African Journal of Emerging Issues
Peer reviewed | Double blind | Interdisciplinary

African Journal of Emerging Issues (AJOEI)
Online ISSN: 2663 - 9335
Available at: https://ajoeijournals.org

PSYCHOLOGY

PREVALENCE OF VICARIOUS TRAUMA AND COPING MECHANISMS AMONG HEALTHCARE WORKERS AT MATHARI NATIONAL HOSPITAL, NAIROBI, KENYA

[1*]Susan Metto, MCP, [2]Dr. Jared Menecha, PhD & [3]Dr. Elizabeth Gichimu, PSyD

[1]Masters Student, Department of Clinical Psychology, Daystar University

[2&3] Department of Clinical Psychology, Daystar University

*E-mail of corresponding author: suemetto@gmail.com

Publication Date: May 2026

ABSTRACT

Purpose of Study: This study assessed the level of vicarious trauma and the coping mechanisms employed by healthcare workers at Mathari National Teaching and Referral Hospital (MNTRH), Nairobi, Kenya.

Problem Statement: Despite growing evidence of psychological distress among Kenyan healthcare workers, limited research has specifically examined VT prevalence and coping strategies in specialized psychiatric referral facilities.

Methods: A convergent parallel mixed-methods design was adopted. Using stratified random sampling and Cochran's formula, a sample size of 168 participants was selected from a population of 330 healthcare workers, of whom 121 completed the study, yielding a 72% response rate. Quantitative data were analysed using descriptive statistics and inferential statistics while qualitative data were analysed thematically.

Result: Findings revealed that 51.2% of participants exhibited low VT, 44.6% moderate VT, and 4.1% high VT. Statistically significant trauma symptoms were recorded across all four dimensions: emotional and cognitive impact, changes in beliefs and worldview, physical and behavioural effects, and work-related stress ($p < .001$). Emotional and cognitive impact recorded the highest mean score ($M = 12.85$). Problem-focused strategies were most prevalent (56.2% high use), followed by moderate emotion-focused coping (58.7%). Maladaptive coping was rare, with 88.4% reporting low engagement. All coping dimensions showed statistically significant variability ($p < .05$).

Conclusion: Healthcare workers at MNTRH face significant psychological burden and there is need for structured trauma-informed interventions tailored for staff in the hospital, staff debriefing systems, and institutional mental health support to promote psychological wellbeing.

Keywords: *Vicarious trauma, coping mechanisms, healthcare workers, psychiatric hospital, psychological wellbeing*

INTRODUCTION

Vicarious trauma (VT), also referred to as secondary traumatic stress, is an occupational hazard affecting healthcare professionals who are repeatedly exposed to patients' traumatic experiences. It is defined as the emotional, cognitive, and psychological transformation that occurs through empathetic engagement with trauma survivors, often resulting in emotional exhaustion, altered cognitive schemas, and a changed worldview (Molnar et al., 2022). Unlike burnout, which results from chronic occupational stress, or post-traumatic stress disorder (PTSD), which arises from direct trauma exposure, VT develops indirectly through sustained exposure to others' traumatic narratives (Figley, 1995). Compassion fatigue and burnout may coexist with VT; however, VT is distinguished by deeper cognitive and perceptual changes, while compassion fatigue is characterized primarily by emotional exhaustion and reduced empathic capacity (Sorenson et al., 2016; Rauvola et al., 2019).

Globally, evidence shows a growing burden of vicarious trauma among healthcare workers. A meta-analysis by Li et al. (2023) found that approximately 30% of frontline healthcare workers experienced moderate to severe secondary traumatic stress during the COVID-19 pandemic. However, studies also show that coping strategies such as peer support, self-care practices, professional debriefing, and resilience training can reduce the severity of VT symptoms and improve psychological wellbeing (Delgado et al., 2022). These coping responses are commonly categorized as adaptive or maladaptive, depending on their impact on psychological functioning. Healthcare workers in mental health settings are particularly vulnerable due to continuous interaction with patients experiencing severe psychological distress. Mental health practitioners are frequently exposed to distressing narratives, increasing their risk of developing VT symptoms such as emotional detachment, reduced empathy, and cognitive disruption (Mento et al., 2020).

In low- and middle-income countries, including Kenya, healthcare systems are often overstretched, and mental health services remain under-resourced, exposing healthcare workers to higher psychological strain with limited institutional support. Kenya's Level 6 referral facilities, particularly Mathari National Teaching and Referral Hospital (MNTRH), manage complex medical and psychiatric cases and high patient volumes, placing significant emotional demands on healthcare workers (Abdi, 2024). This environment increases the likelihood of repeated exposure to traumatic patient experiences, predisposing staff to vicarious trauma.

Local studies indicate that VT is a significant concern among Kenyan healthcare workers. Mutisya et al. (2022) reported that over 40% of psychiatric nurses in Nairobi County public hospitals exhibited high levels of emotional exhaustion and detachment, key indicators of VT. Similarly, Wanja and Kathuku (2021) found that mental health workers at MNTRH frequently experience psychological distress linked to repeated exposure to patients' traumatic histories. Additionally, inadequate staffing, limited supervision, and lack of structured psychological support systems have been identified as contributing factors to secondary traumatic stress among healthcare workers in Kenya (Ng'eno et al., 2020; Omondi et al., 2023).

Despite this, there is limited localized evidence on the latest prevalence of VT among healthcare profession at MNTRH and the specific coping mechanisms they employ in response. This

knowledge gap limits the development of context-specific mental health interventions and workplace support systems. As such, assessing both the prevalence of vicarious trauma and the coping strategies used at MNTRH is essential for informing institutional policies aimed at promoting psychological wellbeing and sustaining quality mental health care delivery.

STATEMENT OF THE PROBLEM

Healthcare workers in Kenya's hospitals operate in highly demanding environments characterized by constant exposure to severe illness, medical and psychiatric emergencies, traumas, and chronic sufferings. This exposure is particularly intense at MNTRH where healthcare professionals routinely engage with patients experiencing severe mental illness, emotional crises, and trauma-related disorders. Continuous empathetic interaction with such patients places healthcare workers at increased risk of developing VT, a psychological condition resulting from indirect exposure to others' traumatic experiences.

Existing evidence indicates a growing burden of psychological distress among healthcare workers in Kenya, with Shah et al. (2021) reporting that 53.6% and 44.3% of healthcare workers in high-level facilities experienced symptoms of depression and anxiety respectively, while 45.8% reported burnout symptoms. Similarly, Mutisya et al. (2022) found that over 40% of psychiatric nurses in Nairobi County public hospitals exhibited emotional exhaustion and detachment, key indicators of VT, while Wanja and Kathuku (2021) documented significant psychological distress among mental health workers at Mathari Hospital due to repeated exposure to traumatic patient experiences. Despite these findings, healthcare systems in Kenya continue to face challenges such as inadequate staffing, high patient volumes, limited psychosocial support, and insufficient trauma-informed interventions, which may further increase vulnerability to VT.

Although several studies have examined occupational stress and burnout among healthcare workers, limited research has specifically assessed the level of vicarious trauma and the coping strategies employed by healthcare workers in specialized psychiatric referral settings such as Mathari National Teaching and Referral Hospital. Consequently, there is insufficient context-specific evidence to inform targeted institutional interventions and policies aimed at promoting psychological wellbeing, strengthening resilience, and improving mental healthcare service delivery. Therefore, this study sought to assess the level of vicarious trauma and establish the coping strategies among healthcare workers at MNTRH, Nairobi, Kenya.

LITERATURE REVIEW

Several studies have examined prevalence of VT among healthcare workers and how different factors shape this. Healthcare cadre appears influential, with nurses consistently reporting higher VT levels than physicians due to more prolonged patient contact (Meadors & Lamson, 2008). A study by Cieslak et al. (2016) found that younger healthcare professionals are more vulnerable to VT due to limited coping experience. A study by Sui and Padmanabhanunni (2016) observed a curvilinear relationship between professional experience and VT, where early-career workers and some mid-career professionals exhibited higher vulnerability due to cumulative exposure.

In Kenyan, Kamau et al. (2021) evaluated a trauma-awareness intervention among healthcare workers and found reduced VT symptoms post-training. Wanja and Kathuku (2021), in a study at Mathari Hospital, reported significant psychological distress and emotional withdrawal among mental health workers due to repeated exposure to patients' traumatic experiences. Similarly, Mutisya et al. (2022) found that over 40% of psychiatric nurses in Nairobi County public hospitals

exhibited emotional exhaustion and depersonalization, key indicators of VT. Further evidence from Omondi et al. (2023) highlighted elevated stress and anxiety among clinical officers in Kenyan referral hospitals, largely attributed to secondary trauma and lack of structured debriefing systems. Wambua et al. (2023) also found that higher educational attainment was associated with lower VT levels, suggesting that cognitive and emotional coping capacity may improve with training; however, the study did not control for workload or cadre differences.

Coping strategies are central to managing the psychological impact of vicarious trauma. These strategies are generally categorized as adaptive or maladaptive. Adaptive coping includes peer support, supervision, physical activity, mindfulness, and counseling, while maladaptive coping includes emotional suppression, withdrawal, and substance use (Folkman & Lazarus, 2022). Evidence suggests that structured psychosocial interventions such as counseling, debriefing, and stress management programs can significantly reduce VT symptoms (Craig & Sprang, 2010). However, in low-resource settings like Kenya, such services are often limited or inconsistently implemented (Jordans & Kohrt, 2020). Kamau et al. (2021) further demonstrated that trauma-awareness training can reduce VT symptoms among Kenyan healthcare workers, although sustainability remains uncertain. Gender differences also influence coping patterns. Women are more likely to use emotion-focused and social support strategies, while men are more likely to underutilize formal psychological support systems (Killian, 2008). However, the effectiveness of coping strategies is strongly dependent on institutional support and availability of mental health resources.

METHODOLOGY

This study employed a convergent parallel design that utilized a mixed methods approach to data collection to assess the level of vicarious trauma and coping strategies among healthcare workers at MNTRH. The study population comprised included medical doctors, nurses, and mental health practitioners such as counselors, clinical psychologists, and psychiatrists working at the hospital. A stratified random sampling technique was used to ensure proportional representation of each professional categories. Using Cochran's formula, a sample size of 168 participants was obtained from a target population of 330 healthcare workers. Eligible participants included healthcare workers who had worked at the institution for at least six months and were actively engaged in clinical duties.

A total of 121 completed questionnaires were returned, yielding a response rate of 72%. Data were collected using a structured socio-demographic questionnaire, the Vicarious Trauma Questionnaire (VTQ), a 40-item coping strategies scale, and semi-structured interview guides. Descriptive statistics including frequencies, percentages, means, and standard deviations were used to summarize participant characteristics, levels of vicarious trauma, and coping strategies. VTQ scores were categorized into low, moderate, and high levels of vicarious trauma, while coping strategy scores were ranked to identify the most frequently used mechanisms.

Pearson correlation and multiple linear regression analyses were conducted to examine associations between participant characteristics, work-related factors, and vicarious trauma, with statistical significance set at $p < 0.05$. Qualitative data from semi-structured interviews were analyzed thematically using Braun and Clarke's six-step framework, and findings were triangulated with quantitative results to enhance interpretation. Ethical approvals were obtained from the relevant institutions, while informed consent, confidentiality, voluntary participation, and psychological support measures were upheld throughout the study.

RESULTS

Sociodemographic Characteristics of Participants

Participant had varied sociodemographic needs as summarized in table 1. Majority of the respondents were aged between 26–35 years, 75(62.0%), followed by those aged 36–45 years, 22(18.2%). Participants below 25 years accounted for 16(13.2%), while those aged 46 years and above formed the lowest proportion 8(6.6%). This distribution indicates that the workforce is largely composed of young and mid-career professionals who are actively involved in patient care. In terms of gender, most respondents were female, 70(57.9%), compared to 51(42.1%) males, showing a slightly higher female representation in the healthcare workforce. With regard to marital status, over half of the participants were single, 71(58.7%), while 48(39.7%) were married and 2(1.7%) were widowed. This pattern reflects a workforce that is predominantly young and possibly still in early career or family stages.

Religiously, the majority of respondents identified as Christians, 111(91.7%), followed by Muslims, 9(7.4%), while 1(0.8%) reported being non-religious. This shows that most participants share a religious orientation, which could influence their coping approaches and perception of trauma. In relation to profession, nurses formed the largest group, 62(51.2%), followed by participants in the "Other" category, 29(24.0%), which may include clinical officers and support staff. Counselors/Therapists accounted for 15(12.4%), Social Workers 9(7.4%), and Doctors 6(5.0%). This distribution reflects the dominant role of nurses in direct patient care and their central involvement in trauma-related work within the hospital. Lastly, the departmental distribution shows that most participants worked in the Inpatient Wards, 46(38.0%), followed by the Outpatient Department, 31(25.6%), and the Maximum Security Unit, 20(16.5%). Smaller numbers were from the Rehabilitation unit, 8(6.6%), and other departments, 16(13.2%). This range indicates that respondents were drawn from both general and specialized care units, providing a balanced representation of healthcare workers exposed to varying levels of trauma-related experiences.

Table 1: Participants Sociodemographic Characteristics

Variable	Category	Frequency	Percent (%)
Age of Participant	Below 25 years	16	13.2
	26–35 years	75	62.0
	36–45 years	22	18.2
	46–55 years	3	2.5
	Above 56 years	5	4.1
Gender of Participant	Male	51	42.1
	Female	70	57.9
Marital Status	Single	71	58.7
	Married	48	39.7
	Widowed	2	1.7
Religion	Christianity	111	91.7
	Islam	9	7.4
	Not religious	1	0.8
Profession	Nurse	62	51.2
	Doctor	6	5.0
	Social Worker	9	7.4
	Counselor/Therapist	15	12.4
	Other	29	24.0
Department/Section	Outpatient	31	25.6
	Rehabilitation	8	6.6
	Maximum Security Unit	20	16.5
	Inpatient Wards	46	38.0

The Level of Vicarious Trauma among Healthcare Workers

Vicarious Trauma Questionnaire Scale was used to measure level of VT among participants and the results are summarized in Table 2. The findings reveal that slightly more than half of the participants, 62(51.2%), fell within the low vicarious trauma category. This suggests that a majority of the healthcare workers experience minimal emotional distress or cognitive disruptions related to indirect exposure to patient trauma, possibly due to adaptive coping mechanisms, professional resilience, or institutional support structures.

A substantial proportion of respondents, 54(44.6%), reported moderate vicarious trauma levels, indicating the presence of noticeable but manageable symptoms such as emotional exhaustion, intrusive thoughts, or altered worldviews. This group may represent employees who are regularly exposed to traumatic patient cases but possess partial coping resources that mitigate severe psychological consequences. Only a small number of participants, 5(4.1%), scored within the high vicarious trauma category. This subgroup reflects individuals who may be experiencing significant distress, detachment, or behavioral symptoms requiring psychological intervention and support.

Table 2: Distribution of Level of Vicarious Trauma

	Frequency	Percent
Low Vicarious Trauma (18-38)	62	51.2
Moderate Vicarious Trauma (39-59)	54	44.6
High Vicarious Trauma (60-90)	5	4.1
Total	**121**	**100.0**

Distribution of Various Dimension of Vicarious Trauma

A one-sample t-test conducted to determine the mean levels of vicarious trauma across four key dimensions. The test value was set at zero to establish whether the observed means were significantly greater than the null hypothesis baseline. The dimensions assessed included emotional and cognitive impact, changes in beliefs and worldview, physical and behavioral effects, and work-related stress as summarized in table 3. The results show that all the subscales recorded statistically significant mean differences at $p < .001$, indicating the presence of vicarious trauma symptoms across all dimensions. The emotional and cognitive impact dimension recorded the highest mean difference ($M = 12.85$, $t = 34.512$), suggesting that most participants frequently experienced intrusive thoughts, emotional fatigue, or difficulty detaching from patients' trauma narratives. This indicates that the emotional demands of caregiving significantly affect their cognitive processing and emotional regulation.

The changes in beliefs and worldview dimension yielded a mean difference of 8.26 ($t = 26.226$), highlighting moderate but noticeable shifts in how healthcare workers perceive trust, safety, and the general goodness of humanity after prolonged exposure to trauma cases. Similarly, the physical and behavioral effects subscale had a mean difference of 8.21 ($t = 26.602$), reflecting symptoms such as fatigue, sleep disturbances, or avoidance behaviors related to trauma exposure. The work-related stress domain recorded a mean difference of 8.56 ($t = 28.229$), signifying that healthcare workers experience persistent occupational strain linked to heavy caseloads, emotional exhaustion, and moral conflict arising from the nature of their work.

Finally, the overall vicarious trauma mean score ($M = 37.88$, $t = 34.517$, $p < .001$) indicates a moderate level of cumulative trauma among participants. The narrow 95% confidence interval (35.70–40.05) further confirms the reliability of the results. These findings imply that healthcare workers at Mathari Teaching and Referral Hospital experience considerable emotional, cognitive, and behavioral consequences stemming from secondary exposure to patients' traumatic experiences. While the intensity may vary across individuals, the consistent significance across all domains underscores the psychological burden inherent in trauma-care professions and the need for structured mental health support within the hospital system.

Table 3: Distribution of Various Dimension of Vicarious Trauma

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% CI Lower	Upper
Emotional and cognitive impact	34.512	120	.000	12.851	12.11	13.59
Changes in beliefs and worldview	26.226	120	.000	8.256	7.63	8.88
Physical and behavioral effects	26.602	120	.000	8.207	7.60	8.82
Work related stress	28.229	120	.000	8.562	7.96	9.16
Overall Vicarious Trauma	34.517	120	.000	37.876	35.70	40.05

Coping Strategies used by Healthcare in Relation to Vicarious Trauma

The study assessed how participants used six key coping dimensions; problem-focused, emotion-focused, social support, avoidant, maladaptive, and spiritual coping in handling work-related stress and trauma exposure and the result is represented table 4. The results indicate that most participants predominantly adopted adaptive coping mechanisms, particularly problem-focused strategies, to manage work-related stress and emotional strain. The findings show that more than half of the respondents, 68(56.2%), demonstrated high problem-focused coping, while 37(30.6%) fell within the moderate range and 16(13.2%) reported low use of such strategies. This suggests that a majority of healthcare workers actively engage in problem-solving behaviors such as seeking solutions, planning, and taking practical steps to address challenging situations.

Regarding emotion-focused coping, the majority, 71(58.7%), of respondents reported moderate levels, 36(29.8%) indicated high levels, and 14(11.6%) reported low levels. This pattern suggests that while emotional regulation techniques such as mindfulness, relaxation, and positive reframing were commonly used, they were not as dominant as problem-focused strategies. For social support coping, nearly half of the participants, 58(47.9%), reported moderate engagement, 41(33.9%) reported low levels, and only 22(18.2%) reported high utilization. This implies that while interpersonal support from colleagues, family, or peers was recognized as important, not all participants consistently relied on such networks when coping with trauma exposure. In terms of avoidant coping, just over half, 63(52.1%), of respondents reported moderate use, 31(25.6%) reported high use, and 27(22.3%) reported low levels. This reflects a tendency among some healthcare workers to disengage or distract themselves as a temporary means of managing stress, though such strategies are generally less adaptive over time. The results for maladaptive coping indicate a highly favorable trend, with a vast majority, 107(88.4%), reporting low engagement in behaviors such as substance use, overeating, or aggression, and only 1(0.8%) reporting high levels. This suggests that most participants avoided negative coping mechanisms despite their exposure to trauma-related stressors.

Spiritual coping was moderately prevalent, with 58(47.9%) of respondents reporting moderate engagement, 22(18.2%) reporting high use, and 41(33.9%) reporting low levels. This highlights the role of faith and spirituality as an important source of strength and resilience for healthcare workers in emotionally demanding clinical environments. Overall, the findings demonstrate that healthcare workers employed a range of coping strategies, with problem-focused and emotional coping being the most dominant adaptive mechanisms, while maladaptive coping remained relatively rare.

Table 4: Coping Strategies Utilized by Participants

Coping Strategy	Level	Frequency (n)	Percent (%)
Problem-Focused Coping	Low (5–11)	16	13.2
	Moderate (12–18)	37	30.6
	High (19–25)	68	56.2
Emotional-Focused Coping	Low (5–11)	14	11.6
	Moderate (12–18)	71	58.7
	High (19–25)	36	29.8
Social Support Coping	Low (5–11)	41	33.9
	Moderate (12–18)	58	47.9
	High (19–25)	22	18.2
Avoidant Coping	Low (5–11)	27	22.3
	Moderate (12–18)	63	52.1
	High (19–25)	31	25.6
Maladaptive Coping	Low (5–11)	107	88.4
	Moderate (12–18)	13	10.7
	High (19–25)	1	0.8
Spiritual Coping	Low (5–11)	41	33.9
	Moderate (12–18)	58	47.9
	High (19–25)	22	18.2

Significance of the different coping mechanisms on level of Vicarious Trauma

A chi-square test of goodness-of-fit was conducted to determine whether the observed differences in coping strategy utilization across various categories and findings summarized in table 5. All coping strategies demonstrated statistically significant variations among participants ($p < .05$). Specifically, problem-focused (χ^2=38.620, p=.002), emotion-focused (χ^2=58.256, p=.000), social support (χ^2=53.074, p=.000), avoidant (χ^2=72.884, p=.000), maladaptive (χ^2=394.603, p=.000), spiritual (χ^2=31.901, p=.044), self-care (χ^2=32.562, p=.008), and cognitive coping (χ^2=65.397, p=.000) strategies all showed significant differences in their use among the respondents.

These findings suggest that healthcare workers at Mathari Teaching and Referral Hospital do not rely uniformly on one type of coping mechanism but instead employ a diverse combination of strategies when dealing with vicarious trauma. The significant differences observed across the coping categories indicate variability in individual coping preferences, possibly influenced by personal, professional, or situational factors such as workload, emotional resilience, or access to support systems. The strong significance in maladaptive coping (χ^2=394.603, p=.000) suggests that while the majority reported low engagement in such behaviors, the few who did exhibited marked differences from the rest, highlighting a small but important group that may require targeted psychosocial interventions. Conversely, the significance in adaptive forms such as problem-focused and emotion-focused coping ($p<.01$) indicates that these strategies are not uniformly practiced but vary in intensity and frequency among staff, possibly reflecting differences in training, experience, or coping awareness.

Table 5: Chi-Square Test Results of Significance

	Problem focused	Emotional focused coping	Social support coping	Avoidant coping	Maladaptive coping	Spiritual coping	Selfcare coping strategies	Cognitive Coping Strategies
Chi-Square	38.620	58.256	53.074	72.884	394.603	31.901	32.562	65.397
df	17	17	20	19	11	20	16	17
Asymp. Sig.	.002	.000	.000	.000	.000	.044	.008	.000

DISCUSSION

The study found that healthcare workers at Mathari Teaching and Referral Hospital experienced statistically significant levels of vicarious trauma across all four dimensions emotional and cognitive impact, changes in beliefs and worldview, physical and behavioral effects, and work-related stress ($p < .001$). The highest mean score was recorded for emotional and cognitive impact ($M = 12.85$), indicating substantial emotional strain, while the lowest was for changes in beliefs and worldview ($M = 8.26$). Overall, the composite vicarious trauma score ($M = 37.88$) reflected a moderate level of cumulative trauma, with 51.2% of participants falling within the low trauma range, 44.6% within the moderate range, and 4.1% in the high range. These findings confirm that healthcare workers at Mathari face significant emotional and psychological challenges associated with repeated exposure to patient trauma. This aligns with Figley's (1995) Compassion Fatigue Theory, which posits that continuous empathetic engagement can lead to emotional depletion and trauma symptoms similar to post-traumatic stress. The results are consistent with Finklestein et al. (2015), who observed that trauma-exposed caregivers often exhibit symptoms such as emotional fatigue, intrusive thoughts, and avoidance behaviors.

The moderate levels of trauma observed echo Leung, Schmidt, and Mushquash (2023), who explained that vicarious trauma may accumulate gradually or emerge suddenly depending on exposure intensity. Furthermore, the relatively low prevalence of high trauma mirrors Scott's (2020) conclusion that, while vicarious trauma is common in caregiving professions, its severity is moderated by personal coping resources and institutional support. Gender differences were minimal, though males reported slightly higher physical and behavioral symptoms than females. The near parity between male and female participants supports Killian (2008), who noted that both genders experience comparable levels of vicarious trauma, with differences primarily in the coping approaches adopted. These findings reaffirm that the emotional demands of caregiving in psychiatric settings, such as Mathari Hospital, present a persistent occupational hazard that requires structured psychosocial support.

The findings revealed that healthcare workers predominantly employed adaptive coping strategies, particularly problem-focused and emotion-focused coping. Over half (56.2%) of the respondents demonstrated high problem-focused coping, and 58.7% reported moderate emotion-focused coping. In contrast, maladaptive coping was rare, with 88.4% of respondents reporting low engagement. Moderate levels of social support (47.9%) and spiritual coping (47.9%) were also observed, suggesting a balanced use of personal, interpersonal, and faith-based coping resources. A chi-square analysis further showed statistically significant differences across all coping dimensions ($p < .05$), confirming that coping styles varied widely among individuals. This supports Lazarus and Folkman's (1984) Stress and Coping Theory, which distinguishes between problem-focused and emotion-focused coping as the primary strategies individuals use to manage stressful

experiences. The high reliance on problem-focused coping reflects the workers' tendency to engage in proactive problem-solving and control-oriented behaviors, consistent with Folkman and Lazarus (2022), who emphasized that adaptive coping enhances psychological resilience and emotional regulation.

The moderate use of social and spiritual coping aligns with Craig and Sprang (2010), who demonstrated that structured peer and faith-based support reduce trauma-related distress among helping professionals. Similarly, Kamau et al. (2021) found that mental health awareness and coping-skills training improved stress management among Kenyan healthcare workers. The minimal engagement in maladaptive coping supports Jordans and Kohrt (2020), who noted that, despite limited access to psychosocial resources in low- and middle-income countries, professionals tend to utilize more adaptive mechanisms when they possess a sense of control and professional purpose. The significant variability across coping categories observed in this study reinforces Lazarus and Folkman's (1984) notion that coping is a dynamic, context-driven process influenced by individual appraisal, resilience, and available institutional support.

CONCLUSION

This study assessed the level of vicarious trauma and coping strategies among healthcare workers at MNTRH, Kenya. Findings revealed that a significant proportion of healthcare workers experience moderate levels of VT arising from continuous exposure to patients' traumatic experiences and psychiatric distress. The findings showed that emotional and cognitive effects constituted the most prominent dimension of trauma, confirming that psychiatric healthcare workers remain vulnerable to psychological strain associated with caregiving. The study further found that healthcare workers primarily utilized adaptive coping strategies, particularly problem-focused and emotion-focused coping, while maladaptive coping mechanisms were minimally employed. Social support and spiritual coping also emerged as important coping resources. These findings suggest that although healthcare workers demonstrate resilience through constructive coping approaches, the persistent presence of vicarious trauma highlights the need for strengthened psychosocial support systems, trauma-informed interventions, and workplace mental health programs to promote psychological wellbeing and sustain quality mental healthcare services.

RECOMMENDATIONS

1. MNTRH and other specialty hospitals should integrate structured debriefing sessions, VT awareness campaigns, and supervisory support systems into routine hospital operations to reduce the level of vicarious trauma among healthcare workers.
2. MNTRH and other specialty hospitals should introduce continuous training on adaptive coping strategies while also promote peer-support programs, counseling services, and wellness initiatives to enhance psychological resilience.
3. Organizational support at MNTRH and other specialty hospitals through adequate staffing, manageable workloads, regular staff wellness assessments, and accessible psychosocial support services to minimize work-related stress and sustain healthcare workers' mental wellbeing.
4. Future longitudinal study to examine how various therapeutic interventions and wellness programs influences change in the level of vicarious trauma among healthcare workers over time.

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