RELATIONSHIP BETWEEN SELECTED PERSONAL ATTRIBUTES AND OCCURRENCE OF VICARIOUS TRAUMA AMONG STAFF IN HOSPICES IN KENYA

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DECLARATION

This Thesis is my original work and has not been presented for a degree in any other University or for any other award.

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DEDICATION

I dedicate this thesis to my beloved husband Elijah Musili and our wonderful children Brian, Ivy and Beverly for their patience, love and for having faith in me. I also dedicate it to my late dad John Mnyika and my loving mom Anastanzia Wanjala, for nurturing and taking me to school. This work is also dedicated my siblings Christine, Diana and Cosmas. Dad thank you for believing in me, I will always remember your wise counsel.

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OPERATIONAL DEFINITIONS OF TERMS

Caregiver: A person or worker who offers care for patients in hospices

Cognitive schema: A caregiver's worldview, beliefs, expectations and assumptions. It includes mental images or pictures that a person may form as a result of exposure to trauma

Compassion Fatigue: Emotional exhaustion or diminished capacity for compassion in the caregiver to engage empathically with the clients they work with.

Client: The hospice patient and his or her significant others including: family members, relatives or friends.

Direct exposure to trauma: Being exposed to/ or witnessing firsthand trauma and pain suffered by patients as well as their families

Empathy: The response of a caregiver to the observed traumatic experiences of clients. It is the caregiver's ability to get into the client's world temporarily in order to understand the client's issues.

Free Standing Hospice: An autonomous unit owned and operated by a hospice management or company staffed with hospice trained personnel providing palliative care.

Faith Based Organization: Hospices that offer palliative care services as faith or community based organizations.

Hospice: An institution that offers specialized care for the chronically and terminally ill patients as well as their significant others

Indirect exposure to trauma: Secondary exposure to trauma; when the caregivers listen to the painful stories from patients and their families.

Palliative Care: Type of care that focuses on prevention/relief of suffering of patients and their families facing challenges associated with life threatening illnesses (WHO, 2002).

Personal attributes: The characteristics specific to the individual hospice staff that could pose as risk for the onset of vicarious trauma. They include: age, gender, occupation, work experience, education level, empathy level and personal trauma history.

Personal trauma history: The individual traumatic experiences of the caregiver consisting of life-threatening events such as: accidents, chronic or terminal illnesses of self or significant others and death of loved ones. It involves witnessing threatening events or experiences in their lifetime.

Risk factors: The features or aspects that make an individual more vulnerable to the onset of VT

Secondary Traumatic Stress: The distress one suffers when exposed to the trauma of other persons with major indicators similar to those of post-traumatic stress disorder.

Self-care: Capacity of an individual to use appropriate skills and strategies to care for self in a way that minimizes adverse effects of one's work.

Therapist: A practitioner such as a psychologist, counsellor or psychotherapist, that offers psychological therapy to clients.

Vicarious Trauma: Adverse changes that occur in a caregiver's inner experience due to indirect exposure to clients' suffering by constant witnessing or through empathic engagement with patients. Indicators are: intrusive imagery, avoidance, arousal, disruptions in worldview, identity, spirituality & belief system.

ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
APCA:	African Palliative Care Association
CF:	Compassion Fatigue
CSDT:	Constructivist Self-Development Theory
EC:	Empathic Concern
FBOs:	Faith Based Organizations
HIV:	Human Immunodeficiency Virus
IRI:	Interpersonal Reactivity Index
KEHPCA:	Kenya Hospice and Palliative Care Association
MOH:	Ministry of Health
NACOSTI:	National Commission for Science, Technology and Innovation
NHPCO:	National Hospice and Palliative Care Organization
PD:	Personal Distress
PT:	Perspective Taking
PTG:	Post Traumatic Growth
SA:	South Africa
SPSS:	Statistical Package for Social Sciences
STS:	Secondary Traumatic Stress
USA:	United States of America
VT:	Vicarious Trauma
VTS:	Vicarious Trauma Scale
WHO:	World Health Organization

ABSTRACT

Vicarious trauma is increasingly recognized as a global phenomenon which affects populations that are directly involved with suffering patients as is the case with staff in hospice settings. Hospice caregivers are constantly exposed to agonizing stories of trauma from patients and their families. This can trigger reactions in the caregiver similar to those experienced by the clients. Research findings indicate that there is a variation in the way caregivers react to vicarious trauma (VT). However, the few studies that have attempted to look at personal attributes that can put hospice caregivers at risk of developing VT have yielded equivocal results. Furthermore, some studies focused entirely on medics leaving out the other staff members who also could be at risk for VT. The current study therefore, aimed to determine the relationship between selected personal attributes namely: age, level of education, work experience, gender, personal trauma history, level of empathy; and occurrence of VT among hospice workers. Constructivist Self Development Theory (CSDT) guided the study. The study utilized a correlational research design. The study targeted all the 120 members of staff in the 21 hospices in Kenya. Random stratified sampling was used to select a total of ten hospices. The study sample comprised 70 members of staff (male and female) in the sampled hospices. Data was collected using four structured self-report tools namely: Brief Trauma History Tool, Vicarious Trauma Scale, Interpersonal Reactivity Index as well as an open-ended instrument. A demographic questionnaire was also included. Data was then analyzed using descriptive and inferential statistics. Correlations between selected personal attributes and occurrence of VT were done. Pearson's correlation coefficient was used to analyze parametric data while chi square was used to test non-parametric data. The study findings revealed a prevalence rate of 67% of VT among hospice workers. Some of the personal attributes namely age, level of empathy and personal history of trauma had a significant positive relationship with the occurrence of VT [age: $r(70) = .256$, $p = .032$; personal trauma history: $r(70) = .275$, $p = .021$; level of empathy: $r(70) = .256$, $p = .032$]. Other demographic variables including: gender, level of education, occupation and years of work experience were found to have no significant correlation with the occurrence of VT. Based on CSDT the study concluded that the self which is the seat of personality regulates the individual's experience of trauma. The findings showed that vicarious trauma is a real threat to care givers working in hospices. The study recommended that there is need to educate caregivers about the existence and possible risk factors of vicarious trauma. It further recommended that, sound organizational interventions, prevention and psychosocial support programmes need to be developed to empower the caregivers so that they can enhance their self-capacities, as well as the wellbeing of the organization as a whole. These findings may guide the development of appropriate preventive strategies and interventions that target risks for development of VT.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Global statistics indicate that there is an increasing number of persons living with chronic and terminal illnesses. These are life threatening conditions that may require specialized care offered in institutions known as hospices. The staff in hospices focus on relieving the pain and suffering of patients and their families facing difficulties associated with life threatening illnesses (World Health Organization [WHO], 2011). It is estimated that over 70% of people with advanced cancer or Acquired Immunodeficiency Syndrome (AIDS) are in need of this kind of care (WHO, 2010). In the Sub Saharan Africa (SSA) it is expected that by 2050 cancer risk will rise by about 60% (Parkin, Sitas, Chirenje, Stein, Abratt & Wabinga, 2008). This implies that there is a great need for hospice care universally. Hospices use a multidisciplinary approach involving among others, doctors, nurses, nutritionists, social workers, counselors and chaplains.

Existing literature on traumatology suggests that, persons caring for clients suffering trauma associated with hospice care are at risk for vicarious traumatization (VT). These clients experience existential distress as well as hopelessness which may vicariously affect the hospice workers. A number of factors including individual attributes could make hospice staff prone to VT. McCann and Pearlman (1990) first used the construct vicarious trauma to depict the changes in a caregiver's inner experience resulting from empathic engagement with traumatized clients.

The term vicarious trauma was used in this study to refer to the adverse psychosocial changes that could occur in hospice staff due to indirect exposure to trauma through constant witnessing of; or empathic engagement with suffering patients. Symptoms of VT included: intrusive imagery, avoidance, arousal and changes in cognitive schemas (Bride & Figley, 2007).Various authors have used the terms: VT, compassion fatigue (CF) and secondary traumatic stress (STS) interchangeably (Bride, Radey & Figley, cited in Graaf, 2010). Subsequently, in this study, VT was considered as a broad construct encompassing STS and CF. The term VT was preferred since it related more to trauma work which is common in hospice care settings.

Life threatening illnesses cause agony to patients in that, they not only affect the physical aspects of the patient, but permeate all other psychosocial and spiritual aspects of the individual. This heavily weighs them down. Physically, patients suffer a myriad of symptoms including among others: intense pain, weight loss, fevers and breathlessness (Bond, Lavy and Wooldrodge, 2008). As the disease progresses, the patient's body may develop gaunt appearances and multiple disabilities. Worden (2009) affirms that witnessing the progression of AIDS can be traumatic for caregivers as the physical wasting alters the former appearance of patient.

Additionally, some patients present with fungating wounds or heavy discharges. Some hospice staff who may not be well prepared for such patient conditions could get traumatized when these changes occur. Hospice staff members offer pain and symptom management (Tetrault, 2012). In institutions with inpatients, the hospice workers may be required to help patients with activities such as taking a bath, using

the toilet as well as change diapers. Caring for these patients could cause staff to develop increased fears regarding their safety and that of significant others rendering them susceptible to vicarious trauma.

Terminally ill patients are psychologically and emotionally vulnerable. Many suffer chronic stress and depression. For some, a diagnosis of a terminal illness means a death sentence which may result in an existential crisis (Onyeka, 2010). They grieve as they count their losses and worry about their families. Their disfigured bodies may evoke shame, guilt or helplessness in patients as well as caregivers, which could easily generate into psychological trauma. Some patients suffer mental disturbances. For example, Bodibe, (2010) noted that in South Africa (SA) 43.7% of AIDS patients suffered mental disorders. The patients' personality gets affected making it hard for caregivers to manage them. Thus, the staff could be traumatized, especially if they are ill equipped to deal with such complex disorders.

Literature shows that in the developed world, healthcare is generally advanced. Patients' conditions are diagnosed early and hospice care is well organized, with complete multidisciplinary teams whose roles are well-defined. In contrast, hospice care is fairly new in SSA. In addition, approximately 80% of patients present with advanced disease (WHO, 2012). Most African countries (Kenya included) lack the developed model with a full hospice team (Cameron, Viola, Lynch & Polomano, 2008, cited in Majuta, 2010). Nonetheless, caregivers across nations face emotional distress. For instance, a study by Abendroth & Flannery (2006) in USA found that 78% of hospice nurses were prone to CF.

Another study in USA revealed that 12% of palliative care physicians reported depressive symptoms, anxiety and sleep disturbances (Vachon & Mueller, 2009). Similarly, nurses providing HIV care in Uganda showed that their ability for compassionate care ebbed as their personal reserves diminished (Harrowing, 2011). Although these statistics implied that many caregivers got adversely affected, some were not affected. The current study sought to determine whether there was a relationship between caregivers' personal attributes and VT occurrence.

Hospice care in Kenya began in 1990 (Kenya Hospice and Palliative Care Association [KEHPCA], 2012) with the opening of the Nairobi Hospice. Subsequently, other hospices were opened up in other parts of the country. Usually, the staff visit patients in hospitals, homes (for the bedridden) and offer daycare services where patients converge to share their experiences. The few available members of staff perform multiple roles. Nurses serve as clinicians, pharmacists, social workers, counsellors and play other roles where practitioners are unavailable (Kinyanjui, 2006, Nyakundi, 2013). Many caregivers are ill prepared for these diverse roles which require empathic engagement with the client. Consequently, members of staff are more exposed to the risk of developing VT particularly when they are unable to maintain empathic boundary or if their competence is threatened.

Death is common in hospices. In fact the approach in hospices is such that it allows patients to prepare for death (Tetrault, 2012). The workers watch their patients as they deteriorate until they die. They witness parents grieving the death of their children and vice versa. They are thus forced to face their own mortality which could make them

experience a sense of futility. Sometimes workers may avoid seeing their patients to escape these distressing feelings. National Cancer Institute (NCI, 2012) asserts that clinicians avoid discussing death with their patients for fear that it may signify loss of hope. Avoidance could be a sign of VT.

Hospice non-medical members of staff play a crucial role in the smooth running of hospices (Swinney, Lee, Rubin, & Anderson, 2007). Their jobs involve administration, psychosocial support, personal care for patients and their cleanliness. They too develop substantial interactions with dying patients. Since nearly 77% are involved in direct patient care (National Hospice and Palliative Care Organization [NHPCO], 2007), the staff are likely to experience some negative effects. This is especially so because at the heart of hospice care is staff-client relationship, which makes empathetic engagement critical. It is against this background that hospice staff form close relationships with their clients. This could pose a risk of developing VT especially if they were unable to maintain healthy empathic boundaries.

Vicarious trauma could adversely affect the members of staff, the hospice and ultimately the clients if it is not adequately addressed. A study in Botswana found that workers caring for cancer patients had elevated levels of disruption in self-trust, self-control, safety and intimacy (Majuta, 2010; Vachon & Mueller, 2009). All staff in hospices are exposed to similar work environment and therefore it can be argued that, they are exposed to trauma at nearly equal rates. However, some of them suffer VT while others do not. The study therefore aimed to establish whether individual attributes related to VT onset among hospice workers.

The Constructivist Self Development Theory (CSDT), on which VT is based, identifies two major risk factors for VT: the nature of the work and factors inherent to the helper (Pearlman & Saakvitne, 1995a). This means that in trauma experience, the traumatic event and individual attributes play a vital role. This study focused on selected personal attributes of staff working in hospices. These were: age, education level, occupation, work experience, gender, personal trauma history and level of empathy. These were selected because they were the commonly cited in literature and were considered as moderators of stress reactions. For example, a study of AIDS caregivers in South Africa (SA) cited risks for VT as: gender; perceived efficacy and personal history of HIV (Graaf, 2011).

Caregivers with trauma history were thought to be more prone to VT, especially when they encountered client trauma similar to their own. Pearlman & McIan (1995) found that helpers with trauma histories experienced more difficulties handling client material. Additionally, it was found that, empathy which was a great asset in caring, could also be a point of real vulnerability to vicarious trauma (Pearlman & Saakvitne, 1995). A major challenge was how caregivers could use empathy to help others without getting adversely affected. Similarly, young age, lower education levels and being female were highlighted in literature as risk factors for vicarious trauma yet some studies produced contrary results. The researcher thus, sought to find out whether these attributes had a bearing on the occurrence of vicarious trauma among hospice workers in Kenya.

1.2 Statement of the Problem

Hospice staff are directly and indirectly exposed to the trauma experienced by the clients they constantly interact with. Their continuous emotional engagements with terminally ill patients plus repeated exposure to numerous losses including loss of lives of some of the patients they serve, renders them vulnerable to VT. However, although all are susceptible to VT some hospice members of staff succumb, while others display a remarkable capacity for resilience and are not adversely affected. The problem underpinning this study is that, although it is well documented that there is a variation in the way hospice staff respond to exposure to traumatic experiences, many previous studies yielded equivocal results. For instance, Graaf (2011) and Osofsky et al., (2008) in their study on VT among nurses and therapists reported that personal trauma history and empathy related to VT onset. Whereas, Majuta (2010), VanDeusen & Way (2006) and Chouliara, Hutchison & Karatzias, (2009) found no correlations between VT and personal factors such as: age, trauma history or empathy.

Moreover, most of these studies tended to focus almost exclusively on one group of staff such as medics and therapists leaving out the non-medical staff who are also directly involved with traumatized clientele and are therefore exposed to VT. In addition, many of the studies available were conducted outside Africa and Kenya which have a different context. Hence, there was a need to further explore the personal attributes that could put some staff members at greater risk for VT compared to others across all cadres of staff in hospice settings in Kenya. The present study therefore, sought to find out the relationship between selected personal attributes and occurrence of vicarious trauma among hospice staff in Kenya.

1.3 Purpose of the Study

The purpose of this study was to determine the relationship between selected personal attributes of staff and the occurrence of vicarious trauma among staff in hospices in Kenya.

1.4 Objectives of the Study

The objectives of the study were to:

1. Find out the prevalence of vicarious trauma among hospice staff in Kenya.
2. Establish the relationship between demographic variables namely: age, occupation, work experience, education level, gender; and occurrence of VT among staff in hospices in Kenya.
3. Determine the relationship between personal trauma history and occurrence of VT among hospice staff in Kenya.
4. Find out the relationship between level of empathy and occurrence of VT among hospice staff in Kenya.
5. Determine strategies that can be put in place to reduce the risk of VT occurrence in hospice caregivers in their work.

1.5 Research Questions

The research questions of the study were:

1. What is the prevalence of vicarious trauma among hospice staff in Kenya?
2. What strategies can be put in place to reduce the risk of VT occurrence in caregivers?

1.6 Research Hypotheses

Based on the objectives the following hypotheses were tested:

1. H_{a1}: There is a statistically significant relationship between occurrence of VT among hospice staff in Kenya and demographic variables namely:
    i. Age
    ii. Gender
    iii. Level of education
    iv. Occupation
    v. Years of experience
2. H_{a2}: There is a statistically significant relationship between level of empathy and occurrence of VT among hospice staff in Kenya.
3. H_{a3}: There is a statistically significant relationship between personal trauma history and occurrence of VT among hospice staff in Kenya.

1.7 Justification and Significance of the Study

Hospice care entails dealing with the terminally ill patients and has a high risk of exposing the caregivers to the development of VT. Determining the prevalence of VT in hospice workers is essential in creating awareness of the existence of this condition among members of staff and other stakeholders involved in hospice care. In essence, a caregiver who has developed VT is incapable of taking care of the patient. Personal attributes play a key role in mediating the development of VT among caregivers. Therefore, identifying the attributes that place workers at risk for, or protect them against VT provides information on how to sustain these professionals in the field; and also helps them meet the significant challenges they face on a daily basis.

Moreover, determining the influence of individual attributes was essential for further development of theory and the subsequent advancement of intervention strategies that were sensitive to individual uniqueness. It was for this reason that the researcher found the study justified.

The results of the study would in effect provide the workers and the stake holders (partners, KEHPCA, Ministry of Health) with critical information on issues regarding caregivers' personal attributes considered as risk factors for VT. This could assist in establishing measures that could address the risk factors and enhance the protective factors to enable the caregivers guard themselves against them. The findings could also lead to developing a line of further research for the Kenyan health sector in related fields among healthcare providers. The findings would also help in developing innovative ways to support staff members; and in creating a conducive environment which recognizes what is required to appropriately sustain work in this very challenging field.

The study also examined the extent to which VT was experienced across different professions in hospices. The findings of the study therefore, would aid the stakeholders in developing organizational competencies in the workplace and ensure appropriate practitioner support. The results would be useful in developing comprehensive policies and laying of strategies by hospice management boards, the Ministry of Health and the national umbrella body - KEHPCA.

1.8 Scope and Limitations of the Study

The study aimed at establishing the relationship between personal attributes of hospice staff, as risk factors and occurrence of VT. Although there were many risk factors for vicarious trauma, the study only focused on the following: demographic variables (age, gender, occupation, work experience and education level), level of empathy (which included empathic components such as: empathic concern, personal distress and perspective-taking) and personal history of trauma among hospice staff in Kenya. This was because these attributes were commonly cited in literature and studies done on individual aspects. The study was carried out only in hospices across Kenya. This could have implications for the generalizability of the study results to other palliative care settings such as the hospital units. The study employed correlational design since it sought to explore the nature of relationships between variables. However this design was limited in that it could not show how one variable caused a change in another variable.

1.9 Assumptions of the Study

This study was carried out with the following assumptions:

i. That some hospice workers in Kenya experienced vicarious trauma
ii. That there were personal attributes within hospice staff that made them vulnerable to vicarious trauma.
iii. That some hospice staff possessed personal attributes that protected them against vicarious trauma.
iv. That the participants were available within the duration of the study and would be willing to share their honest opinions and experience

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature on this study. It begins with a description of the theoretical framework, followed by a review of related studies and ends with a summary of literature review and a conceptual framework.

2.2 Theoretical Framework

The theoretical perspectiveThe theoretical perspective that influenced the study was the Constructivist Self-Development Theory (CSDT).

2.2.1 The Constructivist Self-Development Theory

Constructivist Self-Development Theory propounded by McCann & Pearlman, (1990) was chosen to guide this study. The theory underscores personal attributes in both development and healing of the vicarious trauma. CSDT combines Self-Psychology, Object Relations, Social Learning and Cognitive Theories (Kohut, 1977; Mahler, Pine & Bergman, 1975; Rotter, 1954; Mahoney, 1981; Piaget, 1971 in McCann & Pearlman, 1990). The major assumption of the CSDT includes the understanding that the self is the center of a person's identity and inner life and it has four interrelated features: self-capacities which promote the development and maintenance of positive self-esteem; the ego resources that aid in relating with others; psychological needs that motivate behaviour and the cognitive schemas that are the cognitive manifestations of the psychological needs (McCann & Pearlman, 1990). All these aspects mediate in vicarious trauma. Trauma can disrupt any part of the self-

capacities, needs or schemas depending on the strengths of an individual which are influenced by the personality characteristics and life experiences. According to McCann and Pearlman (1990), adaptation to trauma shows that there is an interaction between life experiences and the self.

Hospice workers whose psychological resources are weak may find themselves emotionally overwhelmed by issues that would not normally impact on them. A caregiver whose ego resources have been impacted negatively, may lack the ability to activate the self-protective skills thus placing him or her at risk for VT. CSDT posits that the psychological needs are mostly impacted by repeated exposure to clients' trauma material. Since each caregiver is unique, the need areas affected differ.

The CSDT assumes that the meaning of trauma is subjective to the survivor in that, individuals are capable of constructing their own perceptions of reality and to alter these perceptions if need arises (McCann and Pearlman, 1990). Individuals differ in the way they give meanings to traumatic events because it depends on how each experiences a particular event. In the context of this study, every hospice member of staff is unique and each one constructs personal realities and meanings as he or she interacts with distressed patients daily. As a result therefore, hospice members of staff who are generally in the same work environment may be affected differently depending on the meanings they ascribe to these stressors and strengths of their personal capacities. Those who view these as threats are bound to get adversely affected while others who make positive meanings out of the situations are less likely to be at risk for VT. The personal realities may include age, gender, socioeconomic

level and the personal histories (Pearlman & Saakvitne, 1995). The theory thus guided the researcher in identifying the personal attributes that could influence the way one adapts to the trauma symptoms or recovery and was thus seen as appropriate in informing this study.

2.3 Review of Related Studies

This section contains a review of literature relating to the occurrence of vicarious trauma in caregivers working in hospices. Literature was reviewed with regard to prevalence of vicarious trauma as well as the personal attributes as risk factors for vicarious trauma among hospice workers.

2.3.1 Symptoms and Prevalence of Vicarious Trauma

Research indicates that persons caring for suffering patients tend to exhibit similar symptoms as those of their clients. The patients' agony, fears or distrust infect the caregiver resulting in changes in their worldview as well as profound disruptions of their cognitive schemas. McCann and Pearlman (1990) used the phrase vicarious trauma to explain this condition. VT concept is associated with constructs such as: secondary traumatic stress (STS) and compassion fatigue (CF), although there are noteworthy differences depending on context (Newell & MacNeil, 2010). The term vicarious trauma has been used in the current study as a broad concept encompassing the two terms, yet, it is crucial to highlight some differences that exist in literature. Figley (2002) defined CF as the behavioral and emotional effects that result from a traumatizing event experienced by a significant other or from caring for a distressed person. STS is the stress resulting from witnessing others' trauma (Figley, 2002).

Some authors argue that CF and STS can occur from a single client while VT is cumulative and probably more devastating.

There is need to recognize and address VT due to its deleterious consequences. Symptoms include: invasive imagery such as flashbacks or nightmares, avoidance, increased arousal, irritability and disruptions of cognitive schemas including diminished capacity for intimacy and trust (Bride & Figley, 2007; McCann & Pearlman, 1990a). These effects can be short or long term, or permanent. VT is an occupational risk as it permeates the personhood of the caregiver impairing the quality of their personal and professional lives. The caregivers' job performance is affected in that they may deliver sub-quality services to clients. Traumatized hospice staff may disassociate from the client, hence, ruin the relationship which is the heart of their service.

VT continues to be prevalent among caregivers although the rates vary. Findings of studies reviewed by the researcher showed rates between 26% and 90%. Dunkley and Whelan (2006) conducted a study in Australia among telephone Behavioural Health Clinicians. The findings indicated a VT prevalence rate of 26%. Similarly, a study in USA on the effect of therapist work and supportive factors on VT in community mental health agencies revealed that 64.1% suffered moderate to high vicarious trauma (Williams, 2010). Although these studies highlighted some personal aspects (such as: gender, age, work experience, childhood trauma) that could lead to VT onset, the focus was only on therapists not other personnel working in the same institutions. This study aimed to fill this gap by including all personnel.

In addition, Middleton carried out a study in USA among child welfare professionals on the relationship between VT and job retention. Results indicated that about 26% - 35% of participants experienced core aspects of VT (Middleton, 2011). Similarly Komachi, Kamibeppu, Nishi, Matsuoka (2012) conducted a study on STS and related factors among nurses in Japanese hospitals. Results indicated a secondary trauma prevalence of 90.3%. These studies showed variations in trauma prevalence rates among caregivers, thus for comparison purposes the current study aimed at establishing the trauma prevalence rate among hospice staff in Kenya.

Moreover, Majuta, (2010) conducted a study in Botswana on the relationship between VT, quality of life and purpose in life among 83 caregivers of cancer patients. Notable in this study were the high levels of disruptions in the caregivers' trust, control, safety and intimacy. This underscores the present study's concern about the levels of VT among caregivers in hospice settings in Kenya whose main clientele are cancer patients. It informs the present study on the individual aspects that play a key role in VT occurrence as well as the subjectivity of the experience. Secondly, the study focused mainly on caregivers' quality of life not specifically on their personal attributes as risk factors for VT, a void that the current study aims to fill. The extent to which hospice staff in Kenya exhibit VT symptoms and how their personal attributes relate to their experiences were of key interest in this study.

2.3.2 Hospice Staff and Vicarious Trauma

Hospice work involves caring to improve both the physical and psychological discomforts of terminal illness and dying, hence staff-client communication is often

emotionally charged (Way, 2010). McCann and Pearlman (1990) posit that, even when caregivers are extensively trained, they may not be fully prepared for the agonizing images or emotions that can be elicited in the course of interacting with suffering clients. A hospice staff may get distressed just by witnessing clients' difficult experiences or due to the empathic bonding with them.

The physical wasting and gaunt images associated with advanced cancer or AIDS leave most patients weak or disabled. Many of them depend heavily on the caregivers for assistance in activities of daily living like: bathing, dressing, taking medications, tube feeding or ventilator care. A study in South Africa found that 16-17% of AIDS patients could not control their bladders or bowels and needed help to the toilet and in bathing (Steinberg, Johnson, Schierhout & Ndegwa, 2002). Dealing with patients' incontinence, bed sores and dressing of cancerous wounds can be challenging even for the trained medics. Depending on their personal constructs, some may find this type of caring fulfilling while others may not; thus rendering them vulnerable for negative outcomes. Therefore, a caregiver who has excessive empathy may not maintain emotional boundary, which may result in vulnerability to VT.

In addition, caregivers experience numerous losses through multiple deaths of patients in a short time. Consequently, they may get emotionally drained. This was affirmed in a study on health personnel caring for HIV/AIDS patients in SA and Zambia, which showed that they felt emotional stress and inability to handle death of patients (Demmer, 2006; Dieleman, Biemba, Mphuka, cited in Gysels, Pell, Straus & Pool, 2011). This stressful scenario could be a precursor for VT onset in caregivers

particularly if their individual attributes make them vulnerable. Hospice caregivers thus suffer cumulative effects of constantly empathizing with mothers of dying children, anguishing patients and watching family members' pain as they struggle to cope with the looming loss of a loved one. This could cause an emotional drain if one's ego resources are inadequate. Consequently, there is need for caregivers to be made aware of personal attributes that could, augment vulnerability to VT.

There are numerous challenges facing hospice staff in Africa, Kenya included (Marete, 2010). These range from scarce resources to handling a large clientele with advanced disease. This is aggravated by the fact that, most hospices maintain limited numbers of professional staff. As a result therefore, staff play multiple roles, some of which they may not be competent in. This could create a positive feeling for some care givers who may use their creativity to help the terminally ill, hence having a sense of fulfillment. But it can also create a sense of lack of control, helplessness and futility in some caregivers which can easily generate into VT.

While it is true that some caregivers cope well with these conditions, others may not possess the strong personal traits to keep up with this work. Given the empathetic engagement that exists with these clients, it is likely that caregivers who are unable to maintain an emotional boundary, may become vulnerable to VT. In addition, caregivers who employ maladaptive coping styles are more prone to VT. This may lead to attrition of expertise among those offering care (Gysels et al., 2011).

2.3.3 Personal Attributes as Risk Factors for Vicarious Trauma

The development of VT is complex as both personal and professional dynamics pose as risk as well as protective factors (McCann & Pearlman, 1990a; Osofsky, Putman, & Lederman, 2008). Various studies have identified predictive factors for VT in caregivers as: exposure to trauma clients; the nature of work, the caregiver's level of empathy, gender, age, years of experience and personal trauma history (Devilly, Wright & Varker, 2009; Sabo, 2008; Adams, Figley, & Boscarino, 2008; Kadambi & Truscott, 2008, cited in VanDeusen & Way, 2006).

Another related study was carried out in South Africa by Graaf (2011) on associations between personal attributes and CF among AIDS caregivers. The study found significant effects on personal attributes such as; gender, personal history of HIV or AIDS and self-care. Nevertheless, personal attributes such as gender and social support may have a variety of effects depending on the cultural context of the individual. Culture defines a sense of self (Neukrug, 2007), hence there is a possibility that hospice personnel in Kenya could respond differently. This led the researcher to hypothesize that there could be an association between specific individual attributes and the occurrence of VT. The following sections will discuss the selected personal attributes that could relate to the onset of VT.

2.3.4. Demographic Variables and Vicarious Trauma

Demographic factors play a vital role in the development of VT in caregivers. These include among others: age, gender, education level, occupation and work experience. The caregiver's age, level of education and work experience may be critical in the

occurrence of VT. Various researchers have found that young workers or those with less professional experience are more at risk of experiencing VT (Baird & Jenkins, 2003; Bride & Figley, 2009; Ghahramanlou & Brodbeck, as cited in Kaladow, 2010). Similarly, Măirean &Turliuc, (2013) conducted a study in USA on predictors of VT beliefs among medical staff in the context of treating human pain. The researchers concluded that increased age and years of service correlated with decreased disruption in beliefs.

An earlier study on VT among self-identified trauma therapists by Pearlman and Mac Ian cited in Canfield (2008), found that those therapists that were new in the workplace experienced more emotional difficulties. This could probably be due to the fact that they are just beginning to integrate the stresses within their work settings. However, other related studies conducted among oncology nurses have found no significant relationship between age or years of experience and trauma (Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris & Olsen, 2010). The findings of these studies were inconsistent. It is worth noting that these studies were done mainly among therapists and nurses leaving out other staff members. Additionally the studies were conducted in the developed countries in the West. It is important therefore to examine if there is a relationship between the age and years of experience and occurrence of VT among hospice staff in a developing country.

Lower level of education has been found to be a risk for VT onset in some cases. Baird and Jenkins, cited in Kaladow, (2010) found that counselors with higher education levels reported less symptoms compared to those with lower education

levels. Various other studies in the West have given similar results. Very little has been done to establish the same among hospice workers in Kenya. According to the Human Rights Watch interview (2010), palliative care is scantily addressed in medical schools in Kenya leaving a majority of Kenyan medics with insufficient skill in this area. (KEHPCA, cited in Human Rights Watch, 2010). The education levels could probably have an effect on how hospice caregivers in Kenya respond to trauma exposure. On the contrary, some studies have found that demographics such as age or education level are not associated with VT onset, (Chouliara, Hutchison & Karatzias, 2009). This study intends to establish whether a relationship exists between age, education level, work experience of the caregiver and occurrence of VT in Kenyan hospices.

Gender is also a common demographic variable in trauma related studies. Many researchers concur that gender may moderate the effects of trauma even when the sources and levels are uniform; one gender may be more vulnerable to negative outcomes than the other (Davis, Burleson & Kruszewski, 2011 cited in Ben-Zur & Zeidner, 2012). Although findings of various studies on gender and VT incidence have been inconsistent, some showed that being female is a risk factor for VT (Bride, 2004; Dunkley and Whelan, 2006; Osofsky et al, 2008; Knight, 2010; cited in Branson, 2011). Other researchers argue that although females are generally exposed to fewer traumatic events compared to males, females exhibit high levels of symptoms (Matud, 2004; Ben-Zur, et al., 2012). A study was done in Israel by Ben-Zur et al., (2012) on gender variations in loss of psychological resources as a result of

vicarious stress in students. The researchers concluded that gender and mastery played a vital role in how one responds to life-threatening events.

Researchers have differed in their views regarding vulnerability among men and women. Literature indicates that women tend to admit issues of vulnerability more than men who are more guarded for fear of appearing weak or incompetent. Socialization and culturally-based learning experiences could probably explain this trend (Ben-Zur et al, 2012). Gender role socialization theories have been used in an attempt to clarify issues relating to gender and trauma. Depending on the socio-cultural context within which the individuals find themselves, men and women may differ in their expressions of emotions, probably due to their societal roles. In some cultures where females are socialized to adopt less effective coping techniques such as avoidance (Rosario, Shinn, Morch & Huckabee, 2006), they may become more vulnerable to VT.

On the other hand, males are taught to assert their independence and masculinity making them more resilient. Although male and female personnel in hospices may respond differently, both may have traits which can cushion or expose them to VT at equal levels depending on their socialization process. This study thus, seeks to establish whether gender differences relate to the experience of VT among staff members in hospices within the Kenyan context. Susceptibility to VT in females could possibly be attributed to their ability to be more empathetic (Baron-Cohen & Wheelwright, 2004; Rueckert & Naybar, cited in Rueckert, Branch, & Doan, 2011). Howard (2011) argues that, women are more likely to seek out help for emotional

difficulties than males. This implies that men could be experiencing similar effects but since they do not voice them out, it is assumed that they are resilient. This study seeks to determine how hospice staff members' gender relates to the occurrence of VT in Kenya.

2.3.5 Personal Trauma History and Vicarious Trauma

Hospice staff may have experienced traumas in their own lives that may influence the way they do their jobs. For example, they may over generalize their experiences or coping strategies to the clients (Figley, 1995). Personal trauma history entails the distinctive individual traumatic experiences of the caregivers (Pearlman & Saakvitne 1995a). In the current study, personal trauma history consists of threatening events experienced by hospice staff as individuals or awareness of traumatic experiences of significant others such as family of origin or friends. The experience may include childhood trauma, serious injuries or chronic and terminal conditions of self or loved ones (Jordan, 2010, as cited in Gerding, 2012). Some researchers have found a history trauma to be a risk factor of VT.

A study on 188 trauma therapists was conducted by Pearlman and Mac Ian (1995). The study found that 60% of the trauma therapists had experienced personal trauma in their lives, and these reported greater VT than did those without a personal trauma history. Additionally, Kassam-Adams (1995) conducted a study on the association between exposure to traumatized clients and STS in therapists in USA. History of trauma was found to be an indicator of trauma symptoms. Another study in Australia on Behavioural Health Clinicians by Dunkley & Whelan, (2006) found personal

trauma history to be a risk factor for VT among the BHCs'. Other studies also found similar results (Adams & Riggs, 2008; Radey & Figley, 2007; cited in Branson, 2011). This was of key interest to the current study in that, it informed the researcher on specific individual attributes that could relate to the onset of VT. Notably, all these studies were conducted outside Kenya in the Western countries. In addition majority were carried out mainly among clinicians in health settings other than hospices.

Consistent with the above research is another study on child welfare which gave similar results. In their study, Bride, Jones, and McMaster, (2007) surveyed 187 workers in child welfare services in USA regarding personal history of trauma, social support, work experience and size of caseload. Results of the study indicated that 92% welfare respondents reported experiencing STS symptoms. Significant relationship was established between secondary traumatic stress levels and personal trauma history (Bride et al., 2007; cited in Middleton, 2011). Similarly, a study in USA revealed that genetic counselors with a trauma history had higher levels of VT, particularly when handling clients with similar trauma (Benoit, Veach & LeRoy, 2007). Again, all these studies were done in the West among therapists unlike the current study which focused on all categories of staff in the hospice settings.

There has been very little vicarious trauma research documented in Africa, particularly in Kenya. Muli-Karugu (2006) conducted a study on the prevalence of VT among caretakers in Kakuma refugee camp in Kenya. It is important to note that in this study 73% were non-medical participants. Results indicated extremely high levels of VT in subscales of safety, esteem and control. About 81% of the participants

had a history of personal trauma. This possibly implies that caregivers with past unresolved traumas tend to have a deeper empathic response which may cause the traumas to be easily triggered and re-lived. These findings mainly concentrated on VT prevalence, while the present study further sought to establish whether there was a relationship between personal trauma and VT among staff. Unlike the previous study which mainly focused on caregivers in a refugee camp, the present study was based on hospice settings in Kenya.

Having a history of personal trauma, however, may not necessarily be a disadvantage to the caregiver. Linley and Joseph, (2007), as cited in Chaverri (2012), observed that it is also very possible that a therapist's personal trauma history can be a factor in his or her personal growth potentially leading to an increased well-being. VanDeusen and Way, (2006) conducted a study in USA to examine vicarious trauma effects in clinicians working with sexual abuse survivors. The study found no association between history of childhood abuse and VT outcomes. Other studies showed similar results (Knight, 2010; cited in Branson, 2011).

Accordingly, if those caregivers with personal trauma histories have undergone therapy and recovered from their trauma, then they may be in a better position to initiate self-care techniques that prevent adverse effects such as VT. The results of these studies regarding personal trauma were contradictory and therefore not conclusive. This formed the basis for one of the objectives in the present study. Many of the existing studies regarding past trauma and VT have evidently been carried out in Western countries with very little done in the African continent, particularly in

Kenya. Most of this research has focused typically on physical or sexual abuse, combat and crises. Furthermore, the implication in the reviewed studies is that the research findings on effects of personal history on occurrence of VT is not unequivocal, hence the need for further research in this area.

2.3.6 Empathy and Vicarious Trauma

Empathy is the capacity to gain insight into another individual's inner experiences and to view the world from their perspective (Hojat, Mangione, Nasca, Gonnella, & Magee, 2005). The ability to empathize leads one to respond empathically as he or she gains insight of the other person's feelings and thoughts. Literature reveals that there is a difference between cognitive and affective empathy. Pearlman and Saakvitne (1995a) clarify that cognitive empathy is the way one experiences life-threatening event as narrated by the traumatized client. It allows one to maintain an understanding of the patient's situation without the risk of developing VT, while affective empathy is how one experiences the client's anguish which may pose a risk for VT onset. Therefore, a caregiver who is overly empathic may be at risk of developing VT.

In assessing level of empathy, Davis (1983), points out that empathy is made up of various components which include among others: perspective-taking, empathetic concern and personal distress. Perspective-taking relates to what Pearlman and Saakvitne (1990) call cognitive empathy in which a person is able to understand the point of view of others. Empathic concern also known as affective empathy refers to the concern and sympathy for others, while personal distress involves feelings of personal anxiety in response to the emotions of other persons.

Empathy has been described as a 'double-edged sword' (Kaladow, 2010), it is a vital tool in hospice care, yet a point of real vulnerability as it may transfer trauma from one person to the next (Figley, 1995). The caregiver may become too over-involved with particular clients in their journey of terminal illness. A study in USA found that caregivers had higher VT scores with risk factors being empathy and compassion (Rose, 2008).

In the context of this study, it appears likely that some hospice staff, could get entangled with patients making it particularly challenging to disengage resulting in staff vulnerability to VT. Jordan (1997) however, argues that vulnerability due to empathy can also become an opportunity for personal growth rather than risk. She argues that safety resides in connectedness with others. Thus, although empathy makes caregivers vulnerable to VT it can also be a protective factor for others. This implies that it is not clear what levels of empathy may be productive or unproductive which is a concern of this study.

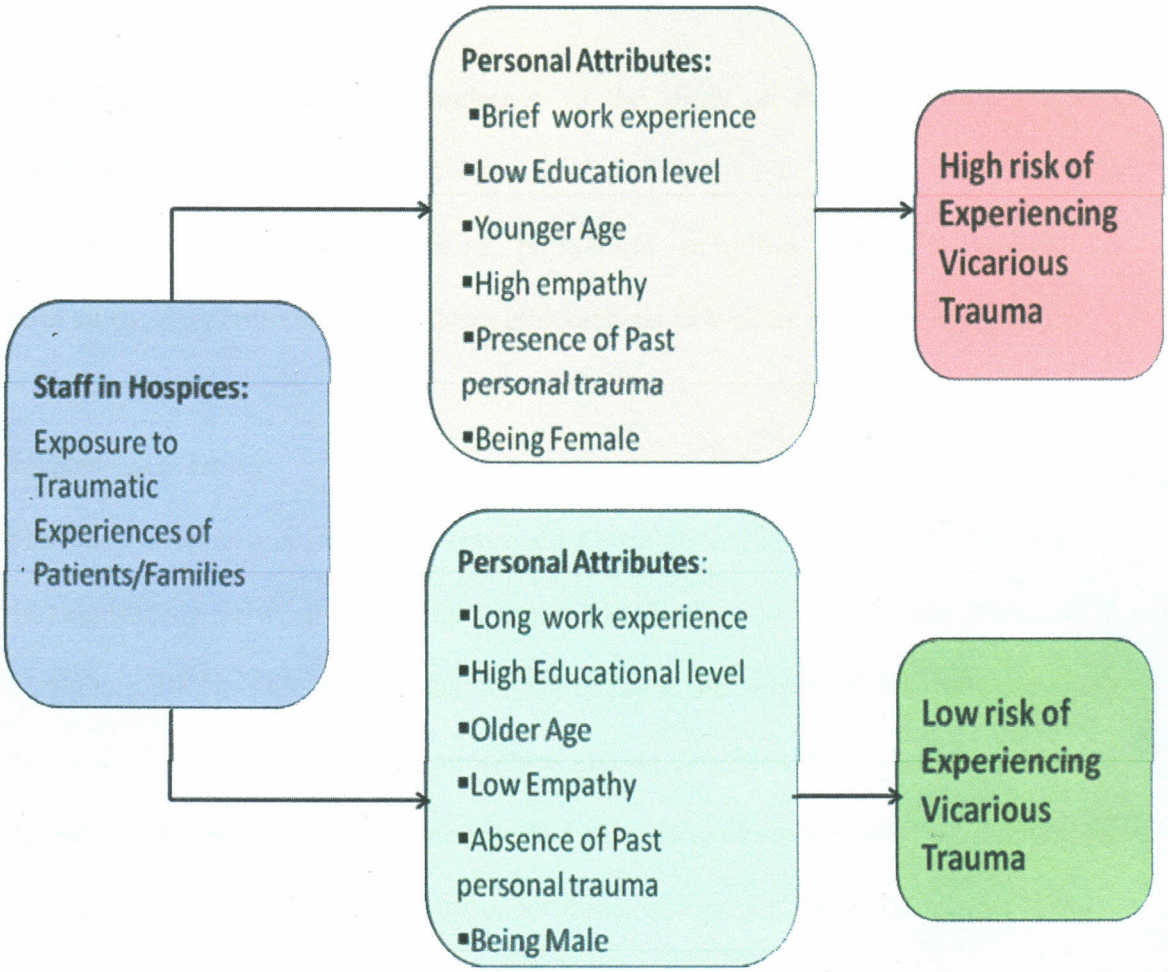
2.4 Summary of Related Studies

This chapter reviewed literature in order to gain an understanding of how personal attributes relate to the onset of VT among caregivers. The theory (CSDT) guiding the study was highlighted. The concept of VT was explored in detail with reference to CSDT. Literature revealed that factors that place individuals at risk for VT revolve around work environment, personal and cultural aspects. There has been limited research on how VT relates to individual's age, experience, education level, gender, personal trauma and empathy. Many studies on VT were limited by inconsistent

findings. The studies also tend to focus mostly on professionals working with populations traumatized by interpersonal violence or crisis workers. This has tended to leave out the people working with the terminally ill. Hospice staff are likely to be prone to VT depending on factors intrinsic to the individual. There is limited local research on VT to guide our understanding and intervention of this phenomenon with regard to hospice workers. It is yet to be conclusively demonstrated that hospice staff across various disciplines within hospices exhibit significant levels of VT, a gap that this study intends to fill. However, the theoretical framework and literature reviewed provide adequate information upon which the conceptual framework is based.

2.5 Conceptual Framework

The conceptual framework is derived from the theoretical framework and literature review. The key variables shown include: personal attributes (age, gender, work experience, education level, occupation, level of empathy and trauma history); and vicarious trauma. In view of literature, it was presumed that individual attributes were predictors of vicarious trauma. The experience of vicarious trauma by a hospice member of staff could be influenced by their personal attributes. A member of staff who has brief work experience, low education level, unresolved trauma, high empathy as well as younger in age may be more likely to experience vicarious trauma as shown in figure 2.1.



Source: Musili 2015

Figure 2.1 Conceptual framework showing relationship between personal attributes and VT

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology of the study on the relationship between personal attributes and the occurrence of VT among hospice workers in Kenya. The chapter presents the research design, population, sampling process, research tools, pilot study, data collection procedures and analysis as well as ethical considerations.

3.2 Research Design

The study adopted a correlational approach. Correlational designs are used to examine the relationship between two or more variables (Orodho, 2003; Heppner, Wampold & Kivlighan, 2008). This design was chosen because the nature of the study was such that it sought to establish any relationships among variables. It also sought to explain the nature of relationships between selected hospice workers' personal attributes (age, gender, level of education, years of experience, occupation, personal trauma history, and level of empathy) and the onset of VT.

3.3 Study Variables

In the present study, the independent variables or predictors which were seen as responsible for bringing about change in VT included the personal attributes namely: age, gender, education level, work experience, personal trauma history and level of empathy of the hospice staff. The dependent variable was the occurrence of VT. The indicators of VT as described by Pearlman and Saakvitne (1990), in their theory (CSDT) include: changes in the worldview, spirituality and self-identity, disruptions

in the cognitive schema (trust, safety, intimacy, power and control), intrusive imagery, avoidance and arousal.

3.4 Location of the Study

The study was carried out in selected hospices across Kenya. There were a total of 21 hospices within the country at the time the study was conducted. The hospices were not evenly distributed throughout the country and were found only in a few counties including Nairobi, Mombasa, Kiambu, Murang'a, Nyeri, Meru, Embu, Nakuru and Uasin Gishu counties. Out of these, eighteen operated as free standing facilities owned and operated by hospice management boards, while three were Faith based Organizations (FBOs) found among communities in the rural settings (KEHPCA, 2013). The study included members of staff working in both free standing and FBO units.

3.5 Target Population

The target population of the study comprised all the staff members employed within the hospices in Kenya. The total number of staff members employed in hospices during the study was 120 according to the statistics obtained from the Kenya Palliative and Hospice Care Association (KEHPCA, 2015). During the time of the study there were a total of twenty one hospices in Kenya. The job designations of hospice staff included: physicians, nurses, social workers, administrators, chaplains, counsellors and other support staff. These are shown in table 3.1.

ble 3.1 Population of Hospice Staff in Kenya

ospice	No of Staff								
	Physicians /Clinical Officers	Nurses	Social workers	Physio-therapists	Admin-istrators	Chaplains	Counsellors	Support staff (Drivers, cleaners, cooks etc)	**Total**
rangá	0	1	0	0	1	0	1	1	**4**
ru - Mbeere	-	2	0	0	1	-	0	2	**5**
ia	-	1	1	1	1	-	0	0	**4**
ret	-	2	1	0	1	-	0	2	**6**
eri	-	3	1	0	1	-	0	2	**7**
ru	1	2	1	0	1	-	0	2	**7**
robi	1	3	1	0	2	-	0	4	**11**
st	0	2	1	0	1	-	0	2	**6**
kuru	1	2	1	0	1	-	0	2	**7**
Catherine's me	0	1	0	0	0	0	0	0	**1**
kamega	0	1	1	0	1	-	0	1	**4**
herine Auley	0	1	0	0	0	0	0	0	**1**
ruma	1	1	0	0	0	0	0	0	**2**
ska Medical ntre	0	1	0	0	1	0	0	1	**3**
ya Roselyne ntre	-	2	0	0	0	-	0	1	**3**
kipia	-	2	1	0	1	-	0	1	**5**
mu	1	2	1	0	1	-	0	2	**7**
hururu	-	1	1	0	1	-	0	1	**4**
bilio	1	3	1	1	2	-	0	5	**13**
Lady spice	1	2	1	1	2	1	0	5	**13**
a	1	2	1	0	0	1	0	2	**7**
TAL	**8**	**37**	**14**	**3**	**19**	**2**	**1**	**36**	**120**

3.6 Sampling and Sample Size

The sample was drawn from the twenty one hospices across Kenya. The researcher utilized two sampling techniques: stratified random sampling as well as purposive sampling. To ensure representativeness proportionate stratified sampling was used to select ten hospices. This guaranteed that participants from each subgroup were included in the final sample. The hospices were first stratified based on ownership criterion into two strata: free standing units which were owned by companies; and faith-based or community-based organizations (FBOs) owned by faith or community based organization and which are mainly found in rural settings. The free standing units comprised eighteen hospices forming 85.7% of the total number of hospices; while faith or community-based ones consisted of three units which formed 14.3% of the hospices in Kenya. A total of eight hospices were selected from the stratum of free standing units and two hospices from the stratum of FBO facilities yielding a total of ten hospices. This was obtained by dividing the proportion of units in each stratum by the total number of the institutions and multiplying it by the desired sample size.

Since the hospices maintained a small workforce, the study included all the staff members comprising male and female personnel in the sampled institutions. Thus a total sample size of 77 staff members from the ten (10) hospices was included in the study. This sample represented 64.2% of the total number of hospice staff in Kenya. This was more than 30% of the total number of the targeted population. According to Borg and Gall, (2003) and Mugenda and Mugenda, (2004), at least 30% of the total population is representative. The specific sample size is presented in table 3.2.

Table 3.2 Sample Size of the Study

Hospices (Ownership)	Professionals	Non-Professionals	Total
Free-Standing Hospices	36	15	51
Faith-Based Organization	16	10	26
Total	52	25	77

3.7 Research Instruments

The current study employed four structured self-report tools to measure the variables as guided by the objectives. They included: a brief questionnaire on demographic information devised by the researcher, a brief Trauma History Questionnaire adapted from Green, (1996), Vicarious Traumatization Scale (VTS) by Middleton (2010) and the Interpersonal Reactivity index (IRI) by Davis (1980) which measured the level of empathy. These scales were considered to be a beneficial method of data collection for three reasons. First they enabled the researcher to obtain a level of standardization. Secondly, the instruments had previously been used with trauma workers, and thirdly, they were relatively short and easy to use as self-administered tools. Each of these tools is described in details below.

3.7.1 Brief Trauma History Questionnaire

Personal trauma history was measured using a scale comprising 12 items selected from the Trauma History Questionnaire (Green, 1996) to form a brief trauma history tool. The scale was modified to suit the context of the participants. Only items that were considered to be relevant to the hospice work like life threatening experiences were selected. For instance: *Have you ever had a family member, relative or close*

friend die? Have you ever had a serious or life-threatening illness? The scale comprised 'yes' or 'no' responses. The items were then scored by adding up the scores of all the 12 items. Scoring was done as follows: No = 0 and Yes = 1. The lowest possible score was 0 while the highest possible score was 12. A higher score meant higher level of trauma.

3.7.2 Vicarious Traumatization Scale (VTS)

The Vicarious Traumatization Scale (VTS) developed by Middleton (2010) was used to measure vicarious trauma among hospice workers. This was adapted to suit the context of the present study sample. Using the results of the pilot study, the items which were found to be confusing to the participants were modified. For instance item forty seven which read in part: *"...I see abuse everywhere..."* was modified to read *"I notice life threatening conditions everywhere."* The 34-item scale was designed to measure the changes within the caregivers' self as well as disruptions in the cognitive schemas of caregiver's identity and belief system (Pearlman & Saakvitne, 1995 cited in Middleton 2011). The Vicarious Trauma Scale was developed through an evaluation of theory and research of the construct and qualitative data collected form earlier study on VT among child welfare professionals (Middleton, 2010). It is a measure based on a 6-point rating scale with response options ranging from: 1 = Strongly Disagree to 6 = Strongly Agree. Higher scores on this scale represent greater VT. The scale is brief and has good psychometric properties.

The scale was also modified such that if participants reported any level of disagreement in regards to scale items (strongly disagree, disagree, and slightly

disagree) the score was zero (0) indicating absence of vicarious trauma and any levels of agreement were scored as: 1= slightly agree, 2= agree, 3= strongly agree indicating presence of vicarious trauma. The lowest possible score for an item was 0, so since there were a total of 34 items, the highest total possible score was 102. The total sum of scores was used to establish the presence or absence of vicarious trauma (VT). For each item, a score of 0 meant absence of VT; while a score of one 1 indicated presence of VT. A total score of up to 17 indicated absence of VT, while a sum of above 17 indicated presence of VT. The scores are grouped in mean ranges as follows: 0 to 17 meant no VT; 18 to 34 meant low VT, 35 to 68 moderate VT, 69 to 102 meant high VT.

3.7.3 The Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index (IRI) by Davis (1980) was used to measure the level of empathy. This tool consisted of selected items from the IRI scale. The adapted scale comprised of 28-items on a 5-point Likert scale which ranged from: "does not describe me well" to "describes me very well". Higher scores on the scales indicate greater empathy. The tool was adapted by the researcher and only three out of the four subscales were used in the study, with each assessing a specific dimension of empathy as follows: the Perspective-Taking (PT) subscale assessed an understanding of the point of view of others (cognitive empathy), the Empathetic Concern (EC) assessed concern and sympathy for others (emotional empathy), while the Personal Distress (PD) examined feelings of personal anxiety in reaction to the emotions of others (Davies, 1983).

Positive statements were scored from 0 to 4, while scores for negative items were reversed from 4 to 0. In order to give a general view, all items were summed up to obtain the overall level of empathy first based on a combined score of the three subscales (ranging from 0 to 84). Thereafter, each subscale was scored separately in order to give weight to each component as guided by the author (Davis, 1980). A higher score indicated a greater level of empathy for the participant.

3.7.4 Open Ended Questionnaire

In addition, an open ended instrument was used to collect qualitative data regarding the practices that facilitate coping with the nature of work in hospice settings. Two open ended questions were used. The first, sought to find out the strategies used by the caregivers to cope with the nature of their work; the second, sought to find out the strategies the organizations could come up with to help caregivers cope with their work.

3.8 Pilot Study

In order to assess the appropriateness of the instrument, the researcher conducted a pilot study in which the questionnaire was administered to 14 purposively selected participants in one hospice. This was carried out in Coast Hospice which is not in the sampled units of the final study. This hospice was selected first because it has similar characteristics with the units in the study sample. Secondly, it serves a wide area within the Coastal region and it provides a variety of services to a wide range of clientele. Analysis and feedback from the pilot data was used to identify any flaws as well as check for consistency in the interpretation of questions and eliminate any

ambiguous items. From the pilot, some challenges in answering some items were noted and adjustments were made appropriately. This enhanced the reliability of the tools.

3.9 Validity and Reliability of the Instrument

In developing the tools, the researcher took time to ensure that each objective was put into consideration. The instruments were adapted from standardized tools and were modified to suit the Kenyan context. To enhance construct validity, the variables under study namely: vicarious trauma and personal attributes were operationalized as guided by existing literature and theory. The researcher made efforts to ensure that items of each of the tools were relevant to the constructs as they were defined in the present study. To enhance content validity, the researcher ensured that items of each of the tools had covered the various dimensions of the constructs as defined in the study. In addition, expert opinion was sought from a team of supervisors and peers who offered recommendations from their research experience to ensure that the items were balanced.

Test-retest method was used to check the reliability of the instruments used in the study. During piloting, the instruments were administered in two successive occasions under similar conditions to 14 participants in a duration of three weeks. The two administrations were scored. The relationship between the scores of the respondents for the two different administrations was established using Pearson Product Moment Correlation Coefficient to determine how similar, stable and consistent the scores of the tool were across time. The results were presented in table 3.3.

Table 3.3 Reliability Coefficient of the Instrument

Administration		Scores of first Trial	Scores of second Trial
Scores of first Trial	Pearson Correlation	1	.681**
	Sig. (2-tailed)		.000
	N	14	14
Scores of second Trial	Pearson Correlation	.681**	1
	Sig. (2-tailed)	.000	
	N	14	14

From table 3.3 the correlation coefficient (r) of 0.681 was established which rounds to the 0.7 threshold recommended by Mugenda and Mugenda (1999). The researcher also made efforts to ensure reliability of each of the tools by ensuring that sufficient items were included without prolonging the tool unnecessarily. The researcher also held discussions with pilot respondents who provided useful feedback regarding the wording and length of the tools. This further enhanced the reliability of the instruments as the items were modified appropriately.

3.10 Data Collection Procedures

With the help of an introduction letter from Kenyatta University graduate school, the researcher processed a research permit from the National Commission for Science, Technology and Innovation (NACOSTI). Data collection commenced after the research permit was granted. The initial contact with hospices was made by phone. A personal visit was made to KEHPCA office as well as the hospices as follow-up. This was also aimed at building rapport and making appointments with the administrators in the selected hospices. After obtaining consent from the participants, the researcher

clearly explained that the information gathered was solely for research purposes and that participation was purely voluntary. The instructions pertaining to keenness and accuracy were spelt out clearly. Thereafter, the participants were invited to participate. The researcher along with three trained research assistants then administered the questionnaires to individual respondents in a private room within the hospices. The completed questionnaires were collected for safe storage.

3.11 Data Analysis and Presentation

Data collected was analyzed using both descriptive and inferential statistics. The descriptive statistics (such as means, percentages and frequencies) was used to describe the various variables. Cross tabulations were found useful in order to give a general picture of the findings. For inferential statistics, Pearson's Chi square and Pearson correlation coefficient were applied to test the null hypotheses. This was to determine the nature of relationships between the participant's personal attributes (gender, age, education level, experience, occupation, personal trauma history and level of empathy) and VT scores.

Chi square was used as a non-parametric test for nominal and categorical data while Pearson's correlation coefficient was applied where variables were found to have a relatively normal distribution. The level of significance was set at $\alpha \leq 0.05$. Data obtained from the respondents was analyzed using the Statistical Package for Social Sciences (SPSS) software program version 20.

3.12 Data Management and Ethical Considerations

Approval for research was sought from Kenyatta University graduate school. Subsequently, ethical clearance was obtained from the Kenyatta University Ethics Review Committee (ERC). The research permit was sought from the National Commission for Science, Technology and Innovation (NACOSTI). The researcher sought permission to access the hospices from the KEHPCA Directorate. Informed consent was sought from the participants before carrying out the study. To ensure protection of research participants' confidentiality, the interviews and filling in of questionnaires was done in a private room within the hospices. The participants were informed that their names will never appear on the survey instruments and they were each assigned codes. The responses provided on the questionnaires were kept confidential. Additionally, participants' informed consent documents were reserved in a locked storage separately from completed questionnaires.

Participants were informed that collected data would be handled with utmost discretion and would be used only for the purpose of the study. All data obtained was kept secure in a locked cabinet. The researcher clarified that participation was voluntary and that one could terminate at any point without any penalty or adverse consequences. The risks in this research involved mild anxiety as participants reflected on unpleasant experiences associated with client situations within hospice care. Participants were debriefed to minimize any adverse psychological effects that could have resulted.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter contains the findings of the study on the relationship between selected personal attributes and the occurrence of vicarious trauma among staff in hospices in Kenya. The chapter begins by giving an overview of the demographic characteristics of the sample used in the study. The sections that follow contain presentations of specific findings guided by the research objectives. The final section gives the summary of the results.

4.2 Demographic Characteristics of the Sample

A total of 77 participants from ten hospices were included in the initial sample of the study. However during data collection, seven (7) members of staff were not available as they were either on leave or away on official duty. Therefore, the final sample size was 70, giving a response rate of 90.9%. Data was collected on demographic characteristics of participants namely: gender, age, level of education, occupation and years of professional experience. These variables were considered important because they have been recognized in literature as relevant in moderating stress and trauma reactions. In the following section, the demographic information of the participants has been classified into two categories namely: general characteristics (age, gender) and socioeconomic characteristics (level of education, occupation and years of professional experience). These are presented in tables 4.1 and 4.2.

Table 4.1 General Demographic Characteristics of Respondents

Demographic characteristics	Frequency (f)	Percentage (%)
Gender		
Males	16	22.9
Females	54	77.1
Age intervals (years)		
<20	1	1.4
21-30	18	25.7
31-40	15	21.4
41-50	26	37.4
51-60	7	10
60+	3	4.3

The sample consisted of both male and females. Table 4.1 indicates that overall, majority of the participants rendering hospice care were female (77.1%) while their male counterparts comprised only 22.9%. Regarding age, majority of the participants (37.4%) fell between 41 and 50 years as shown in table 4.1 above. Participants aged between 21 and 40 years were 47.1%. The mean age of the participants was 40 years. Only a small proportion (1.4%) were less than 20 years. Those over 60 years were also relatively few (4.3%).

Table 4.2 Socio-economic Demographic Characteristics of Respondents

Demographic characteristics	Frequency (f)	Percentage (%)
Level of Education		
Primary Education	2	2.9
Secondary Education	19	27.1
Tertiary Education	27	38.6
University Education	19	27.1
No Response	3	4.3
Occupation		
Physicians	3	4.3
Nurses	24	34.3
Nurse Aids	10	14.3
Social Workers	7	10
Counsellors/Psychologists	0	0
Administrators	4	5.7
Receptionists	7	10
Other Support Staff	8	11.4
No response	7	10
Years of Professional experience		
<1year	12	17.1
1 – 3 years	23	32.9
4 – 6 years	19	27.1
7 – 9 years	4	5.7
10 –11years	3	4.3
Over 11 years	9	12.9

From table 4.2 the findings regarding the level of education showed that 38.6% of the workers had acquired tertiary education, with very few (2.9%) having only primary education. Thus, the bulk of the staff in hospices had some form of certification beyond high school. In terms of occupation, the findings showed that nursing was the main occupation which accounted for 48.6% (nurses and nurse aids). Physicians formed the minority accounting for only 4.3%. There were no counselors or psychologists (0%) in any of the hospices. Regarding professional experience, majority of the participants (60%) indicated that they had worked for one to six years

in hospice care. A significant proportion of the hospice workers (12.9%) had a long working experience of more than eleven years.

4.3 Prevalence of Vicarious Trauma among hospice staff

The findings of this section were guided by objective one of the study which sought to find out the prevalence of VT among hospice staff in Kenya. The aim was first; to establish whether hospice staff in Kenya experience VT and secondly; to determine the levels of vicarious trauma where it was present. The findings of the prevalence of VT were presented first followed by those of levels of VT.

4.3.1 Vicarious Trauma Scores among Respondents

The Vicarious Trauma Scale (VTS) was used to assess vicarious trauma among respondents. The scale which was adapted from Middleton (2010) comprised 34 items with six options ranging from strongly disagree to strongly agree. The scale was modified such that if participants reported any level of disagreement in regards to scale items (strongly disagree, disagree, and slightly disagree) the score was zero (0) indicating absence of vicarious trauma and any levels of agreement were scored as: 1= slightly agree, 2= agree, 3= strongly agree indicating presence of vicarious trauma. The lowest possible score for an item was 0, so since there were a total of 34 items, the highest total possible score was 102. The total sum of scores was used to establish the presence or absence of vicarious trauma (VT). For each item, a score of 0 meant absence of VT; while a score of one 1 indicated presence of VT. A total score of up to 17 indicated absence of VT, while a sum of above 17 indicated presence of VT.

Data on vicarious trauma scores was first analyzed descriptively in order to give an overall picture of the scores of the participants. The descriptive statistics obtained are presented in table 4.3.

Table 4.3 Descriptive Statistics for Vicarious Trauma Scores

N	Valid	70
	Missing	0
Mean		21.86
Median		18.00
Std. Deviation		15.49
Minimum		2.00
Maximum		93.00

From the findings in table 4.3, the lowest score was 2 indicating no vicarious trauma, while the highest was 93; indicating a very high level of vicarious trauma. The mean of VT score was 21.86 indicating a general presence of VT. A visual impression of the vicarious trauma scores is given in a histogram in figure 4.1.

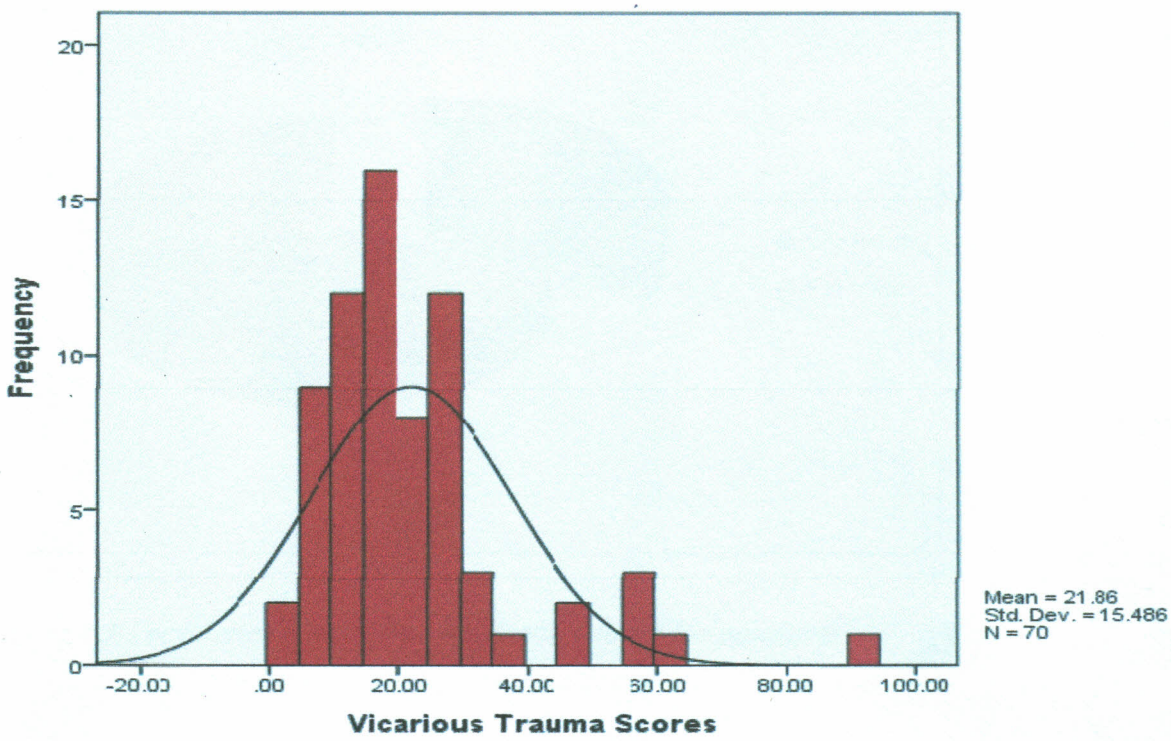


Figure 4.1 Distribution of Vicarious Trauma Scores

The histogram indicates that the distribution of vicarious trauma scores is relatively symmetrical. Many of the scores cluster around the mean ranging between 15 and 30 indicating that many of the respondents experience some level of vicarious trauma.

4.3.2 Prevalence of Vicarious Trauma among Respondents

The prevalence of vicarious trauma (VT) among respondents was established and presented in figure 4.2.

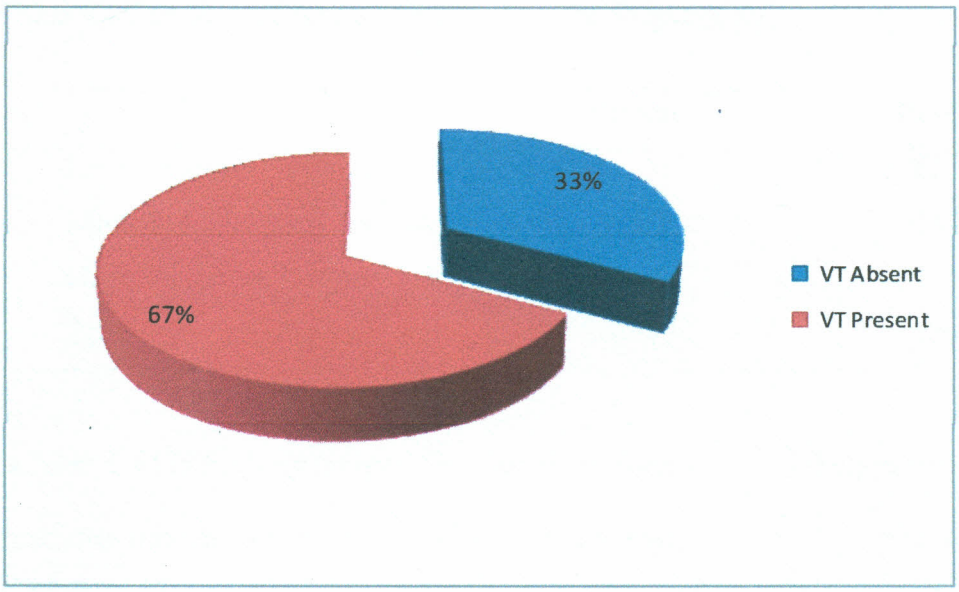


Figure 4.2 Prevalence of Vicarious Trauma among Respondents

The findings in figure 4.2 indicate that out of the 70 participants 67% had experienced vicarious trauma.

Having established the prevalence, the researcher considered it important to find out what levels the vicarious trauma occurred in the respondents. The data on VT scores was thus further analyzed to establish the levels of VT. Low VT meant that participants experienced mild VT, moderate VT meant that the level/effect was significant and required action; high VT meant that they suffered intense or profound vicarious trauma. The findings are presented in Table 4.4.

Table 4.4 Levels of Vicarious Trauma among Respondents

	Frequency	Percent
Low Vicarious Trauma	39	82.98
Moderate Vicarious Trauma	7	14.89
High Vicarious Trauma	1	2.13
Total	47	100.0

In table 4.4 the findings showed that out of the forty seven (47) respondents suffering vicarious trauma, majority (82.98%) of them had low levels of vicarious trauma, while 2.13% experienced high levels of vicarious trauma.

4.4 Relationship between Demographic Variables and Occurrence of VT

The findings of this section are guided by objective two. The aim of this objective was to determine the relationship between occurrence of vicarious trauma and demographic variables namely: gender, age, level of education, occupation and years of professional experience.

Descriptive data analysis on the variables was first carried out to give an overall picture. Thereafter, correlations were computed on the occurrence of vicarious trauma and the demographic variables. Both parametric and non-parametric measures were applied depending on the variable. The finding of each specific demographic variable and its relationship with the occurrence of vicarious trauma is presented in the sub-sections that follow.

The null hypotheses were advanced as follows:

$H_{01.1}$: There is no significant relationship between gender and occurrence of vicarious trauma

$H_{01.2}$: There is no significant relationship between age and occurrence of vicarious trauma

H_{013}: There is no significant relationship between level of education and occurrence of vicarious trauma

H_{014}: There is no significant relationship between occupation and occurrence of vicarious trauma

H_{015}: There is no significant relationship between years of professional experience and occurrence of vicarious trauma

The findings of each hypothesis are presented below:

4.4.1 Gender and Vicarious Trauma

The null hypothesis to be tested was: there is no significant relationship between gender and occurrence of vicarious trauma. Cross tabulations were first conducted on occurrence of vicarious trauma across gender. The findings are presented in table 4.5.

Table 4.5 Occurrence of Vicarious Trauma across Gender

Characteristic	**VT Present**	
	Freq.	**%**
Male	12	25.5
Female	35	74.5
Total	47	100

Out of the respondents who experienced vicarious trauma, a higher proportion of the female participants (74.5%) suffered vicarious trauma compared to their male counterparts.

In order to test the null hypothesis: there is no significant relationship between gender and occurrence of vicarious trauma, a chi square test was performed. Chi square was chosen because data was obtained from a random sample, the observations were independent and in nominal scale which requires the use of a non-parametric test. In addition, chi square is used to determine the significance of a relationship in categorical data and does not involve parameter values (Kothari, 2004). The findings are presented in table 4.6.

Table 4.6 Relationship between Gender and Occurrence of Vicarious Trauma

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.580[a]	1	.446
Likelihood Ratio	.601	1	.438
Linear-by-Linear Association	.572	1	.449
N of Valid Cases	70		

The findings from table 4.6 indicate that there was no statistically significant correlation between gender and occurrence of vicarious trauma $\chi^2(1, N=70) = .58$, $p=.446$. Since the p value was greater than 0.05, we fail to reject the null hypothesis that there is no significant relationship between gender and occurrence of vicarious

trauma. These results suggest that being male or female does not necessarily make a caregiver vulnerable to vicarious trauma.

4.4.2 Age and Vicarious Trauma

The null hypothesis to be tested was that there is no significant relationship between age and occurrence of vicarious trauma. For comparison purposes cross tabulations were carried out on age and occurrence of vicarious trauma. The results obtained were presented in table 4.7.

Table 4.7 Cross Tabulations between Age and Occurrence of Vicarious Trauma

Characteristic	**VT Absent**		**VT Present**	
	Freq.	**%**	**Freq.**	**%**
61+	2	66.7	1	33.3
51-60	4	57.1	3	42.9
41-50	8	30.8	18	69.2
31-40	3	20.0	12	80.0
21-30	6	33.3	12	66.7
< 20	0	0	1	100

As shown in the table 4.7, a total of 80% of those who suffered vicarious trauma were aged between 31-40 years. All respondents aged 20 years and below had vicarious trauma. A large proportion of the caregivers aged 61 years and above (66.7%) had no vicarious trauma.

To test the null hypothesis: there is no significant relationship between age and occurrence of vicarious trauma a Pearson product-moment correlation coefficient (r) was computed. Pearson correlation coefficient was used since the data met the requirement for using a parametric test. The data met the underlying assumptions that:

the data is in interval scale and the variables are bivariately normally distributed. In addition, random sampling was used and the sample in the current study was larger than 30 participants. According to Vogt (2005) a sample larger than 30 approximates a normal distribution. Correlations were carried out on age and occurrence of vicarious trauma at a significance level of 0.05. The findings were presented in table 4.8.

Table 4.8 Correlation between Age and Occurrence of Vicarious Trauma

		Age	Occurrence of VT
Age	Pearson Correlation	1	.256
	Sig. (2-tailed)		.032
	N	70	70
Occurrence of VT	Pearson Correlation	.256	1
	Sig. (2-tailed)	.032	
	N	70	70

*. Correlation is significant at the 0.05 level (2-tailed).

The study findings indicate that there was a significant positive correlation between age and occurrence of vicarious trauma $r(70) = .256$, $p = .032$. Since the p value is less than .05 ($p < .05$), the null hypothesis was thus rejected. Gravetter & Forzano (2009) and Green & Salkind (2003) explain that correlation coefficients of r = .10, r =.30 and r =.50 are interpreted as small, medium and large coefficients respectively. Therefore, the obtained r of .256 which is approximately .30 indicates a moderate positive relationship between age and occurrence of vicarious trauma.

4.4.3 Level of Education and Vicarious Trauma

The null hypothesis to be tested was: there is no significant relationship between level of education and occurrence of vicarious trauma. In order to compare occurrence of VT across hospice workers' levels of education cross tabulations were done and the findings shown in table 4.9.

Table 4.9 Cross Tabulations between Level of Education and Occurrence of Vicarious Trauma

Level of Education	VT Absent		VT Present	
	Freq.	%	Freq.	%
No response	0	0	1	100
University	8	42.1	11	57.9
Tertiary	8	29.6	19	70.4
Secondary	6	30.0	14	70.0
Primary	1	33.3	2	66.7

The study findings in table 4.9 indicate that a large majority (70%) of the respondents who had vicarious trauma were those who had acquired secondary and tertiary education.

To test the hypothesis that; there is no significant relationship between the level of education and occurrence of vicarious trauma, chi square test was carried out. Chi square was used because the data was nominal and therefore a non-parametric test was found useful. The findings are given in table 4.10.

Table 4.10 Level of Education and Occurrence of Vicarious Trauma

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.428[a]	4	.839
Likelihood Ratio	1.710	4	.789
Linear-by-Linear Association	.221	1	.639
N of Valid Cases	70		

The study findings from table 4.10 above indicate that there was no significant relationship between level of education of respondents and occurrence of various trauma (χ^2 (70) = 1.428, p=.84). Since the value of p was greater than .05 (p>.05), we fail to reject the null hypothesis that there is no significant relationship between level of education and occurrence of vicarious trauma. The results show that there is no correlation between level of education and occurrence of vicarious trauma.

4.4.4 Occupation and Vicarious Trauma

The null hypothesis to be tested was: there is no significant relationship between occupation and occurrence of vicarious trauma. At the analysis stage, the hospices staff were categorized into professionals and non-professionals. The professionals comprised of the multidisciplinary team including: doctors, nurses, social workers, therapists, and administrators. The non-professionals comprised the receptionists and other support staff such as drivers, cooks and cleaners among others. Cross tabulations on occupation and occurrence of vicarious trauma were first done and the results presented in table 4.11.

Table 4.11 Cross Tabulations between Occupation and Occurrence of VT

Occupation	VT Absent		VT Present	
	Freq.	%	Freq.	%
No response	0	0	1	100
Non-Professionals	5	23.8	16	76.2
Professionals	18	37.5	30	62.5
Totals	23	32.9	47	67.1

The findings in table 4.11 indicate that vicarious trauma affected the respondents across various occupations. The results showed that 76.2% of the non-professional and 62.5% of the professionals suffered vicarious trauma.

In order to test the null hypothesis: there is no significant relationship between occupation and occurrence of vicarious trauma, chi square test (χ^2) was computed. This was because the variable was in categorical scale which called for the use of a non-parametric test. The findings were presented in the table 4.12.

Table 4.12 Relationship between Occupation and occurrence of VT

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.738[a]	2	.419
Likelihood Ratio	2.080	2	.353
Linear-by-Linear Association	1.675	1	.196
N of Valid Cases	70		

The findings in table 4.12 show that there was no statistically significant relationship between occupation and vicarious trauma ($\chi^2(70) = 1.738$, $p = .419$). Since the p value was greater than 0.05, the null hypothesis that there is no significant relationship between occupation and occurrence of vicarious trauma was retained. This indicates that the occupation of the hospice worker does not make one vulnerable to the experience of VT. This means that all hospice staff irrespective of their occupations are susceptible to vicarious trauma and therefore no group of workers should be ignored when dealing with vicarious trauma.

4.4.5 Years of Professional Experience and Vicarious Trauma

The null hypothesis to be tested was that there is no significant relationship between years of professional experience and occurrence of vicarious trauma. To compare vicarious trauma occurrence across years of professional experience, cross tabulations were conducted and the findings presented in table 4.13.

Table 4.13 Cross Tabulations between Years of Professional Experience and Occurrence of VT

Years of Experience	VT Absent		VT Present	
	Freq.	%	Freq.	%
Over 11	3	33.3	6	66.7
10-11	0	0	3	100
7-9	1	25	3	75
4-6	7	35.8	12	63.2
1-3	8	34.8	15	65.2
<1 year	4	33.3	8	66.7

The findings in table 4.13 indicated that all the respondents who had worked in hospices (100%) for 10 to 11 years experienced VT, while 75% of those who had seven to nine years' experience suffered VT.

Data was subjected to bivariate correlation analysis using Pearson product-moment correlation coefficient to test the relationship between professional experience and occurrence of vicarious trauma. This was because the variables were approximately normally distributed and in interval scale. The findings were presented in table 4.14.

Table 4.14 Correlation between Years of Professional Experience and Occurrence of Vicarious Trauma

		Years of Professional experience	Occurrence of VT
Years of Professional experience	Pearson Correlation	1	-.017
	Sig. (2-tailed)		.888
	N	70	70
Occurrence of VT	Pearson Correlation	-.017	1
	Sig. (2-tailed)	.888	
	N	70	70

The findings from table 4.14 indicated there was no statistically significant relationship between years of professional experience and vicarious trauma $r(70) = .017$, $p = .888$. Since the p value was greater than 0.05, we fail to reject the null hypothesis that there is no significant relationship between and occurrence of vicarious trauma.

4.5 Relationship between Personal Trauma History and Occurrence of Vicarious Trauma

The findings of this section were guided by objective three of the study which sought to determine the relationship between personal trauma history and occurrence of vicarious trauma among hospice staff in Kenya. The null hypothesis to be tested was: there is no significant relationship between personal trauma history and occurrence of vicarious trauma among hospice staff in Kenya. Before testing the hypothesis, descriptive analysis on personal trauma history and occurrence of vicarious trauma was done and findings presented in section 4.5.1.

4.5.1 Descriptive Statistics of Personal Trauma History of Respondents

Personal trauma history was measured using a scale comprising 12 items selected from the Trauma History Questionnaire (Green, 1996). The scale had been modified to suit the context of the participants. The scale comprised 'yes' or 'no' responses. The items were scored by summing up the scores of all the 12 items. Scoring was done as follows: No = 0 and Yes = 1. The lowest possible score was 0 while the highest possible score was 12. A higher score meant higher level of trauma. The findings are presented in the sections that follow.

Data on personal trauma history was first analyzed descriptively in order to give an overall picture. The descriptive statistics obtained are presented in table 4.15.

Table 4.15 Description Statistics on Personal Trauma History among Respondents

N	Valid	70
	Missing	0
Mean		4.81
Median		5.00
Std. Deviation		2.80
Minimum		0.00
Maximum		12.00

From table 4.15, the findings showed that the maximum score was 12. The mean (*M=4.81*) and median are close showing that the distribution is almost normal with a standard deviation of 2.80.

In order to get a visual impression of the distribution of personal trauma history scores among the respondents, a histogram was presented in figure 4.3.

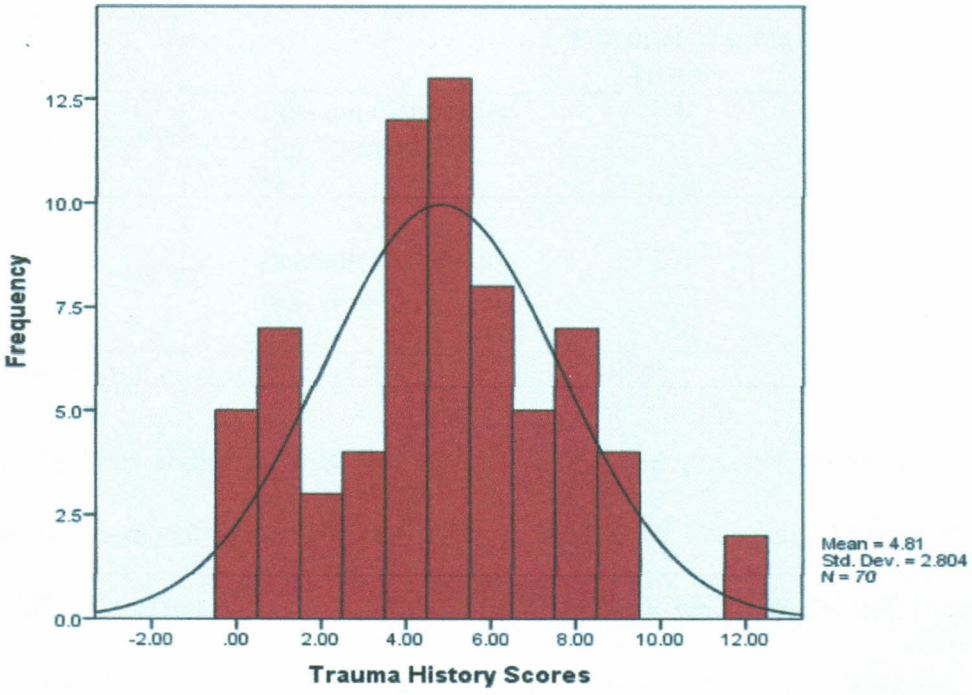


Figure 4.3 Distribution of Personal Trauma History scores

From figure 4.3, the curve is almost symmetrical. Most scores cluster around 3 and 6 with one peak of 12 meaning that, many of the respondents scored moderately, yet there were a few who scored quite highly on personal trauma history. The next data was analyzed on the relationship between personal trauma history and occurrence of vicarious trauma. The findings are presented in section 4.5.2 that follows.

4.5.2 Relationship between Personal Trauma History and Overall VT

To test the null hypothesis: There is no significant relationship between personal trauma history and overall vicarious trauma, Pearson product-moment correlation was computed and its significance tested at an alpha (α) level of 0.05. The Pearson correlation coefficient was chosen because the data was approximately normally distributed. The findings are presented in table 4.16 below.

Table 4.16 Correlation between Personal Trauma History and Occurrence of VT

		Personal Trauma History	Occurrence of VT
Personal Trauma History	Pearson Correlation	1	.275*
	Sig. (2-tailed)		.021
	N	70	70
Occurrence of VT	Pearson Correlation	275*	1
	Sig. (2-tailed)	021	
	N	70	70

*. Correlation is significant at the 0.05 level (2-tailed).

The findings indicated that there was a significant positive moderate relationship between personal trauma history and occurrence of Vicarious Trauma $r(70)=.275$, $p=.021$. Since the p value was less than .05 ($p<.05$), we reject the null hypothesis in favour of the alternative hypothesis that: there is a significant relationship between personal trauma history and occurrence of vicarious trauma. This means that the hospice workers who scored highly on personal trauma history are more likely to suffer vicarious trauma than those with low personal trauma history.

4.6 Relationship between Level of Empathy and Occurrence of Vicarious Trauma among Hospice Staff

The findings of this section were guided by the fourth objective which sought to find out the relationship between level of empathy and occurrence of vicarious trauma. Analysis was first conducted on general empathy and later on each of the dimensions of empathy (perspective-taking, empathic concern and personal distress). Thus, supplementary null hypotheses were advance as described in the subsections that follow.

The null hypotheses tested were:

H_{02}: there is no significant relationship between general empathy and occurrence of vicarious trauma

$H_{02.1}$: there is no significant relationship between perspective taking dimension of empathy and occurrence of vicarious trauma

$H_{02.2}$: there is no significant relationship between empathic concern dimension of empathy and occurrence of vicarious trauma

$H_{02.3}$: there is no significant relationship between personal distress dimension of empathy and occurrence of vicarious trauma

4.6.1 General Level of Empathy

Empathy level was measured by use of the Interpersonal Reactivity Index (IRI) by Davis (1980). This scale was adapted by the researcher and in this study; only three subscales were used. Each subscale comprised 7 items thus making a total of 21-items; on a 5-point likert scale which ranged from: "does not describe me well" to "describes me very well". The subscales included: the Perspective-Taking (PT) subscale which assessed an understanding of the point of view of others, the Empathetic Concern (EC) assessed concern and sympathy for others, while the Personal Distress (PD) examined feelings of personal anxiety in reaction to the emotions of others. Positive statements were scored from 0 to 4, while scores for negative items were reversed from 4 to 0. Higher scores on each of the scales indicated greater empathy.

In order to give an overall image, it was found necessary to determine the general level of empathy first based on a combined score of the three subscales. In the sub-sections that follow, each subscale was scored separately in order to give weight to each component as guided by the author (Davis, 1980).

Data on general empathy scores was descriptively analyzed and the findings were presented in table 4.17.

Table 4.17 Descriptive Statistics of General Empathy Scores

N	Valid	70
	Missing	0
Mean		50.63
Median		49.50
Std. Deviation		8.95
Minimum		27.00
Maximum		71.00

The results indicated a mean of 50.6 and a standard deviation of 8.95. This means that majority of the respondents had average scores. The minimum and maximum scores were 27 and 71 respectively.

In order to give a visual impression of the distribution, a histogram was computed as presented in figure 4.4.

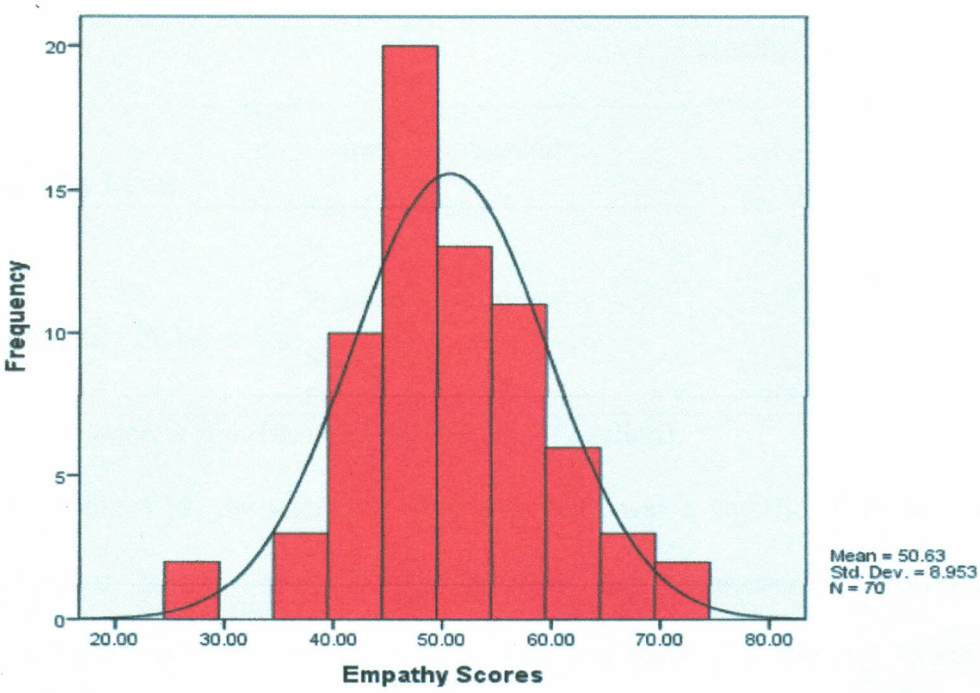


Figure 4.4 Distribution of Empathy Scores among Respondents

From figure 4.4, the curve of the empathy scores is approximately symmetrical. Many scores are clustered around the mean ranging from 40 to 60 depicting a trend of average scores among many respondents.

4.6.2 Relationship between Empathy Level and Occurrence of VT

The null hypothesis that was being tested was: There is no significant relationship between level of empathy and occurrence of vicarious trauma among hospice staff. To test the hypothesis, a Pearson Product-Moment Correlation Coefficient (*r*) was computed. This was because both variables met the key assumptions which were: the data was quantitative, in interval scale and the variables were bivariately normally distributed. Correlations were done at a significance level of 0.05. The findings are presented in the table 4.18.

Table 4.18 Correlation between General Empathy Level and Occurrence of VT

		Empathy Level	Occurrence of VT
Empathy Level	Pearson Correlation	1	.256*
	Sig. (2-tailed)		.032
	N	70	70
Occurrence of VT	Pearson Correlation	.256*	1
	Sig. (2-tailed)	.032	
	N	70	70

*. Correlation is significant at the 0.05 level (2-tailed).

From table 4.18, the results showed that there was a significant positive moderate correlation between general empathy level and occurrence of vicarious trauma $r(70)=.256$, $p=.032$. Since the p value was less than 0.05, the null hypothesis was rejected in favour of the alternative hypothesis that: there is a significant positive relationship between general empathy level and occurrence of vicarious trauma. This means that a higher level of empathy increases the caregiver's vulnerability to vicarious trauma.

Further analysis was done based on each of the three dimensions of empathy in order to assess the weight to each of the aspects that determine the levels of empathy. This was recommended by the author of the scale (Davis, 1980). The scores on each sub scale were analyzed and the findings presented in tables in the sub sections that follow.

4.6.3 Relationship between Perspective Taking and Occurrence of VT

In this section, the null hypothesis to be tested was that there was no significant relationship between perspective taking and occurrence of vicarious trauma. The

Perspective-taking aspect of the respondents was measured and total scores obtained. A Pearson product-moment correlation was computed to test the hypothesis and the findings were presented in table 4.19.

Table 4.19 Correlation between Perspective Taking and Occurrence of VT

		Perspective Taking	Occurrence of VT
Perspective Taking	Pearson Correlation	1	.346*
	Sig. (2-tailed)		.003
	N	70	70
Occurrence of VT	Pearson Correlation	.346*	1
	Sig. (2-tailed)	.003	
	N	70	70

There was a statistically significant positive moderate correlation between perspective taking and occurrence of vicarious trauma $r(70)=.346$, $p=.003$. Since the p value was less than 0.05, the null hypothesis was rejected in favour of the alternative hypothesis. This meant that caregivers with higher perspective taking were more vulnerable to vicarious trauma.

4.6.4 Empathic Concern and Occurrence of Vicarious Trauma

The null hypothesis to be tested was that there was no significant relationship between empathic concern and occurrence of vicarious trauma. To test the hypothesis, Pearson correlation coefficient was conducted on empathic concern scores and vicarious trauma. The results are shown in table 4.20.

Table 4.20 Correlation between Empathic Concern and Occurrence of Vicarious Trauma

		Empathic Concern	Vicarious Trauma
Empathic Concern	Pearson Correlation	1	-.002
	Sig. (2-tailed)		.989
	N	70	70
Vicarious Trauma	Pearson Correlation	-.002	1
	Sig. (2-tailed)	.989	
	N	70	70

From table 4.20, the findings indicated that there was no significant relationship between empathic concern and occurrence of vicarious trauma $r(70)=.-002$, $p=.989$. Since the p value was greater than 0.05, we fail to reject the null hypothesis that there is no significant relationship between empathic concern and occurrence of vicarious trauma.

4.6.5 Personal Distress and Occurrence of Vicarious Trauma

To test the null hypothesis: There is no significant relationship between personal distress and vicarious trauma, Pearson correlation was computed and the findings were presented in table 4.21.

Table 4.21 Relationship between Personal Distress and Occurrence of Vicarious Trauma

		Personal Distress	Vicarious Trauma
Personal Distress	Pearson Correlation	1	.282*
	Sig. (2-tailed)		.018
	N	70	70
Vicarious Trauma	Pearson Correlation	.282*	1
	Sig. (2-tailed)	.018	
	N	70	70

*. Correlation is significant at the 0.05 level (2-tailed).

The findings showed that there was a statistically significant strong positive relationship between personal distress and vicarious trauma $r(70)=.282$, $p=.018$. Since the p value was less than 0.05, the null hypothesis was rejected in favour of the alternative hypothesis. This implies that, a higher personal distress increases a person's vulnerability to vicarious trauma.

4.7 Strategies to Reduce the Risk of Vicarious Trauma

The findings in this section were guided by objective five namely: to determine the strategies that can be put in place to reduce the risk of vicarious trauma among hospice caregivers.

Data was collected using two items which were:

i) The strategies used by the hospice workers to cope with the nature of their work

ii) The strategies that could be put in place by the organization to reduce the risks of negative effects of the work

The responses were analyzed according to themes. The emerging themes were grouped as shown in the subsections that follow.

4.7.1 Strategies to cope with Nature of Hospice Work

In order to collect data in this section, the participants were asked to describe the strategies that they applied in trying to cope with the nature of their work. The findings have been analyzed and categorized as shown in table 4.22.

Table 4.22 Strategies to Cope with Nature of Work

Strategy	Frequency	Percent
Psychological coping		
Keeping caring attitude	6	8.6
Sharing experiences/Talking(debriefing)	6	8.6
Personal therapy	4	5.7
Fun, relaxation, humour	3	4.3
Spiritual techniques		
Prayer	19	27.1
Spiritual support	6	8.6
Reading bible	4	5.7
	5	7.1
Social support		
Social support from family and friends	10	14.3
No response	7	10.0
TOTAL	**70**	**100**

From table 4.22, majority of the respondents (27.1%) reported that they used prayer as a coping mechanism. Some of their comments included:

"To be able to cope, I read the bible" ((Respondent13); "I seek spiritual support" (Respondent 19) holding on to faith (respondent 43); I depend on God's guidance" (respondent 53).

Social support from colleagues, family and friends was reported as another mode of coping accounting for 14.3%. Some of the comments from respondents are hereby stated:

"I usually spend time with my friends and family" (Respondents 18, 19, 37); "listen to music with friends" (respondent 5), "party with friends" (respondent 21). "I go out with my friends"

Another theme that emerged was psychological coping. The respondents reported their personal modes of coping with the psychological effects they were experiencing. Some of the most used coping style in this category included keeping a caring attitude (8.6%), talking or sharing of feelings and to smaller extent, counseling and debriefing (5.7%). These were some of their comments:

"I share my feelings with my colleagues, family and friends "(respondent 19); " "I just decide to love the work and stay focused" (Respondent 25),

Very few respondents used coping styles such as: relaxation, humour, having fun, meditation/reflection and bibliotherapy. Some of their comments were as follows:

"I use humuor" (respondent 35); "crying relieves me" (respondent 48). "I go out to have fun" and dance with my friends" (respondent 28). I ensure that I rest on my day offs" (Respondent 32); I use distraction strategies that divert my thoughts"

"(Respondent 64);"Reading helps me" (respondent 36); I use silence, quiet time, reflection" (respondents 46, 60, 69);

4.7.2 Strategies by the organization to help reduce the Risk of negative effects of work

In this section, the participants were asked to describe strategies that the organization could put in place to reduce the negative effects of their work. The findings were summarized in table 4.23.

Table 4.23 Organizational Strategies to Reduce Vicarious Trauma

Thematic area	Frequency	Percent
Payment and motivation	14	20
Psychological care (counseling/supervision)	20	28.6
Capacity building of care givers	10	14.3
Improving working conditions	6	8.6
staff team building(retreats)	15	21.4
No response	5	7.1
TOTAL	**70**	**100**

From the results in table 4.23 four thematic areas were identified which included: payment and motivation, psychological support of caregivers, capacity building of caregivers, improving work environment and staff team building.

Majority (28.6%) of the participants reported that psychological support for the caregivers by the organization was the most crucial strategy to curb vicarious trauma.

According to respondents, psychological care could be done in form of daily debriefing. The following are comments from some of the respondents:

"There is need for supportive supervision for staff, appreciation by the management and proper communication, (Respondent 13); "the management should provide resources such as counselling offices" (Respondent 11).

Furthermore, as regards psychological care of caregivers, some respondents proposed: *"Promotion of caregivers', support groups" (respondent 63); "counselling sessions by trained counsellors" (respondent 61); "frequent debriefing for staff debriefing" (respondent 68); "employees to have weekly discussions about their experiences" (respondent 64); "outdoor activities psychological support for workers" (respondent)*

Staff team building was another common theme that respondents raised as an important organizational strategy to help reduce the risk of vicarious trauma. The study findings indicated that 21.4% of the respondents suggested that the hospice as an organization could promote team building among the staff. One respondent commented: "*The authorities should encourage working together and team building activities" (Respondent 8).*

A relatively large proportion of the respondents (20%) suggested that improving their payment would enhance their motivation and this could boost their coping mechanisms. Various strategies were considered as motivation for the staff. Some respondents stated:

"The management should give better pay" (Respondent 1); "the administrators could consider special remuneration for staff motivation" (Respondent 2); "there's need to stabilize the financial challenges in hospices" (Respondent 24); "offer paid holidays for motivation", (Respondent 37); "appreciation from the management and staff motivation", (Respondent 60)

The other emerging theme was on organizing for capacity building activities which accounted for 14.3%. Respondents felt that such activities were important and would help them to cope with the nature of their work. Respondents raised comments such as: *"the management needs to organize more seminars and regular training in palliative care as well as problem solving skills for staff members" (Respondent 1); "There's need for staff trainings and educative workshops (Respondent 40).*

Another theme that featured was on improving working conditions, which was reported by 8.6% of the respondents. The caregivers reported that there was need for: "*Good or friendly working environment and regular staff meetings (Respondent 12), equipping the pharmacy and provision of protective gears for staff (Respondent 70), "getting annual leave, building a resource centre for staff as well as provision of more facilities and increasing human resource" (Respondent 20).* In addition, caregivers stated that it was important for employees to have weekly discussions about their experiences, open communication, rotation of duties, stable leadership, and provision for caregivers to form or belong to unions.

4.8 Summary of the Findings

The following is a summary of findings from the data analysis:

The respondents in the current study were sampled from ten hospices across various counties. In terms of demographic characteristics, there were more female respondents (77.1%) than males who accounted for only (22.9%). Regarding age, 37.4% of the respondents fell between 41 and 50 years, with a small proportion (1.4%) being less than 20 years. The mean age was 40 years. In regards to the level of education, many respondents 38.6% had tertiary education, with a few (2.9%) having only primary education. This showed that many of the staff members had education beyond secondary school. Almost half of the respondents were in the nursing occupation which accounted for 48.6%. There were very few physicians and no psychologists. In terms of work experience, many of the staff had worked for one to six years in hospice care

The study found that a substantial proportion of the caregivers (67%) suffered vicarious trauma while 33% did not experience vicarious trauma. Majority of the participants who had vicarious trauma were female (74.5 %) compared to their male counterparts who accounted for (25.5%). There was evidence that a slight majority of those who experienced vicarious trauma in Kenyan hospices were the non-professionals (76.2%) while only 62.5% of the professionals suffered vicarious trauma. This non-professional staff who comprised of receptionists and other support staff experienced vicarious trauma. This indicated that even the support staff who were non-medics within hospices suffered adverse effects.

Overall, the attributes that were found to have significant correlations with the occurrence of vicarious trauma included: age, trauma history and general empathy. However, there were no significant relationships between occurrence of vicarious trauma and personal attributes such as: gender, level of education, work experience as well as occupation. The study findings indicated that there were significant relationships between vicarious trauma and general empathy level as well as empathic subscales: personal distress and perspective taking. There however, was no correlation between empathic concern and vicarious trauma.

The findings of the study showed that many caregivers in hospices used prayer as a coping mechanism. Furthermore, respondents reported that they coped through maintaining a caring attitude and sharing with friends and loved ones. Regarding organizational strategies, respondents reported that better salary packages, staff motivation, psychological support of caregivers, capacity building of caregivers as well as provision of the necessary resources were crucial in mediating trauma.

CHAPTER FIVE
DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter is divided into three main sections. The first section is on the discussion of the findings, the second is based on conclusions drawn from the results and the final section gives recommendations from the study.

5.2 Discussions

The study investigated the relationship between selected personal attributes namely: age, gender, occupation, work experience, level of education level of empathy, personal trauma history; and the occurrence of vicarious trauma among staff in hospices in Kenya. The discussion is done on the demographic information, followed by the discussion of the major findings along the five study objectives.

5.2.1 Demographic Information of Staff in Hospices

Based on the demographic analysis, various observstions were made. With regards to gender, the results of the study indicated that there were more female staff in hospices (77.1%) than males (22.9%). This shows an imbalance which seems to suggest that hospice work is primarily a female profession.This pattern mirrors previous studies which showed that caregiving largely rested on the female population. Graaf (2011), in a study among caregivers of HIV/AIDS patients in South Africa, found that 86.4% of the participants were women. Similarly Middleton, (2010) and Unroe, Cagle, Dennis, Lane, Callahan and Miller (2014), reported more female caregivers accounting for 92% and 93% respectively.

The findings of the current study confirmed the general trend in the Kenyan health sector whereby, majority of the healthcare workers are women (WHO, 2013). This probably means that caring is a role that females assume more easily than males, making most of them join the helping professions. The trend may be attributed to gender role socialization. Depending on the culture where one lives the roles of men and women are culturally defined. Though the trend may be slowly changing globally, the predominant trend in many societies has been that girls and women are socialized to take caregiving and nurturing roles which hospice work entails, as their societal gender roles

With regard to age, generally, the findings show that in Kenya, hospice workers'ages range mainly from 20 years to 60 years. Many caregivers ages (37.4%) ranged between 41 and 50 years with a small proportion (1.4%) aged less than 20 years. Those over 60 years were also relatively few (4.3%). The mean age of the respondents was 40 years. These findings are consistent with Kaladow's (2010) findings that caregivers'ages ranged between 25 to 70 with a mean age of 48.7%. Likewise, in another study on the determinants of grief among workers who cared for terminal cancer patients in Taiwan, the age of respondents ranged between 18.7 to 62.1 years with a mean of 42.9 years (Chiu, Huang, Yin, Huang, Chien, & Chuang, 2010).

The findings in the current study that there were many staff members aged between 41 and 50 years could be attributed to the fact that on average, majority of workers in Kenya are at the peak of their careers within this age group. On the other hand the few staff under the age of 20 years may be due to the fact that the education system in

Kenya is organized in such a way that after secondary education, students join the tertiary institutions, at about the age of 18 and complete their college education at about age 21 to 25. Since hospice work requires that one goes through some training after secondary education, it follows therefore that many young people of this age are generally still in colleges. Additionally, the low numbers of staff aged 60 and above could be explained by the fact that, workers are supposed to retire at the age of 60 years according to the Government of Kenya (Rakoum, 2010). There is a possibility that these few workers who are still offering services in hospices at such an advanced age posses specialized training, experience as well as expertise required to meet the needs of hospice care.

With respect to the level of education, 38.6% of the workers have tertiary education. The bulk of the staff in hospices have secondary education and at least some form of certification beyond high school. These findings are similar to Graaf's (2011) findings that the majority (77%) of the participants had post primary education. This trend is expected in Kenya because it is in line with the health sector requirements that health care personnel should be trained beyond secondary education. Thus training is a key determinant of health care market (Scheffler, Bruckner & Spetz, 2012). In addition, the constitution of Kenya places emphasis on provision of high quality health care services for all Kenyans (Kiambati, Kiio, & Toweett, 2013) which calls for further training after secondary school.

The results seem to suggest that because hospice care is a very specialized kind of care it requires qualified or well trained personnel. Palliative care education in Kenya

is being delivered at certificate or diploma level (KEHPCA, 2013). So it follows that for a person to work in hospice he or she has to undergo some specialized training in palliative care. Thus, many workers join hospice care after they have undertaken training. This explains why most hospices are served by members of staff who have received training after secondary education to care for patients and their families.

In spite of this, the results of the current study show that there are also a few members of staff (2.9%) that have primary education. It is not uncommon to find that most of these are probably support staff who are mainly drivers or persons doing manual labour such as cleaning. According to the National Hospice and Palliative Care Organization (NHPCO, 2007) nearly 77% of hospice staff are involved in one way or another in caring for the patients. These workers also play an important role in that, even though they are not in the medical team treating the patients, they are sometimes called upon to assist in various aspects of caring for the patients. For example, they are called upon to offer a helping hand like lifting, carrying or bathing patients among other services that may arise. This means that they also interact with the patients' suffering and trauma. They are thus exposed to the risk of VT. It is therefore safe to suggest that there is need to accord some form of training in palliative care for the few staff (2.9%) that only have primary education. This may be necessary because, all are involved in care giving in one way or another.

In terms of occupation, majority of the staff (48.6%) in hospices are nurses with a minimal proportion of physicians (4.3%), social workers (10%) and administrators (5.7%). There were no psychologists or counselors. These findings resonate with

findings of a study by Unroe, et al., (2014) whereby the majority of participants in hospice care were nurses. From these findings, the pattern shows that hospices in Kenya have few employees and therefore they may not have complete multidisciplinary pattern teams that are recommended in hospice care to effectively offer holistic care (Ministry of Health [MoH] national palliative care guidelines, 2013).

The holistic care approach is essential because hospice care involves caring for persons who are mainly terminally ill patients, most of who suffer immense physical, emotional as well as psychological pain. As the disease advances, many of them suffer anxiety, grief and depression as they worry about the progression of their conditions as well as the welfare of their families. Therefore an interdisciplinary team is essential to take care of these concerns (Ministry of Health national palliative care guidelines, 2013). A multidisciplinary team is a group of health practitioners with specialized training in different fields who offer a variety of services which amount to holistic care of the patient (Abdulrahman, 2011). The absence of such a team implies that the same personnel take up the various roles where staff are lacking. When the same caregivers are left to care for all the issues of dying patients and their grieving families, there is a risk of prolonged exposure to trauma which increases staff risk to VT. All these issues together with the workload of the staff can be overwhelming for the caregiver.

The researcher observed that most of the facilities fell short of such comprehensive teams. This observation agrees with findings reported by Kinyanjui (2006) and

Nyakundi (2013) that most hospices maintain limited numbers of professionals. The few staff members are expected to perform multiple roles to fill in any gaps in terms of personnel. For example, nurses in most of these hospices assess, diagnose and prescribe medicine for patients. Furthermore, they take on the roles of physicians, social workers, pharmacists, counselors and administrators as well as other roles that need to be filled. This may lead to workload stress which increases the risk for VT. In addition, the roles and responsibilities may not be clear to the caregiver causing feelings of inadequacy or a sense of futility. Such feelings of helplessness in a caregiver could gradually generate into deep psychological turmoil including VT.

Another possible outcome of taking on multiple roles is the issue of dual relationship, where the same caregiver plays several roles with the same client. A caregiver who plays all these roles may find difficulties in maintaining healthy boundaries with patients and their families, exposing him or her to the effects of trauma. It is also possible that some caregivers are not adequately prepared to take up these heavy roles and responsibilities. A hospice worker in such a situation is likely to experience role strain, whereby one senses that he or she is incapable of fulfilling the role expectations (Feldman, 2011) thus increasing the risk of developing VT. The role strain coupled with work overload may drain the staff emotionally increasing the risk for the onset of VT. By limiting staff, the hospice administrators are exposing their own employees to adverse effects of trauma. This may affect the psychological wellbeing of caregivers making them vulnerable to vicarious trauma.

The study findings showed, there were no counsellors or psychologists in any of the hospices. In most cases nurses played the roles of counsellors and psychologists, designations that require intensive and extensive training and supervision. According to Ellington, Reblin, Clayton, Berry & Mooney, (2012), hospice nurses have extensive skills especially in assessment of patients, symptom management as well as communication to assess the holistic needs of clients.

The nursing curricula, including hospice nursing are principally geared towards direct physical care. Although the nurse practitioners are expected to conduct counselling for their clients, the work overload, unclear roles and inconsistent expectations (Kim, Yoo, Lee & Kim, 2014) seem to make it difficult for effective counseling to take place. In addition, some may not be adequately prepared to offer counseling services effectively. This is a major concern as psychological and emotional needs of patients require a psychologist or counsellor who is specially trained to take care of deep emotional needs of clients. Thus a staff member, who is not soundly trained in this highly specialized area, may not adequately address the psychological issues of patients and their families. Effective counselling is essential for both the patients and their families to help them cope with the emotional and psychological issues that arise as a result of the terminal illness. In addition, some of the emotional issues are heavy and may impact negatively on a worker who is not adequately trained. When the caregivers begin to feel inadequate, their ego resources may be drained, rendering them vulnerable to vicarious trauma.

There is evidence that some hospices rely on volunteers to fill in the roles where caregivers are lacking. This boosts the incomplete multidisciplinary teams in these facilities. However, the use of volunteers may have implications in terms of services offered. Where the volunteer fails to turn up, it could possibly cause anxiety or frustration on the part of the employed staff, which then forces the already overworked caregiver to step in and take over the role. This can be stressing therefore increasing the risk of vicarious trauma for the caregiver.

With regards to the staff years' of experience, the bulk (60%) of the caregivers have professional experience of between 1-6 years. Another significant proportion (12.9%) had a long working experience of more than 11 years. This resonates with findings of a study by Abendroth and Flannery, (2006), who found that hospice nurses in a US community-based hospice had worked in hospice nursing for between 6-13 years. The main reason cited by the participants was that they were not hired but `called` to the profession. This possibly suggests that many of the staff consider their jobs a lifetime vocation characterized by selflessness and altruism. This can be a positive attribute on one hand as it gives one a sense of satisfaction in serving. However, on the other hand, it could result in adverse consequences where staff are constantly offering emotional support to patients and their families but they are not getting emotionally nourished themselves, leaving them emotionally drained.

The finding that some employees have worked for several years in hospices (over 7 years) implies that there could be continuity in the facilities. This could mean that the said personnel have acquired relevant skills and experience in hospice care and may

therefore be an asset to the hospices. These caregivers learn to make meaning out of the suffering and death of the patients they interact with; which motivates them to keep working in hospices. These can be very helpful in mentoring the young caregivers who may be joining the facilities especially in the field of self-care in order to reduce or curb the adverse effects of vicarious trauma.

5.2.2 Prevalence of Vicarious Trauma among Hospice Staff

The first objective sought to find out the prevalence of Vicarious Trauma among hospice workers in Kenya. Analysis of data on prevalence of vicarious trauma revealed that, a substantial proportion of the caregivers (67%) experienced vicarious trauma while 33% did not. However, majority of those affected had low levels of vicarious trauma, while a few staff members (2.13%) experienced high levels of vicarious trauma. The results of the current study regarding the prevalence rate of VT among caregivers were not unexpected given the nature of work that hospices caregivers in Kenya do.

Hospice care involves continuous intensive emotional involvement with patients who are terminally ill as well as their significant others. This can be quite straining, depending on a caregiver's personal characteristics and coping. The findings of the current study agree with those of a study by Muli-Karugu, (2006) that, VT prevalence rates among caregivers in Kenya is relatively high accounting for 63%. Mumma (2008), in his study on STS prevalence, severity and predictors among AIDS orphans in Kenya, found high rates of STS. High trauma prevalence has also been found in a

study done among therapists in Eldoret (Kenya) whereby 70% of the respondents were affected (Kabunga, Adina, Margret, Amapesa & Shikanga, 2015). Similarly, other studies done in other parts of the world have found relatively high prevalence rates among caregivers such as: Branson (2011) and Bride (2007) who reported rates of 61.3% and 70% respectively. This shows that healthcare workers across the globe experience similar effects in their work places where they constantly interact with traumatized clientele.

The relatively high prevalence of vicarious trauma could be attributed to the human tendency to react in certain ways in the face of suffering. It is possible that the caregivers' bodies and psyche naturally responds to intense pain, distress and despair. The work of caring for the dying in hospices involves constant exposure to individuals who suffer trauma and anguish. The continuous witnessing of the patients' deteriorating conditions, multiple deaths within a short period, as well as listening to their trauma narratives, can possibly infiltrate the caregivers' worldview which can drain their psychological resources. The cumulative effect could result in temporary or permanent disruptions of the caregivers' cognitive schemas rendering them vulnerable to VT.

Vicarious traumatization results in profound changes in the core beliefs of the caregivers regarding themselves, others and the world. Their psychological needs namely: safety, trust, esteem, intimacy and control are thus deeply affected. The affected caregivers then begin to filter their beliefs through the affected schemas, seeing their world as unsafe, experiencing intrusive imageries, loss of control as well

as emotional numbing. An affected caregiver may be unable to connect empathically with patients, an aspect that is the very heart of hospice care. McCann and Pearlman, (1990) describe the resulting changes of VT to be pervasive, cumulative, and permanent. Moreover, VT could possibly result due to the caregivers' inability to disentangle themselves emotionally from the clients they serve or if the caregiver fails to employ self-care strategies. In addition, VT could occur where supportive measures such as regular supervision and other trauma management practices are lacking.

Although all caregivers are exposed to a potentially traumatizing environment, not all get adversely affected. The findings in the current study imply that there are variations in the way caregivers experience vicarious trauma. It follows therefore, that there could be factors that put the affected caregivers (67%) at risk for VT and on the other hand there may be aspects that protected the caregivers (33%) who did not suffer VT effects. Theoretically, the self is the seat of the person's identity and inner life (McCann & Pearlman, 1990). This means that individuals are self-regulatory. The self is capable of maintaining a balance of wellness through its protective boundaries and coping patterns. This could explain the findings that a proportion of the workforce (33%) has not been impacted on by VT.

The Constructivist Self-development Theory (CSDT) proposes that the meaning of trauma is subjective. The theory further posits that individuals actively construct their realities through development of cognitive perceptions that facilitate the understanding of their trauma experiences (Pearlman & Saakvitne, 1995). This means

that every caregiver is unique and therefore each one constructs personal realities and meanings as he or she interacts with patients.

Changes in the caregivers' perceived realities occur due to the patients' trauma stories and caregivers' individual characteristics. The theory further denotes that humans have self-capacities or inner capabilities which allow them to maintain a coherent sense of identity, positive self-esteem and manage strong emotions. It follows that, a hospice worker who has a strong cohesive self can in fact be protected from the adverse effects of VT. It is also possible that some caregivers have developed resilience over time as they interact with patients. Another probable explanation could be that, the caregivers are involved in trauma management programs that help moderate the trauma effects.

In addition, it is important to note that vicarious resilience and other positive outcomes such as posttraumatic growth (PTG) could also result in the midst of traumatic experiences. PTG means that a caregiver is positively transformed by his or her experience of trauma beyond adjustment (Tedeschi & Calhoun, 2004 cited in Hernández, 2010). Hospice workers could experience positive changes as a result of exposure to trauma, such as resilience or post traumatic growth. Besides, it is possible that caregivers can be affected positively by their clients and they develop vicarious resilience, that is, they experience similar strength, personal control and other coping mechanisms as their clients. The clients' suffering and success stories of how they have managed to cope with their conditions can vicariously influence the caregivers

into building their own resilience. This may explain why some caregivers have served for very long in hospices yet they are not adversely affected.

The fact that majority of hospice workers are affected by vicarious trauma could imply that the positive outcomes such as PTG or vicarious resilience are yet to be experienced/realized by many of the workers. The current study has shown that VT prevalence is relatively high among caregivers in Kenya. Well over half of the respondents had VT. If this condition is not recognized, acknowledged and treated it may affect service delivery to clients as well as the organization.

5.2.3 Relationship between Demographic Characteristics and Occurrence of VT

The findings were guided by the objective: to determine the relationship between selected demographic characteristics and occurrence of vicarious trauma. The hypothesis was: there is a significant relationship between demographic characteristics namely: gender, age, occupation, work experience, education level and occurrence of vicarious trauma.

Descriptive data analysis on gender and vicarious trauma revealed that majority of the participants who experienced vicarious trauma were female (74.5%). This meant that more female caregivers experienced VT than their male counterparts. However, these findings could have been due to the fact there were more females than men who took part in the study. Further analysis was done and Pearson chi square was used to test the significance between gender and vicarious trauma. The results indicated that, there was no statistically significant relationship between gender and occurrence of

vicarious trauma ($\chi^2(1, N=70) = .58, p=.446$). This means that being male or female does not make a caregiver more vulnerable to VT. The results that there was no significant relationship between gender and VT were unexpected given that there is a considerable amount of literature which shows that gender is a determinant of how one experiences vicarious trauma.

The theoretical framework that guided the study clearly shows that it is the 'self' rather than one's gender that is important in determining how one experiences trauma. The findings of the current study resonate with findings of other studies that found no significant relationship between gender and trauma symptoms (Adams & Riggs, 2008; Deighton; Linley & Joseph in Johnson, 2015). The findings of these studies indicate that anyone can experience trauma irrespective of whether they are male or female. Although some studies have shown that gender is a determinant of how one experiences trauma, it appears that the experience of vicarious trauma is individualistic. It is not automatic that gender as an attribute causes vicarious trauma.

The Constructivist Self-Development Theory (CSDT) places emphasis on the self. According to Constructivist Self-Development Theory, the experience of trauma is very subjective and personal. The response to a traumatic event depends on how one appraises the event and the meaning attached to it. This could imply that it really does not matter which gender a person belongs to, it is more about the subjective meaning that one attaches to the event and the way one interprets the situation that determines how one experiences its effects. The theory further posits that the self which is the seat of personality regulates the individual's experience of trauma.

Contrary to the findings of the current study, other studies have found a significant relationship between gender and vicarious trauma and that being female is a risk factor for trauma (Pearlman & Saakvitne, 1990; Osofsky et al, 2008; Cicognani Pietrantoni Palestini & Prati, 2009; Knight, 2010 cited in Branson, 2011). The explanation given for these findings has mainly been based on the gender socialization theory. This has been attributed to societal roles and stereotypes which can influence how different genders experience trauma. In terms of coping, men and women are said to use different strategies. Parks & Novielli (cited in Uren & Graham, 2014) view coping strategies as either emotion- or problem-focused. Some researchers contend that women tend to use "emotion-focused" coping which is concerned with the emotional strain surrounding a situation. Men on other hand use "problem-focused" strategies, which consider a structured approach towards strain, as if seeking a solution to the presenting problems.

The view that females are more vulnerable to trauma than males has been challenged in literature and theory. According to CSDT, individuals, be they men or women can excel and can develop resilience depending on their self-capacities. CSDT holds that people are self-regulatory in nature, they create and recreate themselves and give meanings to their situations. The self is continually developing and one can build oneself, the strength is in the self, thus the ego capacities protect the individual irrespective of gender. Caregivers in hospices may or may not be affected by VT depending on the meaning and appraisal they accord to their work with clients who are terminally ill. According to the feminist theory, women are searching for connectedness with others, therefore, their relational qualities/aspects are perceived as

strengths and channels for healthy growth and not as weaknesses (Herlihy & Corey, 2009). Feminists focus on opportunities to increase women's ability to exert control over their own destinies.

With regard to age and vicarious trauma, the descriptive study analysis revealed that all the respondents aged 20 years and below suffered vicarious trauma while a large proportion of the staff aged 61 years and above (66.7%) had no vicarious trauma. As earlier stated, the staff aged over 61 years may be working in hospices probably because they are considered to be vital assets to these organizations due to their expertise and wealth of experience. Possibly, their skill and considerable experience gained over the years could have helped them to learn how to deal more effectively with the suffering and agony they witness in their patients on a daily basis. This could explain why many of the older caregivers were not affected by vicarious trauma.

Correlation analysis showed that there was a statistically significant positive relationship between age and occurrence of vicarious trauma ($r(70) = .256$, $p < .05$). This could mean that occurrence of VT tends to increase as age of caregivers declines. The younger caregivers are more likely to suffer VT than the older ones. These findings are in line with the empirical literature as well as the CSDT framework which suggests that the self develops over time and in the process, one constructs individual perceptions and realities (Pearlman & Saakvitne , 1995a). This appears to suggest that, as the individual advances in age, it is likely that he or she will develop a coherent sense of identity as well as capacities to self-protect against trauma effects. Another plausible explanation for this result is that since the younger staff members

have worked for fewer years, they have less experience compared to the older ones who have worked longer in the hospice.

These results are consistent with the findings of a study by Pearlman & Mac Ian, (1995) that younger and less experienced counselors exhibited the highest levels of distress. It is expected that the younger staff are more likely to experience vicarious trauma since they have not had adequate opportunities to experience the traumatic incidents to be able to develop coping mechanisms to deal with the trauma they may be exposed to.

According to Constructivist Self Development Theory (CSDT) an individual is constantly going through a process of self-development, therefore, construction of the self is a continuing process in one's life. The younger person is likely to be at a different developmental stage of the self while the older individuals are at a more developed stage. Consequently, it is probable that older members of staff have a more coherent self while the younger ones are still growing. It can thus be argued that an older worker who has developed a coherent self has self-capacities to maintain positive self-identity which enhances resilience to trauma. This coupled with appropriate trauma management activities could protect the caregiver from experiencing the adverse effects of VT. In contrast, another study found that caregivers who are advanced in age experience greater burden than younger ones (Rinaldi et al. 2005, Serrano-Aguilar et al. 2006).

Regarding the level of education, the study findings of the descriptive analysis indicated that majority (70%) of those who had vicarious trauma had secondary and tertiary education. The current study further found that there was no significant correlation between level of education and occurrence of vicarious trauma. This means that the level of education of hospice workers does not determine whether one is susceptible to vicarious trauma. Thus, vicarious trauma can occur in a worker with high level of education as well as the worker whose education level is low. These findings were unforeseen because most of the researchers in the related field have found higher level of education to be a protective factor against vicarious trauma (Adams & Riggs, 2008; Fahy, 2007; Radey & Figley, 2007 cited in Branson, 2011).

Additionally, it is expected that hospice workers who have attained tertiary education are well trained in hospice (palliative) care and therefore, the assumption is that they are adequately prepared to deal with trauma associated with caring for the terminally ill. A number of questions could be raised here with caution, regarding the nature of training received by the caregivers. Several researchers have reported that the topic of vicarious trauma is often not included in academic programs, hence causing caregivers to be ill prepared for the professional and personal triggers of trauma related work (Knight, 2010; Adams & Riggs, 2008; Radey & Figley, 2007). According to Pearlman & Saakvitne, (1995), trauma education reduces the potential of vicarious trauma. Literature shows that most caregivers in Kenya have attended brief training.

The annual report by the Kenya hospice and palliative care association (KEHPCA) showed that the association coordinated brief introductory courses (4 to 5 days) in palliative care for the health care workers to enable them acquire knowledge, skills and attitudes in palliative care (KEHPCA, 2013). Further, according to KEHPCA, some hospitals have been earmarked to become centers of excellence in provision of palliative care services, training and mentoring. This may ensure that caregivers receive extensive training which could help to moderate the occurrence of VT. It is possible that some of the hospice caregivers have only received the brief training which may not have adequately addressed or covered trauma related issues at the work place.

Despite all these arguments, the current study found no significance between level of education of the workers and occurrence of vicarious trauma. As mentioned earlier, response to trauma is a very personal experience. According to the CSDT framework, the self-development process of an individual plays a crucial role in mediating trauma. Depending on the realities that a caregiver has construed regarding the traumatic experience, he or she may be affected adversely or otherwise even when he or she is highly trained. Again even when a caregiver is well trained, if the self is not coherent it is probable that he or she may experience trauma effects. Moreover, if trauma management activities or other relevant support programmes (such as debriefing and professional counselling) are lacking, they would still be vulnerable to VT effects. Similarly, caregivers who are too empathic and are unable to maintain healthy boundaries with their patients are also more likely to be susceptible to trauma effects.

On occupation and vicarious trauma, descriptive analysis revealed that both professional and non-professional members of staff were affected by vicarious trauma. The non-professional staff had a slightly higher prevalence rate (76.2%) compared to the professionals who accounted for 62.5%. The non-professional staff included receptionists, cleaners, cooks and drivers. This means that even though these staff members do not interact with the hospice patients at similar levels as the nurses or medical team, they too get affected. Various studies show that staff (including support staff) in hospice and palliative care settings get adverse psychological effects. A study among registrars in medical oncology and palliative care units in the United Kingdom revealed that they experienced distress, depression and suicidal ideation (Berman et al., 2007, cited in Vachon, 2011).

In the current study, majority of the staff suffering from VT were the non-professionals. This could be explained by the fact that usually the non-medics such as the receptionists are the first ones to encounter the patients that visit hospices. They therefore, witness the suffering and trauma first hand from the patients as they interact with them. In Africa (Kenya included), most of the patients present with advanced disease conditions (WHO, 2012); which can possibly evoke disturbing emotions or anxiety in the staff receiving them. Moreover, theoretical evidence shows that trauma experience depends on the individual's appraisal and the perception one has construed about the situation (McCann &Pearlman, 1990). CSDT framework proposes that most of those who get adversely affected construct irrational realities. The trauma effects could be attributed to the disruption of their worldview as well as their ability to self-protect.

The professional staff who form a large percentage of the medics are also affected by VT. Majority of the professionals in hospices are the nurses who basically run the institutions. Numerous studies have supported the view that nurses are mainly affected due to their interaction with patients. For example, Costello, (in Wilson & Kirshaum, 2011), affirms that nurses have been recognized to have the most extensive interaction with patients compared to other health care professionals. Robin, Meltzer and Zelikovsky (2009), examined the occurrence of secondary traumatic stress among nurses in a children's hospital, and found that 39% of the sample was at risk. Abendroth and Flannery (2006) found that 80% of the participants were at moderate to high risk of developing compassion fatigue.

These study findings appear to base their argument on the fact that hospices nurses play multiple roles which could result in role strain; a view supported by the Role Strain Theory. This theory proposes that increased number of roles leads to overload and strain, which can translate into negative effects on the individual's physical and psychological well-being (Goode, cited in Ahrens & Ryff, 2006). According to Stenberg, Ruland, & Miaskowski, (2010), the many roles nurses are expected to play could make them feel stretched in many directions at once. This coupled with limited resources and staff could strain them even more increasing their susceptibility to vicarious trauma.

Moreover, when their patients do not get well the caregivers could feel a sense of failure or futility resulting in feelings of hopelessness and powerlessness. These emotions then can make them vulnerable to trauma. Research shows that moral

distress among hospice caregivers could result from the multiple roles in caring for intricate end-of-life patients with limited resources increase in nurse-patient ratios as well as organizational demands (Lobb et. al., 2010, as cited in Jonson 2015).

The views in literature however, appear to contrast the notion held by the proponents of CSDT framework which explains how vicarious trauma occurs. CSDT holds that trauma results from the interaction of the client material and the caregiver's personal characteristics (Pearlman & Saakvitine, 1996). The theory further emphasises the adaptive function of one's behaviour and beliefs as well as how the person manages his or her affect. The realities and perceptions that the caregiver constructs determine how trauma affects the caregiver. The nursing job requires that they consistently interact with the patients in hospices. This implies that hospice nurses interact closely with patients and are therefore all exposed to vicarious trauma. The results of the current study show that majority of the nurses were affected, yet some were not. This can be explained by the CSDT framework: those who develop irrational realities are likely to get affected as their capacity to self-protect is affected. Thus with a well-developed and coherent self, a caregiver can interact closely with clients and yet get cushioned from the adverse effects of trauma.

The findings of the current study also showed that there was no significant relationship between occupation and VT. This means that the occupation of the staff is not is necessarily associated with VT. This insignificance could be attributed to the subjectivity of trauma experience as explained by the CSDT framework. A caregiver such as a nurse who is constantly interacting with traumatized clients can still be

resilient depending on the meaning he or she construes about the suffering patients. In addition, keeping a healthy emotional boundary and practicing self-care strategies as well as organizational support could enhance the caregiver's well-being and resilience. All in all the study findings as well as the theoretical framework show that trauma experience is not based on the caregivers profession but the individual's self which is the seat of his or her personality.

With regard to professional experience and vicarious trauma, the majority of those who suffered trauma had work experience of between 7 to 11 years. This could be explained by the fact that individuals do not get used to trauma just because they have stayed in the situation over a long period. Resilience to trauma could be due to the interaction of the work environment and the personal characteristics of the caregiver. Further analysis of data in the current study indicated that there was no relationship between years of work experience and occurrence of vicarious trauma. These findings were not expected considering that literature says that a long professional experience was a moderating factor for vicarious trauma. According to Bride and Figley (2009), the risk of developing trauma is influenced more by the length of experience specifically focused on trauma.

There have been inconsistencies in findings regarding work experience and occurrence of vicarious trauma, with some studies showing positive correlations and others posting inverse correlations. This may be due to the fact that individuals' reactions to trauma material are unique and depend on characteristics of the situation

and the worker's unique psychological needs and beliefs (McCann & Pearlman, 1990).

The findings of the current study contradict findings of other studies which show that caregivers with less professional experience are at a greater risk of developing trauma (Baird & Jenkins, 2003; Bride & Figley, 2009 cited in Kalodow, 2010). These findings can be explained by the CSDT principles which hold that a person actively construes and creates his or her personal realities by developing complex cognitive structures which he or she uses to interpret events (Epstein, 1989; Mahoney, 1981; Mahoney and Lyddon, 1988 in McCann & Pearlman, 1990). The unique way in which trauma is experienced depends partly on the schemas that are central or prominent for the individual.

The effects of trauma may be determined by how a caregiver appraises the situation irrespective of the length of period he or she has worked in the trauma situation. Thus, if an individual appraises the stressor as a threat and views him/herself as lacking the resources needed to cope, then he/she may experience distress. On the other hand, a caregiver who sees a traumatic event as a challenge and opportunity for growth would be confident that he/she has adequate resources to meet the demands, and therefore may not experience distress. Pearlman and McCann (1990) in their theory, posit that trauma is a subjective experience. Thus, despite the job experience one may claim to possess, if the ego resources and self-capacities are not strengthened, he/she may be prone to negative psychological outcomes such as vicarious trauma.

According to the Joanna Briggs Institute (JBI, 2011), caregivers who have developed "personal protective resources" are less likely to get affected by vicarious trauma unlike those who lack such resources. Personal protective resources refer to the way caregivers perceive the situation and their ability to cope with the situation. In view of the findings of this study and the CSDT framework, the caregivers' experience of trauma is subjective and does not necessarily depend on how long they have worked in hospice settings.

5.2.4 Relationship between Personal Trauma History and Occurrence of VT

This section was guided by objective three which sought to find out the relationship between personal trauma history and occurrence of VT. The findings of the current study indicated that generally the caregivers had moderate to high scores on personal trauma history. This gives a general impression that many caregivers have histories of personal trauma. There was also a significant moderate positive relationship between personal trauma history and occurrence of Vicarious Trauma: $r(70)=.275$, $p=021$. Every caregiver has a unique history of experiences that shapes the way he or she will interpret and react to traumatic events. This can help to explain the differences in vicarious trauma levels among caregivers. History of personal trauma refers to the past as well as recent distinct experiences that an individual may have undergone which may impact how he or she responds to present traumatic situations. These past experiences are unique in that they are subjective to the person and they shape the way one views the world especially if they have not been resolved.

Hospice staff may have experienced firsthand traumas in their own lives that may influence the way that they experience effects of vicarious trauma. The findings of the current study resonate with findings of a related study on Behavioural Health Clinicians in which a significant positive relationship was found between the personal trauma history and vicarious trauma symptoms, (Adams & Riggs, 2008). Similarly, Pearlman and Mac Ian (1995) found that 60 % of clinicians who reported a personal history of trauma had significantly more vicarious trauma symptoms.

The findings of the current study also supported findings of other studies that also found significant relationships between personal trauma and vicarious trauma (Graaf, 2011; Devilly & Varker, 2009; Dekel et al. 2007; Martin, 2006). Regardless of the fact that these studies were conducted among healthcare workers of varying cultures and in different locations, personal trauma history correlated with vicarious trauma. These findings imply that caregivers' who have unresolved personal trauma histories are more likely to suffer vicarious trauma. It is possible that unresolved personal trauma can become an issue at work as alluded in a study by Cohen and Collens, (2013), where participants reported that their own personal trauma history was an issue for them in the work place.

Another study on therapists' past traumatic experiences, compassion fatigue and work performance in Eldoret (Kenya), found that 31% of the participants had their duties affected by their past trauma histories (Kabunga Adinab, Disiye, Shikangad & Amapesae, 2015). These findings imply that trauma history could be a real issue not only among caregivers in Kenya, but in healthcare providers across the globe since

these studies were done in different regions. Consequently, a caregiver who suffers a chronic or terminal condition such cancer is likely to get traumatized as he or she encounters client-based trauma that is similar to his or hers. Similarly, a hospice worker who may be caring for a loved one with terminal illnesses similar to his or her clients is more likely to be vulnerable to vicarious trauma. In Kenya cancer or HIV related conditions are the most common conditions that caregivers are likely to be dealing with in the hospices (KEHPCA, 2012). Therefore, if the caregiver or a loved one has cancer or is infected with HIV, caring for a patient with similar illnesses can trigger some emotions. As the caregivers witness their patients' painful conditions, they may get affected particularly if these conditions relate to their own.

Hospice patients suffer multiple complex symptoms ranging from pain, increased weakness, breathing problems, gastrointestinal problems, to decreased levels of consciousness (JBI, 2011). As the patients' conditions deteriorate, caregivers' painful experiences or unresolved traumas may be triggered. As they process their traumatic experiences, caregivers may begin to experience similar symptoms as their clients and in the process they become more vulnerable to vicarious trauma. It is possible that witnessing the disease progression and suffering in the clients could provoke anxiety and fear regarding the caregiver's own future or that of their loved ones.

Moreover, death in hospice settings is common. Caregivers who have not resolved their personal experiences of the deaths of their loved ones could become more vulnerable to vicarious trauma. This is because the multiple deaths of patients and grief experiences in hospices can put the caregiver in touch with their own losses.

Wilson and Kirshbuam (2011) affirm that if personal experiences such as the death of a close relative or friend are unresolved or unaccepted, caregivers could be vulnerable when confronting the death of a patient. This may become more complex particularly if the patient's death had similar features to the one experienced by the caregiver.

In addition, it is also possible that hospice caregivers who have suffered personal trauma have been able to resolve them through psychotherapy or other coping mechanisms. Such caregivers may become more effective as helpers of persons facing similar challenges, becoming the wounded healers. This means that having gone through painful experiences (wounds) in their lives and managed to cope, these caregivers are in a better position to help persons who may be going through similar painful experiences. As they care for others in pain, the caregivers may not suffer the adverse effects of vicarious trauma as they have become more resilient.

It has been recognized in the recent past, that some people cope well even when they face trauma challenges. There are studies that have given contradictory findings to the present study in that, they did not find any relationship between participants' personal history and vicarious trauma (Branson, 2011; Way et al. 2007; VanDeusen & Way, 2006). This could be due to the fact these individuals have learnt to deal with their past experiences, or perhaps working with people facing traumas similar to theirs may be offering the caregivers some satisfaction. This is affirmed by Katz and Johnson (2006) who concluded in their study that, majority of the caregivers had opted to work in palliative care due to their own past life experiences of death, trauma and loss of loved ones. These caregivers view their experiences as forming healthy boundaries

between their own personal lives and professional connections (Genevay and Katz, cited in Wilson & Kirshbaum, 2011).

The CSDT framework on which vicarious trauma is based, places emphasis on the self and how individuals construct their realities (Pearlman & McCann, 1995). The individual's sense of self begins with one's identity, which draws from the personal history of an individual. According to the constructivist theory, the self is ever evolving. The past histories (including childhood memories) are usually remembered and these shape the person's present and future development and growth of the self. The personal history of a caregiver therefore plays a role in the type of self (coherent or weak) that one constructs.

In addition, CSDT posits that individuals are actively creating cognitive schemas or perceptions regarding their life experiences. Cognitive schemas are the conscious and unconscious beliefs and expectations which individuals have about the self and others. It is possible that these beliefs could have resulted due to the past experiences that a person has undergone over time. Therefore when one faces a traumatic event, cognitive processes can be triggered which can result in either no change, positive change or negative change to previous schemas (Cohen & Collens, 2013). This means that a traumatic event can either cause a positive or negative alteration in the caregiver's perceptions. It is therefore possible that significant positive psychological change can occur following a major life trauma (Tedeschi, Calhoun, & Cann, cited in Cohen et al., 2013). This positive transformation is known as post traumatic growth

(PTG). This view implies that there could be caregivers in hospices who have suffered personal traumas which in effect make them more resilient to vicarious trauma.

Overall, the findings of the current study imply that past trauma is a correlate of vicarious trauma. What has emerged is that, the past life experiences and life events in the caregiver's life leaves lifelong trajectories and marks on who a person is and how one interacts with world around him or her. This in a way defines one's susceptibility to particular stresses (Best Start Resource Centre, 2012) and also determines how one reacts to traumatic events. Therefore in trying to understand vicarious trauma it is necessary to also target its correlates such as past history of individuals; and these need to be recognized and addressed.

5.2.5 Relationship between Empathic Engagement and Vicarious Trauma

This section is guided by the fourth objective which seeks to find out the relationship between empathic engagement and occurrence of vicarious trauma. Analysis of data on empathy level revealed that there was moderate to high level of empathy among respondents. With a mean score of 50.6 the performance was slightly above average, meaning, that most respondents indeed applied empathy in their work. The study findings also indicated a significant positive correlation between general empathy level and occurrence of vicarious trauma. This was an expected result because hospice work primarily demands that one employs empathy in order to effectively offer care to the terminally ill patients as well as their families. Literature depicts empathy as a crucial aspect of care giving in hospices and therefore the ability to empathize is a hallmark to helping others, yet it also puts one at risk of developing vicarious trauma.

Sinclair and Hamill (2007) affirm that each person is unique in his or her ability to empathize with others. Perhaps this explains the variations in the expression of empathy among caregivers as depicted by the study findings

The findings that empathy correlates with occurrence of vicarious trauma imply that the higher the level of empathy one engages in, the higher the risk of vicarious traumatization. Thus hospice workers who are highly empathetic may be more vulnerable to trauma. In literature, empathy has been described as a 'double-edged sword' (Kaladow, 2010). This is because it is required as a tool to help understand the client's trauma experience, yet on the other hand, it may be a conduit transferring trauma from one person to the next, leading to vicarious traumatization (Figley, 1995a; Gates & Gillespie, 2008). Therefore, it follows that a caregiver who engages a patient empathetically and is unable to maintain a healthy boundary or disengage emotionally is more likely to get adversely affected.

Hospice caregivers are likely to suffer cumulative effects due to the nature of their work. They constantly engage empathically with terminally ill patients, as well as grieving families or mothers of dying children. A study on caregivers of HIV/AIDS patients in South Africa and Zambia showed that they felt emotional stress and inability to cope with the loss of patients (Demmer, 2006; Dieleman, Biemba, Mphuka, et al., 2007; cited in Gysels et al., 2011). This may result in chronic grief reactions and depression (Vachon, cited in Larson et al., 2006).

On the other hand, as Abendroth & Flannery (2006) explain, a healthy sense of empathy and the strong coping mechanisms as well as healthy detachment play a role in protecting the self and promoting resilience. This notwithstanding, it is possible that a caregiver's capacity to maintain their empathetic stance can become overwhelmed especially when a patient or family member shares more traumatic stories. Reviewed empirical literature clarifies that in the process of empathic engagement with a client, empathic growth or stretch (Abendroth & Figley, 2014) could take place. Empathic growth or stretch is a process that takes place as the caregiver and traumatized client collaborate to understand and make sense out of the trauma and its meaning for the client. This means that transformation which varies from distressing (vicarious traumatization) to highly positive can occur both in the caregiver and the client.

Other authorities in the field of trauma highlight a newer construct in trauma studies called empathic discernment which refers to: the effectiveness in accurately selecting and using the best empathic response for both client and self in the therapeutic setting (Radey & Figley, 2007). In order to use empathy effectively to moderate trauma effects, a caregiver may need to acquire both empathic growth as well as empathic discernment. According to Riggio and Taylor (2000) effective empathy in hospice care is in the form of 'perspective taking' and 'empathic concern' while 'personal distress' is considered as unhealthy. To distinguish these components of empathy, data on each of the three domains was analyzed separately.

The study findings on perspective taking domain and occurrence of vicarious trauma indicated that there was a positive moderate correlation between the two variables: ($r(70)=.346$, $p=003$). This means that a caregiver who displays a high level of perspective-taking is more likely to suffer vicarious trauma than the one with low or no perspective taking. The perspective-taking subscale assessed caregivers' understanding of the point of view of others. It is also referred to as cognitive empathy. Davis (1980) describes perspective taking as the ability to infer mental states and adopt the perspectives of other people; or, seeing things from their point of view.

In addition, Mead (in Pagotto, 2010) explained this cognitive component of empathy as a way for one to take on the role of another in order to understand the worldview of the other person. Another similar view is that by Dymond (in Pagotto, 2010) which explains cognitive empathy as the "imaginative transposing of oneself into the thinking and acting of another person". These views suggest that perspective taking is more about 'thinking' and not so much so about 'feeling' which as seen brings in a sense of protectiveness. This seems to suggest that perspective taking is not an emotional aspect of empathy but more to do with the cognitions. In agreement, Riggio and Taylor (2000) found that empathy in hospice nursing would be healthy or effective in form of 'perspective taking'.

The findings that there was a significant positive correlation between perspective taking and vicarious trauma were unpredicted given that, in literature this component of empathy is viewed as a protective factor. For example, Pearlman and Saakvitne

(1995a) posit that cognitive empathy is the way one experiences life-threatening event as narrated by the traumatized client, without the risk of developing vicarious trauma. Similarly, Hogan (in Pagotto, 2010) views perspective taking as "the intellectual or imaginative apprehension of another's condition without actually experiencing that person's feelings." It appears that this is not the case among the caregivers in the present study, since the results have reflected significant correlations between the two variables. A possible explanation would be that, because people have similar experiences, imagining oneself in another's place can convert the other person's worldview into mental images that evoke similar feelings. This may result in conceiving the other person's suffering, pain and agony. It is possible that self-focused perspective-taking can produce as much pain as that which is felt by the trauma survivor, in this case, the hospice patient. This can place the caregiver at risk for vicarious trauma.

According to Hakkanson (2003), perspective-taking means entering into the perceptual world of another person, and seeing things from his or her worldview. Though this is meant to be temporary, at times the caregiver may get lost in the patients' worldview, which then results in the caregiver experiencing similar emotions as the clients. This resonates with results of studies which showed that perspective taking could elicit strong emotions including distress and sadness as well as feelings of injustice (Davis et al., 1996; Galinsky & Moskowitz, 2000; Galinsky et al., in Pagotto, 2010). In addition it was found that perspective taking tended to influence cognitive representations of self plus others, as well as merging identities.

This implies that a caregiver could imagine what the other person was feeling and in the process enhance this by merging the other person with him- or herself into oneness. In another study, (Pagotto, 2010) concluded that perspective taking may actually be affect-based because the oneness that resulted from this aspect could bring in a sense of interconnectedness with the other person. If this is case then caregivers using perspective taking as they engage with patients may indeed become emotional. This probably suggests that a person in a way appraises the worldview of the other person and begins to see the world through the lenses of that person. These could become precursors of vicarious trauma, meaning that a caregiver expressing perspective taking could be prone to vicarious trauma. For example, a caregiver who could be interacting with a patient who sees the world as unsafe may also begin to view the world as unsafe just like the client. In the process the caregiver's psychological needs (other- and self-safety) will be impacted negatively resulting in disruptions of their cognitive schemas, belief system and worldview (Pearlman & Saakvitne, 1990), a typical sign of VT.

Furthermore, the CSDT framework postulates that individuals make sense of their experiences by creating realities through the cognitive schemas which include beliefs, assumptions, and expectations about self and world (McCann and Pearlman, 1990a). Therefore it is probable that the caregivers assign different meanings to their experiences. The meanings they give to their perceptual world as they interact with their clients' world could render them vulnerable to trauma.

With regard to Empathic Concern and occurrence of vicarious trauma, the findings indicate that there is no relationship between two variables r (70) =.-002, p=.989. These findings were also unexpected because: firstly, empathic concern is the emotional domain of empathy which is viewed in literature as a risk factor for vicarious trauma and secondly, it is at the heart of hospice care hence it is expected that majority of the hospice workers would apply it. The findings of the present study therefore did not agree with the view of Pearlman (1995) that this type of empathy is how one experiences the client's anguish and it may pose a risk for VT onset. In fact Mehrabian & Epstein (1972) described emotional empathy as a vicarious emotional response to the perceived emotional experience of others. This seems to suggest that this empathic concern has a vicarious (indirect) effect on the caregiver using it.

Similarly, emotional empathy has been viewed as becoming emotionally aroused in response to the emotional state of another (Davis, 1996; Jackson, Melzoff, & Decety, 2005 cited in Pagotto, 2010). This view is undoubtedly supported by Hoffman (2008) who defined empathy as ... "an emotional condition triggered by another's emotional state, in which one feels what the other feels or would normally be expected to feel". These views seem to suggest that caregivers with high emotional empathy tend to be more susceptible to trauma effects compared to those with low empathy. The findings of the present study contradict those of a study in USA which found that caregivers had higher vicarious trauma scores with risk factors being empathy and compassion (Rose, 2008).

According to Davis (1996) the author of the interpersonal reactivity scale (IRI) used to measure empathy, persons that score high in empathic concern also score highly in shyness and social anxiety. Although they appear a little nervous and emotionally vulnerable (Davis, 1983c), they score higher in self-control (Tangney, Baumeister & Boone, cited in Konrath, O'Brien & Hsing (2011). This suggests that although caregivers who may use empathic concern when caring for their patients may seem emotionally vulnerable, they in fact have self-control.

The CSDT theorizes that the self has components and sheds light on how the self and perceptions of reality are formed (Pearlman & Saaktvine, 1995). The self-capacities and ego resources form part of these components of the self. The self-capacities allow a person to maintain a coherent self-identity, manage emotions and sustain positive feelings about oneself. On the other hand, the ego resources which include the abilities to set boundaries and self-protect allow one to meet his or her psychological needs. Consequently, a caregiver whose self-capacities and ego resources are strong can apply empathic concern and yet not get adverse effects of trauma.

In addition, the caregivers' control needs which are related to self-management help them to develop the capability to take charge of their lives, express feeling and act freely in their world (Pearlman & Saaktvine, 1995). This therefore makes it possible for the caregivers using empathic concern and who have high self-control to take charge of their lives despite their traumatizing work environment, thus reducing their proneness to trauma. Probably this could explain the non-significance between

empathic concern and occurrence of vicarious trauma among the caregivers in the present study.

Empirical literature has also documented evidence that empathy is a cause for altruism, described as a need to care for others. Perhaps it is due to this need to serve others that has motivated caregivers to work in hospice settings. This need is gratified as they offer their services to the terminally ill and the satisfaction may in the process cushion them against vicarious trauma. The non-significance of empathic concern could also imply that perhaps the caregivers have devised ways to cope as they interact with their clients empathetically. Using their ego resources, it is also possible that they are able to maintain boundaries or disengage emotionally. In concurring with Jordan (1997) it can also be argued that probably vulnerability due to empathy can become an opportunity for personal growth rather than risk. This could be attributed to the fact that in some occasions, safety resides in connectedness with others, thus, empathy could serve as a protective factor for some caregivers.

As regards Personal Distress and occurrence of vicarious trauma, the findings indicated that there was a statistically significant relationship between personal distress and vicarious trauma ($r(70)=.282$, $p=.018$). These findings were probable given that hospice caregivers work in an environment that is filled with distressing narratives of pain and agony. In their interactions with the patients and their families, these caregivers are exposed on a daily basis to the details of the clients' innermost thoughts, emotions and illness experiences. Furthermore, empirical literature advances that personal distress is an aversive emotional state which is characterized

by feelings of personal anxiety and restlessness prompted by witnessing another person's suffering (Batson, 1991; Davis, 1994; Eisenberg & Strayer, 1987 cited in Pagotto, 2010). Other authors have even suggested that personal distress is a result of unhealthy empathy (Riggio &Taylor, 2000), meaning it has adverse effects.

A care giver who experiences personal distress tends to avoid the intense emotions of the patient he or she is interacting with. Instead of connecting with the client as it happens in the case of empathic concern, or perspective taking, in personal distress there is a negative affective state that is caused by incongruent emotions between the self and the other. Consequently, the caregiver uses self-focused emotional response, whereby he or she directs conscious attention to himself or herself (Batson, 1991). The resultant emotions may include discomfort, anxiety, worry or restlessness. These negative emotions are egoistic reactions aimed at reducing or avoiding the stressor, which in this case could be the intense pain and suffering of the terminally ill patients. In the process, the caregiver could become more prone to vicarious trauma effects.

The findings of the present study are congruent with those of a study which showed that oncology social workers who used empathy with patients and their families, experienced traumatic stress (Najjar, Davis, Beck-Coon, & Doebbeling, 2009). Inferring from Nelson-Gardell & Harris' idea, it is possible that empathy used by caregivers when listening to the traumatic details of clients' suffering, becomes a conduit for the personal distress they suffer (Nelson-Gardell & Harris cited in Martin, 2006). These findings suggest that personal distress starts to build up as the caregiver repeatedly interacts empathetically with the terminally ill; and listens over and over to

the graphic descriptions of their agony and painful emotions. The caregiver directs attention to himself or herself in order to avoid the details of the agonizing narratives and traumatizing images from the client. Negative emotions of anxiety sadness, despair and rage may begin to emerge in the caregiver. This may result in emotional withdrawal from the client to avoid the discomfort.

CSDT framework explains that, if the caregiver's ego resources and self-capacities are weakened or disrupted, the outcome could be loss of identity, difficulty in controlling negative emotions as well as inability to self-protect or set boundaries (Pearlman & Saakvitne, 1995). This seems to suggest that empathic distress in the caregiver increases with the intensity of the distress of the trauma survivor, rendering the caregiver susceptible to trauma. The results of the current study have several implications: first, that caring for persons with terminal and chronic conditions is both challenging and strenuous. Secondly, that empathy which is a useful tool that caregivers use for caring for their patients and their families in hospices can be disruptive to their psychological wellbeing. Thirdly, those caregivers working in highly specialized areas like hospice and palliative care settings are likely to isolate themselves and in the process lose sight of empathic caring (Hooper et al., 2010) which is in the heart of hospice care.

Additionally, the caregivers who are constantly exposed to trauma and other stressors can be cushioned from trauma effects if they are helped to recognize and strengthen the psychological resources that they possess. This implies that there is need for

distinguishing the personal characteristics of an individual when assessing for vicarious trauma, rather than making general assumptions.

5.2.6 Strategies used to cope with Nature of Work

The findings in this section were guided by objective five which sought to find out the strategies that could be applied to cope with the nature of work in hospices. The analysis of data on coping strategies was done in two parts which were:

i) The strategies used by the hospice workers to cope with the nature of their work

ii) The strategies that could be put in place by the organization to reduce the risks of negative effects of the work

5.2.6.1 Strategies used by Hospice Staff to cope with Nature of their Work

The researcher found it necessary to find out from the workers, the strategies they use to cope with the nature of work that they do in the hospices. The findings were grouped according to the themes that emerged. The term coping has been used in this study to refer to the specific patterns of and internal processes that caregivers employ in response to stressful circumstances in order to tolerate, minimize, or eliminate stress (Lazarus & Folkman, 1984 cited in Harris, 2012).

The results of the current study showed that majority of the respondents (27.1%) used prayer or spirituality as a coping mechanism. These findings were expected since reviewed literature seemed to suggest that vicarious trauma affects the caregiver's sense of spirituality. Pearlman and Saakvitne (1995a) maintain that VT could result in

loss of a sense of meaning which could cause withdrawal, rage, emotional numbness, confusion, hopelessness and despair in the caregiver. Prayer is a form of emotion-focused coping which is concerned with the emotional strain that the caregiver may be going through. It is part of religious coping which can be defined as a way of adapting to the stress of illness by relying mainly on one's spiritual or religious beliefs. Religion or spiritual practices could be used interchangeably to mean practices and rituals related to the sacred (Koenig, 2009, cited in Bakibinga, Vinje, & Mittelmark, 2014) and not necessarily institutional religious practices.

Empirical literature shows that coping by spiritual or religious means has been associated with positive outcomes (Stepfanek, McDonald & Hess, cited in Uren & Graham, 2013). As they seek spiritual intervention from a higher power through prayer it is possible that the caregivers may draw strength to keep doing their work of caring for the dying, which can be challenging. This is affirmed by Nderitu (2010) and Bukibinga, (2014) who found that nurses in Uganda used faith in God as protective mechanisms. It appears that this faith gave them a sense of meaning and connectedness. Just like their counterparts in Kenya, the Ugandan nurses reported that their faith helped them in their workplaces despite the difficult work conditions.

In addition, praying together gave them a sense of belonging and togetherness as well as strength in providing their services. In the present study a caregiver commented that in order to cope with her work she reads the Bible (Respondent13) while another one maintained that he "depended on God's guidance" to do his work (Respondent 53). This communicates a need in the caregiver to rely on a higher being for strength.

This is probably because their work of caring for the dying makes them feel weighed down physically and emotionally. In other studies conducted in Sweden (Ekedahl & Wengdtom, 2010), and USA (Shinbara & Olson, cited in Bukibinga et al., 2014) healthcare professionals have reported using religion and spirituality respectively to help them cope with the nature of their work.

Additionally, using prayers also helped caregivers to counter feelings of helplessness and boosted their self-confidence. In another study on palliative caregivers in sub Saharan Africa, spiritual beliefs were reported as vital internal resources for caregivers which helped them cope with the reality of the patient's impending death (Streid, Harding, Agupio, Dinat, Downing, Gwyther, Ikin, ...et al., 2014). This implies that spiritual coping is used universally regardless of regional or cultural differences.

The finding that prayer is the most used mechanism probably suggests that prayer is a major coping strategy for many caregivers in the face of difficult circumstances. For some caregivers, prayer gives them a sense of meaning, optimism and assurance (Bussing, Fischer, Ostermann & Matthiessen, 2008, cited in Uren et al, 2013). It appears that maintaining a spiritual connection with a higher being helps strengthen them in the face of trauma challenges and gives them a sense of meaning. This mode of coping is supported by previously reviewed literature which suggests that meditation and spiritual practice are important tools in understanding caregivers' response to witnessing others who are in pain (McSteen, 2010). Additionally,

Pearlman and Saakvtine (1995) found that therapists who had a larger sense of meaning and connection were less susceptible to VT.

There other spiritual coping strategies that the caregivers in the study have applied included meditation or reflection. These are widely used mechanisms to cope especially with psychological and emotional disturbances. As McCann and Pearlman (1990) recommended, self-reflection is very crucial in helping caregivers increase awareness of their psychological needs and cognitive schemas and to identify their personal trauma histories that have not been resolved.

The study findings also indicated that social support was commonly used as a coping mechanism accounting for 14.3%. These findings were in line with empirical literature and research. For example a study in South Africa by Graaf (2011) found that caregivers used social support as a coping strategy. Similarly, Slattery and Goodman (cited in Veen, 2012) concluded that three key contributors of psychological wellbeing at the workplace include; social support, clinical supervision and power access.

Social support has been defined as the "perceived comfort, caring, esteem or help a person receives from other people or groups" (Cobbs, 1976). It involves social networks (linkages among distinct sets of persons) as well as social ties (person to person linkages). This support could be drawn from family members or friends. The support could be emotional, or in terms of giving goods or services, information and appraisal (feedback). Family members or friends can stand with the caregivers by

listening to them, giving positive appraisals or just being present especially in stressful times. This helps the caregiver in that it acts as a buffer between the negative effects of stress or trauma and healthy outcomes.

In addition, social support gives the caregiver an opportunity to share concerns as well as get new insights probably on how to handle certain situations related to their emotional turmoil. In the present study, a caregiver commented that she *"usually spends time with her friends, colleagues and family"* (Respondents 18) and another remarked that he *"goes out with his friends for fun, listens to music, and goes dancing"*. This shows that caregivers reach out to their colleagues at workplace and significant others for support. The main forms of support that featured in this study were in terms of emotional support, information and appraisal; particularly sharing their feelings, probably as a way of ventilating. Financial form of support from friends and family did not feature among the participants within the current study. This could be explained by the fact that these were formal caregivers employed by the hospices. The fact that many of the caregivers in the present study are seeking emotional support could probably imply that many caregivers are drained emotionally by the nature of their work. This has also been reflected by the relatively high prevalence of vicarious trauma among the caregivers in the study.

In their transactional model, Lazarus & Folkman (1984), hold that the social environment provides essential resources that help individuals to deal with stressful life events. Caregiving in hospices can be a very demanding task. For this reason, social support is a crucial component for moderating any negative effects associated

with this kind of work. The presence of emotional, warm and positive social interrelationships tends to reduce the caregiving burden. In a study by Uren et al., (2013), participants expressed that social support was crucial in caregiver's capability to offer care to patients. In the Kenyan culture like in many African communities people have been socialized to value living in communities and in some cases in clans which brings a sense of belonging. Consequently, it is not uncommon to find an individual receiving support from family and friends especially in times of crises or traumatic incidents.

The fact that many caregivers in the current study share their feelings with family and friends is an indication that social support is critical for them given the demanding nature of their work. In contrast, caregivers who receive little or no social support from others tend to report higher psychological and social strain. In her study, Graaf (2011) found that those caregivers who had support from family and friends had lower levels of trauma compared to those who had no support.

Likewise, Streid, et al., (2014), found that social support in form of family members was a coping strategy amongst the caregivers who were working with patients suffering chronic progressive conditions in sub-Saharan Africa. However they also found that not all families were supportive and that others proved to be sources of stress as they placed high demands and expectations on the caregivers. This implies that caregivers need to find healthy social support for them to realize the benefits because poor social support could be a risk factor for stress and trauma.

These findings have implications to the individuals and the organization as well. There is need for caregivers to invest in people and develop healthy social networks even at workplace that can act as a buffer in times of stressful events. In order to promote these networks, the organization could also lay strategies to ensure social support is offered at workplace. According to the constructivist self-development theory, one component of the self includes the need for intimacy which is a psychological need. In seeking social support, the caregiver is basically fulfilling the need for intimacy which helps him or her to feel connected to others and oneself.

The study findings also indicated that respondents applied psychological coping. The most applied strategies that emerged in this category were keeping a caring attitude, talking or sharing, as well as personal therapy or counseling. These are coping techniques widely recognized and recommended in literature. The caregivers reported that for them to cope with their work, they maintained a caring attitude. This could imply that they ensure that they show compassion as well as acceptance towards their patients as well as colleagues. Caring could also imply maintaining empathy at workplace.

In her theory of caring, Swanson (1993) defines caring as the way an individual relates to another on the basis of personal commitment and responsibility. Caring attitude has been described as a concern for the good and comfort of another person (France, Byers, Keraney & Myatt, 2011 cited in Shamloo, 2012), meaning that as they offer their services to the terminally ill, the hospice caregivers would place their clients' needs and interests first. Hence, hospice care requires that the staff accept the

patients, their culture, values, lifestyles and their decisions (Tetrault, 2012). Compassion and empathy play an important role and are at the heart of hospice care. Both attributes are embedded in the nature of the caregiver's training. Caregivers are trained to empathically engage with their patients in order to come up with appropriate interventions.

Maintaining a caring attitude helps the caregiver to remain dedicated as caring for terminally ill patients could be sensitive and delicate. In addition, this possibly helps the caregiver to stay focused on the core principles and ethics of his or her job of putting the patient's/client's interest and needs first. Moreover hospice care calls for virtuous caregivers who can provide emotionally involved care (Olthuis, 2007, cited in Tetrault, 2012). At the center of hospice care is the patient and the family members, all of whom need care from the caregiver. Hospice care emphasizes quality of life and comfort for the dying. Therefore, even with the knowledge and skills from medical training, without a caring attitude, the caregiver may not be able to offer appropriate and quality services in end of life care. Therefore the caregiver concentrates on maintaining the caring attitude in order to keep away any distractors including fatigue, distress among other emotions that may be viewed as negative or barriers to fulfilling this duty or role.

Research has shown that a caring attitude can help lessen the caregiver burden. According to JBI (2011), the attitude of the caregiver towards the work they do influences their personal burden of caregiving. By keeping a caring attitude, the

hospice workers are able to appraise their situation better thus reducing the adverse psychological effects including vicarious trauma.

Empathy has been viewed as a conduit through which caregivers are vicariously affected by trauma. However research has shown that healthy empathy which involves keeping appropriate boundaries could be beneficial to both the client and the caregiver. The client is cared for appropriately while the caregiver offering empathy also could attain positive outcomes such as personal growth. There is evidence that working in the helping field can bring with it positive feelings or satisfaction which can be a protective factor from vicarious trauma (Stamm, 1999 cited in Best Start Resource Centre, 2012).

In psychological coping, respondents also reported that they use talking or sharing with others as a coping mechanism. This is a strategy used widely in coping with stress and trauma. The finding resonates with findings of a study by Collins (2010) that one of the factors that helped mitigate vicarious trauma among caregivers was talking to others. Similarly, Rickerson et al (2005 cited in Wilson & Kirshaum, 2011) conducted a study among staff caring for the elderly in USA and found that 80% of staff used coping styles such as talking to colleagues and friends to help them cope with their response to death of a patient. By talking to others, it is possible that caregivers are helped to release any intense feelings they may have and probably see things in a different perspective as well as feel supported and less lonely. This means that caregivers have a deep need to confide in another significant person about the

struggles they face. This has featured in the present study where many of the hospice workers indicated that they share their feeling with colleagues, friends and family members in order to cope.

A study conducted among American hospice care physicians seemed to support talking to others as a coping style. The study found that commonly used wellness strategies included among others, nurturing relationships and sharing of feelings (Swetz, Harrington, Matsuyama, Shanafelt &Lyckholm, cited in McCann et. al., 2013). In addition, another study done in South Africa found that the caregivers felt that talking to, or sharing with another person resulted in positive outcomes and this made them *"feel alright"* (Uren & Graham, 2013).

Furthermore, some caregivers reported that they ensured they rested on their off days, used distraction strategies to divert disturbing thoughts, read, set aside quiet time and used humuor. According to Pearlman (1995), these strategies can help alleviate vicarious trauma effects. Additionally such mechanisms help the caregiver to maintain a sense of personal identity which is a crucial need according to CSDT. Furthermore, the strategies give caregivers a sense of connection with their emotions as well as stretch their tolerance levels. In addition, these coping strategies help the clinician escape, rest, and play (Bober & Regehr, 2005 cited in Garding, 2012).

The study found that fun, relaxation and humour are least applied coping strategies. Other widely recommended coping styles that did not feature in the current study include: regular physical exercise, adequate sleep and good nutrition as well as nurturing interventions like massage. There is a possibility that these strategies are

given least priority due to financial constraints or time limitations. As discussed earlier, hospices maintain few staff members probably due to lack of resources. The few staff members who play multiple roles may not have adequate time to use some of the coping styles that need time. This is an area that may require more interrogation and addressing.

It is also worth noting that 10% of the participants did not respond to the item asking them to describe how they cope with workplace stressors. There is a possibility that these respondents were not sure of the coping styles they used. It is also likely that they did not apply any coping strategies, which could be a risk for adverse trauma effects given the amount of trauma work involved in hospices. It is also possible that these respondents failed to understand what was asked or how to write it down probably due to their level of education. As shown in the demographics, a small percentage has primary education.

Overall, the respondents in the study have applied adaptive coping strategies which are recommended in literature. Various authors concur that there are adaptive coping styles comprising active coping, positive appraisal self-care, counselling, social support as well as religion/spirituality. Research has shown that caregivers who apply these coping strategies tend to have more satisfaction than those who use maladaptive or avoidant styles (Staines, 2000, cited in Graaf, 2011) such as denial, alcohol or drug use suppression, withdrawal among others. The use of adaptive coping style by caregivers, probably explains why despite the high prevalence of VT (67%) indicated in the present study, majority (82.98%) suffer low levels. However, there is still a

significant proportion (approximately 17%) of the respondents who suffer moderate to high levels of VT, which may need to be addressed appropriately to avoid the deleterious effects of vicarious trauma.

5.2.6.2 Strategies by the organization to help reduce the risk of negative effects of work

Data analysis on organizational strategies revealed the following thematic areas: payment and motivation, psychological support of caregivers, capacity building of caregivers, improving work environment and staff team building. Majority 28.6% of the participants reported that psychological care for the caregivers by the organization was the most crucial strategy to curb vicarious trauma.

Regarding staff payments the study findings indicated that 20% of the respondents suggested that the hospices needed to improve the caregivers' payment in order to motivate them and there by possibly help to alleviate the stress at work. The respondents made statements such as: *"The management should give better pay" (Respondent 1)*; *"the administrators could consider special remuneration for staff motivation" (Respondent 2).* These statement imply that probably the workers' pay in the hospices was inadequate thus lowering their work morale.

Other comments related to the organization facilitating *"staff outings"*, *"staff appreciation"* and *"paid holidays"*. These were suggested as ways to improve working conditions in hospices and in the process motivate the workers. Staff outings may be helpful as a way of relaxing from the stressful work environment as well as

taking a break from the busy work schedules. There could be other indirect benefits such staff bonding which also helps in team building, an aspect that is critical to the holistic care in hospice. As staff member bond, they may find it easier to share their emotional burdens or stresses, which in effect may help them release bottled up emotions. This may help in building their psychological wellbeing thus alleviate trauma effects.

Furthermore, staff motivation can be seen as a way of encouraging or prompting the caregiver towards offering high quality services. Workers who are motivated tend to be more satisfied with the organization probably as they view themselves as part of the team. They may feel supported and are therefore, likely to keep going despite the challenges at work and probably maintain the caring attitude much better.

Organizational support could take the form of positive feedback or recognition received from management or supervisor (Dean, 1998). In addition, it could include more formal supports such as debriefing sessions, staff support groups, regular meetings in which caregivers discuss personal, work-related experiences and feelings with colleagues in a supportive, non-judgmental environment (Le Blanc et al., 2007). Support in form of positive appraisals particularly from the management or team leader can help boost the ego resources especially in the area of self-esteem of the caregiver thereby enhance their coping mechanisms. This can make the caregiver feel supported and appreciated as well as strengthen the psychological resources of the caregivers and reduce the risk of vicarious trauma.

Regular meetings, support groups and debriefing were also proposed as a strategy that the organization could facilitate to help caregivers cope. The comments by the respondents indicated that that there was need for caregivers to share their experiences regularly with colleagues in a formal setting that could help them express their emotions. These meetings could also help them discuss the difficult cases of patients or related issues, which may result in positive feedback and information that can give the caregiver new insight on how to handle the patient. These could be forums where caregivers are provided with psycho-education on how to cope with stresses of work and issues of work-life balance.

Majority (28.6%) of the respondents suggested that the organizations could provide the staff with psychological care and support. They further proposed having counselling sessions by trained counsellors as well as holding weekly discussions about their experiences. The caregivers suggested that the management could organize frequent debriefing for staff, group therapy sessions, recreational activities, supervision as well as outdoor activities.

Hospice work involves intense emotional engagement with patients. They witness as their patients' conditions worsen until they die. The level of engagement may deepen as the patient nears death particularly within the inpatient facilities. Even after the patient has died, caregivers are left with the bereaved families to care for. Loss and grief is part and parcel of hospice care. The agony and anguish of patients and their families leave an emotional mark in the caregiver. This could increase the

susceptibility of the caregiver to trauma, which suggests that psychological interventions are essential.

As the present study findings show, majority of the caregivers are at risk for negative effects of the trauma work they are involved in. For psychological well-being and to help them deal with the stress and trauma conditions at work, the caregivers require psychological support in terms of professional counselling which could be in form of individual or group therapy. This is in line with the findings of a national survey done in USA by Aycock and Boyle (2009) among oncology nurses. The study concluded that organizations should provide preventive supportive services such as counselling and educational measures.

From the responses of the caregivers, it appears that psychological support is a real need in the hospice facilities. The findings of the present study indicate that there were no counselors or psychologists in the facilities. The caregivers comments such as: *the management should provide resources such as counselling offices" (Respondent 11); "counselling sessions by trained counsellors" (respondent 61); and "frequent debriefing for staff debriefing" (respondent 68);* imply that there are no such services offered in these facilities. In addition, these sentiments indicate that psychological and counseling services by professional personnel are perceived as critical by the hospice employees.

The other emerging theme was on organizing for capacity building activities which accounted for 14.3%. Respondents raised comments such as: *"the management needs*

to organize more seminars and regular training in palliative care as well as problem solving skills for staff members" (Respondent 1). On capacity building of care givers, participants stated that educative workshops and seminars, regular training in palliative care, team building as well as problem solving skills were appropriate strategies by the organization. Similar findings were highlighted in various related studies (Graaf, 2011, Collins, 2010; Unroe, et al, Chiu, et al, 2009).

The respondents stated the need for the organizations to educate their staff about healthy living, managing losses, developing stress management techniques, cultivating team effectiveness. These would go a long way to reduce the adverse trauma effects among the caregivers. These findings concur with studies carried out in various areas. In their study, Flannelly, Green and Kudler (2011), found that work related social support was critical for enhancing personal resource required to counter trauma effects at workplace.

In a research conducted among 14 nurses working with pregnancy loss in gynaecology wards in Northern Ireland (McCreight 2004, cited in Wison and Kirshaum, 2011) it was found that continuous education for new and old staff could help them cope with the grief and loss they experienced at the workplace. Likewise, Fessick (2007) reported that a staff retreat which included education on loss and grief for twenty oncology nurses was seen as helpful in supporting the staff through their experiences of loss and grief. The staff reported that this gave them an opportunity to share their experiences, improved their coping mechanisms and enhanced teamwork.

Another theme that emerged was on improving working conditions. The participants reported that there was need for the organizations to promote: "*Good or friendly working environment and regular staff meetings (Respondent 12),* Caregivers felt that it was important for employees to have regular discussions about their experiences possibly because this would encourage open communication among staff which would be helpful in sharing their struggles at work. Open sharing could be a useful coping strategy that could reduce caregiving burden in that the caregiver would not feel left alone and critical information regarding management of patient cases could be shared.

The comments also centered around taking care of staff welfare through increasing the number of staff members and provision of leave to enable caregivers take breaks from the heavy workloads. One respondent commented: *"granting annual leave to staff, building a resource centre as well as provision of more facilities and increasing human resource" (Respondent 20).*This gives an impression that staff in hospices hardly get adequate time off from work probably because of the heavy work load as well as inadequate nummers as indicated by the respondents.

These factors have been highlighted in literature as increasing the risk for negative effects including vicarious trauma. This concurs with the findings by Hagopian, Zuyderduin, Kyobutungi, & Yumkella (2009 cited in Bakibinga, et al., 2014), that Ugandan caregivers work lives were a source of frustration due to heavy workloads, low financial gains, inadequate facilities and supervision. There is evidence that taking time off work helps to alleviate trauma symptoms. The findings of the current

study have implications for practice in terms of care of the caregivers in hospices. The study findings indicate the following as crucial coping strategies that need to be promoted in hospices: psychological care, social support, spiritual care, improving terms and working conditions, team building as well as staff capacity building.

The findings also have implications for the management of hospices and other stake holders. There seems to be discontent among the caregivers regarding their welfare at their place of work. This is likely to cause personal distress among staff and possibly affect their morale. Consequently, the low morale could result in low quality service delivery. The management may need to look into the welfare of the caregivers so that they feel supported. This is likely to boost their morale which is crucial for the difficult work they do in the hospices and could go a long way in curbing vicarious trauma and other adverse effect that are likely to emerge.

5.3 Conclusions

The following conclusions were drawn from this study:

The study found that there was a relatively high prevalence of VT among staff working in hospices with some few experiencing high levels of VT. There was evidence that a bigger percentage of the non-professionals was at a higher risk of suffering VT. This shows that even the support staff who are non-medics within hospices get adversely affected by the nature of the work they do. This means that vicarious trauma is a concern in hospice settings. This empirical evidence supported the existing literature that vicarious trauma is a major issue of concern among personnel working with clientele in trauma related settings such as hospices.

Contrary to what the study had hypothesized, significant relationships were established between some personal attributes and occurrence of vicarious trauma among hospice workers in Kenya. These attributes included: age, personal trauma history and level of empathy. This informed the researcher to reject null hypotheses that: there were no significant relationships between personal attributes (including age, personal trauma history and level of empathy) and occurrence of vicarious trauma among hospice staff in Kenya. From these findings, it can be concluded that an interaction of personal factors plays an important role in the experience of vicarious trauma as explained by literature and the Constructivist Self-Development Theory (CSDT). This implied that caregivers who had high empathy levels, unresolved trauma histories and were young in age were more susceptible to vicarious trauma.

It is worth noting that there were no significant relationships between some personal attributes (gender, level of education, work experience and occupation) and occurrence of vicarious trauma among hospice staff in Kenya. This suggests that gender, education level, occupation or work experience, do not directly determine susceptibility of caregivers to vicarious trauma. This means that the development of the self of the individual appeared to have some influence in the way the caregiver responded to trauma material.

The findings underscored a number of strategies that hospice staff members used to cope with their work. Respondents reported that they used spiritual, social as well as psychological support. The findings of the study showed that many caregivers in

hospices used prayer as a coping mechanism. With regards to what the organizations could do in terms of enhancing their coping mechanisms; respondents proposed that the hospice management could improve working terms and conditions, enhance psychological care, promote staff team building as well as develop capacity building programmes. It appears that these activities are not practiced effectively in some of the institutions, thus leaving the workers more vulnerable to VT.

5.4 Recommendations

In view of the findings and conclusions of this study, several recommendations are suggested for caregivers, hospice administrators, researchers, stakeholders and policy makers who have individual and collective responsibility of ensuring that effective and quality services are offered in hospices for all Kenyans who require them.

5.4.1 Recommendations for Policy Makers (Ministry of Health, KEHPCA)

1. The high prevalence of vicarious trauma among hospice staff is of concern. There is need for the stakeholders to recognize and acknowledge that vicarious trauma is a real occupational risk; and address it appropriately through formulation of policies that target relevant and practical intervention strategies. It is crucial that all hospice staff, professional as well as support are actively supported to reduce the risks of VT
2. There is need to develop and implement more integrative training programmes in palliative and hospice care which would recognize the existence of VT phenomenon within hospices. There is need also work on incorporating VT reactions in their curriculums in order to demystify the belief/notion that

caregivers are immune to VT as well as reduce any stigma towards caregivers who suffer the condition – that they are not properly qualified to do the caring job.

3. There is need to educate hospice personnel about the existence and possible risk factors of trauma related effects at workplace and the dangers they pose to the individual, caregivers as well as the institutions.
4. The study established that presence of past trauma history in the caregiver poses a risk for onset of VT. For this reason, there is need to develop appropriate assessment measures so that therapeutic interventions for caregivers with unresolved trauma can be advanced to help them.
5. Empathy is used as a very powerful tool in caregiving. Yet it has also been established as a risk factor. There is need to ensure that caregivers are trained and guided to use empathy while ensuring healthy boundaries are maintained.

5.4.2 Recommendations for Managers and Administrators of Hospices

1. Develop sustainable prevention and intervention programmes at organizational level that can ensure the wellbeing of staff and thus lead to quality services.
2. Regular self-care activities need to be encouraged across all the professions to moderate the effect of vicarious trauma.
3. Enhance organizational support for caregivers in the form of help and advice relating to their work with clients. There is need to establish supportive programmes such as individual counseling, as well as peer or support groups in hospices.

4. The majority of factors causing stress in the hospice workforce could be alleviated by good management practice such as involving the staff in decision-making.
5. Training settings have a responsibility to provide relevant information on what the caregivers will encounter on the ground such as trauma-related issues at work.
6. There is need to enhance psychological support for caregivers particularly by incorporating psychologists and counsellors in the multidisciplinary teams in hospices.
7. Organizational leaderships have the capacity and ethical responsibility to create supportive work environments to help minimize the effects of vicarious trauma.

5.4.3 Recommendations for Further Research

The current study focused on the personal attributes of hospice staff and how they relate to the occurrence of vicarious trauma. Given the fact the study only focused on selected personal attributes and vicarious trauma among hospice staff in Kenya, several recommendations can be made as follows:

1. The present study was done among hospice employees of all cadres. It may be necessary to carry out a study on volunteer caregivers who form part and parcel of many hospice and palliative care units.
2. The study focused only on the personal attributes of caregiver. There is a need to carry out studies on other possible risk factors that may cause the

occurrence of vicarious trauma among hospice workers as well as other palliative care units such as those in public hospitals.

3. The present study focused only on vicarious trauma among hospice staff. There is a need to carry out studies to establish existence of positive outcomes such as vicarious resilience and pos-traumatic growth (PTG) among caregivers.
4. The fact that the study was cross sectional and used a correlational design which only shows relationships, there may be a need to carry out studies using other designs which may be longitudinal in nature in order to establish the causal effects of vicarious trauma.
5. The current study was done in hospice settings only. It is important to carry out similar studies in the other palliative care units such as those in hospital wings.

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APPENDICES

Appendix A1: Introduction Letter and Consent Form

My name is Phelista Musili; a Ph.D Student in Kenyatta University. I am currently undertaking a study on "The relationship between selected personal attributes and occurrence of vicarious trauma among staff in hospices in Kenya". The information will be used by the Ministry of Health and Kenya Hospices and Palliative Care Association (KEHPCA) to develop innovative strategies to support staff and to create a conducive environment in order to sustain workers in this very demanding field.

Procedures to be followed

Participation in this study will require you to fill in a questionnaire containing statements or questions regarding: demographic information, past traumatic experiences, as well as emotional responses related to working with traumatized individuals. This will take about 15 minutes.

You have the right to refuse participation. In this study, participation is voluntary. You may withdraw from participation at any point without any penalty or choose not to respond to any item(s). The information you will provide will be used strictly for the purpose of this study.

Discomforts and Risks

Despite the fact that there are no physical risks involved in this study, some questions may require you to disclose personal information that may be potentially sensitive. The questions are simple and straightforward. The questions concerning your history of traumatic experiences could cause you to recall difficult events which could make you feel uneasy. If there is anything you feel uncomfortable answering, you are not obligated to do so.

Benefits

Although the research is for educational purpose, your participation will greatly contribute to the understanding of the effects of working with traumatized populations and the general wellbeing of palliative and hospice caregivers. The results of the study may guide in developing of appropriate strategies to prevent the adverse effects of working with the terminally ill patients.

Confidentiality

Filling of the questionnaires will be done in a private room within the hospice premises. All data collected in this study will be confidential and anonymous. No

identifying information will be collected. Your name will not be recorded on the questionnaire. All questionnaires will be coded and secured under key and lock in a cabinet at Kenyatta University.

Contact Information

In case you have any questions you may contact me on cell: 0722 713042 or Dr. Beatrice Kathungu on 0727 893955 or Dr. Ann M. Sirera on 0715 457405 or Kenyatta University Ethics Review Committee Secretariat on chairman.kuerc@ku.ac.ke, secretary.kuerc@ku.ac.ke, erc2008@gmail.com.

Participant's Statement

All the above information regarding my participation in the study is clear to me. I have understood that the survey is entirely voluntary and that I can withdraw my participation at any time without any consequences. By participating in the study, I understand that the main risk for me is the discomfort that information required may cause. I also understand that my records will be confidential.

I do hereby accept to participate in the study.

Name of participant: _____

Signature or thumbprint: _____ Date: _____

Investigators Statement:

I the undersigned have adequately explained to the participant the study procedures to be followed, possible risks and benefits that are likely to result from the study as well as issues related to confidentiality.

Researcher's Name: _____

_____ _____

Researcher's signature: Date

Appendix A2: Research Instruments

SECTION A: Demographic Questionnaire

Kindly tick [√] the blank spaces provided below as it applies to you.

1. Gender: Male [ ]
   Female [ ]
   Other (Specify) [ ]

2. Age: ≤ 20 [ ]
   21 – 30 [ ]
   31 - 40 [ ]
   41 – 50 [ ]
   51 – 60 [ ]
   61+ [ ]

3. Years of professional experience working in hospice
   ≤ 1year [ ]
   1 – 3 years [ ]
   3 – 6years [ ]
   6– 9years [ ]
   9– 11years [ ]
   Over 11years [ ]

4. Level of Education/Training:
   Primary Education [ ]
   Secondary Education [ ]
   Tertiary Education [ ]
   University Education [ ]
   Other (specify) _____

5. Occupation/Profession:
   Physician [ ]
   Nurse [ ]
   Nurse Aid [ ]
   Social worker [ ]
   Counsellor/Psychologist [ ]
   Administrator [ ]
   Receptionist [ ]
   Other (Specify) _____

SECTION B: Personal Trauma History Questionnaire

The following is a series of questions about serious or life-threatening events that could have happened to you. For each event, please indicate (circle) whether it happened or not

Event		Circle one	
6	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a pick-pocket, conning or mugging?	No	Yes
8	Have you ever had a serious accident at work, in a car, or somewhere else? (**If yes**, please specify)_____	No	Yes
9	Have you ever experienced a natural disaster such as landslide, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify)	No	Yes
10	Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify)	No	Yes
11	Have you ever been in any other situation in which you feared you might be killed or seriously injured? (**If yes**, please specify below)_____	No	Yes
12	Have you ever been in any other situation in which you were seriously injured? (**If yes**, please specify below)	No	Yes
13	Have you ever seen someone seriously injured or killed? (**If yes**, please specify who below)_____	No	Yes
14	Have you ever had a close friend or family member murdered, or killed? (**If yes**, please specify relationship [e.g., mother, grandson, etc.] below)_____	No	Yes
15	Have you ever had a family member, relative or close friend die? (**If yes**, please specify relationship below)_____	No	Yes
16	Have you ever had a serious or life-threatening illness? (If yes, please specify below)	No	Yes
17	Is any of your family member, relative or friend currently living with a life threatening or chronic illness? (**If yes**, please specify the illness and relationship)	No	Yes
18	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**If yes**, please indicate below)_____	No	Yes

SECTION C: Vicarious Traumatization Scale (VTS)

Consider each of the following statements about you and your **current** situation. Please indicate using a tick (√) which applies to you. There are no right or wrong answers.

Statement	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly agree
19. Because of my work, I realize that the world is not as safe as other people think it is.						
20. When people ask me what I do for my job, I want to tell them I do something else for a living.						
21. The nature of my work affects me to the point where I am not always able to do my best at work.						
22. My work negatively impacts how I function in my personal life.						
23. The nature of my work makes it difficult for me to be intimate with people.						
24. I feel that my work makes it difficult for me to be intimate with people.						
25. I feel that I am able to make a difference in the lives of the people I serve.						
26. I feel that I am successful						

in my job of working with the terminally ill patients and their families.						
27. When I am not at work, I find myself thinking about work.						
28. When I am not at work, I have trouble paying attention to what my partner/friend/loved ones are saying.						
29. I have trouble putting myself before my clients (patients).						
30. My work has a negative effect on me spiritually.						
31. I feel conflicted about the decisions I make at work.						
32. I wish I could do more for my clients.						
33. I feel contaminated as a result of my work.						
34. Due to the nature of my job, I often feel confused about what is going on in the world today.						
35. As part of my job, I am exposed to images that are traumatic or disturbing in nature.						
36. I observe my colleagues						

being negatively impacted by the disturbing (distressing) nature of this work.						
37. My work leaves me feeling emotionally numb.						
38. My work leaves me feeling physically drained.						
39. My work leaves me feeling helpless.						
40. My work affects the way I think about other aspects of my life.						
41. I have flashbacks or disturbing dreams about the patients I see at my workplace						
42. Due to the traumatic nature of my job, I have less compassion for the patients I see at work.						
43. The nature of my work has led me to make poor decisions in my personal life.						
44. The nature of my work has led me to make poor work-related decisions						
45. Due to the nature of my work, I am less likely to trust others.						
46. Due to the nature of my work, I am less likely to be patient with my co-workers.						

47. Due to the nature of my work, I am easily angered by my loved ones.						
48. As a result of my work, when I am out in public, I tend to notice life threatening conditions almost everywhere.						
49. Most people wonder how I can do this work.						
50. I feel uncomfortable admitting to other people that I work with chronically/terminally ill patients.						
51. Most people wouldn't do the work I do.						
52. My own distressing life experiences are a concern to me in the work place.						

SECTION D: Interpersonal Reactivity Index (IRI)

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by ticking (√) whichever applies to you. Answer as honestly as you can.

Statement	Statement describes me				
	Not very well	Not well	Fairly well	well	Very well
53. I often have tender, concerned feelings for people less fortunate than me.					
54. I sometimes find it difficult to see things from the "other person's" point of view					
55. Sometimes I don't feel very sorry for other people when they are having problems.					
56. In emergency situations, I feel apprehensive and ill-at-ease.					
57. I try to look at everybody's side of a disagreement before I make a decision.					
58. When I see someone being taken advantage of, I feel kind of protective towards them.					
59. I sometimes feel helpless when I am in the middle of a very emotional situation.					
60. I sometimes try to understand my friends better by imagining how things look from their perspective.					
61. When I see someone get hurt, I tend to remain calm.					
62. Other people's misfortunes do not usually disturb me a great deal.					
63. If I'm sure I'm right about something, I don't					

waste much time listening to other people's arguments.					
64. Being in a tense emotional situation scares me.					
65. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.					
66. I am usually pretty effective in dealing with emergencies.					
67. I am often quite touched by things that I see happen.					
68. I believe that there are two sides to every question and try to look at them both.					
69. I would describe myself as a pretty soft-hearted person.					
70. I tend to lose control during emergencies.					
71. When I'm upset at someone, I usually try to "put myself in his/her shoes" for a while.					
72. When I see someone who badly needs help in an emergency, I panic.					
73. Before criticizing somebody, I try to imagine how I would feel if I were in their place.					

SECTION E: Open-Ended Questionnaire

What strategies do you apply in trying to cope with the nature of your work?

What strategies that in your opinion, need to be put in place by the organization in order to reduce the risk of negative effects that may result in hospice staff members:

Additional comments/thoughts:

Appendix A3: Ethical Review Board Clearance

KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Email: chairman.kuerc@ku.ac.ke
secretary.kuerc@ku.ac.ke
ercku2008@gmail.com
Website: www.ku.ac.ke

P. O. Box 43844 - 00100 Nairobi
Tel: 8710901/12
Fax: 8711242/8711575

Our Ref: KU/R/COMM/51/383

Date: 26th November, 2014

Phelista M. Musili
Kenyatta University,
P.O Box 43844, Nairobi

Dear Musili,

RE APPLICATION NUMBER PKU/264/I 240– "RELATIONSHIP BETWEEN SELECTED PERSONAL ATTRIBUTES AND OCCURRENCE OF VICARIOUS TRAUMA AMONG STAFF IN HOSPICES IN KENYA" - VERSION 2

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic **"Relationship between selected personal attributes and occurrence of vicarious trauma among staff in hospices in Kenya."** Version 2 received on 26th November, 2014.

2. APPLICANT
Phelista M. Musili, Department of Psychology.

3. STUDY SITE
Selected Hospices across Kenya

4. DECISION
The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 26th November, 2014.

5. ADVICE/CONDITIONS
i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.
If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.

PROF. NICHOLAS K. GIKONYO
CHAIRMAN ETHICS REVIEW COMMITTEE

I ..PHELISTA M. MUSILI..accept the advice given and will fulfill the conditions therein.

Signature..... Dated this day of..14 – 01 – 2015.....
cc. Vice-Chancellor

Appendix A4: Research Permit

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471, 2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

13th November, 2014

NACOSTI/P/14/0233/3869

Phelista Marura Musili
Kenyatta University
P.O. Box 43844-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Relationship between selected personal attributes and occurrence of vicarious trauma among staff in Hospices in Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **selected Counties** for a period ending **31st December, 2014.**

You are advised to report to **the County Commissioners and the County Directors of Education of the selected Counties** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. S. K. LANGAT, OGW
FOR: SECRETARY/CEO

Copy to:

The County Commissioners
Selected Counties.

The County Directors of Education
Selected Counties.