

Emotional intelligence and compassion fatigue among psychotherapists in selected districts of Northern Uganda

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Abstract

Globally, close to 50% of the professionals working with traumatised individuals have issues related to compassion fatigue. In Uganda, although compassion fatigue is prevalent among psychotherapists, there is limited evidence of relationship between emotional intelligence and compassion fatigue. This study set out to fill this gap. Data were collected from a random sample of 207 psychotherapists working in Northern Uganda, who completed Emotional Competency Inventory version-2.0 and Professional Quality of Life version-5 questionnaires. Chi-square and Fischer's exact tests were used to analyse the data. Findings revealed that all the four elements of emotional intelligence (social awareness, self-awareness, self-management, and social skills) were inversely related to levels of compassion fatigue and were statistically significant at $p < .0001$. The study recommended that organisations offering psychotherapy services could focus on building emotional intelligence of their psychotherapists. Increasing emotional intelligence of psychotherapists is necessary to enable them deal more effectively, with their feelings and thus directly decrease the level of compassion fatigue thereby protecting their mental and physical health.

Keywords

Compassion fatigue, emotional intelligence, psychotherapists, Uganda

Compassion fatigue remains a global phenomenon affecting close to 50% of those providing services to vulnerable clients (Injeyan et al., 2011). Continued exposure to traumatic events of clients has the propensity to increase the risk of compassion fatigue among psychotherapists (Hinderer

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et al., 2014). It is common for psychotherapists to develop this health problem given their close interaction with traumatised clients (van Mol et al., 2015). Joinson describes compassion fatigue as a situation where the caregiver is frustrated as a result of undergoing job tensions and is exhausted of service delivery (Borhani et al., 2014). It also refers to the emotional, physical, and spiritual exhaustion that results when an individual is exposed to firsthand trauma experiences of primary victims (Peery, 2010; Sabo, 2011), which reduces the psychotherapist's capacity to provide empathy to a traumatised individual (Adams et al., 2006). Characteristics of compassion fatigue include re-experiencing personal trauma, flashbacks, nightmares, intrusive thoughts, avoidance or numbing of reminders of the event, and increase in physiological arousal (Stamm, 2010).

Researchers have acknowledged the existence of compassion fatigue and the possibility that it may be an underestimated occupational hazard for those providing care services (Devilly et al., 2009; Harr & Moore, 2011). Compassion fatigue may have severe consequences including but not limited to: feeling of loss of hope, inability to engage in productive therapeutic relationships with patients, development of post-traumatic stress disorder symptoms such as strong difficulty in concentrating, feelings of anxiety, easily startled, irritability, difficulty sleeping, and excessive emotional (Portney, 2011; van Mol et al., 2015). Long-term effects include reduced empathy, reduced sense of control, diminished sense of personal safety, absenteeism, and drug or alcohol use (Portney, 2011). Professionals who experience compassion fatigue are more likely to be at risk of making poor judgements such as poor treatment planning and abuse of clients (Drury et al., 2014). Suicide which is common among mental health profession is also attributed to unaddressed consequences of compassion fatigue (Joiner, 2005; Kleespies et al., 2011; Pope & Tabachnick, 1994).

There is growing evidence of researchers and organisations seeking to develop strategies of addressing issues of compassion fatigue, although attention has generally focused on other professions instead of psychotherapists (Dunkley & Whelan, 2006; Figley, 2003). Professionals providing care to vulnerable population need high levels of emotional intelligence to maintain personal vitality and professional functioning so as to deliver an effective and efficient service to clients. Different researchers define emotional intelligence differently, but all of them embrace the four-branch emotional intelligence constructs of: perceiving, understanding, managing, and 'utilising' emotions. For instance, Salovey and Mayer (1990) defined emotional intelligence as the ability of individuals to identify, use, understand, and manage their own emotions positively to relieve stress, communicate effectively, empathise with others, and to overcome challenges and defuse conflict. On the contrary, Di Fabio et al. (2012) defined emotional intelligence as a set of interconnected emotional social skills and behaviours that influence how well individuals understand themselves, others and how they manage the pressure in their environments. It is an individual's ability to perceive, appraise, understand, regulate, and utilise one's own emotions and those of others (Guy & Lee, 2015; Lee, 2013).

Emotional intelligence plays a central role in explaining human functioning (Muchinsky, 2000), and individual performance and personal health (Barsade & Gibson, 2007). Higher levels of emotional intelligence are positively related to assertiveness, willingness to use social support networks, better problem-solving skill, adaptation, and a lower level of anxiety (Poret et al., 2010). Individuals with high emotional intelligence are less prone to work-related problems (Akbari & Tavassoli, 2011). Conversely, individuals with low emotional intelligence tend to have higher levels of work-related stress, engage in self-destructive behaviours such as drinking alcohol, smoking, and blame colleagues for their mistakes (Kun & Demetrovics, 2010). In addition, low levels of emotional intelligence may contribute to compassion fatigue for psychotherapists (Gutierrez & Mullen, 2016).

The literature reviewed showed that emotional intelligence is related to individual well-being (Mayer et al., 2008). The clients' mental agony may not be recognised if the psychotherapists fail

to recognise their own emotions (Gutierrez & Mullen, 2016). Thus, those working in war zone areas need emotional intelligence more to be able to manage clients well. For example, studies done in Rwanda by Iyamuremye and Brysiewicz (2008) showed that there was a high level of compassion fatigue among psychotherapists who worked with victims of war. In Uganda, the two decades of violence and conflict between the Lord's Resistance Army (LRA) and the government forces in the north off the country led to brutal killings, displacement, and populations suffering from emotional and psychological effects due to trauma (Kabunga & Muya, 2014; Vinck et al., 2007). The Juba peace truce brokered in 2005 brought a shift in humanitarian efforts towards not only economic recovery but also emotional and psychological rehabilitation. The significant response to such events relied heavily upon psychotherapists. However, the impact of working with victims of war on the psychotherapists' well-being has had little attention especially in Ugandan context. Besides, there seems to be dearth of studies on the relationship between emotional intelligence compassion fatigues among psychotherapists. Hence, this study's aim was to study the relationship between emotional intelligence compassion fatigues among psychotherapists in northern Uganda. The study hypothesised that there is no statistically significant relationship between social awareness and levels of compassion fatigue and there is no statistically significant relationship between self-awareness and levels of compassion fatigue, between self-management and levels of compassion fatigue, and between social skills and levels of compassion fatigue among psychotherapists.

Methods

A cross-sectional correlational research design employing quantitative approaches was used. The study used registration records by the Gulu District Non-Government Organisation Forum (2016) and the UN Office for the Coordination of Humanitarian Affairs (2015) from which 24 organisations employing a total of 382 psychotherapists provided psychosocial support. Survey questionnaires were used to collect data.

Participants

The participants in the study included 4 psychiatrists, 29 psychologists, 35 professional counselors, 45 mental health nurses, 33 clinical social workers, and 22 marriage and family therapists with working experience of at least 2 years and above. In total, 220 participants were randomly selected for the study out of whom 13 did not complete giving 94% response rate. More than half of the study participants, 56% ($n=116$), were men and 44% ($n=91$) were women with the age ranging from 25 to 65 years.

Instruments

Emotional Competency Inventory (ECI) 2.0, a 360° tool standardised by the Hay Group in 2002 was used to measure emotional intelligence after obtaining permission from the author. The tool consisted of 72 items distributed on the four dimensions (self-awareness, social management, self-management, and social skills). A 5-point response format (from 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Unsure*, 4 = *Agree*, and 5 = *Strongly Agree*) was used. All the domains of emotional intelligence of the respondents were rated as low, average, or high levels based on the guidelines (Hay Group, 2005). The tool showed adequate test-retest reliability values with coefficient of $r=.79$, as well as a good face and construct validity similar to that found in other countries. Professional Quality of Life version 5 with a score range of 5–50, which showed a good and adequate internal consistency,

was used to measure compassion fatigue (Stamm, 2010). The scores were grouped into low compassion fatigue with a score of 22 and below, average compassion fatigue having scores between 23 and 41, and high compassion fatigue having scores between 42 and above. In the present sample, the researcher found adequate reliability of $r = .84$, which is above adequate benchmark coefficient of .50. The two tools were preferred because they had been previously used in African context (Kabunga et al., 2019).

Procedure

Instruments were administered to respondents at pre-arranged times and secured venues for each of the selected districts. Coordinators of the organisations were contacted through both emails and letters. Respondents were contacted on phone and in some cases physically through coordinators of the organisations that employed them. Afterwards, the survey questionnaires were distributed to the respondents who filled the questions according to instructions given. The completed questionnaires were later collected by the researcher for onward analysis.

Ethical considerations

The researcher obtained permission to collect data from the Uganda National Council for Science and Technology and ethical approval from the National HIV/AIDS Research Committee of Makerere University. Informed written consent was obtained from respondents after explaining to them the purpose and nature of the study. Respondents were also guaranteed of confidentiality of the information provided, and they were assured that they could withdraw from the study with no repercussions. Respondents anonymously completed the questionnaires within the time allotted to the researcher. Respondents took about 50 min to complete the questionnaires considered in this study.

Data analyses

All statistical analyses were performed using R (R Core Team, 2015) with statistical significance set at $p < .05$. The Shapiro–Wilk test results showed that the respondents' scores were not normally distributed. Since the continuous variables were not normally distributed, they were summarised as median and the corresponding interquartile range (IQR). Minimum and maximum scores were also provided. Both Pearson's chi-square test and Fischer's exact test were used to obtain the relationship between emotional intelligence domains and levels of compassion fatigue.

Results

From Table 1, majority of the respondents, 60.4% ($n = 125$), had high levels of compassion fatigue, almost one quarter of the respondents, 23.7% ($n = 49$), reported average level of compassion fatigue, and 15.9% ($n = 33$) had low level of compassion fatigue. Therefore, a good number of psychotherapists were frequently exposed to stories about trauma from clients.

Table 2 below shows that all the respondents with low levels of social awareness 100% ($n = 6$) had high level of compassion fatigue, while 77.6% ($n = 59$) of those with average levels of social awareness reported having high level of compassion fatigue and 41.9% ($n = 52$) of those with high level of social awareness reported average levels of compassion fatigue. Only 19.3% ($n = 24$) of those who had high levels of social awareness reported high level of compassion fatigue. From the

Table 1. Levels of compassion fatigue.

Levels of compassion fatigue	N	Percentage
≤22 (low)	33	15.9
23–41 (average)	49	23.7
≥42 (high)	125	60.4

Table 2. Social awareness and levels of compassion fatigue.

Compassion fatigue	N	Low	Average	High	p value
Social awareness					
0–29	6	0.0% (0)	0.0% (0)	100% (6)	<.0001 ^a
30–45	76	7.8% (6)	14.4% (11)	77.6% (59)	
46–60	124	38.7% (48)	41.9% (52)	19.3% (24)	

^aFisher's exact test.

*Correlation is significant at .05 level.

Table 3. Self-awareness and compassion fatigue.

Compassion fatigue	N	Low	Average	High	p value
Self-awareness					
0–29	0	0.0% (0)	0.0% (0)	0% (0)	<.0001 ^a
30–45	82	3.7% (3)	8.5% (7)	87.8% (72)	
46–60	124	24.4% (30)	34.1% (42)	41.5% (51)	

^aFischer's exact test.

*Correlation is significant at the .05 level.

results, it is clear that compassion fatigue decreases with increase in levels of social awareness. This decreasing trend was justified by the data with $p < .0001$, which statistically significant at an alpha value of .05. Therefore, the null hypothesis that there is no statistically significant relationship between social awareness and levels of compassion fatigue is rejected.

Table 3 indicates that 87.8% ($n=72$) of the respondents with average levels of self-awareness reported high levels of compassion fatigue, almost half of those with high levels of self-awareness (41.5%) reported experiencing high levels of compassion fatigue, and none of the respondents had low level of self-awareness. The results show a statistical significance with increase in levels of self-awareness being correlated with a decrease in level of compassion fatigue at $p < .0001$ for alpha value $\alpha = .05$. Therefore, the null hypothesis is rejected. Interestingly, results also showed that 41.5% of the psychotherapists who scored high in self-awareness also exhibited high levels of compassion fatigue, implying that practitioners with higher levels of self-awareness tend to have higher levels of compassion fatigue simultaneously.

Table 4 indicates that almost all the respondents, 91.7% ($n=11$), with low level of self-management experienced high level of compassion fatigue, while 70% ($n=56$) of the respondents with average levels of self-management had high level of compassion fatigue and almost half of those with high levels of self-management, 48% ($n=60$), and a small portion, 8% ($n=10$), reported average and high level compassion fatigue, respectively. The drop in levels of compassion fatigue as

Table 4. Self-management and levels of compassion fatigue.

Compassion fatigue	N	Low	Average	High	p value
Self- management					
24–53	12	0.0% (0)	8.3% (1)	91.7% (11)	<.0001 ^a
54–71	80	12.5% (10)	17.5% (14)	70.0% (56)	
72–120	115	36.0% (45)	48.0% (60)	8.0% (10)	

^aFisher's exact test.

*Correlation is significant at the .05 level.

Table 5. Social skills and levels of compassion fatigue.

Compassion fatigue	N	Low	Average	High	p value
Social skills					
24–53	14	0.0% (0)	14.2% (2)	85.7% (12)	<.0001 ^a
54–71	48	13.7% (8)	20.6% (12)	65.5% (28)	
72–120	145	31.7% (46)	45.5% (66)	22.7% (33)	

^aFischer's exact test.

*Correlation is significant at the .05 level.

levels of self-management increase was statistically significant at $p < .0001$. Therefore, the null hypothesis of no statistically significant relationship between self-management and levels of compassion fatigue among psychotherapists was rejected.

Table 5 indicates that most of those who had low levels of social skills, 85.7% ($n=12$), and those with average levels of social skills, 65.5% ($n=28$), had high levels of compassion fatigue. The results also show that almost half, 45.5% ($n=66$), and nearly one fourth of the respondents, 22.7% ($n=33$), who had high social skills reported average and high levels of compassion fatigue, respectively. Evidently, the results demonstrated that high levels of social skills lead to low levels of compassion fatigue and vice versa, $p < .0001$, which is less than alpha values of .05. Hence, the null hypothesis that there is no significant relationship between social skills and levels of compassion fatigue among psychotherapists is rejected.

Discussion

The study sought to establish whether there is a relationship between emotional intelligence and compassion fatigue among psychotherapists in northern Uganda. Research on such topics has been rather fragmentary. Although the small sample size used may not allow for strong conclusions, its findings are particularly noteworthy. For instance, the study found that 60.4% respondents had high levels of compassion fatigue implying psychotherapists in northern Uganda are at risk of compassion fatigue. The result of this study concurs with studies in similar circumstances and population such as Oklahoma City trauma psychotherapists after a terror attack (Jacobson, 2012; Wee & Myers, 2002), which revealed that almost 65% of the respondents exhibited high degree of compassion fatigue. The results in this study are further supported by similar results found by Myers and Zunin (1994), which showed that 60.5% of the Northridge Earthquake psychotherapists met criteria for compassion fatigue.

This study supports findings from another study by Chrestman (1995), which found that psychotherapists who work with the ordeal of clients have an increased chance of experiencing a shift in their own psychological well-being. Farrenkopf (1992) also observed that 33% of the psychotherapists who treated sexual offenders reported high levels of compassion fatigue. This is not shocking given that at the time, psychotherapists in Gulu and Amuru districts operated in volatile security situation and dealt with complicated cases on a daily basis. This situation can result in an inability not only to nurture (Finzi-Dottan & Kormosh, 2016) but also increased susceptibility to compassion fatigue.

The study also found meaningful relationships between all the constructs of emotional intelligence and compassion fatigue. For instance, findings from the study showed that there existed a relationship between social awareness and levels of compassion fatigue, implying that social awareness has influence on compassion fatigue. This was supported by a study by Tartakovsky (2015), which found out that a psychotherapist with an innate ability to understand what other people or clients are going through overcomes difficult times drama free. Berr et al. (2000) also reported that individuals who consider others' feelings and emotions are emotionally and psychologically healthier than their counterparts who are not. Similar findings from other previous studies also indicate that the higher the levels of social awareness, the less the chances of susceptibility to compassion fatigue (Bush, 2009; Stamm, 2010). This could be due to the fact that one's ability to recognise emotions of others helps them to not only to build effective relations with others but it also helps them gain better access to social support resources. This is important in protecting the individuals against work-related problems including compassion fatigue. Psychotherapists who have social awareness skills are sensitive and can adapt to the environment. The hallmark of social awareness is being able to relate to others.

This study contrasts with other previous research by Regehr, Goldberg & Hughes (2002) and MacRitchie and Leibowitz (2010), which indicate that as level of social awareness increases, compassion fatigue also increases. However, this discrepancy may not be surprising because the literature shows that empathy is a paradox. That is, despite it being an excellent resource for psychotherapists, it may be a major key factor in the transmission of traumatic material from the primary victim to a psychotherapist and thus makes one susceptible to compassion fatigue (Figley, 2003). Second, psychotherapists differ in level of resilience. While some are affected at the slightest provocation, others are not even though they may be exposed to similar trauma (Sabo, 2011).

Findings from the study found that an increase in self-awareness leads to a decreasing trend of compassion fatigue among psychotherapists. This implies that psychotherapists who have high level of self-awareness are very adept at understanding both their own emotions and that of the others. In addition, psychotherapists who are more in tune with their own emotions are more equipped to establish effective emotional boundaries in their lives (Grant, 2013). They will know when to say no to things that they think will over burden them. This study concurs with the findings of Kerr et al. (2006) that self-awareness describes those individuals who have an accurate understanding of their strengths and weaknesses.

Interestingly, results indicated that psychotherapists who scored high in self-awareness also exhibited high levels of compassion fatigue. This means that some practitioners with higher levels of self-awareness may also develop higher levels of compassion fatigue simultaneously. Therefore, compassion fatigue and emotional intelligence can coexist in practitioners depending on different situations. However, higher levels of emotional intelligence may be required to significantly check the impact of compassion fatigue in psychotherapists. These findings are in agreement with previous studies by Killian (2008) among frontline licenced psychotherapists who identified several key risk

factors in developing work compassion fatigue of which the most frequently occurring was the ability to recognise and meet one's own needs (self-awareness). A study by Benson et al. (2007) among a surgical population also revealed that understanding of emotions was a significant predictor of health-related problems. The findings suggest that self-awareness plays a role in compassion fatigue.

Results of the study show a relationship between self-management and levels of compassion fatigue. The finding revealed a decreasing trend of compassion fatigue as self-management increases. Findings of the study are supported by Bradberry and Greaves (2009), which stated that psychotherapists who are high in self-management can harness even negative emotions, can adapt to changing circumstances, and manage them to achieve intended goals. Keefer et al. (2009) also suggested that the inability to regulate strong negative emotions exacerbates the negative impact of stress on health through potentially harmful coping behaviours. Broadly speaking, individuals who are proficient in self-management abilities are resilient under stress and pressure and can take proactive steps towards restoring their emotional balance and regulating negative emotion.

This study complements the existing literature which indicates that low level of self-management is negatively associated with increased levels of compassion fatigue (Augusto-Landa et al., 2011; Zeidner et al., 2013). Salovey (2001) discovered that the failure of self-management has negative effect on health. This study also compares positively with a study by Alvinia and Ahmadzadeh (2012), which observed that individuals who regulate their emotional states are healthier. Likewise, Zeidner et al. (2013) found out that negative effect among health-care professionals was associated with emotion-focused coping. It is evident from the above that the proneness by psychotherapists to compassion fatigue is an indication of the inability to effectively manage their emotions when dealing with other individuals, colleagues, and clients. This provides a strong argument that self-management could play a vital role in the development of compassion fatigue.

Finally, results from the study show that when levels of social skills among the psychotherapists increase, their levels of compassion fatigue decrease. This is supported by a variety of studies which explain such a relationship. A study by Choi (2011) found that psychotherapists who have high levels of social support demonstrated lower levels of compassion fatigue. Salovey and Mayer (1990) asserted that an individual with good social skills is able to interact comfortably with others and also to persuade, negotiate, and settle disputes. Similarly, Murray et al.'s (2009) study on trauma discovered that nurses with poorly established relationships with co-workers were more likely to experience compassion fatigue. Killian (2008) identified several key risk factors in developing work-related compassion fatigue one of which was lack of social support. Eriksson et al. (2001) also found that social support determined psychological adjustment among international relief workers. Murray et al. (2009) also concluded that social skills have the potential to alleviate stress-related conditions at work and improve compassion satisfaction for those who interact more. Psychotherapists who are higher in social skills are better able to engage in friendships with a wide range of individuals. Therefore, to maintain a healthy well-being there is need to have both personal and professional social support (Meyer & Ponton, 2006).

Results of this study (as seen in Table 5), however, indicate that a considerable number of respondents (22.7%) had both high levels of social skills and high levels of compassion fatigue. This suggests that it is possible for some psychotherapists to feel overwhelmed by compassion fatigue, despite having high levels of social skills. Therefore, the finding suggests that social skills are vital for the well-being of both the psychotherapist and clients and the management of compassion fatigue among psychotherapists.

This study was limited to northern Uganda. Another limitation is that all the indicators in this study (compassion fatigue and emotional intelligence) relied on self-report. Also, multivariate statistics were not conducted, which is a major limitation. The study could not establish causal links between emotional intelligence and compassion fatigue given the study design. Future studies

could look into the extent to which emotional intelligence can predict compassion fatigue in a given population. They could also focus on specific types of mental health practitioners like counsellors and social workers. In addition, qualitative exploratory studies may contribute to a better understanding of the topic.

Conclusion

This study has practical implications for psychotherapists and organisations. First, the results show that it is possible for psychotherapists working in war ravaged zone to develop high levels of compassion fatigue. Also, emotional intelligence is highly associated with levels of compassion fatigue and that emotional intelligence may act as buffers against known risk factors of compassion fatigue in human service work. Moreover, in the provision of psychotherapy services and training, psychotherapists who are low in emotional intelligence deserve consideration since it may end up affecting both their physical and mental well-being. Individuals at risk of developing compassion fatigue, in particular, may benefit from intensive and well-structured programmes for improving their coping skills in dealing with stressful work situations. There are serious consequences of compassion fatigue on both the psychotherapists and the clients. It is therefore important for organisations to focus on retaining psychotherapists through attention to their psychological welfare, training, and management and to appropriate job design to reduce many of the known risk factors like heavy case load.

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