biggest referral hospitals in Kenya and Sub-Saharan Africa. Kenyatta hospital is also a favourite site for counsellor trainees seeking practicum training and experience. While working at the hospital, the counsellors become witnesses to human suffering at a very early period in their counselling careers. This willingness to serve others in times of hopelessness is a sign of altruism in its purest form (Robinson and Carry, 2005). Altruism is often described as behaviour motivated by concerns for others, internalized values or personal factors such as self-rewards or goals rather than a desire to avoid punishment or external social rewards (Eisenberg et al, 1999, p.1360).

### **1.7 Operational Definitions of Terms**

**Altruism:** The human behaviour that is motivated by concern for other people or by internalized values and self-rewards.

**Compassion satisfaction:** The feeling of fulfilment or pleasure that care-givers experience from helping others when they work within their levels of competency.

**Compassion fatigue:** The reduced capacity for empathy towards client's that care-givers experience as a consequence of recurrent exposure to traumatic material.

**Contextual factors:** Environmental or constitutional factors that may influence an individual's perception and reactions to specific situations

**Gender:** An individual's perception of being either male or female and the cultural role expectations of that gender.

**Level of training:** The accumulation of knowledge, skills and attitudes that enable an individual to perform a task at a minimum level of acceptability within a prescribed professional qualification.

**Personal factors:** Those elements that is unique to an individual such as personality, self-concept, and motivation that influence his/her life world.

**Resilience:** The human ability to recover from adversity strengthened and more resourceful.

## **1.8 Summary**

This chapter is about the importance of understanding Compassion fatigue among counsellors, and it is defined as stress resulting from helping or wanting to help traumatized people. It will be followed by chapter two which discusses the literature review, chapter three which outlines the methodology, chapter four on data analysis and chapter five which is a summary of the findings.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Introduction

The experience of being a counsellor is typically one of attempting to respond adequately and helpfully to complex and confusing sources of information. At most, counselling is a highly diverse activity which is delivered within a broad range of contexts (McLeod, 2009). It is more often embedded in other helping professions such as medicine, nursing, social work, teaching and pastoral work. This literature review is therefore not limited to experiences of counsellors alone but also examines the impact on other helpers in related helping professions. It is obtained from psychology books some of which might be the only edition in existence, academic premier journals, dissertation abstracts, international Google scholar and psych-articles

The bulk of the literature herein is informed by the generally accepted assumption that counsellors and other helpers get a sense of satisfaction from doing their work well (Ekundayo, Gregson, Haltom& Billings, 2013) but when they closely identify with the clients to the point of absorbing the clients' problems and pain, it can lead to fatigue. Compassion and empathy are some of the most important qualities for sustaining people who work with others who are distressed. However, research on compassion fatigue which emerged from observations of psychological problems among care-givers in the health service, have found that compassion fatigue scores negatively in relation to compassion satisfaction (Thompson et al, 2014). Compassion fatigue which is often referred to as secondary trauma, vicarious trauma or burnout is a state in which the counsellor experiences emotional, social, physical and spiritual exhaustion that diminishes the counsellor's desire, ability and the energy to feel and care for others (McHolm, 2006)

Compassion fatigue is therefore believed to develop through prolonged exposure to clients' traumatic material. The symptoms are nearly identical to clients suffering from

post-traumatic stress disorder (PTSD). Suffering from compassion fatigue may presently impact on the counsellor's beliefs about others or self and the capacity for tolerance and interpersonal relationships are also affected. Compassion fatigue is an occupational hazard not just for counsellors but for all people who work in helping professions. However, it should be differentiated from occupational stress in that while occupational stress arises from poor working conditions such as heavy workload, compassion fatigue is an end result of caring too much. The objective of understanding how personal and contextual factors contribute to compassion fatigue, is to sensitize helpers about the need to challenge themselves in general in order to remain objective in difficulty circumstances and provide quality care. In order to understand how counsellors may experience compassion fatigue it is important to examine closely the nature of the counselling relationship and the diverse populations that they serve. Medical health personnel, teachers, social workers, aid workers and family members involved in caring for their loved ones are likely to seek the counsellors' attention. A holist approach of looking at the magnitude of compassion fatigue among counsellors is to look at how these other helpers are affected.

### **2.2:1 Prevalence of Compassion Fatigue**

Compassion fatigue was defined formerly by Charles Figley in 1995 (Potter, Deshields, Berger, Olesh & Clerk (2013) as a combination of secondary traumatic stress and burnout that is experienced by helping professionals and other care-givers. On one hand, burnout is defined as a state of physical, emotional, and mental exhaustion caused by depletion of a helper's inability to cope with the current environment in which the person is working (Maslash, 1982). Compassion fatigue or secondary traumatic stress on

the other hand is defined as, “the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1999, p.10). Compassion fatigue is also referred to as the cost of caring for people with emotional pain. Inability to focus, physical and mental exhaustion, decreased productivity, self-doubt, general unhappiness and loss of passion and enthusiasm for one’s vocation are some of the recorded detrimental effects. Compassion fatigue emerges suddenly without warning and can remain undetected by professionals who experience it. But, if it remains untreated it can lead to depression. Some authors (Okech & Kimenia, 2012) compare it to post traumatic stress disorder because it produces similar signs and symptoms such as low mood, irritability, poor sleep patterns, nightmares and anger. Compassion fatigue has been documented among counsellors, nurses involved in palliative care, oncology, and aid workers and among other healthcare professionals. It is associated with high labour turn over, depersonalization, and decreased performance. Among nurses compassion fatigue has been documented as ranging between 16%-39% (Hooper, Craig, Javrin, Wetsel & Reimels, 2010; Potteret al., 2010 & Yoder 2010).

Although the prevalence of compassion fatigue is common among nurses it does not appear to last long and the type of service delivered does not correlate with the level of compassion fatigue. A research carried out in British Columbia, Canada among hospice palliative care workforce found that volunteers reported high levels of compassion satisfaction than the full time employees (Slocum-Gori, Hemsworth, Chan, Carson & Kazanjia (2011). Compassion satisfaction was also associated with the institution and integrative services. These results have implications for counsellors who are often called to volunteer their services when disaster happens and majority of whom offer counselling services as part of their other occupations. The unifying force for the helpers is the capacity for and ability to demonstrate empathy.

Another research whose aim was to evaluate a compassion fatigue resiliency program for oncology nurses found that although the prevalence of compassion fatigue is common among health care professionals ( 16% - 39%) it can be mitigated by organizations developing and implementing intervention programs (Potter et al, 2012). Participants of this program reported personal and professional benefits. These results agree with results by Cohen-Katzet et al, (2005) where nurses reported greater relaxation and improved relationships at work and home. One of the major learning resources the participants appreciated most was the provision of a safe space and a voice where they could share their thoughts and experiences with others in similar circumstances.

## **2.2:2Compassion Fatigue among Health Care Workers**

Much research has been carried out to investigate the quality of life among various care giving professionals such as; social workers, counsellors, chaplains, emergency department nurses, health professionals responding to disasters and law enforcement (Smart, et al., 2013). Qualitative evidence suggests that compassion fatigue among such professionals is as a result of continued exposure to the suffering and trauma of others, which eventually depletes the personal resources available to the helpers to combat the negative emotions arising from their work (Zeidner, et al., 2013). Compassion fatigue should be differentiated from occupational stress that stems from mutual dependence between the domains of work and family. Stressors related to work-family interface manifests when work demands become difficult to exercise independent of family demands and vice versa (Nehash & Sahin, 2011).

Among health care workers in the US, increased levels of compassion fatigue is related to the number of work place injuries, an increase in infections in patients while at the hospital as well as an overall reduction in their productivity (Smart, et al., 2013).

Unlike counsellors and psychotherapists in the country who are required to receive therapy usually on a weekly basis, nurses do not have the same regulations despite the fact that, they are also required to meet unique patient needs and the fact that the boundaries between them and their patients are less clear (Lester, Compassion Fatigue, 2010). In comparison, health professionals in Kenya showed a tendency to take up a larger workload, demonstrated indifference towards patients as well as showing increased uncertainty with regard to their role descriptions. The overall result was a steady decline in productivity; however, there is very limited information with regard to this topic in the Kenyan environment. One investigation of compassion fatigue among medical workers at Kenyatta National Hospital (KNH), Nairobi found that the prevalence of compassion fatigue among Medical Practitioners was 29.1% and 33.1% among nurses. Both self (individual and relatives) (93.1 %) and work environmental (91.0 %) factors were found to be major contributors. With these being the result of the first ever study of this kind; the findings suggest the need for a rescue program to assist health practitioners in the country to deal with their compassion fatigue (Kokonya, et al., 2015).

### **2.2:3 Compassion Fatigue among Aid Workers**

Aid workers are a unique category of care givers in that, they are often posted to hostile environments such as war zones to try and assist specific groups of people such as Internally Displaced Persons' residing in camps which have a high turnover. Furthermore, aid workers must adapt to the cultural orientation of the area as well as limited psychological support services while being exposed to the fear, pain and suffering of the individuals they seek to assist, as expressed by the similar stories they tell. Aid workers hardly have any recovery time and must rely on individual service delivery rather than team orientation. In the case of aid workers in Darfur, a survey consisting of a group

made of Sudanese and international aid workers revealed that the Sudanese nationals experienced higher levels of compassion fatigue than the international workers. Furthermore, it revealed that women and health professionals experienced higher levels of compassion fatigue than men and emergency care workers. It should be noted however, that the overall level of secondary traumatic stress could be significantly less than the recorded findings as some of the symptoms could also be attributed to non-psychotic psychiatric stress resulting from the hostile high pressure work environment (Musa & Hamid, 2008).

#### **2.2:4 Clinical Implications of Compassion Fatigue**

Studies have shown that compassion, empathy and care for patients can personally and professionally enrich the lives of care givers. At the same time, care givers experience profound emotional reactions to the suffering of their patients. As a result, they may lose the ability to show compassion to their patients in addition to suppressing their emotions. They may also experience feelings of; anger and helplessness. (Smart, et al., 2013). Among nurses, compassion fatigue may manifest itself as a permanent change in the nurse's compassionate abilities with many of those who do not care enough at present, have been those who once cared too much before the burn-out begun to set in (Lester, Compassion Fatigue, 2010).

Individuals suffering from compassion fatigue may also experience symptoms similar to P.T.S.D. such as; disturbances in sleep patterns, nightmares, anxiety and avoidance of disturbing images and anything that may serve as a reminder of the trauma (Smart, et al., 2013), low mood, increased irritability and high levels of anger (Lester, Compassion Fatigue, 2010). Some care givers may exhibit changes in their mental state such as; disturbances in their world views, seeing people as either victims or perpetrators,

hyper-vigilance due to a diminished sense of security, feelings of incompetence with regard to dealing with patients experiencing certain types of trauma, a reduced sense of purpose and diminished functioning of the ego with regard to time and identity (Kokonya, et al., 2015).

Other symptoms of secondary traumatic stress include; social withdrawal, ineffective communication, aggression, pessimism, cruelty and depression, which was recorded higher among women and health care professionals in comparison to men and emergency care professionals. Studies have also shown that it can manifest itself physically in the form of exhaustion, headaches and stomach aches which result in poor performance, absenteeism and tardiness at the work place (Musa & Hamid, 2008).

Compassion fatigue can also go un-detected among some health care professionals, and manifest itself as a sudden transition from hard work and high energy to depression characterized by an inability to get out of bed in the morning (Lester, Compassion Fatigue, 2010). Research has shown that among certain individuals, increased stress levels among care givers especially nurses, results in decreased sleep and lower energy levels, which increases the likelihood of making unhealthy lifestyle styles that further deteriorate the care giver's physical and mental health (Smart, et al., 2013).

### **2.2:5 Personal Factors that may Precipitate Compassion Fatigue**

One of the theories investigating the origin of compassion fatigue suggests that, counsellors are affected by empathizing with the traumatic experiences of others such that, they begin experiencing emotional responses similar to the sufferer's actual or anticipated emotions (Zeidner, et al., 2013). As such, the qualities that make an individual an effective counsellor, such as empathy, compassion and a caring personality are the

same qualities that make the counsellor vulnerable to compassion fatigue (Thompson, Amatea, & Thompson, 2014). In addition, the perception of self also plays a major role in determining the level of compassion fatigue experienced by a counsellor (Lawrence & Lee, 2013).

One of the factors determining the level of compassion fatigue in counsellors is emotional intelligence. The rationale behind emotional intelligence is that it determines how one regulates negative emotions and assumes that, individuals with high emotional intelligence are more likely to use mood-regulating strategies to counter negative emotions while, individuals with low emotional intelligence are likely to use avoidance strategies (Zeidner, Hadar, Matthews, & Roberts, Personal Factors Related to Compassion Fatigue in Health Professionals, 2013). In addition, research has begun investigating the effectiveness of using of personal resources such as; active problem-focused strategies and emotional focused coping to combat compassion fatigue with results indicating that, such strategies are more effective with regard to combating compassion fatigue as opposed to maladaptive strategies such as; substance abuse (Thompson, Amatea, & Thompson, 2014). Emotional intelligence does present challenges with regard to measurement. However, a review of studies by Mathews, Seiner & Roberts (2012) suggests that emotion management is the most suitable predictor of the signs of an emotional disorder, ability to cope and the quality of inter-personal interaction among mental health professionals (Zeidner, Hadar, Matthews, & Roberts, Personal Factors Related to Compassion Fatigue in Health Professionals, 2013).

Secondly, mindfulness described as, “the moment-to-moment non-judgmental awareness, characterized by an open and receptive approach to living in the present moment,” (Thomson, Amati & Thomson, 2014, pg. 75) is another personal factor that is examined in relation to compassion fatigue. Characterized as both a dispositional and a

situational trait or response, mindfulness practices have positive results with regard to alleviating stress and compassion fatigue in the healthcare field and as such, have taken up a greater role in trauma counselling. This is because being mindful enables the counsellor to be aware of the environment around them and their own self with regard to their feelings and emotional responses. Thus, being mindful enables one to identify triggers of negative emotional responses and respond to them effectively thus, reducing the risk of burn out as a result of accumulated negative emotions (Thompson, Amatea, & Thompson, 2014). Some counsellors opt to care about their clients only during sessions then try not to think about them until their next appointment. Such is an example of the struggle between caring too little for the client's needs and caring too much for them in an attempt to cope, which sadly has proved unsuccessful for a large number of professionals (Lester, Compassion Fatigue, 2010)

Thirdly, Research has shown that the benefits arising from counselling clients, known as compassion satisfaction is negatively correlated with compassion fatigue. Furthermore, compassion satisfaction is believed to motivate counsellors as they do their work by giving them positive feedback for their efforts (Thompson, Amatea, & Thompson, 2014). However, it should be noted that studies have shown that individuals, who are highly self-critical and shame-focused, have difficulty developing feelings of contentment or warmth in both their personal and professional relationships and are as such less likely to experience compassion satisfaction. In addition, helpers who have difficulty generating positive emotional responses as a result of early childhood trauma or neglect are less likely to experience compassion satisfaction, and can be assumed to have a higher risk of developing compassion fatigue (Lawrence & Lee, 2013).

In addition to the above, studies have shown that counsellors who put more effort in sustaining relationships with the people around them as well as using self-care

practices such as; meditation, healthy eating, exercising and having hobbies outside of the workplace, are more likely to experience compassion satisfaction than those who opt to isolate themselves and make no effort to practice self-care (Thompson, Amatea, & Thompson, 2014). In contrast to self-care, self-criticism has been shown to increase an individual's vulnerability to mood and anxiety disorders, eating disorders and substance abuse, all of which increase the risk of a helper developing compassion fatigue. Furthermore, qualitative evidence suggests that individuals with psychological disorders have increased difficulty in understanding the concept of self-compassion which evokes feelings of hopelessness within them (Lawrence & Lee, 2013).

Further, studies investigating the impact of demographic factors such as age and gender have given conflicting results; with some studies claiming that gender or age have no direct relationship with the level of compassion fatigue experienced by a mental health professional. Other studies have shown that male counsellors were more likely experience negative emotions as a result of doing their work as opposed to female counsellors. Another group of studies attributed a higher level of compassion fatigue being experienced among younger counsellors (Thompson, Amatea, & Thompson, 2014).

Other factors believed to influence the level of compassion fatigue on an individual level include; the sleep habits of the care givers, their educational level, marital status and work history (Smart, et al., 2013).

### **2.2:6 Contextual Factors that may Influence Compassion Fatigue**

Among health care workers in the US, there is limited information on the impact of; the number of shifts worked, the various work-settings, the number of years worked, the population served and the number of hours worked per week, on the level of compassion fatigue. Research has shown that care givers working in the non-critical

departments of the hospital had higher burn out rates than those working in the emergency and critical-care departments (Smart, et al., 2013). One of the contextual factors that have been researched is the counsellor's perception of work environment measured by the frequency of the counsellor experiences of fairness in decision making, adequate financial compensation, flexibility in work hours , clinical preparedness to serve the types of clients on the counsellor caseload and the nature of the job ( Thomson et al., 2014). However, in the absence of a legal framework within which counsellors work in Kenya, some of these factors might be difficult to measure (Githongo, 2015). Clinical preparedness is assumed to accrue from the level of training a counsellor has attained and the experience gained from working in the field.

Among health care professionals in Kenya, nurses were found to be three times more likely to be affected by compassion fatigue as compared to the other health care professionals, especially those with middle-level college education (Kokonya, et al., 2015). In a study conducted at the Kenyatta National Hospital (KNH), investigating the relationship between the length of time worked in the hospital and compassion fatigue, practitioners who had spent between 11 – 15 years working as care givers, reported the highest level of compassion fatigue, while those who had spent 16 – 20 years in their roles experienced the lowest levels of burn out (Kokonya, et al., 2015).

In their effort to assist others, counsellors may sometimes find themselves in situations where their own past traumatic experiences are similar to those experienced by their clients (Musa & Hamid, 2008). A study conducted among therapists in Kenya showed that 39% of those who had experienced prior trauma had their job performance affected. However, counsellors who recorded high levels of compassion fatigue had their job performance significantly affected (Amir, Adina, Disiye, Shikanga, & Amapesa, 2015).

### **2.2:7 Conceptual Framework**

This study is informed by the transactional model that view stress as a result of the individual's interpretation or perception of a situation as threatening his or her ability to achieve important goals or meet occupational and life demands. In the primary appraisal the person makes an initial judgment about the significance of the situation as whether stressful, positive, controllable, challenging or irrelevant. The secondary appraisals involve the person assessing his/her own ability to cope with the situation given the resources and options available. The effects of stress are physiological (elevated blood glucose levels, increased heart rate); psychological (anger, anxiety, apathy, depression); behavioural (difficulty in communication) and cognitive (poor concentration, or inability to make sound decisions) which have serious impact on the individual's physical and mental health.

In this study, compassion is defined as the stress resulting from helping or wanting to help people experiencing emotional pain (Figley, 1999). The stress is assumed to be as result of the interaction of the individual counsellor's personal factors and the context in which he/she is working and may happen at three levels of possible determinants. At the immediate level stress is caused or influenced by the counsellors primary evaluation of the magnitude of the traumatic event with respect to the damage caused and the intermediate level is caused by the counsellor's assessment of their ability to deal with the trauma. This is further reinforced by social and environmental factors and absence of adequate professional help. At the structural level, the counsellor's innate capacity for resilience is eroded by their past experience with trauma and coping mechanisms.

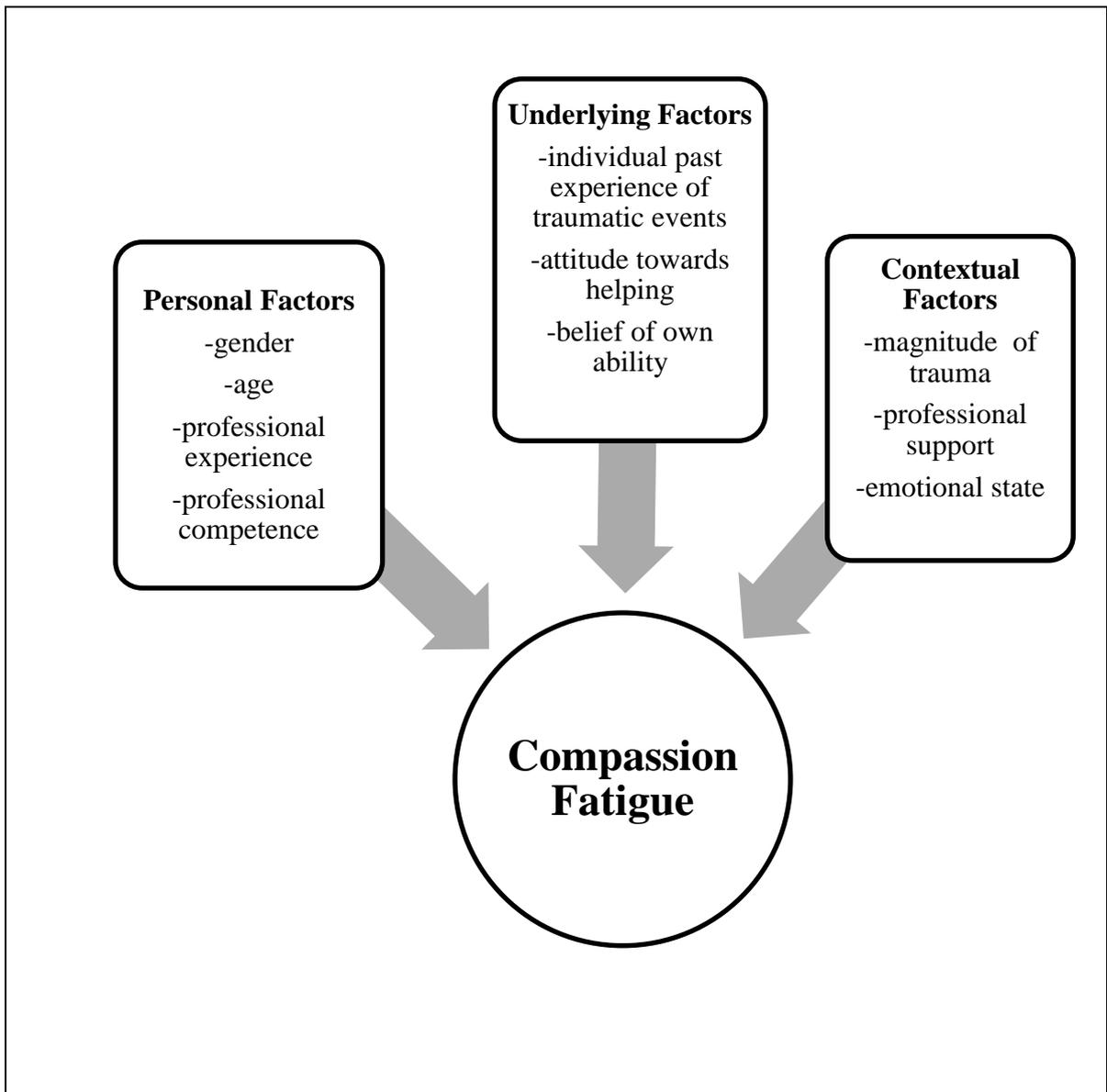


Figure 1: Determinants of Compassion Fatigue (*author generated*)

The research study is therefore, further informed by a bio-psycho-social-spiritual approach to understanding the prevalence of compassion fatigue as experienced by counsellors. This approach recognizes that, it often takes a combination of biological, psychological, social cultural and spiritual factors to result in the development of specific mental health problem and hence, treatment should address all the dimensions (Sue & Sue, 2006). Human beings are therefore assumed to carry a vulnerability that can be biological in origin (genetic predisposition to stress) psychological (personality trait that increases the person's inability to deal effectively with stress) social- cultural (growing up in a stressful environment that can lead one to doubt their abilities) or spiritual (attaching or searching for meaning in any stressful encounter). Vulnerability however, does not automatically result in a mental health problem, but there must be some kind of trigger (Sue & Sue, 2006).

### **2.2:8 Biological Dimension**

The biological perspective posits that psychological disorders are caused by structural abnormalities in the brain, disordered biochemistry or faulty genes. The structural abnormalities in the brain can be caused by brain injuries, disease or environmental factors and this can affect an individual right across the lifespan. The specific area of the brain damaged and the extent to which it is damaged influence the type of symptoms one develops. The biochemical theories focus on the neurotransmitters, the messengers that carry impulses from one neuron, or nerve cell, to another in the brain and in other parts of the nervous system. The biochemical theories suggest that psychological symptoms may be associated with the number and functioning of the receptors for transmitters or too little or too much of a particular transmitter in the synapses of the brain (Nolen-Houseman, 2005)

The genetics theory of abnormality is concerned with the extent to which behaviour tendencies are inherited and by what process do genes affect behaviour (Sue& Sue, 2006).Pre disposition of psychological disorders can be determined through family history sties, studies, twin studies and adoption studies.

### **2.2:9 Psychological Dimension**

The psychological approach to psychological disorders focus on the development of healthy personality. Although there are many definitions and understanding of the term personality, it is generally used to describe deeply ingrained, relatively persistent patterns of thought, feeling and behaviour of a person. It refers to the characteristics (traits) or a combination of characteristics that unique to a person. The most obvious aspects of an individual's personality are 'temperament', which refers to a person's emotional and behavioural reactions. Some aspects of personality are not necessarily visible to casual observers and include abilities, intelligence, values, beliefs and personal attitudes concerning appropriate and inappropriate behaviour. There are several theories that explain how the personality is formed but one can assume that one theory is not enough to explain everything about one'sbehaviour (Kane& Byrne, 2006). These theories are grouped into four categories; psychodynamic, cognitive behavioural, humanistic and postmodern schools of thought.

### **2.2:10 Social-Cultural Dimension**

The social cultural approaches suggest that in order to understand people's problems, one need to look beyond the individual and his/her family to the larger society. Societies create stresses for some people and subcultures that sanction maladaptive ways of coping with these stresses.

First, social economic disadvantage is a risk factor for mental health problems. Individuals who are poor tend to live in neighbourhoods where they are exposed to violence and inadequate schools and where there are few resources for everyday living such as running water, electricity, proper access roads and little cohesion among neighbours.

Second, war, famine, and other man-made and natural disasters have caused disintegration of societies. Research has shown that individuals from war torn countries who have had to flee and live as refugees show high rates of posttraumatic stress disorders. A study of citizens of Afghanistan found that 42% could be diagnosed with post-traumatic stress disorder and 72% had some sort of anxiety symptoms (Cardozo et al., 2004).

Third, social norms and policies that stigmatize and marginalize certain groups put individuals in these groups at increased risk for mental health problems. According to Harzenbuehler(2009) and Sue & Sue (2006) gay, lesbian, bisexual and transgender individuals suffer higher rates of depression, anxiety and substance abuse as compared to heterosexuals. Social-cultural discrimination at the level of state policies can affect the citizens' mental health.

Fourth, societies may influence the types of psychopathology their members show by having implicit or explicit rules about what types of abnormal behaviour is acceptable (Sue & Sue, 2006). Some disorders are specific to certain cultures.

### **2.2:11 Spiritual Dimension**

Psychologists in supporting their clients address emotional hurt that cannot be physically identified, yet, it is overwhelming real. Although there are no empirically researched theories on spirituality and how it impacts on counselling some individuals claim those human beings in their work are searching for meaning of their existence and their purpose for their lives. Frankal (1967) as quoted in Meyer et al.,(2008) looks at spirituality as that which differentiates human beings from other living things who are physical, bio-chemical and psychological ( have needs and drives), as human beings are the only ones who are able to transcend themselves in their relatedness with others and nature. The spiritual self is that part of the human being that is able to connect with others or empathy.

Spirituality therefore refers to the sensitivity to moral, ethical, humanitarian and existential issues with or without reference to any religious doctrine. It is an innate human quality and is often noticed in effective counsellors (Grim, 1994, p.154). It is also defined as the animating force in life, represented by such images as breath, wind, vigour, and courage (Corey et al., 2007).

The interaction of these factors can result in compassion fatigue in counsellors and can further be explained by the transactional model in which interactions in two directions are considered together, such as one other and back or one subsystem to another and back.

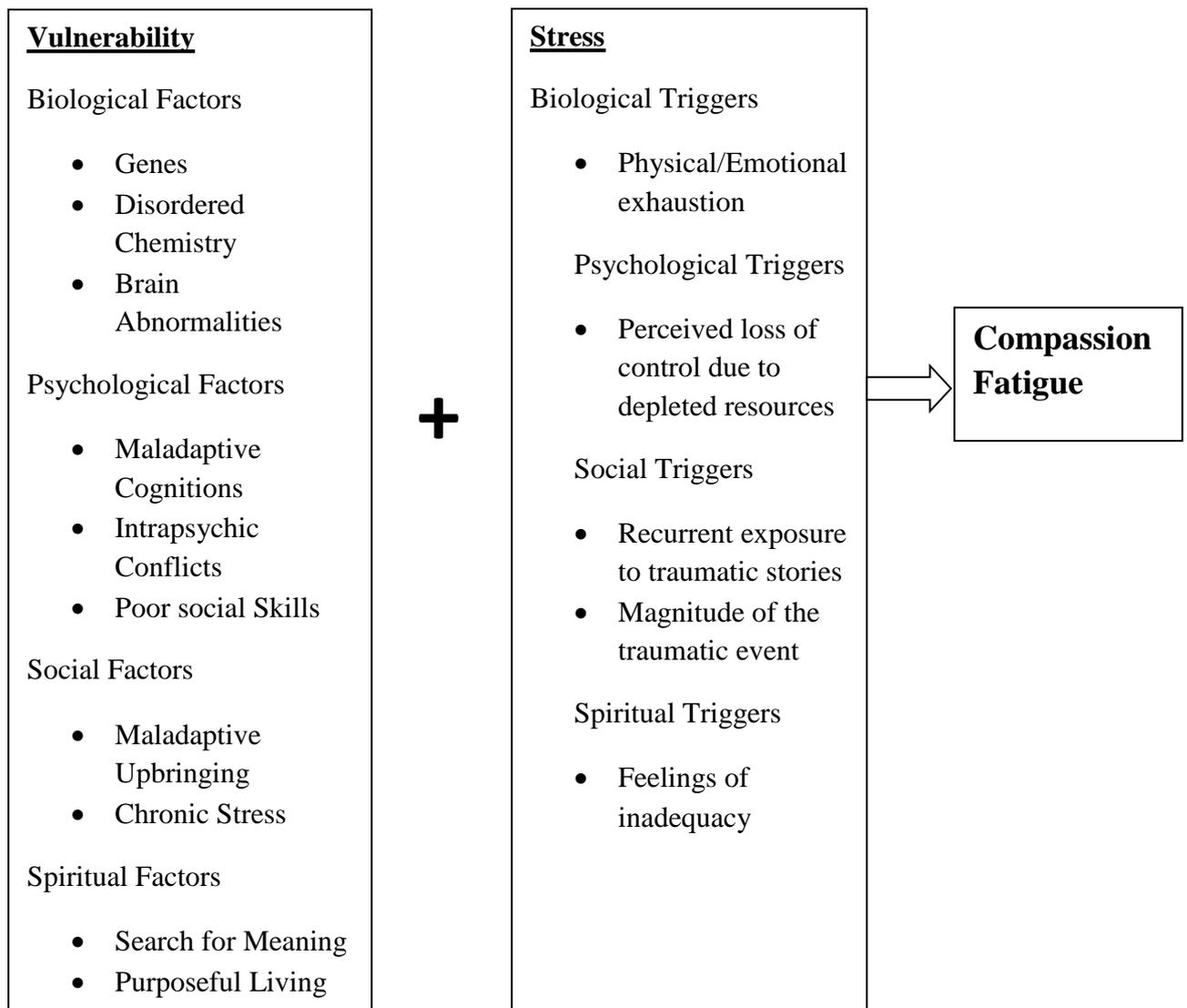


Figure 2: The Vulnerability Stress Model of the Development of Compassion Fatigue (adapted from Sue & Sue, 2006).

### 2.3 Summary

This chapter presents a review of previous topic-related studies by other researchers on compassion fatigue. It highlights the impact of the phenomenon not only on counsellors but other helpers who by the very nature of their professions are often called upon to offer psychological support. Counselling is therefore looked at as a cross-cutting service whose providers may include medical personnel and aid workers.

## **CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY**

### **3.1 Introduction**

This chapter is about research methodology. It will include the research design, population and sampling design used. It will also discuss the data collection methods, research procedure and data analysis strategies.

### **3.2 Research Design**

A research design is a plan that describes how specific aims and objectives of the study are addressed and the process the investigator will follow from inception to the completion (Mugenda & Mugenda, 2012)

For this study a cross-sectional descriptive survey was used and it involved the administration of two research instruments. According to Kothari (2004), a descriptive design is suitable for examining such facts.

### **3.3 Study Population and Sampling Design.**

A research population is the sum total of all elements in the universe of interest for a specific study according to Mugenda and Mugenda (2012). The target population for the current study was individuals, who have received some counsellor training to the minimum of a diploma level, identify themselves as counsellors and is working as counsellors either on full basis or as part of their other occupations. The inclusion criteria was all counsellors registered with a professional body such as the Kenya Counselling and Psychologists Association and at least six months post qualification experience in the field. The exclusion criteria will be counsellors practicing in Nairobi but are not registered by any professional body or are not associated with any professional body.

The sampling frame is a list of all elements in the population from which the sample is drawn (Rensburg et al, 2009). The sampling frame for this study was the list of all counsellors practicing in Nairobi and is registered with either Kenya Counselling and Psychologists Association or other recognized professional bodies. The sampling technique was purposive sampling which allows the researcher to apply specific criteria for choosing research participants (Mugenda, 2011).

Currently there are three professional bodies that register counsellors in Kenya. The Kenya Counsellors' and Psychologists Association's (KCPA) member registrations with people with a diploma level training and 300 hours of client work. The head office is located in Nairobi but it has regional branches across the country. The other two professional bodies, Kenya Psychologists Association (KPA) and Kenya Guidance and Counselling Psychologists Association (KGCPA) register individuals with a minimum Bachelor's degree in psychology. Kenya Psychologists Association has its head office in Nairobi while, Kenya Guidance and Counselling Psychologists Association (KGCPA), whose members generally practice counselling in learning institutions, has its head office in Eldoret but its members are spread across the country.

The sample size was calculated using, the formula recommended by Lewis and Thornhill (2009). They stated that a sample size can be calculated as follows:  $n = \frac{p\% * q\% * (z/e \%)^2}{}$ . Assuming a worst case scenario where p and q stand at 50% each, at a confidence level of 95% within an error of  $\pm 10$ , then sample size would be given as;  $n = 50 * 50 * (1.96/10)^2 = 97$  respondents

The writers further suggests that where target population is less than 10,000 the sample size can be adjusted, with no effect to its accuracy using the formula

$n' = n / ((1) + (n/N))$  such that for the current study the formula would apply as follows:  $n' = 97 / ((1) + (97/2450))$

According to the Kenya Counselling and Psychologists Association data base there are three thousand eight hundred and seventy (3870) counsellors registered with the association. Two thousand four hundred and fifty (2450) are operating in Nairobi as indicated by their registered addresses. This gives an adjusted sample size of 94 respondents.

### **3.4 Data Collection**

The researcher made use of questionnaires to collect the primary data but also make use of unstructured interviews in situations where the participants needed some explanations. The choice of the questionnaires as a data collection instrument was that questionnaires can be administered easily by those who have access to the participants, are low on cost, are generally accepted as anonymous and also allow for rapid data collection (Cooperb & Schildler, 2003). They also allow the participants' time to think carefully about the questions before they answer and most people view time allowed as a sign of respect. The interview was not more than forty minutes (40) and some ended sooner by natural process or request from the respondent or researcher depending on the circumstances. For this study, the research instrument was a self-administered questionnaire with two parts: (i) a researcher designed social demographic questionnaire (SDQ) which includes gender, age, level of counsellor training and the work-setting and (ii) the professional quality of life scale (PRoQOL). The Pool is a 30 item self-report measure developed by Stamm (2005) and adapted from the compassion fatigue self-test (Figley & Stamm, 1996). It included three subscales; compassion satisfaction, secondary traumatic stress (compassion fatigue) and burn out. Items are scored on five-point like type scale (1= never and 5= often). The range of all possible scales on each subscale is 5-50 with higher scales reflecting higher levels of that particular component. Scores of

between 23 and 41 are considered average. Scores of 42 and above the secondary traumatic stress indicate potential problems in that area while scores of 22 and below indicate low risk (Stamm, 2009)

The professional quality of life scale (Proqol) was chosen for its Validity and reliability. Validity is the degree to which a research instrument measures what it claims to measure while, reliability is the consistency and dependability of data collected through repeated use of the instrument under the same conditions. The developers of the professional quality of life scale Pool) report that the alpha reliabilities for each of the scales of the instrument for the normal sample were as follows: compassion satisfaction .88 while secondary traumatic stress/compassion fatigue .81 and burnout is .75 which makes the scale reliable (Stamm, 2009) as cited in Thieleman &Passionate (2014).

### **3.5 Data Analysis Strategies**

Collected data was cleaned and stored in a Microsoft Excel database and subsequently analysed using statistical package for social science (SPSS version20.0) Descriptive statistics were used to compute the means and standard deviations for numerical variables as well as frequencies for nominal variables. The significance of the association between the various variables and compassion fatigue were tested using the chi-square test statistic ( $\chi^2$ ) and a finding of  $p < 0.05$  was considered statistically significant.

### **3.6 Ethical Issues**

Research approval was obtained from the Internal Review Board (IRB) of the United States International University-Africa. The researcher employed the services of a research assistant who is trained in research methods and had taken the course as part of her undergraduate program. The research assistant was solicited through a referral process from close associates of the researcher who are familiar with the research assistant's

previous work. After selection, the assistant was trained by the researcher on the use of research tools, how to handle any possible questions from the research participants and how to ensure confidentiality in the process of handling the questionnaires on a one to one basis. This training however, was an on-going process given that some unexpected development occurred such as; participants asking questions outside of the questionnaires. Specifically, the parameters of confidentiality were explained to her. These parameters included ensuring that any notes made as part of data collection were destroyed and that any report from a research participant that by its' nature might compromise the identity of that participant was omitted.

The researcher ensured that the participants had the capacity to give voluntary consent and made every effort to ensure comfort and minimize risks. They were therefore informed about the purpose of the study, the procedures and the researchers expectations of the participants, the possible benefits that would accrue to the participants and the general community, a clear description of the possible risks and discomforts and the participants right to withdraw from the study without any negative consequences. Some of the possible risks and discomforts that the researcher anticipated for the participants were that they participants may become tired or experience emotional discomforts. In the event of this happening, and break was required the interview was postponed to a later date or terminated altogether. Most of the participants however, experienced satisfaction for contributing to an investigation of social concern which may be of benefit to others at a future date.

The participants were also informed about any arrangements about provision of a safe space characterized by confidentiality and respect for difference where they can share individual experiences of their being part of the study. No participant however, felt the need to utilize such space.

### **3.7 Summary**

This chapter is about the methodology employed by the researcher to collect data; it describes the research design sampling frame and the research instruments used. The next chapter describes how the data collected was analysed and interpreted.

## **CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION**

### **4.0 Introduction**

This chapter presents the study findings whose main objective was to determine how the personal and contextual factors associated with practitioners may influence compassion fatigue as experienced by counsellors practicing in Nairobi, Kenya. Other Objectives were to determine levels of compassion fatigue among psychological counsellors practicing in Nairobi, Kenya, assess whether counsellor personal factors of gender, length of time spent in the field and level of training are predictors of compassion fatigue and establish what personal resources mitigate against compassion fatigue among counsellors in Nairobi, Kenya.

#### **4.1:1 Response rate**

The study targeted a sample size of 94 respondents calculated from the Kenya Counsellors and Psychologists Association's register as the sampling frame. A total of 120 questionnaires were distributed among the target population of counsellors and 106 were completed and returned giving a response rate of 88%. Out of the 106 questionnaires returned 10 participants had indicated they were registered by a different body other than the ones on the list. All the completed questionnaires were used in the analysis because the overall assumption of the study was that the study engaged a power of 0.80 and more, that there was a need to increase the sample size.

#### **4.1:2 Scoring the Scales**

The components of Component Fatigue scale that were used consisted of the 10 items in the Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009). Once the data was entered into the IBM SPSS V20 statistical software,

Compassion Fatigue scores were computed by summing the scores of the items using the syntax below:

*Compassion*

*Fatigue=*sum(*Item2,Item5,Item7,Item9,Item11,Item13,Item14,Item23,Item25,Item28*).

*Note: The items are derived from Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009).*

#### **4.1:3 Reliability**

Cronbach's alpha was used to measure internal consistency of the data collected. Since each participant was seen as independent from all others, Cronbach's alpha was calculated for the scale, the sub scales and the items. The Cronbach's alpha ( $\alpha$ ) generated from IBM SPSS 20 for the Compassion Fatigue each with was .74. According to Cronbach (1951), an alpha ( $\alpha$ ) in the range  $0.7 \leq \alpha < 0.9$  indicates good internal consistency of the data collection instrument.

#### **4.2 Personal Factors (Socio-Demographic Characteristics of the Respondents)**

The demographic profiles of the respondents were analysed using descriptive method including frequencies across five variables; gender, age, marital status, highest level of counsellor education and post qualification experience or the number of years a counsellor had been working in the field. The findings of Table 4.2 indicated that more females (63.2% than males 36.8%) participated in the study. The results point towards gender disparity in favour of females with regard to counselling. One reason for this could be because females are normally considered more nurturing than males. When asked about their age, the highest proportion was above 41-50 years old (28.3%) as

shown in Table 4.2. 72.6% of the surveyed respondents indicated that they have ever been married with the highest proportion, (36.8%), stating that they have Diploma level as the highest level of counsellor education. In seeking to determine their length of service as counsellors, 46.2% of the surveyed respondents stated that they have worked as counsellors for more than 5 years. Table 4.2 shows the distribution of participants according to their gender, age, marital status, highest level of counsellor education and post-qualification counsellor experience.

**Table 4.2: Breakdown of the Socio-Demographic Characteristics of the Respondents**

<b>Variables</b>		<b>Frequency</b>	<b>Percentage</b>
Gender	Male	39	36.8
	Female	67	63.2
Age (years)	20-30	9	8.5
	31-40	27	25.5
	41-50	30	28.3
	51-60	23	21.7
	Above 60	17	16.0
Marital status	Married/Ever married	77	72.6
	Never Married	29	27.4
Highest level of Counsellors Education	Diploma	39	36.8
	Bachelor's degree	34	32.1

	Master's degree	25	23.6
	Doctorate degree	8	7.5
Post Qualification Counsellor Experience	Below one year	13	12.3
	1-5 years	44	41.5
	Above 5 years	49	46.2

### 4.3 Contextual Factors

The larger proportion of the counsellors surveyed (28.3%) indicated that they practice counselling in a counselling agency whereas 14.2% practice in a medical health facility. Private counselling practice was only experienced among 11.3% of the respondents. The results also revealed that 9.4% of the counsellors surveyed were not registered with a professional body. Majority of counsellors, are registered with KCPA (81.1%) with others mentioning KPA (5.7%) and KGCPA (3.8%). Most of counsellors surveyed (58.5%) indicated that they occasionally volunteer their counselling in response to disasters and 64.2% indicated that they receive counselling supervision occasionally.

#### 4.3:1 Place of counselling practice

The highest proportion (28%) of the counsellors surveyed work for counselling agencies, 14% work in the medical health facilities, 13% work in universities, 11% operate as private practitioners whereas 10% of the surveyed counsellors practice in middle level colleges. Figure 4.3 below shows the distribution of the places where respondents practice counselling.

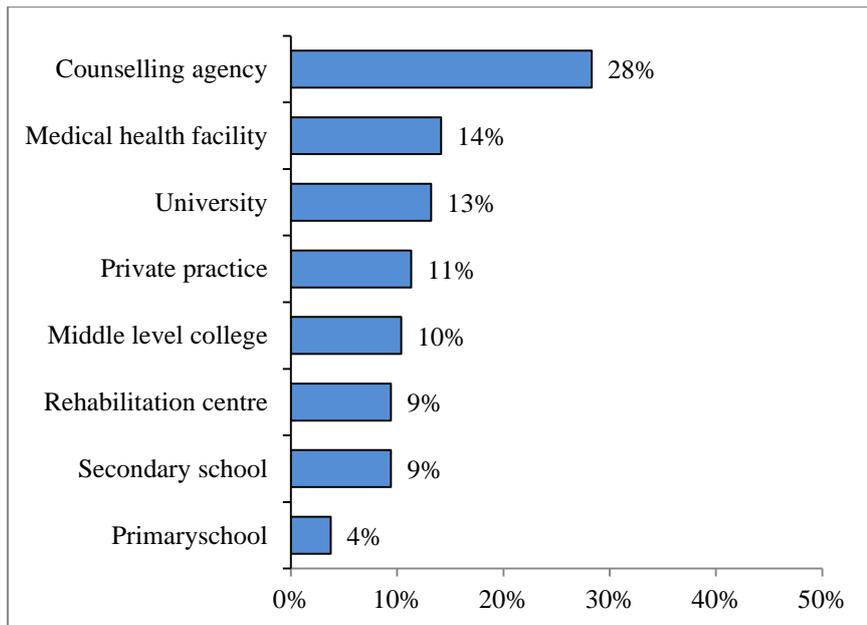


Figure 4.3: Place of counselling practice

#### 4.3:2 Registration with a professional body

Based on the results of Figure 4.3 only 9% of the counsellors indicated that they are not registered to a professional counsellors' body.

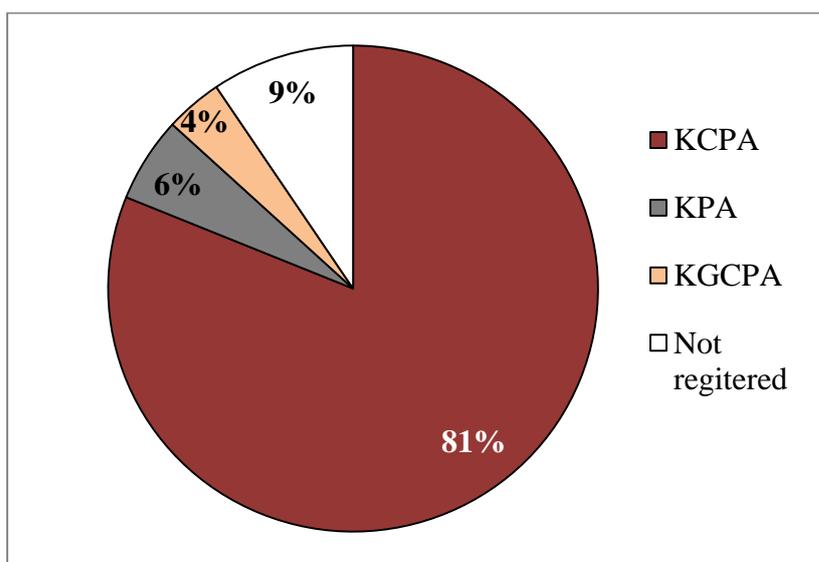


Figure 4.3 Professional body registered with

### 4.3:3 Volunteering for Counselling Services in Response to Disasters

The respondents were asked the extent to which they offer volunteer counselling services in situations of disasters. The results of Table 4.3 indicates that majority of the counsellors surveyed (58.5%) stated that they volunteer the counselling services occasionally. Whilst 14.2% of the counsellors stated that they always volunteer their services, 27.4% indicated that they have never volunteered their counselling services in response to disasters.

**Table 4.3 Frequency of Volunteering and Frequency of Counselling Supervision**

<b>Variables</b>		<b>Frequency</b>	<b>Percent</b>
Frequency of volunteering	Always	15	14.2
	Sometimes	62	58.5
	Never	29	27.4
Frequency of counselling supervision	Weekly	17	16.0
	Bi-weekly	21	19.8
	Occasionally	68	64.2

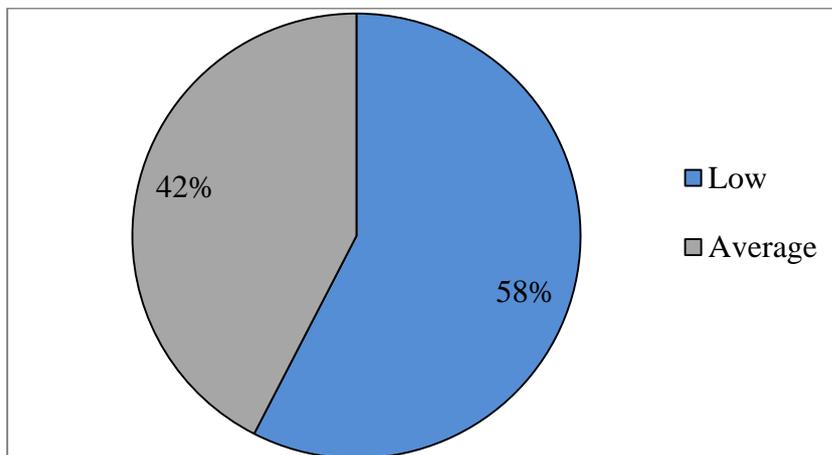
*Note: N=106*

### 4.3:1 Frequency of Receiving Counselling Supervision

When asked the frequency of receiving counselling supervisions, majority of the counsellors (64.2%) stated that they receive counselling occasionally. Only 16.0% of the counsellors stated that they receive counselling supervisions weekly with 19.8% stating that they receive the supervisions bi-weekly.

#### 4.4 Levels of Compassion Fatigue among the Psychological Counsellors

To understand the levels of compassion fatigue, the study used Stamm (2012) methodology. This methodology posits, that if the sum of compassion fatigue scores is 22 or less, then the scale level is low and if the sum of the compassion fatigue score was between 23 and 41, the level is average whereas if the compassion fatigue score was 42 or more, then the level is high. The result of the level of compassion fatigue was summarized in the pie chart shown in Figure 4.4 below.



*Figure 4.4.: Levels compassion fatigue among counsellors practicing in Nairobi*

The results of Table 4.4 indicate that low level of compassion satisfaction was witnessed among majority of the surveyed counsellors (58%) with 42% showing average compassion satisfaction level. This result rejects the assumption that exposure to recurrent client trauma stories makes counsellors vulnerable to compassion fatigue. It can also mean that there are other intervening factors that were not a subject of this study.

#### 4.5 Do Personal Factors Predict The Levels of Compassion Fatigue?

To understand the extent to which personal factors predict compassion fatigue, Analysis of Variance (ANOVA) was used. The results were presented as shown in Table 4.5 below.

**Table 4.5: Extent to which personal factors predict compassion fatigue**

Source		M	SD	p-value
Gender	Male	20.6	5.5	0.511
	Female	21.9	5.7	
Marital status	Married/Ever married	21.1	4.8	0.372
	Never Married	22.2	7.4	
Age	20-30	21.8	7.6	0.902
	31-40	21.1	4.6	
	41-50	22.0	6.1	
	51-60	21.7	6.0	

	Above 60	20.4	5.0	
Level of counselling education	Diploma	20.7	5.6	
	Bachelor's Degree	21.6	5.9	0.945
	Master's Degree	21.0	5.4	
	Doctorate Degree	22.5	4.7	
Number of professional experience years	Below one year	20.5	4.7	
	1-5 years	23.0	6.2	0.581
	Above 5 years	20.4	5.3	

*Note: M =Mean, SD=Standard Deviation;*

*Dependent variable: Compassion Fatigue Scores (CFS); Confidence level at 95%*

The results of Table 4.4 indicated that male counsellors had insignificantly lower compassion fatigue score (M=20.6, SD=5.5,  $p>.05$ ) than their counterpart females counsellors (M=21.9, SD=5.7). Gender is therefore not a significant predictor of compassion fatigue.

Similarly, counsellors who indicated that they had ever been married in their life had insignificantly lower compassion fatigue score (M=21.1, SD=4.8,  $p>0.05$ ) than those who have never married (M=22.2, SD=7.4). This implies that marital status is not a significant predictor of compassion fatigue. The results of the distribution of compassion fatigue scores along age groups depicted that those aged between 41-50 years experienced

the highest scores of compassion fatigue ( $M=22.0$ ,  $SD=6.1$ ). The results of Table 4.4 also indicate that those aged above 60 years had the lowest compassion fatigue score ( $M=20.4$ ,  $SD=5.0$ ). However, age is not a significant predictor of compassion fatigue at 95% confidence ( $p>.05$ ).

Table 4.5 results indicate that counsellors with Doctorate Degrees in counselling had insignificantly higher compassion score ( $M=22.5$ ,  $SD=4.7$ ,  $p>.05$ ) than those with other levels of counselling education especially those with diploma levels ( $M=20.7$ ,  $SD=5.6$ ). Therefore, level of counselling education is not a significant predictor of compassion fatigue.

The last personal factor that was tested by the survey was the number of years of professional experience. The results of Table 4.5 indicate that counsellors who have practiced counselling between 1-5 years had insignificantly high compassion fatigue score ( $M=23.0$ ,  $SD=6.2$ ,  $P>0.05$ ) compared to those who have practiced counselling for more than 5 years ( $M=20.4$ ,  $SD=5.3$ ) which indicates that tenure in counselling professional is not a significant predictor of compassion fatigue.

It can therefore be concluded at 95% confidence that personal factors are insignificant predictors of compassion fatigue.

#### **4.6 Extent to Which Contextual Factors Predict Compassion Fatigue**

The four contextual factors examined included: place of counselling practicing, professional bodies registered with, frequency of counselling volunteering and frequency of receiving counselling supervision. To understand the extent to which these factors predict compassion fatigue, ANOVA was used with compassion fatigue scores as the dependent variable. The results were summarized as shown in Table 4.6 below.

**Table 4.6: Extent to Which Contextual Factors Predict Compassion Fatigue**

Variables		M	SD	p-value
Place of counselling practicing	Medical health facility	23.7	6.0	0.67
	Primary school	22.0	2.2	
	Secondary school	22.9	8.6	
	Middle level college	21.9	6.0	
	University	20.8	4.8	
	Counselling agency	20.8	4.8	
	Private practice	20.8	5.1	
	Rehabilitation centre	19.6	6.2	
Professional body registered with	KCPA	21.9	5.5	0.18
	KPA	20.3	5.1	
	KGCPA	16.0	2.4	
	Not registered	20.4	6.6	
Frequency of counselling volunteering	Always	19.2	4.9	0.25
	Sometimes	21.8	5.1	

	Never	21.9	6.8	
Frequency of receiving counselling supervision	Weekly	20.0	3.7	
	Bi-weekly	19.5	4.6	0.46
	Occasionally	22.4	6.1	

*Dependent variable: Compassion Fatigue Scores; Confidence level at 95%*

The results of Table 4.6 indicate that counsellors working in medical health facilities had the highest scores of compassion fatigue (M=23.7, SD=6.0). On the flipside, those working in Rehabilitation centres had the lowest scores of compassion fatigue (M=19.6, SD=6.2). However, place of counselling practice does not significantly predict compassion fatigue ( $p>.05$ ).

The study also sought to understand the level at which registration with counselling bodies predict compassion fatigue. The results of Table 4.5 revealed that counsellors registered with KGCPA had lower compassion fatigue scores (M=16.0, SD=2.4) than those registered with KCPA (M=21.9, SD=5.5). However, there was no sufficient evidence to prove that registration with a professional body is a predictor of compassion fatigue at 95% confidence ( $p>.05$ ).

Another key area of study was to understand whether frequent counselling volunteering in response to disaster predicts compassion fatigue. From Table 4.5, those who are frequent with counselling volunteering showed had lower compassion fatigue level (M=19.2, SD=4.9) than those who have never volunteered (M=21.9, SD=6.8) or

those who volunteer occasionally ( $M=21.8$ ,  $SD=5.1$ ). Similarly, there was no sufficient evidence to conclude that frequent counselling volunteering in response to disaster predicts compassion fatigue ( $p>.05$ ).

The last contextual factor studied was the frequency of receiving counselling supervision and how it predicts compassion fatigue. Those who receive counselling supervision frequently; weekly ( $M=20.0$ ,  $SD=3.7$ ,  $p<.05$ ) had significantly lower compassion fatigue compared to those who receive counselling supervision occasionally ( $M=22.4$ ,  $SD=6.1$ ) at 95% confidence level. It can therefore be concluded that frequency of receiving counselling supervisions is a significant predictor of compassion fatigue.

#### **4.7 Summary**

This chapter is about results and finding of the research. It presented the responses on the counsellors' experience of compassion fatigue in graphic charts and diagrams. The next chapter discusses the results and findings of the study. Based on these a brief conclusion and recommendations is provided.

## **CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATION**

### **5.1 Introduction**

This chapter discusses the results and findings of the research study that evaluated the presence of compassion fatigue based on the personal and contextual factors that influence compassion fatigue among counsellors. In addition, it will give conclusions and recommendations based on the literature review.

### **5.2 Summary of the Key Findings**

This study evaluated the presence and extent to which personal and contextual factors may influence compassion fatigue among counsellors from the knowledge of level of counsellor training, post-qualification experience, the working environment and demographic characteristics. It provides some new insights into how exposure to recurrent traumatic stories impacts on counsellors. The study reveals that although counsellors experience compassion fatigue and it may indeed be considered an occupational hazard, the satisfaction they get from helping militates against any serious psychological impairment.

The first objective was to evaluate the presence of compassion fatigue among counsellors and the results show that they do experience (25%). These results are consistent with others (Kokonya et al., 2015) but differ with Yonder (2010) whose results reported very high level.

The second objective was to assess whether the personal factors of gender, age, marital status, level of training were predictors of compassion fatigue. These factors were found not to influence compassion fatigue. However, females in this research sample were

found more likely than males to experience compassion fatigue. There was also, slight inverse relationship between the length of time the counsellor had worked as a counsellor and compassion fatigue with more years working in the field associated with less compassion fatigue.

The third objective was to determine whether the contextual factors combined measured by place of counselling, willingness to seek supervision, volunteering for counselling in times of disaster would influence compassion fatigue. The highest level of those experiencing compassion fatigues those practicing in medical facilities while those who experienced least were working in rehabilitation centres. The researcher's expectations were that these two groups would have similar levels and the explanation could be that there were other compounding factors that were not subject this study. However, at 95% confidence level, the place of counselling has no significant relationship with compassion fatigue.

The last objective was to establish whether the use of personal resources as measured by seeking supervision and registration with a professional body would mitigate against compassion fatigue. The researcher assumed that those who seek supervision are aware of how their work as helpers impacts on them and are willing to take restorative measures. Being a member of a professional body is also looked at as wanting to maintain ethical practice as professional bodies to a code of ethics that they expect their members to adhere to. The results indicated that those who received supervision regularly were less likely to experience compassion fatigue. These results are consistent with other published (Zeidner et, al, .2013) where the nurses under the study reported appreciating this type of support.

### **5.3 Limitations of the Study**

One limitation of the study was the exclusive use of self-reporting. Self-reporting can be influenced by social desirability bias where participants may present themselves in the best possible light, rather than answering honestly. For example, some counsellors when approached opted not to participate without giving any explanation. The purposeful sampling procedure used also limits the generalization of the results to whole populations as the strategy involved the recruitment of participants through employment in certain geographical areas.

Another limitation is that several counsellors had difficulty understanding some of the questions relating to compassion fatigue, which may have influenced how they responded, even after receiving explanation. Further, the participant's response may reflect where that particular individual was feeling at that point in time and the answers can change a few minutes later if the circumstances changed.

### **5.4 Discussions**

This study has contributed to the current knowledge about compassion fatigue by reporting expected levels in a group of Kenyan counsellors. The results of this study highlighted that research into the presence of compassion fatigue among counsellors has received little attention compared to other care-givers based on the literature available. This presents a knowledge gap that offers opportunities for further research. An additional area of research to study is to investigate available or mitigating interventions whose aim is to assisted counsellors manage the effects of compassion fatigue.

One unique feature of this study is the use of the Transactional Stress Model to provide a theoretical basis for studying compassion fatigue. The model conceptualizes a

closely interactional relationship between individuals and their internal and external environments and how this can result in compassion fatigue. This has relevant implications for counselling as the best treatment is that which looks at the person holistically. The model therefore appreciates that counselling process is a duo-process that affects the counsellor as much as it affects the client. This is what Egan (2010) refers to as a collaborative alliance.

#### **5.4 Conclusion**

The study has demonstrated that counsellors like other health professionals, suffer compassion fatigue (25.5%) among counsellors in Nairobi. It has revealed that although, counsellors experience compassion fatigue and it may indeed be considered an occupational hazard, the satisfaction they get from helping mitigates against any serious psychological impairment. One other significant result is that there is no correlation between compassion satisfaction and compassion fatigue ( $r=0.4$ ;  $p>0.5$ ). This can be interpreted to mean that having low compassion fatigue does not necessarily indicate compassion satisfaction.

#### **5.5 Recommendations**

- The counsellor training programs should focus on empowering the trainee with resources or personal development tools such as emphasizing on the importance of supervision. This would help them as they transit in the world of work or social entrepreneurship and are no longer under the protective care of their trainers.

- Continued research is still needed to fully explain the phenomenon of compassion fatigue with the ultimate goal of ensuring that counsellors understand it, are able to sense early warnings and receive essential interventions
- These findings may guide policymakers/implementers in developing effective work place policies that are both client and counsellor friendly. Of special note among the policy makers are the educationists who can add this to the existing curriculum.

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## **APPENDIX: A**

### **PARTICIPANT QUESTIONNAIRE**

#### **Section A: Social Demographic Information (SDQ)**

1. What is your gender?  
Female    
Male
2. What is your age?  
Below 30  31- 45  Above 45
3. What is your marital status  
Married  Never Married
4. What is the highest level of counsellor education having you attained?  
Diploma   
Bachelor's degree   
Master's degree   
Doctorate degree
5. What is your post qualification counsellor experience?  
Below one year   
1-5 years   
Above 5 years
6. Where do you practice your counselling?  
Medical health facility   
Primary school   
Secondary school   
Middle level college   
University   
Counselling agency   
Private practice   
Rehabilitation center
7. Which professional bodies are you registered with?  
KCPA  KPA  KGCP  Other  Not Registered

8. Do you volunteer your counselling services in response to disasters?

Always ( ) Sometimes ( ) Never ( )

9. How often do you receive counselling supervision?

Weekly ( ) Bi-weekly ( ) occasionally ( )

## SECTION B: Screening for Compassion fatigue and Compassion satisfaction

### (Proqol) Version 5 (2009)

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative ways. Below are some –questions about your experiences, both positive and negative, as a counsellor. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced things in the *last 30 days*.

1=Never      2=Rarely      3=Sometimes      4=Often      5=Very Often

		never	rarely	sometimes	often	Very often
1	I am happy					
2	I am preoccupied with more than one person I counsel					
3	I get satisfaction from being able to counsel people					
4	I feel connected to others					
5	I jump or am startled by unexpected sounds					
6	I feel invigorated after working with those I counsel					
7	I find it difficult to separate my personal life from my life as a					

	counsellor					
8	I am not as productive at work because I am losing sleep over traumatic experiences of a person I counsel					
9	I think that I might have been affected by the traumatic stress of those I counsel					
10	I feel trapped by my job as a counsellor					
11	Because of my counselling, I have felt “on edge” about various things					
12	I like my work as a counsellor					
13	I feel depressed because of the traumatic experiences of the people I counsel					
14	I feel as though I am experiencing the trauma of someone I have counseled					
15	I have beliefs that sustain me					
16	I am pleased with how I am able to keep up with counselling techniques and protocols					
17	I am the person I always wanted to be					
18	My work makes me feel satisfied					
19	I feel worn out because of my work as a counsellor					
20	I have happy thoughts and feelings about those I counsel and how I could help them					
21	I feel overwhelmed because my					

	workload seems endless					
22	I believe I can make a difference through my work					
23	I avoid certain activities or situations because they remind me of frightening experiences of the people I counsel					
24	I am proud of what I can do to counsel					
25	As a result of my counselling, I have intrusive, frightening thoughts					
26	I feel “bogged down” by the systems					
27	I have thoughts that I am a “success” as a counsellor					
28	I can’t recall important parts of my work with trauma survivors					
29	I am a very caring person					
30	I am happy that I chose to do this work					

## APPENDIX B: Professional Quality Of Life Scale (ProQOL) Approval

### *Compassion Satisfaction and Compassion Fatigue*

*(ProQOL) Version 5 (2009)*

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I am preoccupied with more than one person I *[help]*.
- \_\_\_\_\_ 3. I get satisfaction from being able to *[help]* people.
- \_\_\_\_\_ 4. I feel connected to others.
- \_\_\_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_\_\_ 6. I feel invigorated after working with those me *[help]*.
- \_\_\_\_\_ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- \_\_\_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
- \_\_\_\_\_ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
- \_\_\_\_\_ 10. I feel trapped by my job as a *[helper]*.
- \_\_\_\_\_ 11. Because of my *[helping]*, I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a *[helper]*.
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
- \_\_\_\_\_ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- \_\_\_\_\_ 15. I have beliefs that sustain me.
- \_\_\_\_\_ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
- \_\_\_\_\_ 17. I am the person I always wanted to be.
- \_\_\_\_\_ 18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. I feel worn out because of my work as a *[helper]*.
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my case *[work]* load seems endless.

- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [*help*].
- \_\_\_\_\_ 24. I am proud of what I can do to [*help*].
- \_\_\_\_\_ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a [*helper*].
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_\_\_ 29. I am a very caring person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.

## **APPENDIX C: Respondent Consent Form**

My name is Nancy Wambui Mirera, a student at United States International University –Africa, where I am pursuing a Master of Arts Degree in Counselling Psychology. As part of my Degree requirements I am completing a research study and I would like to include you in my study. My research supervisor at USIU –Africa, Dr. Michelle Karume may be contacted by email [mkarume@usiu.ac.ke](mailto:mkarume@usiu.ac.ke) or tel. **020 360 6306** if you have questions at any time.

Your written consent is required to participate so that I can confirm that you have been informed of the study and that you agree to participate. You are free to decline or discontinue your participation at any time during the study if you wish to do so. All the information obtained in this study will be kept confidential; a number will be assigned to all research forms to ensure your privacy is protected. Your name or identity will not be given in any report or publication

The purpose of this research is to gain further understanding of compassion fatigue as experienced by counsellors practicing in Kenya and how personal and contextual factors influence the development of the phenomenon. You will be asked to complete a questionnaire with 30 questions about the circumstances and frequency of your emotional experiences within a period of 30 days. This is not a test, there is no deception in these questions, and there is no right or wrong answers, simply answer the questions as honestly as you can. These questionnaire forms should take between 30 minutes but not longer than 45 minutes to complete in one sitting. A demographic form including you age and other basic information will also be requested.

The outcome of the information obtained during this research will be summarized and utilized in my Thesis study. Participant names will not be utilized, as shown below a

number will now be assigned to ensure your identity is kept confidential during and after this study is completed.

My Consent to Participate:

By signing below, I consent to participate in this study

\_\_\_\_\_

\_\_\_\_\_

Signature of Respondent

Today's Date

\_\_\_\_\_

\_\_\_\_\_

Principal Researcher

Today's Date

Respondent Number to be used on all documents: \_\_\_\_\_



## APPENDIX E: Confidentiality Agreement for Other Researchers

This confidentiality form is an agreement between USIU-A's IRB and the undersigned who will have access to individual-identifiable original records (electronic or paper), or any other matters regarding the research process.

**IRB Number:** \_\_\_\_\_

**Other Researcher's Name:** Karen Njeri Mwangi:                      Date:

\_\_\_\_\_

**Title of research:** Personal and Contextual Factors that may Influence Compassion Fatigue as Experienced by Counsellors Practicing in Nairobi, Kenya.

In conducting this research project, I agree to the following:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format.
2. Keep all research information in any form or format securely maintained on a daily basis, during the process of conducting and writing research.
3. At the conclusion of the research, dispose of any documents that contain identification information, such as participant names or other information that could reveal identity of the human subjects; as approved by the principal investigator.

Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Karen Njeri Mwangi  
(**Other Researcher**)

Signature

Date

Witness

Signature

Date

## **APPENDIX F: Respondent Debrief Form**

Thank you for participating in this study. The purpose of this study is gain an understanding of personal and contextual factors that may influence compassion fatigue as experienced by counsellors practicing in Nairobi, Kenya. Your participation will help researchers gain more insights into experiences of counsellors' exposure to trauma stories.

In the event you have distressful reactions to the questions presented to you in this study, you may want to seek counselling support, and a list of counselling referrals is being provided for your reference

Once again thank you for your participation.

Nancy Wambui Mirera (Principal Investigator)

Signature: \_\_\_\_\_