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Sociodemographic Characteristics and Compassion Fatigue among Caregivers of Children with Physical Disabilities in Nairobi County, Kenya: An Explanatory Sequential Mixed-Methods Study

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ABSTRACT

Caregiving for children with physical disabilities involves sustained demands that may place caregivers at risk of compassion fatigue (CF). Evidence regarding the association between sociodemographic characteristics and CF among caregivers in Kenya remains limited. This study examined whether selected sociodemographic characteristics were associated with CF among caregivers of children with physical disabilities in Nairobi County. An explanatory sequential mixed-methods design was used, comprising a cross-sectional survey of 150 caregivers receiving services through two rehabilitation organisations, followed by semi-structured interviews with a purposively selected subgroup. Sociodemographic information was collected using a structured questionnaire, and CF was assessed using the Professional Quality of Life Scale, Version 5. Pearson's chi-square tests examined associations, and Cramér's V described effect magnitudes. Qualitative data were analysed thematically. CF was present in 134 of 150 caregivers (89.3%) and was prevalent across all sociodemographic categories. No statistically significant association was observed between CF status and age, gender, marital status, education, income, years of caregiving, or relationship to the child. Qualitative findings identified family dynamics and limited social support, financial and employment strain, and cultural beliefs and identity pressures as recurring sources of caregiving difficulty. CF was widespread but not statistically concentrated within particular sociodemographic groups. Approaches based solely on demographic characteristics may be insufficient for identifying caregivers experiencing CF.

KEYWORDS: *compassion fatigue; caregivers; physical disability; sociodemographic characteristics; Kenya; mixed methods.*

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INTRODUCTION

Caregivers of children with physical disabilities assume sustained responsibilities extending beyond routine parenting, including assistance with mobility, daily activities, therapy attendance, and management of health-related challenges ([1]; [2]). These responsibilities can affect physical health, emotional wellbeing, social relationships, and economic participation. In resource-constrained settings, demands are intensified by limited rehabilitation services, financial constraints, inadequate formal support, and disability-related stigma ([3]; [4]).

Compassion fatigue (CF) describes distress associated with caring for others and is commonly conceptualised through burnout and secondary traumatic stress ([5], [6]; [7]). Burnout reflects exhaustion associated with prolonged demands, whereas secondary traumatic stress concerns trauma-related responses arising from exposure to another's suffering ([8]). The Professional Quality of Life Scale (ProQOL) is widely used to assess compassion satisfaction, burnout, and secondary traumatic stress ([7]).

Research suggests that sociodemographic characteristics may influence caregiver burden by affecting access to resources and social support ([9]; [10]). In Kenya, caregivers of children with

disabilities report social isolation, financial constraints, limited services, stigma, and difficulty balancing caregiving with employment ([1]; [3]; [4]). Similar challenges have been documented in other sub-Saharan African settings ([11]).

However, the presence of a sociodemographic disadvantage does not necessarily mean that CF will be concentrated within that group. Caregivers sharing different demographic characteristics may experience similar caregiving demands. Examining whether CF differs across demographic categories is therefore important for determining whether demographic characteristics can meaningfully identify caregivers requiring support ([12]).

Evidence specifically examining sociodemographic characteristics and CF among caregivers of children with physical disabilities in Kenya remains limited ([13]; [14]; [15]). This study therefore examined the relationship between selected sociodemographic characteristics and CF among caregivers in Nairobi County, complemented by qualitative accounts of caregivers' experiences. The research question was: Are age, gender, marital status, education, income, years of caregiving, and relationship to the child associated with compassion-fatigue status?

THEORETICAL PERSPECTIVE

The study was informed by Figley's Compassion Fatigue framework, which conceptualises CF as a consequence of sustained exposure to others' suffering in caring relationships ([5], [6]). Prolonged caregiving demands can contribute to emotional exhaustion and secondary traumatic stress, particularly when opportunities for recovery and support are limited ([16]). The framework is useful for understanding why CF may occur across demographic groups, as the caregiving context itself may expose caregivers to common stressors regardless of individual characteristics. This framework guided the examination of whether sociodemographic characteristics, which may influence access to resources and support, were associated with CF status.

METHODS

Study Design

An explanatory sequential mixed-methods design was used, in which quantitative findings are examined first and qualitative data subsequently explain or contextualise those findings ([17]). The quantitative component used a cross-sectional design; the qualitative component used semi-structured interviews. Integration occurred at interpretation, where qualitative themes illuminated the quantitative pattern of CF across demographic categories.

Study Setting and Participants

The study was conducted in Nairobi County, Kenya, among caregivers accessing services through the Association for the Physically Disabled of Kenya (APDK) and the Cerebral Palsy Society of Kenya (CPSK). Eligible participants were adult caregivers actively providing care for a child with a physical disability for at least six months and able to communicate in English or Kiswahili. A total of 150 caregivers participated in the quantitative component. A census approach was used because the accessible population was small (approximately 140–150 caregivers), and including all eligible participants maximised statistical power and representativeness. A purposively selected subgroup of 10 participated in semi-structured interviews.

Measures

Participants provided information on age, gender, marital status, education, monthly income, duration of caregiving, and relationship to the child through a researcher-developed socio-demographic questionnaire. CF was assessed using the ProQOL-V ([7]), which measures compassion satisfaction, burnout, and secondary traumatic stress. For this study, CF was operationalised as a binary outcome: participants scoring within the moderate or high range on both the Burnout and Secondary Traumatic Stress subscales were classified as having CF present. This operational definition was used as an analytical classification and was not considered a clinical diagnosis.

Data Collection

Following ethical approval, eligible caregivers completed the quantitative questionnaire after providing informed consent. Semi-structured interviews were subsequently conducted with a purposively selected subgroup, exploring caregiving demands, family relationships, social support, employment and financial circumstances, and disability-related challenges. Interviews were audio-recorded with permission.

Data Analysis

Quantitative data were analysed using SPSS. Descriptive statistics summarised participant characteristics and CF status. Pearson's chi-square tests examined associations between CF status and each sociodemographic variable, with significance evaluated at $\alpha = .05$. Cramér's V described effect magnitudes.

Qualitative data were analysed thematically, involving familiarisation with transcripts, identification of patterns, theme development, and interpretation in relation to quantitative findings. The two strands were integrated during interpretation.

Ethical Considerations

Ethical approval was obtained from the Daystar University Institutional Scientific Ethics Review Committee (DU-ISERC), and research authorisation was obtained from the National Commission for Science, Technology and Innovation (NACOSTI). Permission was obtained from APDK and CPSK. Written informed consent was obtained from all participants, and confidentiality was maintained through participant codes.

RESULTS

Sociodemographic Characteristics

The study included 150 caregivers. Most were aged 28–37 years (48.0%) or 38–47 years (30.0%). Women constituted 82.7% of the sample. Most participants were married (63.3%), followed by single participants (31.3%). Regarding education, 45.3% had completed secondary education and 42.7% had tertiary education. Most reported monthly income below KES 20,000 (79.3%). Most had been caregivers for 1–5 years (43.3%) or 6–10 years (42.7%), and most were parents (91.3%). Table 1 summarizes these findings.

Table 1. Sociodemographic Characteristics of Caregivers (N = 150)

Characteristic	Category	n	%
Age	18–27	22	14.7
	28–37	72	48.0
	38–47	45	30.0
	48–57	6	4.0
	58+	5	3.3
Gender	Female	124	82.7
	Male	26	17.3
Marital status	Married	95	63.3
	Single	47	31.3
	Widowed	5	3.3
	Divorced	3	2.0
Education	No formal education	7	4.7
	Primary	11	7.3
	Secondary	68	45.3
	Tertiary	64	42.7
Monthly income (KES)	<20,000	119	79.3
	20,001–50,000	25	16.7
	50,001–75,000	5	3.3
	>100,000	1	0.7
Years of caregiving	<1	9	6.0
	1–5	65	43.3
	6–10	64	42.7
	10–15	7	4.7
	16–20	4	2.7
	21+	1	0.7
Relationship to child	Parent	137	91.3
	Sibling	6	4.0
	Grandparent	5	3.3
	Aunt	1	0.7
	Uncle	1	0.7

Note. KES = Kenyan Shillings.

Compassion Fatigue Status and Associations

CF was present in 134 of 150 participants (89.3%). CF was prevalent across all sociodemographic categories, ranging from 60.0% among participants aged 58 years or older to 100.0% among those aged 48–57 years and those divorced.

No statistically significant association was observed between CF status and age, $\chi^2(4) = 5.37$, $p = .252$; gender, $\chi^2(1) = 0.76$, $p = .383$; marital status, $\chi^2(3) = 1.01$, $p = .799$; education, $\chi^2(3) = 0.14$, $p = .933$; income, $\chi^2(3) = 6.97$, $p = .073$; years of caregiving, $\chi^2(5) = 8.70$, $p = .121$; or relationship to the child, $\chi^2(5) = 9.36$, $p = .095$.

Effect sizes were generally small, although income, years of caregiving, and relationship to the child showed comparatively larger associations. These findings are tabulated in Table 2.

Table 2. Associations Between Sociodemographic Characteristics and Compassion Fatigue Status (N = 150)

Variable	χ^2	df	p	Cramér's V
Age	5.37	4	.252	.189
Gender	0.76	1	.383	.071
Marital status	1.01	3	.799	.082
Education	0.14	3	.933	.031
Income (KES)	6.97	3	.073	.216
Years of caregiving	8.70	5	.121	.241
Relationship to child	9.36	5	.095	.250

Note. Statistical significance evaluated at α = .05.

Qualitative Findings

Three thematic domains emerged including family dynamics and social support deficits; financial and employment strain; and cultural beliefs and identity pressures. Caregivers described marital abandonment, limited support from extended family, and reliance on neighbours for emotional and practical support under family dynamics and social support deficits. These accounts illustrate that marital status alone may not represent the availability of meaningful support. Under financial and employment strain, participants reported difficulty maintaining employment alongside caregiving, adapting work around the child's needs, or leaving employment. Financial constraints sometimes disrupted therapy attendance. Caregivers described stigma surrounding disability, including beliefs associating disability with curses or occult practices under cultural beliefs and identity pressures. Expectations to remain strong and prioritise the child's needs created additional pressure. These pain-points appeared to cut across formal demographic categories, providing contextual explanation for the absence of statistically significant associations between CF and the sociodemographic variables examined.

DISCUSSION

This study found that CF was highly prevalent (89.3%) but not statistically concentrated within particular sociodemographic groups. The findings are consistent with the substantial caregiving burden documented among caregivers of children with disabilities ([18]; [19]).

The absence of statistically significant associations challenges the assumption that caregivers with particular demographic characteristics can be identified as the primary group at risk. Women had a somewhat higher proportion of CF than men, but the difference was not statistically significant. The predominance of women among caregivers is consistent with evidence that mothers frequently assume substantial caregiving responsibilities ([1]; [13]). However, male caregivers may also experience considerable strain.

Marital status did not distinguish CF status. Qualitative accounts suggest that support availability and relationship quality may be more informative than marital status alone, as some married caregivers received limited support while some single caregivers had supportive networks.

Income produced one of the larger observed associations, although it did not reach statistical significance. The high proportion of participants reporting low income and qualitative accounts of employment disruption indicate that economic circumstances remain important aspects of the caregiving context ([13]; [20]). The absence of statistical significance should not be interpreted as evidence that financial circumstances are irrelevant.

Duration of caregiving and education were not significantly associated with CF. Intensive caregiving demands may be present from early in the caregiving trajectory and may persist over time. Education may influence resource access but does not eliminate practical caregiving responsibilities.

Qualitative findings indicate that important sources of strain may operate within demographic categories. Family support, financial security, employment flexibility, stigma, and caregiving demands can vary considerably among people sharing the same demographic characteristics. Consequently, screening relying solely on demographic characteristics may fail to identify many caregivers needing assistance ([21]; [22]).

The findings are consistent with Kenyan literature documenting stigma, inadequate services, social isolation, and financial difficulties among caregivers ([1]; [3]; [4]). Evidence from Zimbabwe similarly indicates restricted employment opportunities and limited formal support ([11]).

IMPLICATIONS FOR PRACTICE

Psychosocial screening should not be restricted to particular demographic groups. Because CF was prevalent across demographic categories, services should be accessible to all caregivers. Assessment should extend beyond demographic characteristics to include social support, financial strain, employment disruption, caregiving intensity, and emotional wellbeing. Support programmes should address relational and structural pressures alongside individual coping, and disability-related stigma should be addressed through community education.

STRENGTHS AND LIMITATIONS

A major strength was the mixed-methods approach, which combined systematic quantitative analysis with contextual qualitative accounts. The study included caregivers from two established disability-service organisations, allowing representation of varied demographic characteristics.

Five limitations should be considered. The cross-sectional design prevents causal inference. The CF-present group was substantially larger than the CF-absent group (134 vs. 16), limiting statistical power. Several demographic categories contained very small numbers, producing unstable subgroup estimates. CF was analysed as a binary classification derived from ProQOL subscales, which should not be interpreted as a clinical diagnosis. The qualitative findings were obtained from a purposively selected subgroup and provide contextual depth rather than statistical representation.

CONCLUSION

Compassion fatigue was highly prevalent among caregivers of children with physical disabilities in Nairobi County (89.3%) but was not significantly associated with age, gender, marital status, education, income, years of caregiving, or relationship to the child. Qualitative accounts indicated that family and social support deficits, financial and employment strain, and cultural beliefs and identity pressures were important aspects of caregivers' experiences. Demographic characteristics alone may have limited utility for identifying caregivers experiencing CF. More comprehensive approaches considering caregiving demands, social support, economic circumstances, and psychosocial wellbeing may provide a more useful basis for identifying and supporting caregivers at risk.

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