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The Prevalence of Compassion Fatigue Among Caregivers of Children with Physical Disabilities in Selected Rehabilitation Clinics, Nairobi County, Kenya

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ABSTRACT

Caregiving for children with physical disabilities imposes significant emotional and physical demands, creating a high-risk environment for compassion fatigue (CF), a condition characterized by the erosion of empathy and emotional resilience due to prolonged exposure to suffering. The situation is particularly acute in Sub-Saharan Africa and Kenya, where systemic challenges and limited support resources exacerbate caregiver vulnerability. This study aimed to establish the prevalence of compassion fatigue among caregivers of children with physical disabilities attending selected rehabilitation clinics in Nairobi County, Kenya. A quantitative cross-sectional design was employed, with data collected from 150 caregivers recruited through a census of all eligible caregivers from two major rehabilitation centers, including The Association for the Physically Disabled of Kenya (APDK) and the Cerebral Palsy Society of Kenya (CPSK). Compassion fatigue was assessed using the Burnout and Secondary Traumatic Stress subscales of the Professional Quality of Life Scale (ProQOL). Analysis revealed an overwhelming prevalence rate of 89.3% (n=134), with 96.0% of caregivers experiencing moderate burnout and 92.0% experiencing moderate secondary traumatic stress (STS). These findings indicate an extreme level of psychological distress among this caregiver population. The study concludes that there is an urgent and critical need for targeted mental health support interventions and policies designed to mitigate compassion fatigue and build resilience among these essential caregivers in Nairobi County.

KEYWORDS: *compassion fatigue; caregivers; physical disabilities; children; prevalence; Nairobi County; Kenya; cross-sectional study; Professional Quality of Life Scale (ProQOL).*

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INTRODUCTION

Caregiving, particularly for children with physical disabilities, represents a profound commitment that often extends over many years, encompassing significant physical, emotional, and psychological demands. Within this context, compassion fatigue (CF) has emerged as a critical occupational hazard, characterized by a gradual erosion of empathy and emotional resilience resulting from prolonged exposure to the suffering of others (Yang et al., 2021; Figley, 2002). For caregivers of children with physical disabilities, the relentless nature of providing daily assistance with mobility, medical needs, and personal care, coupled with the emotional intensity of the role, creates a high-risk environment for the development of CF (Luca et al., 2024; Shahali et al., 2024). The manifestation of CF includes emotional symptoms such as hopelessness, irritability, and decreased job satisfaction, as well as physical symptoms like chronic fatigue, sleep disturbances, and a weakened immune system (Luca et al., 2024; Yang et al., 2021), ultimately compromising both the caregiver's well-being and the quality of care provided.

Globally, compassion fatigue is recognized as a pervasive occupational challenge, particularly within high-stress healthcare environments. Research conducted in various international settings highlights the significant emotional toll on caregivers. For instance, a systematic review by Cocker and Joss (2016) established that professionals in healthcare, emergency, and community services are at substantial risk, often due to prolonged exposure to patient trauma and suffering. This is especially pronounced in fields like oncology, where studies have found compassion fatigue prevalence rates of 35.83% among nurses in cancer treatment centers (Ortega-Campos et al., 2020). Further supporting this observation, research from Saudi Arabia found that 52.1% of healthcare workers experienced moderate to high levels of compassion fatigue (Almadani et al., 2023). The risk extends beyond formal healthcare settings to family caregivers. In the United States, approximately 59.5% of family caregivers report signs of compassion fatigue, with those caring for individuals with severe disabilities being especially vulnerable due to the intensive and long-term nature of the care required (Shahali et al., 2024). The emotional and physical manifestations are well-documented, encompassing emotional exhaustion, feelings of hopelessness, irritability, and a reduced ability to empathize (Yang et al., 2021; Figley, 2002), all of which can severely impact the caregiver's well-being and the quality of care provided.

Within the Sub-Saharan African region, the dynamics of compassion fatigue are exacerbated by systemic challenges such as limited access to healthcare resources, socioeconomic constraints, and underdeveloped mental health support systems. A systematic review analyzing the prevalence among healthcare professionals in this region found that approximately 70% experience some level of compassion fatigue, with the rate climbing to 74% in Eastern Africa (Kabunga et al., 2021). This suggests that caregivers working in highly emotionally taxing environments, such as those caring for individuals with chronic conditions or disabilities, face an elevated risk. Studies from specific countries within the region corroborate this high prevalence. In South Africa, research focusing on oncology healthcare professionals revealed that 56.2% of participants reported average levels of compassion fatigue (Mlaba et al., 2023). Similarly, a study in Uganda highlighted that nurses suffering from compassion fatigue also faced comorbid psychological issues like depression and anxiety, exacerbated by challenging work environments and a lack of psychological support (Kabunga et al., 2021). The combination of intense emotional involvement, the physical demands of caregiving, and often under-resourced environments creates a perfect storm for widespread compassion fatigue, affecting both the mental health of caregivers and the quality of care they provide.

At a local level in Kenya, the plight of caregivers, particularly those caring for children with physical disabilities, is a significant yet under-researched concern. The burden of caregiving is intensified by the constant demands of managing medical appointments, therapies, and day-to-day care, leading to overwhelming stress for many caregivers (Kiambati, 2024). According to a national survey, this burden is particularly pronounced among those who care for children with severe physical disabilities, such as cerebral palsy, often preventing caregivers from engaging in economic activities or self-care (Republic of Kenya, Ministry of Education, Science and Technology, 2018). Empirical studies within Kenya have begun to quantify this issue, revealing alarming rates of compassion fatigue. A study conducted in Nairobi County among caregivers of terminally ill patients found a prevalence rate of 90% (Mulwa, 2022). Another study focusing on caregivers in public and private children's homes in Nairobi reported that 96.3% experienced compassion fatigue (Mwaura, 2022). These challenges are compounded by cultural stigma surrounding disability, which can lead to social exclusion and isolation for families, and a critical lack of formal support structures and accessible mental health resources (Bunning et al., 2022). This confluence of factors leaves Kenyan caregivers navigating their responsibilities with limited institutional or community support, drastically increasing their susceptibility to compassion fatigue and its negative sequelae.

This study is underpinned by the Transactional Model of Stress and Coping (TMSC) (Lazarus & Folkman, 1984) and the Compassion Fatigue Resilience Model (CFRM) (Figley & Ludick, 2017). These theoretical frameworks conceptualize CF not merely as a response to a stimulus but as a dynamic process determined by how individuals perceive and appraise caregiving stressors (primary appraisal) and evaluate their resources and ability to cope (secondary appraisal). The models emphasize that without adequate coping mechanisms or systemic support, the caregiver's emotional resources become depleted, leading to distress and functional impairment.

Despite the documented severity of caregiver burden in Kenya, a significant gap persists in the literature. While studies have explored CF in healthcare workers and caregivers of terminally ill patients, there is a dearth of empirical research specifically investigating the prevalence of CF among caregivers of children with physical disabilities within the unique socio-cultural and economic context of Nairobi County.

Previous research has often focused on broader mental health outcomes or specific disability types without quantifying the specific prevalence of CF in this demographic, which is crucial for designing targeted interventions (Kiambati, 2024; Mulwa, 2022). Therefore, the objective of this study was to examine the prevalence of compassion fatigue among caregivers of children with physical disabilities attending selected rehabilitation clinics in Nairobi County, Kenya.

Method

A. Research Design

This study utilized a quantitative, cross-sectional research design to investigate the prevalence of compassion fatigue among caregivers of children with physical disabilities attending rehabilitation clinics in Nairobi County, Kenya. The design was selected to provide a snapshot of compassion fatigue levels at a specific point in time (Creswell & Creswell, 2018), allowing for the assessment of both the magnitude and distribution of this psychological phenomenon within the target population. This approach facilitated the efficient collection of data from a substantial sample size while maintaining methodological rigor in measuring the key construct of interest.

B. Participants and Sampling Procedure

The study participants were caregivers of children with physical disabilities attending rehabilitation clinics in Nairobi County, Kenya. A census sampling approach was employed to recruit participants from two major rehabilitation centers: The Association for the Physically Disabled of Kenya (APDK) and the Cerebral Palsy Society of Kenya (CPSK). This method involved inviting all eligible caregivers who accessed services at these facilities during the data collection period to participate in the study. The final sample consisted of 150 caregivers who met the study criteria and provided complete data.

Specific criteria were established to determine participant eligibility. Inclusion criteria required that participants be actively providing care for children aged 1-10 years with diagnosed physical disabilities, affiliated with either APDK or CPSK rehabilitation clinics, engaged in caregiving for at least six months, adult caregivers (18 years or older), and fluent in either English or Swahili. Both primary and secondary caregivers were eligible to participate. Exclusion criteria were designed to minimize confounding variables and ensure participant safety. Caregivers were excluded if they were caring for children without physical impairments (such as those with only developmental or cognitive disabilities), were currently participating in other psychological interventions or mental health therapies, or had diagnosed severe psychiatric or cognitive disorders that would impair their ability to participate meaningfully in the study or provide informed consent.

C. Measures

Compassion fatigue was assessed using the Professional Quality of Life Scale (ProQOL), version 5 (Stamm, 2010), a 30-item self-report measure that evaluates three distinct dimensions: Compassion Satisfaction, Burnout, and STS. The burnout and STS subscales were used to operationalize compassion fatigue. Participants rated the frequency of their experiences on a 5-point Likert scale ranging from 1 (never) to 5 (very often). Raw scores were summed for each subscale and categorized into low, moderate, or high levels according to the instrument's standardized scoring guidelines (Stamm, 2010). A participant was identified as having compassion fatigue if their summed score on either the burnout subscale or the STS subscale fell within the moderate (23-41) or high (42-50) range. Only participants scoring in the low range (≤22) on both subscales were classified as not having compassion fatigue. The ProQOL has demonstrated strong psychometric properties in various cultural contexts, including previous applications in African populations (Jensen et al., 2022). In the current study, both subscales showed excellent internal consistency, with Cronbach's alpha coefficients exceeding 0.70, indicating satisfactory reliability for research purposes.

D. Procedure for Data Collection

Data collection was conducted following approval from the Daystar University Institutional Scientific Ethics Review Committee (DU-ISERC) and the National Commission for Science, Technology, and Innovation (NACOSTI). Authorization was also obtained from the administrative bodies of both participating rehabilitation centers. Potential participants were approached during their scheduled visits to the rehabilitation clinics and provided with comprehensive information about the study's purpose and procedures. Those who provided written informed consent completed the survey instruments in a private setting within the clinic facilities. The questionnaires were available in both English and Kiswahili to accommodate language preferences, and trained research assistants were present to address any questions or concerns. The assessment required approximately 20-30 minutes for completion, and participants were reminded of their right to withdraw at any point without penalty.

E. Ethical Considerations

The study implementation adhered to rigorous ethical standards throughout the research process. Ethical approval (United States Department of Health, Education, and Welfare, 1979) was obtained from the DU-ISERC prior to participant recruitment. Additional research authorization was secured from NACOSTI, in compliance with national research regulations. Written informed consent was obtained from all participants after a detailed explanation of the study objectives, procedures, potential risks, and benefits, in accordance with the principles outlined in the Belmont Report (United States Department of Health, Education, and Welfare, 1979). The principle of voluntary participation was emphasized, and participants were assured that their decision to participate would not affect the services they or their children received (Beauchamp & Childress, 2019). Confidentiality was maintained through the use of coded identifiers instead of personal information, and all data were stored securely with access restricted to the research team, consistent with recommendations for protecting sensitive participant information (European Union, 2016). The researchers maintained cultural sensitivity throughout the data collection process, recognizing the vulnerable status of the participant population and ensuring respectful engagement at all times (Mirza et al., 2023). These measures were implemented to uphold ethical principles of autonomy, beneficence, and justice throughout the study (American Psychological Association [APA], 2017).

F. Data Analysis Strategy

Data analysis was performed using IBM SPSS Statistics Version 26. Descriptive statistics, including frequencies and percentages, were computed to determine the prevalence rates of compassion fatigue. Participants scoring in the moderate or high ranges on either the Burnout or Secondary Traumatic Stress subscales were classified as experiencing compassion fatigue. The overall prevalence rate was calculated as the proportion of caregivers meeting these criteria relative to the total sample. Cross-tabulations were generated to examine the distribution of compassion fatigue across different demographic categories, providing a comprehensive profile of the phenomenon within the study population.

Results

The prevalence of compassion fatigue was determined by classifying participants who scored in the moderate or high ranges on either the burnout or secondary traumatic stress subscales of the ProQOL. Analysis revealed that 134 out of 150 caregivers met the criteria for compassion fatigue, resulting in a prevalence rate of 89.3%. This finding indicates that compassion fatigue affects the overwhelming majority of caregivers in this population. Further analysis of the subcomponents showed that 144 participants (96.0%) reported moderate levels of burnout, while 138 participants (92.0%) reported moderate levels of secondary traumatic stress. Only 16 caregivers (10.7%) did not meet the threshold for compassion fatigue, scoring in the low range on both subscales. These results, as outlined in Table 1, demonstrate that both the chronic strain of caregiving (burnout) and trauma-specific symptoms (secondary traumatic stress) contribute substantially to the overall compassion fatigue experience in this population.

Table 1: Prevalence of Compassion Fatigue and Its Definitive Components (N = 150)

Variable	Category	*n*	%
Compassion Fatigue	Present	134	89.3
	Absent	16	10.7
Burnout	Moderate	144	96.0
	Low	6	4.0
Secondary Traumatic Stress	Moderate	138	92.0
	Low	12	8.0

As shown in the results, the prevalence of compassion fatigue was exceptionally high among the study participants. The distribution across the subcomponents indicates that burnout affected nearly all caregivers in the sample, while secondary traumatic stress was also present at alarming rates. These findings establish a clear pattern of significant psychological distress among caregivers of children with physical disabilities in Nairobi County, Kenya, highlighting the urgent need for targeted mental health support interventions for this vulnerable population.

Discussion

A. Summary of Key Findings

This study sought to establish the prevalence of compassion fatigue among caregivers of children with physical disabilities attending rehabilitation clinics in Nairobi County, Kenya. The findings reveal that compassion fatigue is not merely present but is a near-ubiquitous experience within this population. An overwhelming majority of caregivers were found to be experiencing clinically significant levels of this condition, characterized by a high prevalence of both the emotional exhaustion and weariness of burnout and the trauma-specific symptoms associated with secondary traumatic stress. This indicates a severe and widespread mental health burden among those providing care to children with physical disabilities in this setting.

B. Interpretation of Findings

The finding that compassion fatigue is exceptionally pervasive aligns with and extends the existing literature on caregiver burden in low-resource settings. The results are consistent with previous studies conducted in similar contexts, such as Mwaura (2022), who reported a CF prevalence of 96.3% among caregivers in children's homes in Nairobi, and Mulwa (2022), who found a prevalence of 90% among caregivers of terminally ill patients. This consistency across different caregiving populations within Kenya suggests that the high prevalence is not an anomaly but rather a reflection of a broader systemic issue. The results are further supported by international studies, such as those by Narayan and Kesavan (2023) in India and Abeasi et al. (2024) in Ghana, which also documented substantial caregiver burden and negative mental health outcomes, albeit at slightly lower rates. The slightly higher prevalence in the current study may be attributed to the intense physical and emotional demands specific to caring for children with physical disabilities, who often require continuous hands-on assistance with mobility, therapy, and daily living activities, exacerbating the caregiver's physical strain and emotional depletion.

These findings strongly support the study's underlying theoretical frameworks. Figley's CSFM posits that prolonged exposure to the suffering of others, combined with high empathic engagement, leads to emotional exhaustion and a reduced capacity for empathy. The caregivers in this study, constantly engaged in managing their children's pain, medical crises, and societal challenges, perfectly exemplify this model. Furthermore, the results resonate with Lazarus and Folkman's TMSC. The high prevalence of CF suggests a critical imbalance between the immense environmental demands of caregiving—financial strain, social stigma, and lack of institutional support—and the available coping resources accessible to these caregivers. The chronic nature of these demands appears to overwhelm their adaptive capacities, leading to the high levels of burnout and STS observed.

C. Theoretical Implications

The findings of this study have significant theoretical implications. Firstly, they provide strong empirical validation for Figley's model in a non-Western, low-resource context, demonstrating its cross-cultural applicability to caregivers of children with disabilities. The model effectively captures the psychological sequelae of long-term, empathetic caregiving in a setting where formal support structures are limited. Secondly, the results extend the TMSC by highlighting that when environmental demands are consistently and overwhelmingly high, as they are for these caregivers, individual coping resources and socio-demographic factors may become less salient in preventing negative outcomes. The pervasiveness of CF across all demographic subgroups in the sample suggests that the structural and contextual factors—such as poverty, stigma, and inadequate healthcare systems—create a level of strain that overshadows the potential moderating effects of individual characteristics. This points to the need for theories of caregiver stress to place a greater emphasis on macro-level, systemic drivers of distress in addition to individual appraisals and coping mechanisms.

D. Practical Implications

The practical implications of these findings are profound and urgent. The near-universal prevalence of compassion fatigue constitutes a public mental health crisis that directly impacts the quality of care provided to vulnerable children. Firstly, there is a critical need to integrate routine mental health screening for compassion fatigue into standard care protocols at rehabilitation clinics and pediatric disability services. Utilizing validated tools like ProQOL during regular clinic visits could facilitate early identification of at-risk caregivers. Secondly, healthcare providers, social workers, and community health volunteers working with families affected by disability require training to recognize the signs of compassion fatigue. This would enable them to provide basic psychological first aid and make appropriate referrals.

Furthermore, the results necessitate the development and implementation of targeted support interventions. Promising interventions could be scaled through community-based programs and support groups. Beyond individual-level interventions, policy actions are required. Advocacy for increased governmental and institutional support is essential. This could include the provision of respite care services, financial assistance programs, and the strengthening of community-based support networks to alleviate the overwhelming demands placed on caregivers. Ultimately, supporting the caregiver is not merely an act of compassion but a fundamental component of ensuring the health and wellbeing of the child with a disability.

E. Limitations

While this study provides crucial insights, three limitations specific to this prevalence analysis must be acknowledged. Firstly, the cross-sectional nature of the data limits our understanding to a single point in time. Compassion fatigue is a dynamic process, and this design cannot capture fluctuations, trajectories, or the causal pathways leading to its development. Secondly, the reliance on self-report measures, while necessary, introduces the potential for response biases. Caregivers may underreport or overreport symptoms due to social desirability concerns or the stigmatization of mental health issues. Thirdly, the sample was drawn from two major rehabilitation centers in an urban setting. While this allowed for access to a relevant population, it may limit the generalizability of the findings to caregivers in rural areas or those who are not connected to any formal support services, who may experience an even greater burden.

F. Directions for Future Research

Based on these findings and limitations, three avenues for future research are warranted. Firstly, longitudinal studies are needed to track the development of compassion fatigue over time. Such research could identify critical windows for intervention and explore the causal relationships between caregiving demands, coping strategies, and the onset and progression of CF symptoms. Secondly, future research should employ qualitative dominant mixed-methods approaches to delve deeper into the lived experiences of these caregivers. While this study quantified the problem, rich qualitative inquiry is necessary to fully understand the contextual nuances, cultural meanings, and specific daily stressors that contribute to CF, thereby informing more culturally sensitive and effective interventions. Finally, research should explore the specific barriers and facilitators that caregivers face in accessing mental health support. Understanding why caregivers do not seek help, even when experiencing significant distress, is essential for designing accessible and acceptable support services that can effectively address this widespread crisis.

Conclusion

This study unequivocally establishes that CF is not an isolated occurrence but a pervasive and severe public health crisis affecting the vast majority of caregivers of children with physical disabilities in Nairobi County, Kenya. The alarming prevalence rate underscores a profound level of psychological distress that threatens both caregiver wellbeing and the quality of care provided to a vulnerable pediatric population. These findings provide robust, empirical evidence that validates the application of established theoretical models, such as Figley's CSFM and the TMSC, within this specific cultural and socio-economic context, highlighting how immense and chronic caregiving demands overwhelm personal resources. Consequently, this research issues an urgent and non-negotiable call to action for healthcare policymakers, rehabilitation service providers, and mental health practitioners to immediately prioritize the systemic integration of mental health screening and accessible, targeted psychological support services into standard care protocols. Addressing this epidemic of compassion fatigue is not merely a supportive measure for caregivers but a fundamental prerequisite for sustaining the health of the entire family unit and ensuring positive outcomes for children with disabilities.

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