

Relationship between Self-care Practices and Vicarious Posttraumatic Growth among
Counsellors in Nairobi County, Kenya

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DECLARATION

I, the undersigned do declare that this research report is my original work and it is not as a result of some collaborative effort. It has not been previously presented to any other institution. The sources used in the document have been appropriately cited and duly acknowledged in full.

I do agree that the research document could be accessible for references and duplicating at the will of the University

Student: Joyce Waweru 20/00923

Signature

Date.....

We hereby certify that this research project is original piece of work, and fulfils all the requirements.

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Signature

Date.....

DEDICATION

This research is devoted to my sons: Austin and Alvin. What I owe you is my best effort to be a person worth emulating. Thanks for continually shaping me and helping me grow. I also dedicate this study to my family for inspiration and believing in my dreams.

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ABSTRACT

Vicarious posttraumatic growth in the counselling professionals remains an attractive aspect of research and practice because it influences the quality of services that counsellors deliver. Self-care practices have been fronted to enable counsellors achieve vicarious posttraumatic growth. However, there is paucity of empirical research on the relationship between self-care practices and vicarious posttraumatic growth. The objective of this study was to examine the relationship between Self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County. Theories underpinning the study included Linley and Josephs' organismic valuing theory and Orem's theory of self-care. The study was quantitative, and adopted a correlational survey design. A proportionate sample size of 306 participants was determined using Yamane's formulae, providing for 10% attrition. Data was collected using two standardized scales: the Self-Care Assessment Worksheet and the vicarious posttraumatic growth inventory. Data collected was coded and entered into the SPSS version 25 to generate frequencies, percentages, means, standards deviations, Pearson's correlation coefficients, and significance values. In regard to objective one, the results showed those whose self-care practices were balanced was at 48% as opposed to imbalanced at 52%, this shows lower levels of self-care practices. On second objective, findings indicated high level of VPTG among respondents slightly higher at 52.5% compared to moderate and low levels, indicating a higher number of counsellors had experienced VPTG in their work. Regarding third objective, an overall two-tailed test showed there is a significant relationship between self-care practices and vicarious posttraumatic growth among the respondents. Predictive relationship established that practicing balanced self-care had a 1.73 times likelihood to experiencing higher levels of VPTG. The study made recommendations on how to achieve balanced self-care practices to optimize VPTG. Further recommendations were made for policies that provide for active participation of counselling professionals in essential self-care practices to accelerate their posttraumatic growth.

TABLE OF CONTENTS

DECLARATION	i
DEDICATION.....	ii
ACKNOWLEDGEMENTS.....	iii
ABSTRACT	iv
LIST OF TABLES	ix
LIST OF FIGURES	x
OPERATIONAL DEFINITION OF TERMS	xi
ABBREVIATIONS AND ACRONYMS	xii
OPERATIONALIZATION OF CONCEPTUAL VARIABLES	xiii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction.....	1
1.2 Background to the study.....	1
1.3 Statement of the Problem	5
1.3 Purpose of the study	7
1.4 Research Objectives	7
1.4.1 General Objective.....	7
1.4.2 Specific Objectives.....	7
1.5 Research Questions	8
1.5.1 Central Question.....	8
1.5.2 Associated Questions.....	8
1.6 Research hypothesis	8
1.7 Significance of the Study.....	9
1.8 Scope and Delimitation of the Study.....	10
1.9 Assumptions of the Study.....	10

1.10 Chapter Summary.....	11
CHAPTER TWO: LITERATURE REVIEW.....	12
2.1 Introduction.....	12
2.2 Theoretical Framework	12
2.2.1 Linley and Joseph’s Organismic Valuing Theory.....	12
2.2.2 Orem’s Theory of Self-Care	14
2.3 Empirical Literature Review	15
2.3.1 Levels of Self-Care Practices among Counsellors	16
2.3.2 Levels of Vicarious Post Traumatic Growth among Counsellors.....	23
2.3.3 Relationship between Self-Care Practices and Vicarious Posttraumatic Growth among Counsellors.....	30
2.4 Conceptual Framework	33
2.5 Chapter Summary.....	34
CHAPTER THREE: RESEARCH METHODOLOGY.....	35
3.1 Introduction.....	35
3.2 Epistemology	35
3.3 Research Design.....	36
3.4 Location of the Study	36
3.5 Target Population	37
3.6 Sampling Design	37
3.6.1 Sampling Frame	38
3.6.2 Sampling Technique.....	38
3.6.3 Sample Size Determination	39
3.7 Research Instruments	40
3.8 Pre-testing of Instruments.....	42

3.8.1 Validity	42
3.8.2 Reliability	43
3.9 Data Collection Procedures	44
3.10 Data Analysis	44
3.11 Ethical Considerations	46
3.12 Chapter Summary	47
CHAPTER FOUR: RESULTS	48
4.1 Introduction.....	48
4.2 Response Rate.....	48
4.3 Reliability of the Scales	49
4.4 Participants' Socio-demographic Characteristics	50
4.5 Level of Self-care Practices among Counsellors in Nairobi County	51
4.6 Levels of Vicarious Posttraumatic Growth among counsellors.....	56
4.9 Relationship between Self-Care Practices and Vicarious Posttraumatic Growth.....	59
4.10. Limitations of the Study	63
4.11 Chapter Summary.....	64
CHAPTER FIVE: DISCUSSION.....	65
5.1 Introduction.....	65
5.2 Demographic Characteristics	65
5.3 Level of Self-Care Practices Among Counsellors in Nairobi County	66
5.4 Level of Vicarious Posttraumatic Growth Among Counsellors in Nairobi County	69
5.5 Relationship Between Self-Care Practices and Vicarious Posttraumatic Growth among counsellors in Nairobi County	72
5.6 Re-visiting Conceptual Framework	75
5.7 Chapter Summary.....	77

CHAPTER SIX: SUMMARY, CONCLUSION, AND RECOMMENDATIONS	78
6.1 Introduction.....	78
6.2 Summary.....	78
6.3 Conclusion	80
6.4 Recommendations	81
6.5 Recommendations for Further Research	83
6.6 Chapter Summary.....	84
REFERENCES	85
APPENDIX A: Introduction letter.....	96
APPENDIX B: Participant Consent Form	97
APPENDIX C: Questionnaire for participants	98
APPENDIX D: Request for permission to Use VPTG Scales	103
APPENDIX E: Scoring of scales	104
APPENDIX F: Debrief form	105
APPENDIX G: Tangaza University Research Permit	106
APPENDIX H: Tangaza University Ethics Clearance.....	107
APPENDIX I: Permission to Conduct Research in KCPA	108
APPENDIX J: NACOSTI Research License	109
APPENDIX K: Map of Nairobi county	110
APPENDIX L Plagiarism report	115

LIST OF TABLES

Table 1: Target Population	38
Table 2: Proportionate distribution of the participants to the seven registration statuses	40
Table 3: Number of Items in Each Area of the Self-Care Assessment Worksheet	41
Table 4: Data analysis	45
Table 5: Response Rate	48
Table 6: Participants Sociodemographic Characteristics	50
Table 7: Frequency of balanced and imbalanced self-care practices.....	53
Table 8: Levels of self-care practices.....	54
Table 9: Levels of self-care practices in relation to demographic characteristics	54
Table 10: Classification of VPTG levels among respondents	57
Table 11: Levels of VPTG in relation to Demographic Characteristics	57
Table 12: Relationship between self-care practices and VPTG.	59
Table 13: Coefficient test of linear relationship between self-care relationship and vicarious posttraumatic growth.....	60
Table 14: Two tail test between self-care practices and VPTG.....	62
Table 15: Binary Logistic regression testing the predictability of balanced self-care practices and VPTG.....	62

LIST OF FIGURES

Figure 1: Relationship between self-care practices and vicarious post traumatic growth.	33
Figure 2: Total Scores for self-care practices among counselors	52
Figure 3: Total of self-care practices	52
Figure 4: Totals of VPTG among respondents	56
Figure 5: Relationship between total self-care practices and total VPTG	59
Figure 6: The logistic regression showing the relationship between practicing balanced self-care and higher level of VPTG.	63
Figure 7: Relationship between self-care practices and vicarious post traumatic growth.	76

OPERATIONAL DEFINITION OF TERMS

Self-care	An individual's ability to take care of self to be healthy and well, do their job, and care for others. Self-care determines counselors' ability to promote health and cope with counselling challenge.
Self-care practices	They include intentional steps that professionals undertake as part of taking care of self.
Counsellors	Professionals that work with clients experiencing a wide range of emotional and psychological difficulties. The task of counsellors is to help the clients undergo effective change and enhance their wellbeing.
Posttraumatic growth	Positive psychological change that results from a struggle with traumatic or extremely challenging circumstances in a person's life.
Vicarious posttraumatic growth	The experience of growth that results from an individual's indirect exposure to trauma.

ABBREVIATIONS AND ACRONYMS

ACA:	The American Counseling Association
APA:	The American Psychological Association
KCPA:	The Kenya Counseling and Psychological Association
PTG:	Posttraumatic Growth
PTSD:	Posttraumatic Stress Disorder
SPSS:	Statistical Package for Social Sciences
VPTG:	Vicarious Posttraumatic Growth
VT:	Vicarious Traumatization

OPERATIONALIZATION OF CONCEPTUAL VARIABLES

Self-care practices: In this study the concept was used to refer to activities professionals engage in to promote their wellbeing. The researcher used Self-care Assessment worksheet a scale published to measure activities indicative of self-care behaviors on dimensions such as physical, psychological, emotional, spiritual and professional self-care. As a multidimensional tool for assessing self-care, the SCAW seeks to gauge six dimensions, with each dimension having a different number of items: physical care (15 items), psychological care (13 items), emotional care (11 items), spiritual care (17 items), workplace self-care (12 items), and balance (2 items). The SCAW scales are gauged on a five-point Likert scale and are scored using five real numbers, which are 1-it never occurs, 2-never, 3-rarely, 4-occasionally, and 5-frequently. After rating the dimensions of the scale, the scores for all 70 items are summed up. The highest score is 350 while the minimum possible score is 70.

Vicarious posttraumatic growth: This refers to the experience of growth as a result of working with clients who have been exposed to trauma. In this study posttraumatic growth inventory, a 21 item Likert scale developed by Tedeschi and Calhoun (1996) was used to measure the indicators of growth among the counsellors. This scale measures five distinct forms of growth: relating to others, identifying new possibilities, personal strength, spiritual change, and appreciation of life. Participants rate the extent to which they have experienced the growth described in each item on a 6-point Likert scale, and scores can range from 0 to 105. It has been argued that scores below 60 indicate a low level of growth, scores between 60-79 indicate a moderate level of growth, and scores 80 or above indicate a high level of growth.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

The study explored the relationship between self-care practices and vicarious post-traumatic growth among counsellors. This first chapter provides an introductory background to the study. It highlights the problem under research focus, the purpose and objectives, hypothesis, significance and assumptions that guided the research. The scope and delimitations that set the boundaries within which the researcher carried out the study are also highlighted.

1.2 Background to the study

One of the most significant developments of the second half of the twentieth century is the field of counseling. Although counselors have helped people to transform their lives, the profession has been recognized as both challenging and rewarding (Skovholt, 2016). Their daily activities involve working closely with individuals presenting with psychological distress and suffering from various mental health disorders. The work relies upon relational and emotional capacities that are drawn upon during therapy sessions. Increasingly, researchers and clinicians have directed their attention toward examining the emotional toll that psychotherapy may impose upon mental health professionals and the impact of such work on the quality of their professional life (Laverdière et al., 2019).

According to De Vries and Olf (2009), as much as 80% of the general population will experience a traumatic event in their lifetime. As such, between 82% and 94% of clients seeking therapy are estimated to have experienced at least one trauma in their lifetime, while between 31% and 42% report symptoms of posttraumatic stress. Mental health practitioners are most likely to come into contact with persons who have experienced at least one traumatic event. Psychotherapy can be emotionally charged, intense and involves the therapists' empathic

engagement in the pain of their client. According to Helm (2010), therapists may find it challenging to maintain professional distance when exposed to the potent content of their clients' traumatic experiences, despite having been taught the principles of psychotherapy, which include the importance of professional boundaries

Mental health counselors are at danger of getting vicarious or secondary trauma because to the number of traumatic experiences they are exposed to. Williams, Helm, and Clemens indeed contend thus: “the incidence of trauma in the United States has become immense and pervasive, [and] mental health counselors are inevitably indirectly exposed to demoralizing stories of trauma, disempowerment, and abuse” (2012: p 133). Working frequently with individuals experiencing undue turmoil in their lives can negatively affect counselors, particularly those not adequately engaged in self-care practices and techniques. Several terms are used in reference to the indirect exposure to trauma including “vicarious traumatization”, “secondary trauma stress”, “compassion fatigue” and “burnout”. Such terms describe the negative impacts of indirect traumatic exposure on the health and well-being of health-care professionals. In a survey of 339 psychotherapists, Aafjes-van Doorn, K., et al. (2020) found that, respondents who took the Vicarious Trauma Survey (VTS), majority reported feeling more tired, about one-third felt less competent in their professional skills, and half said they were less able to emotionally connect with their clients, compared to before the pandemic. Overall, nearly 63% of those surveyed reported moderate levels of vicarious trauma.

More than 20 years of research have established the reality of vicarious trauma, but the body of work on the positive impact, known as vicarious post-traumatic growth, is relatively small. In adopting the positive psychology perspective, there is a growing body of evidence testifying to the positive psychological changes that can result from people’s struggle with stressful and traumatic experiences. Helping professionals describe growth as a change in worldview, being more expressive emotionally in personal relationships with a newfound

purpose and meaning to the trauma work (Bartoskova, 2017). More than 70% of trauma counselors describe a positive reaction to their traumatic exposure, such as living life more fully, treating others differently and with more kindness and being more expressive emotionally in their own personal lives.

The studies of Secondary Posttraumatic growth are based on the main posttraumatic growth studies. Relationship development, openness to new experiences, inner fortitude, spiritual evolution, and life appreciation are the five domains of development highlighted by Tedeschi et al. (2018) following traumatic events. As a result of their posttraumatic healing, people who have survived traumatic experiences often gain a greater appreciation for life and a deeper sense of significance in their interpersonal interactions. Similarly, self-confidence is defined as having faith in one's own talents. Recognizing the good change an individual has experienced through an existential lens is central to the spirituality area.

Just as in the case of the posttraumatic growth (PTG) experienced by victims of trauma, a study in South Africa by Manning Jones et al. (2017) observed that working with trauma victims, increased practical wisdom, benevolence, self-worth, acceptance of others and faith in and appreciation of the activities they undertake. Counselors are likely to change life goals and perspectives, client-inspired hope, increase self-awareness, resourcefulness and presence during their work. Over seventy percent of trauma counselors in a research by Arnold et al. (2005) had positive reactions, including engaging in life more completely, being kinder to others, and being more emotionally expressive in their personal lives. Psychotherapists involved in the latter study were able to identify positive consequences of their work including witnessing clients' growth, greater personal strength, positive character changes, spiritual growth and enhanced appreciation of their own good fortune. These changes were consistent with the posttraumatic growth often experienced by direct trauma survivors, hence validating the claim that participants were exhibiting a vicarious form of posttraumatic growth.

The field of positive psychology and preventive medicine are flourishing, and with them comes the advocacy of self-care as a means of mitigating the damaging effects of stress on one's personal and professional life. Self-care behavior is recognized as an important component for the helping professionals who practice in the field of counseling or training to become a helping professional. Practicing self-care may help prevent or lower the levels of stress and burnout that can befall professionals who work in the field of counseling (Zellmer, 2004).

The British Association of counseling and psychotherapy describe self-care as: an ongoing process of caring for oneself; making a conscious effort to do things that maintain, improve and repair mental, emotional, physical and spiritual wellness (2018). The World Health Organization (WHO) definition states that self-care refers to activities individuals undertake with the intention of enhancing health, working toward preventing disease, limiting illness and restoring health that will be beneficial to the individuals in their personal as well as their professional lives (ASMI, 2009). Self-care in addition refers not only to an engagement in various practices but also to the development of a caring attitude even to oneself (Kissil & Niño, 2017). According to Colman et al. (2016), self-care is not a luxury, but a clinical and ethical imperative in the mental health professions and is thus important in the understanding of one's potential effectiveness of various forms of self-care practices. Self-care has been associated with greater well-being, higher levels of positive affect, flourishing, and clinical performance, compassion satisfaction and quality of life.

The subject of self-care has however received relatively scanty attention in available documentation, having been subsumed under the rubric of social support and active and avoidant coping strategies. Harrison and Westwood (2009) have, for example, categorized self-care strategies among mental health therapists into six domains. The physical domain covers healthy eating and exercise, while the mental (embrace continued education and mindful

awareness), emotional -personal therapy and trusting relationships, spiritual - meditation, meaning and purpose in life), aesthetic -noting beauty in life, and finally work-life balance – covers maintaining a healthy equilibrium. Zahniser et al. (2017) contends that overall, engagement in career-sustaining behaviours is linked to a greater sense of personal accomplishment and a lesser tendency to depersonalize clients. In fact, experienced mental health practitioners, or those who might be called master therapists, refer to self-care as a key aspect of professional functioning. Self-care strategies have been reported to protect against STS, burnout and mental illness, as well as enhance the likelihood of VPTG.

Although the lack of comprehensive research on psychotherapists' self-care is, in many ways, explicable, it is nonetheless troubling, as Norcross (2000) pointed out. The frank examination of professional counselors' well-being is needed in the context of a continuously evolving and ever-challenging mental health service business. In the context of a rapidly changing and an ever-challenging mental health service industry, the unflinching discussion of the well-being of professional counselors is warranted. While international studies yield results on the relationship between self-care and positive changes within counsellors, there are no available studies that have investigated this relationship among Kenyan counsellors. It is on this premise that the researcher seeks to undertake a study to establish the extent to which a significant relationship exists between self-care practices and VPTG among counsellors in this country. An increased awareness of these relational aspects could guide future trainings and support for promoting this vital mental health resource.

1.3 Statement of the Problem

Counsellors and psychologists' daily activities involve working closely with individuals presenting with psychological distress and suffering from various mental disorders. This work relies upon relational and emotional capacities drawn upon during therapy sessions.

Increasingly, researchers and clinicians have directed their attention toward examining the emotional toll that psychotherapy may impose on mental health professionals and the nature of the impact of such work on the quality of their professional lives (Molnar et, al., 2017). Counselors, as pointed out by Norcross and VandenBos (2018), are tasked with helping their clients develop and evolve. Unfortunately, there is a lack of research that documents how counselors' own mental health improves as a result of their work to improve the mental health of their clients. Counselors should be sure to answer this important question.

It is likely that routine exposure to traumagenic material can be linked to overall decreased well-being, reduced physical and mental health, as well as impaired intimate relationships (Rizkalla & Segal, 2019). Counsellors' compromised well-being can in turn unknowingly impede the quality of therapeutic relationships, service provision and therapeutic outcomes (Delgadillo et al., 2018). Their well-being is an important aspect of the counseling service which influences the effectiveness of the therapeutic relationship, accelerates the therapeutic process, directly impacts treatment effectiveness and client well-being and certainly promotes and enhances professional competency. Thus, it seems obvious that cultivating the psychological well-being of counselors is essential. The well-being of the therapist has raised recent interest among researchers.

In Nairobi County, the population experiences myriads of traumatic occurrences such as bereavement, domestic violence and sexual abuse, terror attacks, political and economic crisis, as well as natural disasters. In such situations, counsellors are called upon to provide trauma counseling. They share the emotional burden of trauma, listen to tales of human suffering and observe emotions of fear, helplessness and horror registered by trauma victims. They are expected to be empathic, understanding and compassionate yet they must also control their emotional needs and responsiveness in dealing with their clients.

Miller & Sprang (2017) observed that while helping clients move towards well-being, practitioners can often overlook their own needs. As a result, engaging in self-care can often be found at the end of a practitioner's to-do list hence indicating that it is not viewed as priority issue. A few studies describe self-care and social support networks as important factors in preventing and alleviating vicarious trauma.

Despite its immense importance in the welfare of helpers, counselors, among others, researchers and psychologists in Nairobi County grant self-care relatively little attention. Yet, the value of empirical research focused primarily on the area of and role of self-care cannot be under estimated. Nairobi County is one of the most populace Kenyan Counties with a relatively higher number of counselors handling a myriad of cases of traumatic nature. It is these important gaps that the study sought to fill by exhaustively examining self-care practices among counselors within the target County, and the extent to which they act as predictors of vicarious post traumatic growth.

1.3 Purpose of the study

The purpose of the study was to examine the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County, Kenya.

1.4 Research Objectives

This study was guided by one general objective and three specific objectives.

1.4.1 General Objective

The objective of this study was to examine the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County, Kenya.

1.4.2 Specific Objectives

- i. To investigate the level of self-care practices among counsellors in Nairobi County.

- ii. To measure the level of vicarious posttraumatic growth among counsellors in Nairobi County.
- iii. To examine the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County.

1.5 Research Questions

Research question is a clear, focused, concise, complex and arguable question around which the researcher centers the research. This study was based on one central and two associated research questions.

1.5.1 Central Question

What is the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County?

1.5.2 Associated Questions

- i. What are the levels of self-care practices among counsellors in Nairobi County?
- ii. What is the level of vicarious posttraumatic growth among counsellors in Nairobi County?
- iii. Is there a relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County?

1.6 Research hypothesis

A hypothesis is a tentative answer to what the researcher considers as ought to be possible outcome. This study involved testing the following hypothesis:

H₀: There is no significant relationship between self-care practices and vicarious post traumatic growth among counsellors in Nairobi County.

H₁: There is a significant relationship between counselors' self-care practices and their vicarious post traumatic growth among counsellors in Nairobi County.

1.7 Significance of the Study

A research study's significance refers to its unique contributions and describes how specific people will gain from its findings. It can be significant in numerous ways to policy makers, industry, researchers, training institutions, psychologists, among others. The proposed study's findings will make valuable contribution to the following;

Counseling professionals/practitioners: the study will provide health professionals with a comprehensive synthesis of literature relating to levels of Self-care practices and VPTG among counsellors; this may have practical implications as to how they can further facilitate VPTG in their workplace.

Counselling discipline/industry: the study findings can contribute and enrich the body of empirical research knowledge on the constructs related to development of vicarious posttraumatic growth among trauma counselors. In this way, the proposed study is likely to be a key reference point for scholars and researchers with interest in the same and other related areas.

Counsellor training/educational institutions: a better understanding of how mental health providers can experience positive growth in the course of their professional work with trauma clients is useful for informing graduate education curricula and postgraduate professionals' continuing education courses that not only raise awareness, but also serve to emphasize self-care practices among counselors. Another important contribution is that of enhancing formulation and use of theories in explaining self-care practices among counsellors.

Policy makers: the findings can inform the formulation of policies touching, for example, on the promotion of self-care practices to facilitate vicarious posttraumatic growth among counsellors.

1.8 Scope and Delimitation of the Study

Scope refers to the disciplinary boundaries under which research is planned to be conducted, while *delimitation* involves the researcher's choices in terms of demarcating the perimeters within which the study will be conducted (Sahaya, 2017). A research study's *delimitations* describe the characteristics arising from the scope limitations and by the conscious exclusionary and inclusionary decisions made during the development of the study plan.

The scope of the proposed study was to determine the relationship between self-care and vicarious posttraumatic growth among counsellors in Nairobi County. The study only determined the prevalence of VPTG, and extent of self-care practices. The researcher has chosen Nairobi County as it has more counsellors registered by Kenya Counselors and Psychologists Association (KCPA 2017) than other Kenyan Counties.

The proposed study delimits involvement of counsellors within the profession who are not fully registered with the Kenya Counsellors and Psychological Association. This is based on assumptions that they may not be practicing under regulations of the Kenyan body of association. It will be also difficult to ascertain their practice ethics as they may not be monitored by a regulatory body.

1.9 Assumptions of the Study

According to Maina (2015), *research assumptions* refer to essential but unverified facts that are assumed to be true. In this specific proposed study therefore, the investigator presumes that the participating counselors will:

1. have attended to clients presenting with traumatic issues;

2. constitute a representative sample of counselors working with trauma clients in Nairobi County;
3. interact with the data collection instruments in an honest and candid manner, and,
4. have the identical or similar experiences concerning trauma.

1.10 Chapter Summary

This introductory chapter has made reference to literature on the relationship between self care practices and vicarious posttraumatic growth among counsellors globally, nationally and regionally in the background of the study. It has defined the purpose of the proposed study, its objectives, research questions, hypothesis, scope and delimitations, as well as the significance and researcher's assumptions. In the following chapter, the researcher reviews available documentation of empirical research , theories and policies relevant to the proposed study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter is structured into three main parts. The first discusses the theories that underpin the theoretical framework; the second consists of an extensive review of relevant empirical literature review based on the study's objectives and lastly conceptual framework. The section will also highlight the gaps within literature that the study sought to address.

2.2 Theoretical Framework

According to Hofferth and Moon (2011), theories as conceptual lenses through which researchers, scholars or policy makers view and understand the world, how decisions are made and humans ultimately govern themselves. Linley and Josephs' organismic valuing theory and Orem's theory of self-care will both guide the proposed research.

2.2.1 Linley and Joseph's Organismic Valuing Theory

Organismic Valuing Theory (Joseph & Linley, 2005, 2008) is an integrative framework of posttraumatic growth grounded in an existential, humanistic and person-centred philosophy. It is governed by the fundamental premise that human beings are constantly striving towards higher levels of psychological functioning. According to this theory, humans have an innate ability to *recognize* what can significantly enhance their wellbeing. People constantly evaluate their experience, which motivates them to take action when they sense that it is not fulfilling their needs. According to Joseph and Linley (2008), the theory, when applied to one's cognitive experience following a traumatic event, can explain why some people appear unaffected and others negatively affected by the incidence, yet a third group demonstrates positive posttraumatic growth.

Similar to the Cognitive processing theory, Tedeschi and Calhoun (2014) argued that organismic valuing theory begins with the assumption that every individual has a specific view of oneself and the world around one. This notwithstanding, a traumatic event can shatter these perceptions (Joseph & Linley, 2005; 2008). Should this happen, individuals are likely to experience symptoms of distress such as, avoidance and intrusive thoughts, which indicate the need for the event to be cognitively processed. At this point, one of three possible outcomes can occur. Firstly, one takes the easiest and most common course of action to allow one to move on quickly from the traumatic event (Joseph & Linley, 2008) by assimilating the traumatic event into one's existing schemas. Hence, individuals shape information about the traumatic event to fit their own existing beliefs.

Joseph and Linley (2008), however, opine that the event also leaves the person vulnerable to future posttraumatic distress. A second outcome can take the form of negative accommodation of the experience. In this case, individuals change their beliefs about self and the world negatively in order to account for the traumatic event. As a result, the individual develops feelings of helplessness and hopelessness. The third outcome likely to take place might involve a third group of individuals likely to change their beliefs about self and the world in a positive manner, hence accommodating the event in a way that benefits one. The result is a positive change to one's relationships, self-perceptions, life philosophy and enhancement of one's psychological well-being. It is this (third) outcome that defines the posttraumatic growth phenomenon.

Whether someone assimilates, negatively accommodates or positively accommodates trauma information is influenced by one's social environment, personality, previous traumatic history and the way one might have previously processed past traumatic events. The Organismic valuing theory thus offers an explanation why the outcomes of two individuals' similar traumatic events can be so different.

The cumulative and transforming effects of working with traumatic incidents survivors could lead to cognitive shifts with pervasive effects on therapists' cognitive schemas, such as identity, world view, beliefs and psychological needs (Tedeschi & Calhoun, 2014). Enhancement of the professional through deployment of self-care practices can potentially decrease the risk of vicarious trauma, and in turn improve the therapeutic relationship and treatment outcomes. The examination of therapists' responses to treating survivor clients is however, relatively new with ongoing efforts to address the deleterious effects of vicarious trauma and the value of integrating self-care practices.

2.2.2 Orem's Theory of Self-Care

Orem's theory postulates that self-care solely focuses on the undertakings instigated and executed by persons (for example, therapists) for their own well-being preservation. Orem (2001) defines self-care practices as activities that have to be initiated by the individual in order to sustain the wellbeing of self. Active self-care practice sustains human development and functioning. Such behaviours are learnt, and not only focus on requirements, but also generate stability amidst stressors, day-by-day undertakings, relaxation and time-out. Additionally, practicing self-care activities promote and preserve human life, functioning and well-being. The theory of self-care is applied among the nurses and clinicians within the counselling landscape to enhance growth as clinicians. However significant related theoretical aspects can relate to counsellors and in the view of this investigator to the proposed study. By relating Orem's theory to this study, the researcher attempts to emphasize and explain the importance of self-care among counselors by impressing on them the need to practice self-care. Dorsey and Murdaugh (2003) defined self-care management as engaging in specific therapeutic behaviours and implementing social activities to access resources and improve health status and quality of life.

According to Orem (2001), there are both internal and external orientations of self-care. The internally-oriented self-care practices tend to regulate one's feelings and thoughts thereby regulating internal factors or one's external alignments. Hence the external and the internal orientations have to operate together for the well-being of the counsellor. Thus, thoughtful self-care undertakings have to be conducted for the sustenance of the counselors' well-being. Externally oriented self-care "is the deliberate action performed by an individual that involves interactions with others or the environment" (Banfield, 2011, p. 101). Several self-care requisites including maintaining bowel movement, balancing activity and rest, food, water, air, among others should, according to Orem (2001), be carried out in order to complete the self-care acts. Well-performed self-care practices contribute to the development of the person and maintain human functioning. People can learn self-care activities through family and friends. Although self-care theory is a nursing theory it will be applied in the current study to highlight the importance of self-care practices to enhance the quality of life for counsellors. Management of self is an essential aspect to providers of health services as it enables them to provide the desired therapeutic behaviour.

Organismic Valuing Theory and Orem's theory of self-care provides a basis for explaining how self-care works to promote counselors' vicarious posttraumatic growth. The theories support the notion that counsellors who adopt self-care practices suggested by Orem will achieve improved growth despite the exposure to traumatic situations. The theories are relevant to the study because they attempt to explain the operation of self-care and vicarious posttraumatic growth.

2.3 Empirical Literature Review

This sub-section reviews available documentation of relevant empirical research beginning with self-care, followed by vicarious posttraumatic growth and the final subsection examines the potential relationship between these two variables.

2.3.1 Levels of Self-Care Practices among Counsellors

Since Dorothea Orem first introduced the self-care theory to the academic canon, self-care routines have been the subject of much study. Existing self-care definitions take a health-oriented or clinical approach. Based on the World Health Organization (2021, p.43), self-care involves “the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker”. The scope of self-care includes “health promotion, disease prevention and control, self-medication, giving care to dependent people, seeking hospital, specialist or primary care when needed, and rehabilitation, including palliative care” (WHO, 2021, p. 43). Similarly, Eva et al. (2018), defined self-care as the practice of engaging in activities related to health and the utilization of behaviours that promote health for the purpose of enhancing well-being and acquiring a better lifestyle.

The proposed study however adopts the definition of Bradley et al. (2013), which describe self-care as behaviours or experiences that stimulate improvement and sustainability of the counsellors by promoting good health and general wellbeing. Clearly from these definitions, self-care encompasses mental, emotional, physical, psychological and even spiritual well-being – variables no Studies have examined the levels of self-care practices among counselors, with results showing that counselors have a wide range of self-care practices and beliefs about its importance. The research has found that self-care practices are important in helping counselors manage the stress that is commonly associated with their jobs, as well as to promote a healthy lifestyle and lifestyle balance.

The emotional connection between patients and counselors has been known to cause a degree of stress, having an effective self-care practice can help counselors better understand the importance of self-care and how it can help them in their jobs. A systematic review of the literature by Hildebrandt et al. (2020) found that good self-care practices are associated with

improved mental health among counselors. This finding is supported by a study by Nguyen et al. (2020) which found that counselors who engaged in self-care practices were more likely to have better mental health, lower stress levels, and overall better job satisfaction. The same study showed that older or more experienced counselors also had better self-care practices than their younger counterparts. In addition to the mental health benefits associated with self-care, other studies have also found that it can help counselors develop better relationships with their patients.

A study by Jubrail et al. (2020) found that self-care practice helped counselors be more in-tune and present with their clients, providing them with better emotional support and healing. Moreover, self-care practices can help counselors maintain their professional boundaries. Researchers Al-Hawsawi et al. (2020) discovered that counselors who practiced self-care were better able to maintain boundaries with their clients such as avoiding dual relationships and managing feelings of burnout and emotional exhaustion.

Another benefit of self-care practice is the ability to help counselors better manage their time and energy. Jones and Hall's (2020) research indicated that counselors who practiced self-care were more resilient and better capable of dealing with the demands from their job more effectively. Furthermore, this study showed that self-care practices can help counselors better manage their work-life balance and free up time for rest, recreation, and leisure activities.

Since therapists rely heavily on themselves as their most important therapeutic tools, this intentional and proactive promotional act of good health and general well-being is paramount in their work with clients. Coaston (2017) acknowledged the need to develop an attitude of self-compassion and mindfulness in the context of a self-care plan to create space for an authentic, kind response to the challenges inherent in counseling. Thus, self-care is undeniably crucial in the counselor's professional and personal life, and the lack of it can

potentially cause harm to, for example, a therapist (Coaston, 2017). The significance of self-care among the counselling professionals has been studied by several researchers, including Thomas and Morris (2017), Andrews et al. (2020), and Şimşir Gökçalp (2022). Thomas and Morris (2017) identified that creative self-care provides a therapeutic value in the process of creating, increasing awareness, externalizing the problem, and symbolic containment of the problem.

Despite the study by Thomas and Morris lacking an empirical grounding, the authors developed a seven-part model for creative self-care that focuses on adoption of nourishing activities, planning for self-care, and consistently evaluating progress. Andrews et al. (2020), found that self-care enhances counsellors' performance and ensure long-term mental stability rather than being consumed by compassion fatigue. Şimşir Gökçalp's (2022) qualitative study of Turkish school counsellors revealed that self-care activities lead to improved wellness and school productivity.

Recent research has extensively analyzed ways and approaches to self-care among counsellors. Jie et al. (2021) examined the relationship between burnout, resilience, and self-care among a random sample of 96 marriage and family counsellors in Malaysia; the findings revealed significant relationships between the constructs in which burnout was negatively correlated to both resilience and self-care but self-care was positively correlated with self-care. Although Jie et al. (2021) had arrived at robust findings about the centrality of self-care among counsellors, the study did not include the aspect of practices that is key in the current study. Moreover, the study was contextualized in Malaysia, whose contextual realities may be dissimilar to the Kenyan dynamics, implying that its findings cannot be readily generalized to the Kenyan context. Despite the limitation, a sample size of 96 counsellors and statistical processes that the study applied helped to generated robust findings that emphasized the need

to enhance marriage and family counselors' personal and professional development by paying attention to burnout, resilience, and self-care.

Şimşir Gökalp (2022) was inspired to conduct a qualitative investigation of school counselors in Turkey's perspectives on self-care because of the impact it has on their ability to maintain their professional vigor and flourish. The study revealed that engaging in activities that boost self-care practices and actively addressing barriers to self-care increases the benefits of self-care among family counsellors. However, the study was limited to school counsellors and based on the Turkish context. Moreover, a small sample size of fifteen licensed school counsellors limits the global generalization of the study findings. Nevertheless, Şimşir Gökalp (2022) suggested the need for future researchers replicating the topic to other contexts using quantitative research methods that permit inclusion of large samples to validate the study findings.

The results of a short, in-depth study (n = 3 participants) by Baker and Gabriel (2021) also emphasized the importance of promoting and encouraging practitioner participation in self-care activities during the pre-service and in-service phases of their careers. Consistent with the assertion by Jie et al. (2021) the researchers acknowledge the necessity of adopting a preventative and proactive approach to self-care to minimize the prevalence and possibility of burnout and emotional exhaustion. Counselors' intentionality and personal responsibility are central in the self-care because they have control of their emotional and physical wellbeing; hence, they can make informed decisions about being well enough to work.

Patsiopoulos and Buchanan (2011) conducted a qualitative narrative inquiry study to explore this construct. They sought to answer the research question relating to how experienced counselors practice self-compassion. The study participants had a minimum of six years of counseling experience and should have already identified self-compassion as an important

aspect of their professional growth. One noteworthy finding of the research was that self-care strategies could be performed without attention to self-compassion. With these participants, Self-compassion however enabled these participants to nourish themselves, practise self-care regularly, as well as develop work-life balance. The study revealed that most study participants referred to their self-care plans as means of maintaining balance. In addition to ensuring that leisure time was a most common aspect of self-care, the participants also identified the need for solitary time, but also time with spouses, family members, friends and community members.

Others identified self-care strategies including: getting enough sleep, healthy/nutritious eating, regular exercise, yoga, meditation, massage, time in nature, creative projects, helpful attitudes (such as enjoying successes and allowing themselves to cry when needed), humor, personal therapy, complementary healing practices, and spiritual/religious practices. However, the study was based on a Canadian context and limited to only fifteen White counsellors, meaning that the findings are not readily generalizable to the global context.

The importance of clinical mental health professionals understanding the potential effectiveness of various forms of self-care practices cannot be underrated. Pakenham's (2017) study sought to investigate the effects on self-care in CPTs of an acceptance and commitment therapy (ACT) university course with an explicit focus on self-care skills in addition to ACT competencies. The study used the Self Care Assessment Worksheet (SCAW) model to determine the self-care actions of mental health practitioners. Findings from the study confirmed a range of self-care practices that span four domains of self-care, including physical, psychological, emotional, spiritual, professional and balance. To begin with, physical self-care incorporates the "physical activity such as exercise, sports, and household activities. Its benefits have been extensively covered in literature particularly in regard to emotional well-being and the practice of regular physical activity. Research findings from the study by VanKim and

Nelson (2013) showed that regular physical activity reduces stress, anxiety and depression in adults. However, VanKim and Nelson based their study on a sample of 94 undergraduate students in the United States, implying a contextual gap because the study was neither based on the Kenyan context nor focused on the counsellors.

Psychological self-care denotes working on ways to be mentally healthy such as practicing mindfulness, going for therapy, or reading a book (Brownlee, 2016). This term refers to one's own personal therapy (psychological treatment, in any form) for psychological distress or impairment experienced. Research indicates an important connection between emotions and health (Cloitre et al., 2019). Hence, practicing emotional self-care is important to both mental and physical health. Negative patterns of cognition related to poor emotional adjustment; include overwhelming helplessness, negative self-talk, self-blame, and a crisis of confidence (Robinson et al., 2019).

In spiritual self-care, individuals search for a deeper meaning of life and its connection to a higher power. The constructs of religiousness and spirituality are viewed by some as interchangeable and by others as two clearly distinct concepts (Pargament, 2007). However, religiousness is a core subset of spirituality because religious people are inherently spiritual. Roysircar, (2008) observes social self-care as one's regular involvement in relationships outside of nuclear and extended family networks. It pertains to establishing, nurturing, and maintaining social networks and friendships through community involvement and group affiliation.

Research Barnes et al. (2020) showed that a person's overall health is positively impacted upon by daily nurturing interactions with family members. Workplace or professional self-care could involve the therapist engaging in supervision, peer groups and limiting their commitments at work (Thériault et al., 2015; Thompson et al., 2012). The final aspect of the

SCAW Model is Balance, which is its own tenant of self-care and also indicates how well each area of self-care is being attended to.

The literature reviews that Posluns and Gall (2020) conducted presented past empirical research in relation to specific domains of self-practice such as awareness, spirituality, balance, social support, flexibility, and physical health. Thus, taking a proactive approach to self-care became evident from the review findings, signaling the need to actively integrate self-care directly into training programs for clinicians and quality assurance processes of professional organizations within the mental health field. Studies on self-care practices are mostly contextualized to the well-being of practitioner trainees, including graduate students in clinical psychology programs. Posluns and Gall (2020) argued that although the population represents individuals who take an active role in the provision of mental health services, the results from such studies may be somewhat biased because graduate students tend to experience higher stress levels and other negative symptoms because of multiple demands of the career.

The foregoing literature was intended to increase the understanding of programs, activities, and approaches that counselling professionals in Nairobi County use as part of self-care practices. However, most studies reviewed in this section were contextualized to different countries, which exhibit varied contextual dissimilarities with Kenya's Nairobi County context. The countries included Malaysia, Turkey, and Canada. Other studies were focused on different populations of helping professionals such as undergraduate students, leaving a knowledge gap in self-care practices as they relate to counselors. Vast literature in self-care practices lacks empirical grounding because the researchers adopted secondary research methods, which provides obsolete and sometimes biased findings. The gap evident in past studies on self-care practices among counselors is the paucity of literature that illustrates the dynamics of counselors in Nairobi County. The current study intends to fill the gap by conducting an

empirical analysis of the self-care practices evident among the counselors in Nairobi County, Kenya.

2.3.2 Levels of Vicarious Post Traumatic Growth among Counsellors

Post-traumatic growth is a positive psychological process that occurs when individuals experience significant life events associated with traumas, such as death, injury, or exposure to a natural disaster. It is the process of adapting to and making the best of a difficult situation or experiences that result in growth, increased self-efficacy, and personal development. This paper reviews the empirical literature on the level of vicarious post traumatic growth (VPTG) among therapists, focusing on existing research in the field.

Past studies have found that therapists tend to experience higher levels of vicarious PTG than their clients, possibly due to the synthesizing and meaningful work they do in their everyday profession. For example, in a study by Tracey et al. (2011), 84 counselors and social workers completed surveys measuring PTG scores. The researchers found that the therapists experienced higher levels of PTG than their clients, with the counselors receiving the highest ratings.

Radcliffe et al. (2018) investigated the influence of occupational characteristics and counseling factors on therapists' PTG. The study evaluated 108 therapists across many dimensions, including years in practice, specialty, and age. Results showed a favorable link between PTG and occupational characteristics and counseling factors, with therapists reporting higher levels of PTG who also reported higher levels of experience, empathy, and job satisfaction.

The role of empathy in vicarious PTG cannot be overlooked. In one study by Zook et al. (2020), 176 counselors across various settings were surveyed for their level of empathy and PTG. The analyses showed that empathy had a significant positive correlation with PTG, with therapists who were more empathic reporting higher levels of PTG. Furthermore, the effect of

empathy on PTG was stronger among the male counselors than for the female ones. This suggests that when it comes to PTG, counseling roles and gender play an important role.

In a related study, Awolola (2015) surveyed 280 mental health professionals living in different provinces in Canada. The researchers found that the level of PTG was higher among therapists with higher levels of empathy. Additionally, therapists who were more open to the client's emotions were also found to experience greater PTG than those who were less open

Over the years, as research has increasingly explored positive psychological change after traumatic life events, studies have also started to investigate this phenomenon in individuals vicariously exposed to trauma such as family members, carers, as well as professionals (Splevins, et al., 2010). Vicarious post traumatic growth is defined as the personal growth and meaning gained through another's trauma (Abel, et al., 2014). The development of VPTG goes through the same process as that of PTG. Traumatic events experienced by trauma clients constitute a significant challenge for the cognitive schemata of the professionals tasked to aid. It is these challenges that trigger cognitive activity in the form of trauma processing in the form of cognitive strategies for coping with trauma.

The concept of trauma and growth in direct victims has been explained in literature from varied perspectives. Based on the argument by Aldwin and Levenson (2004), the direction of change after the occurrence of a traumatic event is largely dependent on the nature of the traumatic event and the resources that an individual possesses at the time of the event. Although the posttraumatic growth concept has been moderately studied, extant literature shows that most studies, albeit identifying growth after undergoing traumatic experiences, are based on samples selected from among the public without specifying if they include counsellors or not.

Both negative and positive consequences may occur as two distinct phenomena in an individual exposed to trauma. The aforementioned observation provided an impetus for Zieba et al. (2019) to explore the possibility of positive and negative effects of trauma coexisting.

Findings generated from a sample of 72 Polish participants who were asked to recount their trauma experiences and provide answers to the questions regarding the effect of trauma on their thinking of self and the world confirmed positive changes in personal strength (26.09%), interrelationships (24.22%), and appreciation of life (21.12%). Furthermore, the study found a positive correlation between the frequency of words referring to negative emotions and posttraumatic growth. Despite the robustness of the study findings, Zieba et al. (2019) acknowledged the limitations of the study, including having based their study on a group of psychology students that might be a feminized group. Such a weakness may limit the generalizability of the findings to experiences in the whole population. The need to expand the study to a more diverse of groups of adults, which may include counsellors, is recommended.

Moreover, Sheridan and Carr (2020) supported the assertion by Zieba et al. (2019), who found out from their studies that trauma survivors described experiences of deeper self-discovery that resulted in a strong 'survivor identity' and improved sense of self. In their study, Sheridan and Carr (2020) examined the lived experiences of posttraumatic growth in adult survivors of institutional childhood abuse using semi-structured interviews administered to a purposive sample of nine survivors of historical institutional abuse in Ireland aged 41-75 years. Findings from the study supported improvement in survivor identity and engendering growth. However, the study's reliance on qualitative research method implied involving a small sample that could not permit the generalizability of the findings. It is also worth noting that the study was contextualized in Ireland, which has different features from the Kenyan context. The sample of the study included survivors of historical institutional abuse, but the authors did not specify if it included counsellors that are the interest of the current study. Counsellors tend to experience high intensity of compassion fatigue following an engagement with a client who with an emotionally draining experience; thus, investigating their ability to achieve self-growth rather than submerging into the jaws of compassion fatigue is crucial.

Slade et al. (2019) found the components of posttraumatic growth in 64 (83%) of the recovery narratives, indicating that the posttraumatic growth should be an inherent part of mental health recovery. However, similar to Sheridan and Carr (2020), Slade et al. used a qualitative research method and contextualized their study in England using a sample of adults living with psychosis and currently not using mental health services. The sample did not include counsellors, hence, cannot reflect their realities concerning posttraumatic growth. Despite the limitation, the study indicated an unquestionable increase in participants' perceived importance of life, feelings of self-control over an individual's self-management, improved personal relationships, and spiritual engagement. The inconsistency of the changes with the posttraumatic growth that the trauma survivors experienced validated the claim that the participants had experienced a vicarious form of posttraumatic growth.

In modern times, VPTG is a well-established phenomenon reported among a range of health professionals, including therapists, social workers, counselors, and doctors. However, most studies are skewed to the general population of healthcare professionals rather than specifically focusing on counsellors who handle most traumatic experiences. For example, O'Donovan and Burke (2022) investigated the factors associated with post-traumatic growth in healthcare professionals. The findings from a systematic review of the existing literature (n=27 articles included) revealed that post-traumatic growth is a multi-faceted aspect that results from a range of factors, including demographic, personal, work-related, environmental, and interpersonal factors. The limitation of the study is that it relied on secondary sources to conduct a systematic review. The problem of secondary sources is that some of the sources may be obsolete and an increased possibility of transferring biases from the original studies to the systematic review. Despite the aforementioned gap, the results highlighted several psychological interventions that can be applied to cultivate post-traumatic growth in counselling contexts. The current study attempts to address the limitations by relying in

primary sources of information to elucidate vicarious post traumatic growth among counsellors.

Similarly, Long (2020) conducted a qualitative interview of eleven supervisors of refugee trauma counsellors working in Forum of Australian Services for Survivors of Torture and Trauma (FASSTT); the study findings positively supported the earlier models of the co-occurrence of vicarious trauma and vicarious posttraumatic growth. Five of its participants agreed that the counsellors they supervised engaged in meaning making. The conversations between the counsellors and the survivors of trauma may be interpreted to have encouraged counsellors to develop new ways of reviewing their world, value systems, their sense of self and relationships with others. Some participants identified the positive element on the counsellor as a motivator of remaining in this field of work, despite the exposure to very traumatic material. Despite the study being contextualized on the Australian background, the findings were used to recommend the necessity of supervisors conducting supervision practices in a manner that assists counsellors to process how their clients' trauma disclosures affect their levels of stress and change their perception of self, role, and worldview.

Other studies, including Sui (2016) Coleman et al. (2021), have found similar positive changes underlying the rewarding nature of the work related to helping others were observed among psychologists, therapists, helpers and social workers working with sexual violence survivors and family violence victims, and the psychotherapists working in the fields of gender-based violence in South Africa. Similarly, Sui's et al. (2016), study exploring the experiences of a group of South African psychologists who worked predominantly with trauma survivors acknowledged their growth in the work of trauma. Their narratives included a greater appreciation of their own lives and relationships, as well as a renewed sense of personal strength and resilience. The participants reported changes in one or more of the domains of

growth outlined by Tedeschi and Calhoun (1996), as well as changes in their philosophy of life, improved interpersonal relationships and self-perception.

Comparative studies involving several groups of professionals indicate that medics and therapists scored more highly in VPTG than the others (Manning-jones et al., 2017; Oginska-Bulik & Juczynski, 2020). Manning-jones et al. (2017), investigated whether a curvilinear model explained the vicarious posttraumatic growth-secondary traumatic stress relationship in a sample of 365 participants that included nurses, psychologists, counsellors, social workers, and medical doctors. The study findings supported the hypothesis despite seemingly being largely governed by the curvilinear relationship among psychologists. The results from Bartoskova's (2017) study showed that counsellors were more expressive emotionally in personal relationships, and had a new found purpose and meaning of their trauma work. In support of the above, Vishnevsky and colleagues (2015) noted among those working with victims of trauma an increase in practical wisdom, benevolence, self-worth and faith in the efficiency of the undertaken activity, appreciation of their work as well as a higher acceptance of others. A counselor may experience a change in life goals and perspectives, client-inspired hope and an increase in self-awareness, resourcefulness and presence during their work. While these studies were partly or wholly focused on the counselors' perspectives, they were not carried out in Nairobi; hence, the findings cannot be readily generalized to the Kenyan context.

Evidently, numerous research studies have sought to investigate possible determinants of positive consequences of indirect exposure to trauma among mental health professionals. Among the variables investigated are organizational factors specifically occupational load and support from the working environment, and individual factors through which a particular role is ascribed to cognitive trauma processing (Kang et al., 2018; Manning-Jones et al., 2017; Morse-Karzen, 2016). Similarly, empathy and coherence relate positively with VPTG by moderately reducing the psychological distance between a helping professional and a client

within the empathic engagement. Although ample research attention has been given to the concept of VPTG, quantitative studies examining its prevalence among counsellors in Nairobi County is limited. It is worth noting that some studies focusing on vicarious posttraumatic growth have generated important insights using secondary research. While secondary methods have been criticized for obsolescence and possible transmission of original biases to the current studies, researchers using meta-syntheses and systematic reviews have revealed that healthcare practitioners can achieve outstanding posttraumatic growth from practical engagements.

Specific health crises usually generate opportunities that boost post-traumatic growth among healthcare workers. During the disease outbreaks such as COVID-19 and MERS, healthcare workers' physical and mental health is majorly threatened. In connection to this, Hyun et al. (2021) explored the factors associated with post-traumatic growth among healthcare workers who experienced Middle East Respiratory Syndrome (MERS) outbreak using a mixed method study. The researchers adopted a quantitative research approach, which involved collection of data from 78 participants and qualitative reviews from seven nurses. The study findings confirmed that resilience has a significant impact on posttraumatic growth ($p=0.001$). It was evident from the study that the participants experienced the development of resilience in terms of hardiness, persistence, optimism, and support.

Hyun's et al. (2021), study exhibited conceptual, methodological, and contextual gaps. The study did not assess the self-care practices among nurses as a variable, which is the predictor variable in this study. Methodologically, the study adopted a sequential mixed research design in which the quantitative study was conducted first to determine the significant factor (resilience). Thus, the qualitative data analysis was limited to the aspect of resilience only. Contextually, the study was conducted in South Korea among healthcare workers without a specific focus on the counsellors. The context may exhibit dissimilarity with the Kenyan context. Hence, despite the findings confirming a positive link between experiencing a health

crisis with improved resilience, the findings cannot be readily generalized to the Kenyan context, signaling the need for a study that can consider the specific dynamics of the counsellors in Nairobi.

The reviewed literature could provide comprehensive insights about the post-traumatic growth among counselors in Nairobi County. However, closely-related studies focused on different concepts, such as the coexistence of positive and negative effects of trauma and resilience, which are not the exact concepts of the current study. The populations from which samples were selected, such as psychology students, adults living with psychosis, nurses, and healthcare workers could not allow the generalization of the findings to the counselors. The geographical context of the studies reviewed included Poland, Ireland, England, Australia, South Africa, and South Korea, whose contextual features cannot be similar to Kenya. The current study intends to address the conceptual and contextual gaps by concentrating mainly on the vicarious post traumatic growth among counsellors in Nairobi County, Kenya.

In conclusion, the research reviewed in this paper suggests that therapists tend to experience higher levels of vicarious PTG than their clients. This can be attributed to the higher levels of empathy they possess, as well as the meaningful work they do in their profession. Research has also indicated that there are various occupational variables and counseling factors, such as experience, job satisfaction, and openness to the client's emotions, which play an important role in the VPTG experienced by therapists. To completely understand the predictors of vicarious posttraumatic growth among counsellors, more study is needed

2.3.3 Relationship between Self-Care Practices and Vicarious Posttraumatic Growth among Counsellors

The concept of vicarious posttraumatic growth (VPTG) has become increasingly explored in recent psychological research, as it has been identified as a positive consequence of the shared experiences of those exposed to several forms of traumatic stress (Adams, Finley,

& Davis, 2017). VPTG has been disproportionately studied amongst counsellors due to potential occupational hazards associated with their roles. It is now generally accepted that VPTG in counsellors can be an uplifting outcome for those exposed to traumatic events. An important body of research has examined the impact of various self-care practices on VPTG in counsellors; conversely, the impact of VPTG on self-care practices has been understudied. This review will therefore examine the current literature surrounding the role of self-care practices in relation to VPTG among counsellors.

Vicarious posttraumatic growth (VPTG) is a construct that has been developed out of the posttraumatic growth (PTG) model, which suggests that individuals exposed to traumatic or stressful situations may emerge with a greater understanding of themselves, their relationships and an acceptance of life's transience (Tedeschi & Calhoun, 1995). In contrast, the VPTG construct has been used to study how symptoms associated with posttraumatic stress disorder (PTSD) or occupational stress might be minimized or ameliorated in those with whom a counsellor has a close relationship. This includes clients, supervisors, colleagues, family members and friends.

Given the psychological stress associated with the roles of counsellors, particularly those working with trauma survivors, the potential role of self-care practices to reduce or ameliorate the experience of vicarious posttraumatic growth has become evident in the literature. Rushing & Bhui (2007) studied the impact of self-care practices on VPTG in counsellors and found that those counsellors with the highest levels of self-care practices had the lowest levels of VPTG. Specifically, the study found that self-care practices related to both physical and psychological health had a moderating effect upon VPTG, suggesting that those counsellors with better self-care practices were more resilient to experiencing vicarious posttraumatic growth.

Other studies have similarly indicated that self-care practices can play an important role in buffering counsellors from the symptoms associated with VPTG. For example, Plascencia, Rushing & Weaver (2015) examined the efficacy of self-care practices among mental health counsellors and found that practices such as mindfulness improved counsellors' ability to cope with vicariously experienced trauma. It was speculated that through engaging in self-care practices, counsellors were better able to process the emotional responses to complex traumatic events, therefore leading to improved psychological health.

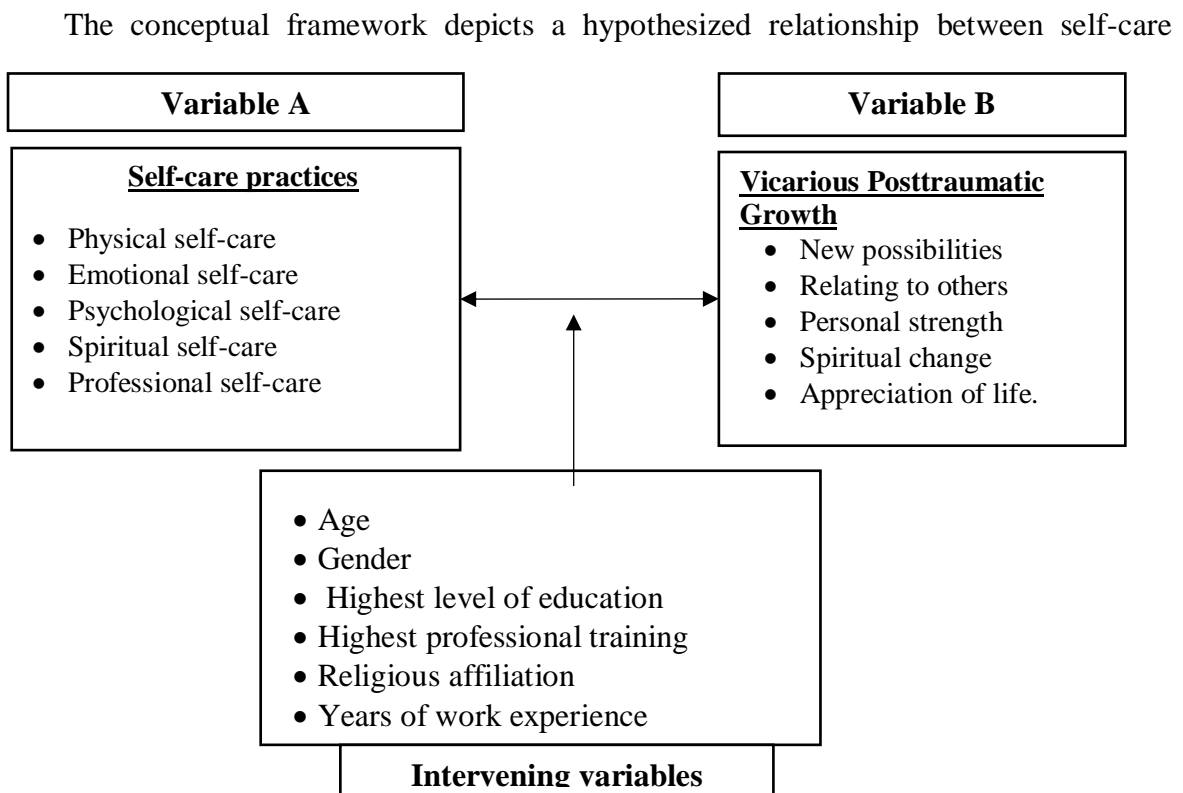
Moreover, a recent study by Colvin, et al. (2021) examined the impact of self-care practices on burnout and vicarious trauma in counsellors. The study found that when self-care practices such as stress management, exercise and relaxation were engaged in, both burnout and VPTG were significantly reduced. To further explore this relationship, the study utilized a quantitative approach to investigate the association between self-care practices and VPTG. Results indicated that there was a significant positive correlation between self-care practices and VPTG, suggesting that through the implementation of self-care practices, counsellors could experience improved resilience, reduced levels of VPTG and greater overall well-being.

The empirical literature on the relationship between self-care practices and VPTG in counsellors has identified that the implementation of self-care practices can lead to improved psychological and emotional health. Various studies have proposed that self-care practices in combination with other supportive strategies may lead to increased resilience and reduced levels of vicarious traumatization. The findings suggest that counsellors should incorporate self-care into their daily lives in order to reduce the risks associated with work-related vicarious trauma. Moving forward, additional research is needed to further explore the relationship between self-care practices and VPTG. Furthermore, empirical research is needed to evaluate the efficacy of different types of self-care practices on VPTG in counselling contexts.

2.4 Conceptual Framework

The following framework is structured into three variables each of which is defined by operational indicators that will guide their measurements. The conceptual framework presented is structured into two variables; Self-care practices and VPTG. To graphically demonstrate the analysis, the investigator has used a double pointed line that links the two variables. The conceptual framework is as shown in Figure 1.

Figure 1: Relationship between self-care practices and vicarious post traumatic growth.



Source: Author (2022)

practices and vicarious posttraumatic. The framework also recognizes the possibility of intervening variables explaining the process through which the two variables are related. Variable A is the self-care practices whose indicators include physical self-care, emotional self-care, psychological self-care, spiritual self-care, and professional self-care. The second variable is vicarious posttraumatic growth. The indicators of vicarious posttraumatic growth include

new possibilities, relating to others, personal strength, spiritual chance and appreciation of life. Intervening variables that the study tentatively views to explain the relationship between self-care practices and vicarious posttraumatic growth include age, gender, highest level of education, highest professional training, religious affiliation, and years of experience. However, it cannot be conclusively decided the relationships are significant until the study is conducted and statistical processes executed to generate values to test the levels of significance.

2.5 Chapter Summary

The literature review critiqued existing literature relating to the variables of the study: self-care practices and vicarious posttraumatic growth. Literature on the two variables is extensive, but it was evident from the reviewed studies that extensive methodological, conceptual, and contextual gaps are dominant. Most studies reviewed used either qualitative or secondary methods. Qualitative studies are barely generalizable due to small sample sizes while secondary studies are characterized by obsolescence and possibilities of biases. Conceptually, most studies focused on either variable separately or with a different variable. It was rare to find a recent study that had analyzed the relationship between self-care practices and vicarious posttraumatic growth. In terms of context, most studies were conducted in the West and East, with only a handful of studies contextualized to the African context, mostly South Africa. The population given attention in the reviewed literature included the general public, healthcare professionals in general, and student in graduate programs. The gaps indicate a scarcity of literature and signal the need for a study that investigates the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi, Kenya.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The research methodology chapter presents a justification of the methods, techniques, and approaches that the study used to collect, analyze and interpret the findings. The main items discussed in this section include the research design, population and sampling, research instruments, pilot testing, data collection procedures, data analysis and presentation, and logistical and ethical considerations.

3.2 Epistemology

According to Al-Ababneh (2020), epistemology is the theory of knowledge that deals with the process of gathering knowledge and the sources from which it is gathered. Epistemologies relevant to social sciences research include positivism, interpretivism, and pragmatism. The current study adopted the positivist epistemology. Positivism is a research philosophy that emphasizes the use of objective scientific methods and data to explain and understand phenomena. It is based on the belief that external reality exists and can be studied objectively, free from any bias or preconceived notions. The study chose to use positivism because it would provide clear and reliable data, which can be used to make informed decisions, as well as help to identify important trends and patterns that can be used to improve processes and outcomes of counseling. However, positivism research philosophy has been criticized for being time consuming and expensive as it requires considerable resources to collect data. It can also be difficult to ensure unbiased data collection. Despite the limitations, the study plans to use positivism because of its insistence on objectivity as a source of knowledge.

3.3 Research Design

Research design is the methods and plan to be used in research for data collection and analysis to meet the research question (Vogt, Gardner & Haeffele, 2012). The first choice for the research design is the quantitative and qualitative approaches. Quantitative research is a method of collecting and analyzing numerical data, while qualitative research is a method of collecting and analyzing non-numerical data. The study adopted a quantitative research approach. The quantitative approach was suitable for this study because it allowed participants' views to be converted into measurable numeric values.

The study adopted a correlational survey design. Based on the definition by Taherdoost (2016), a correlational survey design investigates relationships between variables without the researcher controlling or manipulating any of them. A correlation design reflects the strength and/or direction of the relationship between two (or more) variables. The design was relevant to the study because it sought to evaluate and test the significance of the relationship between self-care practices and vicarious post traumatic growth among counsellors in Nairobi County.

The researcher gathered data, measured and analyzed them statistically. Numerical data collection was done through the use of quantitative questionnaires that were analyzed using Statistical Package for Social Sciences (SPSS), version 25. Data analysis for this study was achieved through approved statistical ways with the aim to circulate the findings.

3.4 Location of the Study

The location of the study was Nairobi County, which harbors the capital city of Kenya. Nairobi County is one of the 46 counties in Kenya that harbors the capital city of Kenya with a population of 4,397,073 covering an area of 696.1 km² (Kenya National Bureau of Statistics, 2019). The county has eleven sub counties, seventeen electoral constituencies, and eighty-five wards. The eleven sub-counties include Dagoretti, Embakasi, Kamukunji, Kasarani, Kibra, Lang'ata, Makadara, Mathare, Njiru, Starehe and Westlands. Nairobi County is the center of

professionals in Kenya that has majority of the counsellors working across the county's sub counties. The county also has majority of the counselling centers and active counselling professionals serving hundreds of clients daily. Hence, Nairobi County provides a suitable location for the study due to its accessibility and availability of most counselling professionals.

3.5 Target Population

Graziano and Raulin (2010) define population in research as the larger group that all the people of interest belong. Currently, the total number of registered counsellors in Kenya is 2,080; out of these, 904 are operating in Nairobi County (KCPA, 2023). The current study included counsellors, primarily engaged in offering therapy with clients in Nairobi County. In terms of gender, the study targeted both males and females from all ethnicities. The majority of the participants are aged 25 years and above. The educational levels of the participants were any professional counselor training that enables a professional to register and provide counselling services. A significant number of the population members are socioeconomically stable and may be married or not married. The key eligibility determinant is being registered with the KCPA and currently providing counselling services within Nairobi County. KCPA is the association that is recognized by the government currently as the umbrella body for counsellors in Kenya. Counsellors were the population of interest for the study as they are likely to have attended to clients presenting with traumatic experiences due to relatively high levels of trauma incidences in Nairobi County. Therefore, the target population for the current study was the 904 counsellors registered in Nairobi County as per the KCPA register.

3.6 Sampling Design

This section identified and justified the sampling frame, sampling technique, and sample size determination.

3.6.1 Sampling Frame

The sampling frame is the list of all members from which a researcher draws a sample. It includes a list of all population members that can be selected to participate in a study (Sharma, 2017). The sampling frame for the current study included counsellors in Nairobi County registered with the KCPA. The population is distributed into seven categories of the KCPA statuses, as shown in Table 1.

Table 1: Target Population

Status of the Counsellors	Target Population	Percentage
Ordinary members	101	11.2%
Associate counsellor status (route A and B)	198	21.9%
Accredited counsellor	216	23.9%
Senior accredited counsellor	109	12.1%
Associate counsellor supervisor	136	15.0%
Accredited counsellor supervisor (route A and B)	115	12.7%
Senior accredited counsellor	29	3.2%
Total	904	100%

Source <https://www.socialresearchmethods.net/kb/samptype.php>.

3.6.2 Sampling Technique

To enable sampling for the study, proportionate sampling was utilized. Proportionate sampling involves identifying different strata in a population and drawing a particular number of elements from each stratum based on a given rate (Sharma, 2017). The sample frame of 904 counsellors was distributed based on their percentages to the study. Once the sample was identified, a random sampling technique was used to assign the participants to each category of KCPA's registration statuses. Simple random sampling involves getting sample so that every member of the population has an equal chance of being selected (Graziano & Raulin, 2010).

From the data base of registered counselors operating within Nairobi, the researcher employed a computer-based Random Number Generator to create a list of participants from each category (Papageorgiou, 2020). The Computer-Based Random-Number Generator randomly generated a list of participants equal to the determined sample size from each category. The generated list included, email addresses, and phone numbers of the randomly selected participants, which the KCPA authorities used to administer the questionnaire. Simple random sampling was preferred in this study because it provided equal opportunities for all the members of the population to participate. This helped to reduce biases and improve the robustness of the results.

3.6.3 Sample Size Determination

The sampling design enabled the researcher to select a sample that participated in the study. A sample is a subset of the population of interest (Graziano & Raulin, 2010). It is a decided map concluded on data collection from any sample identified in the preferred population. The study used Yamane's formula to determine the sample size (Yamane, 1967).

Based on the formula:

$$n = N/1+N(e)^2$$

Where: n is the required sample size, N is the population, and e is 0.05.

$$n = 904/1+904*0.05^2$$

$$n = 277.300613 \sim 278$$

According to this formula the sample size of this study was 278 participants. However, it is important to address the attrition concern within the sample size. Mugenda and Mugenda (2003) described attrition as the loss, a participant's withdrawal, or even misplacement or damage of questionnaires during data collection or analysis. Providing for attrition requires researchers to add 10% of the sample size on top of the determined sample size (Mugenda & Mugenda, 2003). Thus, 10% of 278 is 27.8~28. After providing for attrition, the sample size

was 306 participants. The sample was distributed across the seven categories as shown in Table 2.

Table 2: *Proportionate distribution of the participants to the seven registration statuses*

Status of the Counsellors	Target Population	Percentage	Sample size
Ordinary members	101	11.2%	34
Associate counsellor status (A and B)	198	21.9%	67
Accredited counsellor	216	23.9%	73
Senior accredited counsellor	109	12.1%	37
Associate counsellor supervisor	136	15.0%	46
Accredited counsellor supervisor (A & B)	115	12.7%	39
Senior accredited counsellor	29	3.2%	10
Total	904	100%	306

Proportionate allocation implied that categories with the higher population could provide larger samples than categories with lower populations.

3.7 Research Instruments

The term “instruments” refers to devices or techniques used to measure specific characteristics or attributes of people, objects, or events. To facilitate this research, a quantitative questionnaire was used. The questionnaire contained two sections; first, a socio demographic section developed by the researcher to capture demographic variables such as age, gender, education level, professional training and years in professional counseling. Section two of the questionnaire had two scales.

The first scale is the Self-Care Assessment Worksheet (SCAW) (Saakvitne & Pearlman, 1996). The SCAW has information on various aspects of self-care. SCAW being a

self-care indicator measures the degree to which individuals engage in a variety of self-care activities and strategies, the counsellors rated themselves accordingly on whether they perform the activity on a 5-point Likert scale. The instrument measures six areas of self-care: physical, psychological, emotional, spiritual, professional workplace, and balance, as shown in Table 3.

Table 3: Number of Items in Each Area of the Self-Care Assessment Worksheet

Self-care area	Number of Items	Minimum Score Possible	Maximum Score Possible
Physical care	15	15	75
Psychological care	13	13	65
Emotional care	11	11	55
Spiritual care	17	17	85
Workplace self-care	12	12	60

Source: Alkema (2008)

Different numbers of items are presented throughout the subscales to evaluate various aspects of the respondent's self-care. Participants are asked to indicate how frequently they engage in various pursuits using a Likert scale ranging from 1 (never) to 5 (very often). Once the dimensions have been rated, the scores from all 70 items are added together. Scores range from an all-time high of 350 to an all-time low of 70. The scores provided a basis for analyzing the levels of balanced and imbalanced self-care practices among the counsellors in Nairobi City County.

The second scale on vicarious posttraumatic growth (PTG) inventory, adopted the posttraumatic growth inventory. PTG Inventory is a 21-item Likert scale developed by Tedeschi and Calhoun (1996) that is used to measure the factors of PTG among the trauma victims. This scale measures five distinct forms of growth: relating to others, identifying new possibilities, personal strength, spiritual change, and appreciation of life. Participants rated the extent to which they have experienced the growth described in each item on a 6-point Likert

scale, and scores can range from 0 to 105. It has been argued that scores below 60 indicate a low level of growth, scores between 60-79 indicate a moderate level of growth, and scores 80 or above indicate a high level of growth (Feder et al., 2008). The PTGI has good psychometric properties (Tedeschi & Calhoun, 1996), and has been used numerous times in previous research to measure VPTG (Linley & Joseph, 2007). This tool was used to measure vicarious posttraumatic growth among counsellors.

3.8 Pre-testing of Instruments

A pilot study is a mini version of full study, also described as a trial run done to prepare for the study. It also pre-tests research instruments like questionnaires. Mugenda and Mugenda (2003) recommended that a questionnaire should be circulated to a small study size (10%) of the sample to assess the research instruments for validity and reliability for uniquely developed research instruments. The process of consent form involved creates a consent form, which outlined the details of the research, including potential risks and benefits, rights of the participants, contact information standards confidentiality and how to withdraw from the study. A pre-test was populated among 31 participants to test the instrument validity and reliability. The 31 participants included the counsellors registered with the KCPA and currently working in Kiambu County. The pre-test results were used to determine the validity and reliability of the questionnaire and determine the length of time that each participant would require to respond to the study.

3.8.1 Validity

Validity provides a measure of the collected data in relation to the issue being covered (Taherdoost, 2016). Graziano and Raulin (2010) explain that for a measure to be valid, the scale must measure what it is supposed to measure. To strengthen the validity of the instrument, face and content validity are checked to ensure that the questionnaire has a logical link with the objectives of the study. The study by Ibrahim et al. (2021) showed that the validity of the

content of the SCAW was determined by a panel of experts from Faculty of Nursing Universitas Padjadjaran who unanimously agreed that the items satisfy the validity requirements. Cadell et al. (2015) conducted a discriminant analysis using Confirmatory Factor Analysis and found that the difference of the chi-square statistics between the constrained and standard models is significant ($\chi^2 > 3.84$, $df = 1$, $p > 0.05$), indicating high validity.

3.8.2 Reliability

Reliability refers to the level of consistency of a measure (Taherdoost, 2016). A test is considered reliable when it can be used by different researchers under stable conditions, giving consistent results and the results do not differ, hence giving consistency and can be replicated over a period of time. Cronbach's Alpha test was used to measure the internal consistency reliability. To analyze levels of self-care practices using a t-test, the data split into two samples: one sample was for people with high levels of self-care practices and the other sample for people with low levels of self-care practices. The t-test was then used compare the means of the two groups to determine if there is a statistically significant difference between them. The threshold for reliability in Cronbach's alpha is 0.7. The SCAW has a reliability of 0.75 (Ibrahim et al., 2021). The test-retest reliability analysis by Weekes (2014) using correlation analysis confirmed that the SCAW is a reliable instrument. The results for each domain of the SCAW were 0.83 (physical care), 0.78 (psychological care), 0.79 (emotional care), 0.91 (spiritual care), 0.79 (work/professional care), and balance (0.79).

Weiss and Berger (2006) assessed the internal consistency of the posttraumatic growth inventory. The results showed that Factor I (5 items) has an internal consistency of 0.85. Factor II (6 items) had a coefficient alpha of 0.87 while Factor III (2 items) had a coefficient alpha value of 0.87. Cadell et al. (2015) also found that all the subscales had reliability values exceeding 0.70, which provided evidence that the PTG subscales are reliable for the study.

3.9 Data Collection Procedures

Mugenda and Mugenda (2003) described data collection as the process of gathering, measuring, and analyzing data from all relevant sources to provide a basis for answering the research questions and evaluating outcomes. The data collection process commenced after the securing the relevant permits. First, the researcher sought an authorization from the Program Leader of the Counselling Psychology Department. The letter was used to make an application for the clearance to conduct research from the Tangaza University College Research Ethics Committee (TUREC). The researcher used the letter, to apply for a research permit from the National Council for Science, Technology and Innovation (NACOSTI). The NACOSTI permit and the TUREC clearance enabled the researcher to seek permission from the KCPA and provided a basis for requesting the KCPA administration to disseminate the questionnaire through their authoritative email.

An introduction letter was prepared and attached to the questionnaire link to explain the research focus and need. The letter assured the participants of confidentiality through informed consent that their names were not included in the questionnaires and the use of the data collected is only for academic purposes. The respondents were also assured that they would withdraw at any time. The data collection process involved the researcher through assistance by KCPA personnel disseminate the questionnaire to the participants using emails accessed through the KCPA. The targeted participants were required to fill in the survey and submit it. The researcher provided 30 days for the targeted respondents to fill in the questionnaire, after which the link was revoked to allow for data analysis.

3.10 Data Analysis

Marshall and Rossman (1999) describe data analysis as a procedure of putting order, structure and meaning to an accumulation of collected data. The responses were inspected to remove those with incomplete and inaccurate data. This study applied both descriptive and

inferential statistics to analyze data collected. Descriptive statistics was used to understand the sample group, since it can only be applied to the said group under study, while inferential statistics extends the knowledge gained to the population hence generalization can be achieved. Statistical Package of Social Sciences (SPSS version 25) was key in compiling and analysis of data to make it relevant. The data analysis process involved use of the SPSS commands to generate descriptive and inferential statistics. Table 4 provides a further illustration of data analysis procedures.

Table 4: Data analysis

Data analysis of:	Variable type	Purpose of the test	Type of the test
Demographics characteristics	Norminal and scale	To collect participants' demographic characteristics	Frequencies, percentages, means, and standard deviation.
Objective 1	Scale	To measure the levels of self-care practices.	Normality test
Objective 2	Scale	To measure the levels of VPTG.	Normality test
Objective 3	2 scale variables	To test the relationship between self-care practices and VPTG	Pearson's correlation coefficient
Hypothesis H0	2 scale	To test the significance of the relationship between self-care practices and VPTG	Pearson's correlation coefficient
Hypothesis Ho	2 scale	Test significance of relationship between self-care practices and VPTG	Pearson's correlation coefficient

Table 4 shows that the analysis results include frequencies, percentages, measures of central tendency (mean and standard deviation), normality test, Analysis of Variance (ANOVA), t-test, and Pearson's correlation coefficient. Descriptive statistics was used to describe the characteristics of data. James and Sinister (2020) stated that descriptive statistics present or describe data in an easily understandable quantitative form. Descriptive statistics, such as frequencies, percentages, means and standard deviations helped to describe variable

characteristics of self-care practices and vicarious posttraumatic growth. Inferential statistics (correlations and regressions) generated values to measure the associations and relationships between self-care practices and vicarious posttraumatic growth. Thus, ANOVA, Pearson's correlation measured the association and relationship between self-care practices and vicarious posttraumatic growth. The p-values provided a basis for testing the null and alternative hypotheses. The p-values (significance values) generated from the regression analysis provided a basis for rejecting or not rejecting the hypotheses ($H_0: p < 0.05$ -reject, $p > 0.05$ -do not reject). The data was presented using charts, graphs and frequency tables.

3.11 Ethical Considerations

The study required two levels of authorization. The first level was university approval, which was sought after successfully defending the proposal. The Tangaza University College provided an approval letter to legitimize the study. The second level of authorization was the NACOST (National Commission for Science, Technology and Innovation) license. The approval letter was attached to the proposal and submitted to NACOSTI, which provided a research permit to authorize the study.

The participants in this study were informed about the research, that is, the aim and benefit of the study before data collection. The participants were assured that all their responses would be treated strictly confidential and the researcher did so. Moreover, participants were informed that their information would be presented in a combined form and not as individuals and the researcher did the same. Participants were also assured with confidentiality for the information they were providing in the study. Participation was a free choice; nobody was forced to participate in the study. The participants were having a right to withdraw from the study at any time if they did not want to continue participating in the study.

Since target populations were all mature adults, they were able to decide freely if they wanted to participate in the study or not. The online questionnaire form had a consent seeking

section. Upon giving consent to be part of the study respondents were able to access the questionnaire. The information received from the participants was treated with confidentiality. It was only used for intended academic purpose and not otherwise.

3.12 Chapter Summary

This chapter has discussed and justified various methods, techniques, and approaches that the study adopted to collect, analyze, and interpret the research findings. The chapter identified and explained the epistemology, research design, and the geographical location of the study. Moreover, target population and sampling aspects, including the sampling design, frame, and technique were explained to show how the sample size was determined. The chapter further justified the use of established research instruments and how the instruments were pre-tested to determine reliability and validity. Other critical elements discussed in the research methodology chapter are data collection and analysis procedures and ethical considerations for the study.

CHAPTER FOUR

RESULTS

4.1 Introduction

The results chapter presents the study findings in relation to the research objective that focused on analyzing the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County, Kenya. The results presented in this chapter include the response rate, reliability statistics, participants' demographic characteristics, and the result for each objective, including test of hypotheses. The types of statistics used to analyze the results include descriptive and inferential. Tables are used to summarize the results to enhance clarity.

4.2 Response Rate

The response rate compares the sample size that the researcher targeted against the number that responded and responses that spoilt. Table 5 presents the response rate of the KCPA counsellors in Nairobi County.

Table 5: Response Rate

Respondent	Sample targeted	Returned Quest.	Spoiled quest.	Sample used for study	Returned rate %	Spoiled rate %	Sample used rate %
Questionnaire	306	249	28	221	81.4%	9.2%	72.2%

The study targeted a sample size of 306 counsellors, including attritions working in Nairobi County and registered with the Kenya Counselling Psychological Association (KCPA). Out of the possible 306 respondents targeted, 81.4% (n = 249) counsellors had responded to the online questionnaire by the end of the participation period, 9.2 percent (n = 28) were considered spoiled due to being incomplete. The remaining 72.2 percent (n = 221) were incorporated into the study. According to Mugenda & Mugenda (2003), a response rate of 50%

is considered satisfactory, 70% is good, and above 70% is great, so the percentage of questionnaires was sufficient for data analysis.

4.3 Reliability of the Scales

This study used two types of standardized scales: the Self-Care Assessment Worksheet (SCAW) (Saakvitne & Pearlman, 1996) and the vicarious posttraumatic growth (PTG) inventory (Tedeschi & Calhoun, 1996). The SCAW scales seeks to gauge six dimensions, with each dimension having a different number of items: physical care (13 items), psychological care (13 items), emotional care (11 items), spiritual care (17 items), workplace self-care (12 items), and balance (2 items). The SCAW scales are gauged on a five-point Likert scale and are scored using five real numbers, which are 1-it never occurs, 2-never, 3-rarely, 4-occasionally, and 5-frequently. After rating the dimensions of the scale, the scores for all 65 items are summed up. The highest score is 350 while the minimum possible score is 65.

The second scale posttraumatic growth inventory (PTG) is a 21 item Likert scale developed measures five distinct forms of growth: relating to others, identifying new possibilities, personal strength, spiritual change, and appreciation of life. Participants rate the extent to which they have experienced the growth described in each item on a 6-point Likert scale, and scores can range from 0 to 105. It has been argued that scores below 60 indicate a low level of growth, scores between 60-79 indicate a moderate level of growth, and scores 80 or above indicate a high level of growth.

It was necessary to compute Cronbach's alpha to determine the extent to which the scales were accurate and reliable to measure the counsellors' self-care practices and vicarious posttraumatic growth. The Cronbach's alpha for the Self-Care Assessment Worksheet (SCAW) was 0.917 while that of vicarious posttraumatic growth (PTG) inventory was 0.884. Cronbach et al. (1965) stated that a scale that scores a good internal consistency is suitable for data collection. Based on the assertion by Selvam (2017), measures that indicate an internal

consistency of between 0.6 and 0.7 are acceptable while those that score above 0.7 are good. Cronbach's alpha scores above 0.7 indicate that the scales employed in this investigation are reliable.

4.4 Participants' Socio-demographic Characteristics

The researcher analyzed the socio-demographic characteristics of the counsellors based on the details provided in the questionnaire. The characteristics included in the questionnaire were age, gender, highest educational level attained, religious affiliation, highest professional training, and years of experience. The analyzed socio-demographic details implies that the sample was representative of the population because it across varied diversity groups. Table 6 provides details of the participant's socio-demographic characteristics.

Table 6: Participants Sociodemographic Characteristics

Variables	Frequency	Percent
Respondent's age categories		
21-30 years	21	9.5
31-40 years	70	31.7
41-50 years	81	36.7
51-60 years	42	19.0
61-70 years	7	3.2
Respondent's gender		
Male	66	29.9
Female	155	70.1
Respondent's highest educational level attained		
Form IV	2	0.9
Diploma/Bachelor	148	67.0
PG Diploma/Masters	69	31.2
PhD	2	0.9
Respondent's religious affiliation		
Christian	214	96.8
Islamic	6	2.7
Hinduism	1	0.5
Respondent's highest professional training		
Diploma/Higher Diploma	31	14.0
Undergraduate	128	57.9
Postgraduate	62	28.1
Respondent's years of work experience		

Under 5 years	35	15.8
6-10 years	60	27.1
11-15 years	47	21.3
Above 16 years	79	35.7

As indicated on Table 6, the frequency of respondents aged 41-50 years was higher at 36.7% (n = 81) compared to the respondents aged 21-30 years at 9.5% (n = 21), 31-40 years at 31.7% (n = 70), 51-60 years at 19% (n = 42) and 61-70 years at 3.2% (n = 7). Concerning the gender distribution, the frequency of female respondents was higher at 70.1% (n = 155) as opposed to male counterparts at 29.9% (n = 66). Also, with reference to the highest educational level attained by the respondents, the frequency of the respondents who had diploma/bachelor's degree was the majority at 67% (n = 148) compared to those with Postgraduate diploma/master's degree at 31.2% (n = 69), Form IV and PhD at 0.9% (n = 2) respectively.

With reference to the respondent's years of work experience, the respondents who had worked for over 16 years were higher at 35.7% (n = 79) as against those who have worked for less than 5 years at 15.8% (n = 35), 6-10 years at 27.1% (n = 60), and 11-15 years at 21.3% (n = 47) being the minority.

4.5 Level of Self-care Practices among Counsellors in Nairobi County

The first objective in this study sought to investigate the levels of self-care practices among the respondents in this study. The Self-care assessment worksheet (SCAW) was used to collect data from the respondents. The SCAW assesses five dimensions of self-care practices such as physical care, psychological self-care, emotional, spiritual, and workplace/professional. The researcher computed the total scores for each self-care practice. The results are presented in Figure 3.

Figure 2: Total Scores for self-care practices among counselors

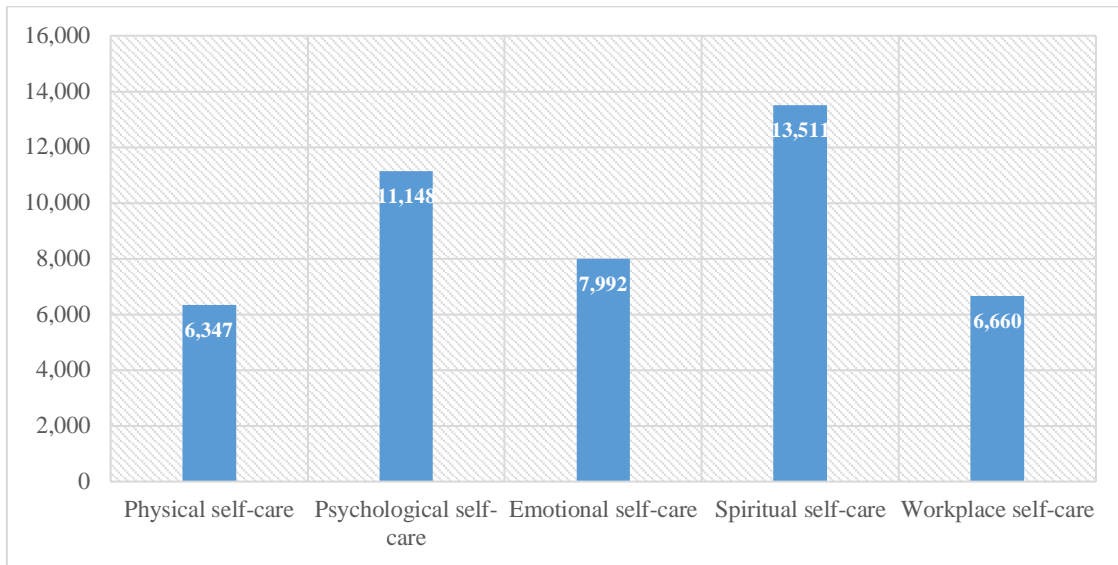


Figure 2 shows that spiritual self-care had the highest score (13,511). The second most practiced self-care practice was psychological self-care which scored 11,148. Emotional self-care was the third most practiced (7,992) and the fourth and fifth were workplace self-care (6,660) and physical self-care, respectively.

The total score on the scale were further computed using grand means since the items in each of the subscales were different. The findings are shown in Figure 2.

Figure 3: Grand mean total of self-care practices among counsellors

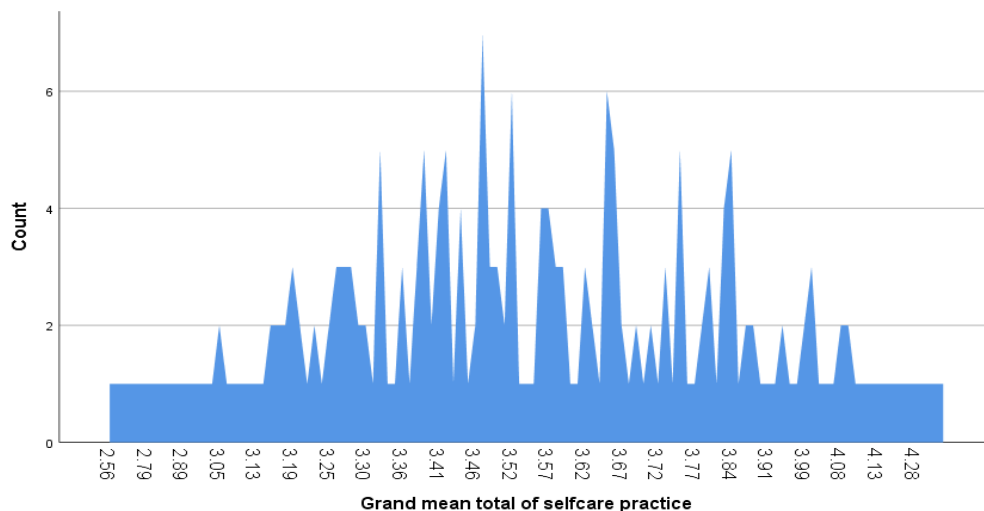


Figure 3 indicates the distribution of the grand mean total of self-care practices across all the subscales which are indicative of the various dimensions. Since each subscale contained different numbers of items the researcher computed the means of each subscales, then the grand mean totals of the self-care practices. The distribution indicate that majority of the respondents scored a mean of between 3.46-3.57.

The study sought to interrogate the frequency of balanced and imbalanced levels of self-care practices among the respondents. The total scores of the five dimensions of self-care practices were added together to find the grand mean $3.54 \pm (SD:.349)$. The results are tabulated on table 7.

Table 7: Frequency of balanced and imbalanced self-care practices

Variable	Grand Means	Frequency	Percentage
Imbalanced self-care practice	0.00 – 3.54	115	52.0%
Balanced self-care practice	3.54 – 5.00	106	48.0%
Total		221	100

Table 7 shows the frequency of the respondents who practiced balanced self-care. The respondents who scored below the grand mean (0.00 - 3.54) were considered to exhibit imbalanced self-care practices, whereas the respondents who scored above the grand mean (3.54 – 5.00) was considered to practice balanced self-care practice. Therefore, the frequency of balanced self-care practices was 48% (n = 106). This means that slightly above half of the respondents at 52% (n=115) have imbalanced self-care practices.

Since each of the subscale contained different number of items and therefore a mean was computed for each to ascertain both low and high levels for each of the five dimensions of self-care practices. Table 8 indicates the distribution of the respondent’s scores on SCAW.

Table 8: Levels of self-care practices

Variables	Frequency & %	Mean & Std. dev	Skewness	Kurtosis
Physical self-care				
Low level	138 (62.4%)	.376 ± (SD:.485)	.517	-1.748
High level	83 (37.6%)			
Psychological self-care				
Low level	108 (48.9%)	.561 ± (SD:.501)	-.046	-2.016
High level	113 (51.0%)			
Emotional self-care				
Low level	123 (55.7%)	.443 ± (SD:.498)	.229	-1.965
High level	98 (44.3%)			
Spiritual Self-care				
Low level	123 (55.7%)	.443 ± (SD:.498)	.229	-1.965
High level	98 (44.3%)			
Professional workplace self-care				
Low level	97 (43.9%)	.561 ± (SD:.497)	-.248	-1.956
High level	124 (56.1%)			

Table 8 shows the descriptive statistics of the respondent's scores on self-care assessment worksheet. Concerning the physical self-care, the mean physical self-care was 3.20. The respondents who scored 3.20 or below were considered to have low level of physical self-care, whereas the respondents who scored 3.21 or above were considered to present with high level of physical self-care. The frequency of low level of physical self-care was higher at 62.4% (n = 138) as opposed to high level of physical self-care 37.6%.

Descriptive analysis was used to determine frequency scores, and Chi-Square test used to examine whether there is any significant relationship between the demographic factors and levels of self-care practices. The results are shown on Table 9

Table 9: Levels of self-care practices in relation to demographic characteristics

Variables	Levels of Self-care Practice			Chi-Square test		
	Total	Imbalance	Balanced	X ²	df	Sig
Respondent's age						
21-30 years	21 (9.5)	10 (4.5)	11 (5.0)	1.496	4	.827
31-40 years	70 (31.7)	38 (17.2)	32 (14.5)			
41-50 years	81 (36.7)	41 (18.6)	40 (18.1)			
51-60 years	42 (19.0)	21 (9.5)	21 (9.5)			
61-70 years	7 (3.2)	5 (2.3)	2 (0.9)			

	Respondent's Gender					
Male	66 (29.9)	28 (12.7)	38 (17.3)	3.333	1	.068
Female	155 (70.1)	86 (39.1)	68 (30.9)			
	Respondent's highest educational level attained					
Form IV	2 (0.9)	2 (0.9)	0 (0.0)	2.026	3	.567
Diploma/Bachelor	148 (67.0)	75 (33.9)	13 (33.0)			
PG Diploma/Masters	69 (31.2)	1 (0.5)	1 (0.5)			
PhD	2 (0.9)					
	Respondent's religious affiliation					
Christian	214 (96.8)	112 (50.7)	102(46.2)	1.103	2	.576
Islamic	6 (2.7)	3 (1.4)	3 (1.4)			
Hinduism	1 (0.5)	0 (0.0)	1 (0.5)			
	Respondent's highest professional training					
Diploma/Higher Diploma	31 (14.0)	20 (9.0)	20 (9.0)	4.042	2	.132
Undergraduate	128 (57.9)	57 (25.8)	57 (25.8)			
Postgraduate	62 (28.1)	29 (13.1)	29 (13.1)			
	Respondent's years of work experiences					
Under 5 years	35 (18.8)	11 (5.0)	24 (10.9)	7.922	3	.048
5-10 years	60 (27.1)	36 (16.3)	24 (10.9)			
11-15 years	47 (21.3)	24 (10.9)	23 (10.4)			
Above 16 years	79 (35.7)	44 (19.9)	35 (15.8)			

Table 9 presents the distribution of sociodemographic characteristics and levels of self-care practices. Concerning the age distribution, data shows that the frequency of balanced level of self-care practices was higher among the respondents aged 41-50 years at 18.1% as opposed to 21-30 years at 5%, 31-40 years at 14.5%, 51-60 years at 9.5% and 61-70 years at 0.9%. However, majority of the respondents with imbalanced self-care practice were also among the respondents aged 41-50 years at 18.6%, followed by aged 31-40 years at 17.2%. Chi-square test shows that there was no significant difference in the distribution of the respondent's age and the levels of self-care practices ($p=0.827$). This means that data was almost equally distributed with no significant difference.

4.6 Levels of Vicarious Posttraumatic Growth among counsellors

The second objective in this study sought to evaluate the level of vicarious posttraumatic growth among the respondents. Vicarious Posttraumatic Growth (PTG) Inventory was used to collect data from the respondents. VPTG is a 21-item Likert scale that measures trauma victims' posttraumatic growth, the possible minimum possible score is 0 while the maximum possible score is 105.

The distribution of responses on VPTG score ranged from a score of 49 to 105 as shown in figure 3.

Figure 4: Totals of VPTG among respondents

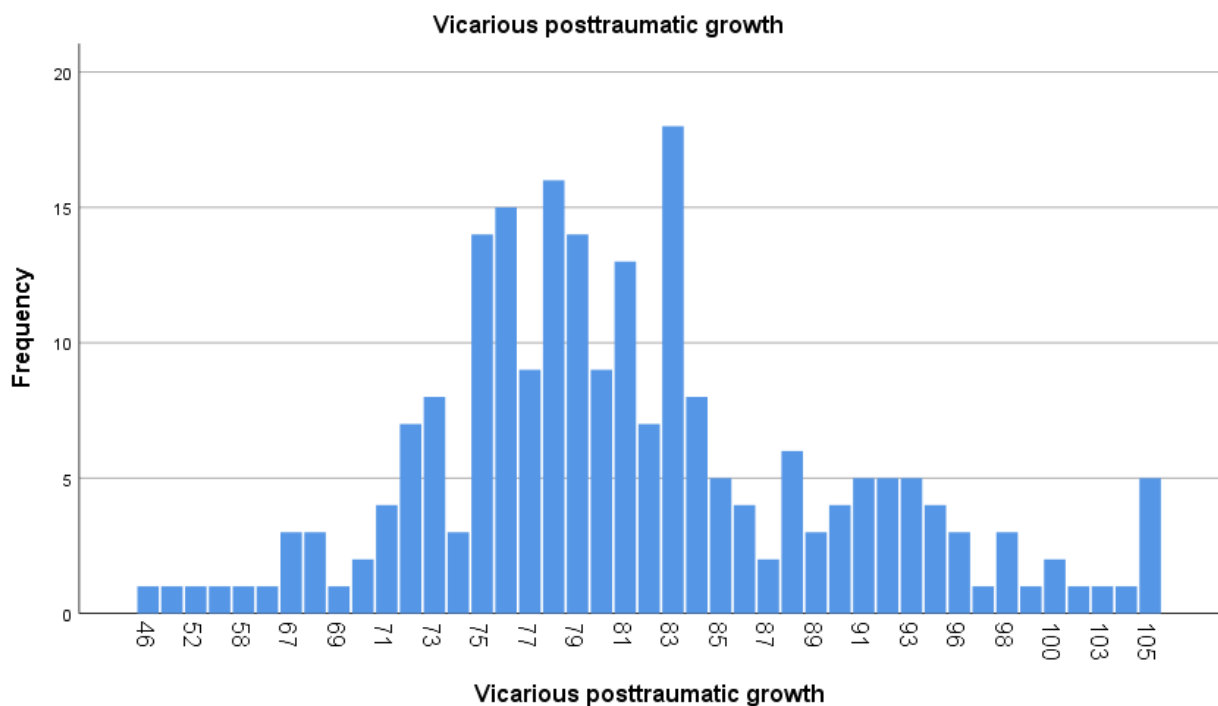


Figure 4 shows the distribution of responses on various level of VPTG among the respondents. The score with majority is 83 with a frequency of 17.

From the responses scores on the PTG inventory, scores below 60 indicated a low level of growth, between 61 and 79 indicated a moderate level of growth while those of 80 and above indicated a high level of growth. Table 10 shows the respondents' scores on VPTG.

Table 10: Classification of VPTG levels among respondents

Variables	Ranges	Frequency	Percent
Low level of growth	0-60	5	2.3
Moderate level of growth	61-79	100	45.2
High level of growth	80-105	116	52.5
Total		221	100

The Table presents the frequency of Vicarious Posttraumatic Growth (PTG) levels. The frequency of high level of growth was slightly higher at 52.5% as opposed to moderate level of growth at 45.2% and low level of growth was minimal at 2.3%. This implies that slightly more than half of the respondents had high level of vicarious posttraumatic growth.

The levels of VPTG among the respondents were also compared against the participant's social demographic characteristics and chi square test performed to assess significance. The results are shown on table 11.

Table 11: Levels of VPTG in relation to Demographic Characteristics

Variables	Total	Classification of VPTG			Chi-Square
		Low	Moderate	High	
Respondent's age					
21-30 years	21 (9.5)	2 (0.9)	4 (1.8)	15 (6.8)	$x^2 = 18.270$ $p = 0.019$
31-40 years	70 (31.7)	2 (0.9)	36 (16.3)	32 (14.5)	
41-50 years	81 (36.7)	1 (0.5)	43 (19.5)	37 (16.7)	
51-60 years	42 (19.0)	0 (0.0)	16 (7.2)	26 (11.8)	
61-70 years	7 (3.2)	0 (0.0)	1 (0.5)	6 (2.7)	
Respondent's Gender					
Male	66 (29.9)	2 (0.9)	36 (16.3)	28 (12.7)	$x^2 = 3.859$ $p = 0.145$
Female	155 (70.1)	3 (1.4)	64 (29.0)	88 (39.5)	
Respondent's highest educational level attained					
Form IV	2 (0.9)	0 (0.0)	0 (0.0)	2 (0.9)	$x^2 = 5.831$ $p = 0.442$
Diploma/Bachelor	148 (67.0)	2 (0.9)	73 (33.0)	73 (33.0)	
PG Diploma/Masters		3 (1.4)	26 (11.8)	40 (18.1)	

PhD	69 (31.2) 2 (0.9)	0 (0.0)	1 (0.5)	1 (0.5)	
	Respondent's religious affiliation				
Christian	214 (96.8)	4 (1.8)	98 (44.3)	112 (50.7)	$\chi^2 =$
Islamic		0 (0.0)	2 (0.9)	4 (1.8)	43.915
Hinduism	6 (2.7) 1 (0.5)	1 (0.5)	0 (0.0)	0 (0.0)	p = 0.000
	Respondent's highest professional training				
Diploma/Higher Diploma	31 (14.0)	1 (0.5)	8 (3.6)	22 (10.0)	$\chi^2 = 8.204$ p = 0.084
Undergraduate	128 (57.9)	2 (0.9)	67 (30.3)	59 (26.7)	
Postgraduate		2 (0.9)	25 (11.3)	35 (15.8)	
	Respondent's years of work experiences				
Under 5 years	35 (18.8)	1 (0.5)	6 (2.7)	28 (12.7)	$\chi^2 =$
5-10 years	60 (27.1)	2 (0.9)	30 (13.6)	28 (12.7)	18.215
11-15 years	47 (21.3)	2 (0.9)	27 (12.2)	18 (8.1)	p = 0.006
Above 16 years	79 (35.7)	0 (0.0)	37 (16.7)	42 (19.0)	

Table 11 displays the distribution of social demographic characteristics and levels of vicarious posttraumatic growth. Regarding the age distribution, frequency of moderate level of vicarious posttraumatic growth (VPTG) was higher among the respondents aged 41-50 years as opposed to 31-40 years at 16.3%. Similarly, high level of VPTG was slightly higher among the respondents aged 41-50 years at 16.7% compared to the respondents aged 31-40 years at 14.5%, 51-60 years at 11.8% and other age categories. Chi-square test indicates that the difference in the distribution of the respondents' age categories and classification of VPTG was significant ($p = 0.019$). This implies that significant relationship exists between the respondent's age and levels of vicarious posttraumatic growth.

Concerning the respondent's gender distribution moderate level of VPTG was higher among female respondents at 29% as opposed to male respondents at 16.3%. Likewise, the frequency of high level of VPTG was higher among female respondents at 39.5% as opposed to male respondents at 12.7%. Meanwhile, Statistical test indicates that the difference in the distribution of respondents' gender and levels of VPTG ($p = 0.145$).

4.9 Relationship between Self-Care Practices and Vicarious Posttraumatic Growth

The third objective sought to analyze whether levels of relationship between self-care practices and vicarious posttraumatic growth. The researcher sought to examine the relationship between total self-care practice and total VPTG among the respondents. The distribution of the scores is as indicated in Figure 4

Figure 5: Relationship between total self-care practices and total VPTG

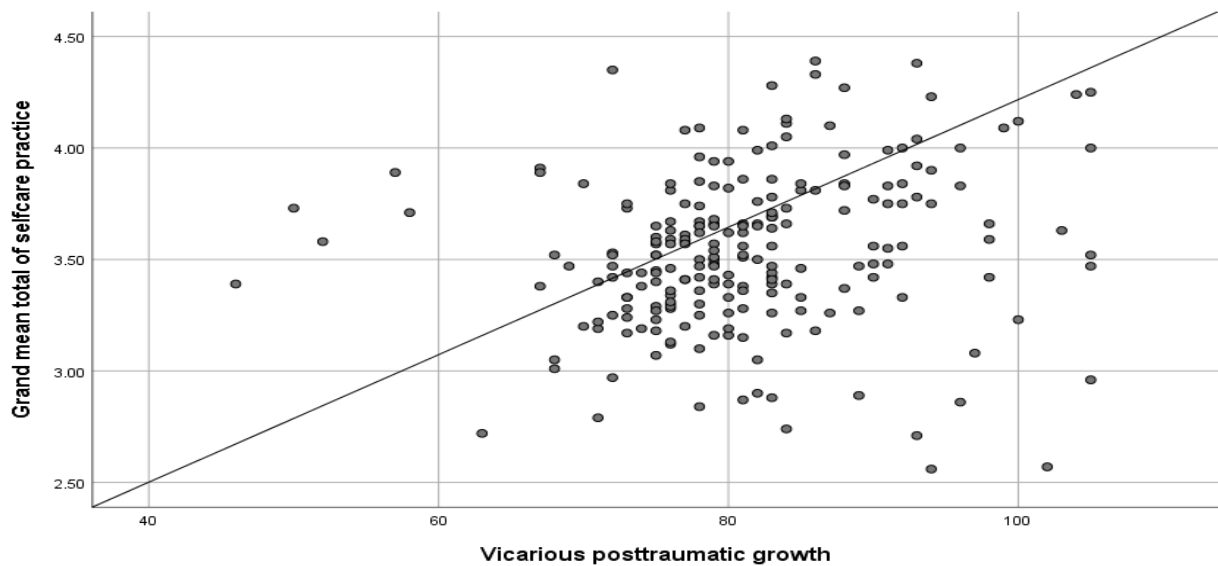


Figure 5 shows a visual representation of how the total scores for each variable relates with each other. There is a positive insignificant relationship between self-care practices and vicarious posttraumatic growth among the respondents.

Pearson correlation test was carried out to investigate the levels of relationship within the dimensions of self-care practice and VPTG. Table 13 presents the findings of the test.

Table 12: Relationship between self-care practices and VPTG.

	VPTG	Physical	Psychological	Emotional	Spiritual	Professional
VPTG	-					
Physical	.005	-				
Psychological	-.013	.291**	-			
Emotional	.264**	.267**	.290**	-		
Spiritual	.264**	.211**	.308**	.652**	-	

Professional	.130*	.196**	.285**	.349**	.331**	-
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** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (1-tailed).

As indicted in the Table, data shows a positive correlation between emotional self-care practices and VPTG at 2-tailed significant level ($r = .264$; $p = 0.01$). A positive correlation in this data implies that the two variables move in the same direction. This means that increase in the level of emotional self-care practices also increases the level of VPTG. Therefore, the higher the emotional self-care practices, the higher the victorious posttraumatic growth. Furthermore, this study found a positive correlation between levels of spiritual self-care practices and levels of VPTG at 2 tailed ($r = .264^{**}$; $p = 0.01$). Positive correlation from this data implies that as the level of spiritual self-care practices increases, the level of VPTG also increases. This suggests that the higher the level of spiritual self-care practices, the higher the level of victorious posttraumatic growth.

The researcher performed coefficient test to establish the possible linear relationship between self-care practices and vicarious posttraumatic growth among the respondents. Chi-square results and levels of significance for the two variables were included. The findings of the test are as shown in Table 13.

Table 13: Coefficient test of linear relationship between self-care relationship and vicarious posttraumatic growth

Variables	Total	Vicarious posttraumatic growth			X ²	Sig.
		Low	Moderate	High		
Levels of physical self-care						
Low level	138 (62.4)	0 (0.0)	69 (31.2)	69 (31.2)	.005	.071
High level	83 (37.6)	5 (2.3)	31 (14.0)	47 (21.3)		
Levels of psychological self-care						
Low level	108 (48.9)	2 (0.9)	49 (22.2)	57 (25.8)	.161	.922
High level	113 (51.0)	3 (1.4)	51 (23.1)	59 (26.7)		
Levels of emotional self-care						
Low level	123 (55.7)	2 (0.9)	73 (33.0)	48 (21.7)	22.265	.000
High level	98 (44.3)	3 (1.4)	27 (12.2)	68 (30.8)		
Levels of spiritual self-care						
Low level	123 (55.7)	3 (1.4)	71(32.1)	49 (22.2)	18.036	.000

High level	98 (44.3)	2 (0.9)	29 (13.1)	67 (30.3)		
	Levels of professional self-care					
Low level	97 (43.9)	2 (0.9)	52 (23.5)	43 (19.5)	4.893	.087
High level	124 (56.1)	3 (1.4)	48 (21.7)	73 (33.0)		

Table 13 presents the contingency coefficient test of linear relationship between dimension of self-care practices and vicarious posttraumatic growth. The Chi-square test indicates that there was no significant difference in the distribution of physical self-care and levels of VPTG ($p = 0.071$). This means that there was no linear relationship between physical self-care practices and levels of VPTG.

In relation to levels of psychological self-care, data collected indicate that respondents who score high on level of psychological self-care equally scored high on high level of VPTG (26.7%) as opposed to moderate level of VPTG (23.1). Also, the respondents with low level of emotional self-care score higher on moderate level of VPTG at 33% compared to high level of VPTG at 21.7% and low level of VPTG at 0.9%. The Chi-square test showing contingency coefficient indicates a significant relationship ($p=0.000$). This implies that the higher the level of emotional self-care practices, the higher the level of vicarious posttraumatic growth.

Chi-square test shows that there was a significant linear relationship between the levels of spiritual self-care practices and levels of VPTG ($p =0.000$). This implies that the higher the level of spiritual self-care practices, the higher the levels of vicarious posttraumatic growth. Consequently, data on levels of professional self-care practices indicates that the respondents with high level of professional self-care also scored higher in high level of VPTG at 33% compared to moderate level at 21.7% and low level of VPTG at 1.4%. However, the contingency coefficient test shows that there was no significant relationship between the two variable ($p = 0.087$). That means the difference in the distribution was not significant.

This study was guided by two hypotheses, a null and alternate hypothesis. Pearson correlation test was conducted to ascertain whether there is relationship among the two variables. The findings of a two tail test are shown in Table 14.

Table 14: Two tail test between self-care practices and VPTG

		Correlations	
		Grand mean total of self-care practice	Vicarious posttraumatic growth
Grand mean total of self-care practice	Pearson Correlation	1	.176**
	Sig. (2-tailed)		.009
	N	221	221
Vicarious posttraumatic growth total	Pearson Correlation	.176**	1
	Sig. (2-tailed)	.009	
	N	221	221

** . Correlation is significant at the 0.01 level (2-tailed).
 R = .176 ** p = 0.009

Table 14 shows $r=.176$ which shows a positive relationship between the variables. With this finding the Null hypothesis is nullified and Alternate hypothesis that asserted a possible relationship between the variables accepted. The scores indicate that an increase in one variables results to an increase in the other variable.

Binary logistic regression was conducted to test the predictability of practicing balanced self-care on higher level of VPTG. The result of the testing is shown in table 15 and figure 6.

Table 15: Binary Logistic regression testing the predictability of balanced self-care practices and VPTG.

		Estimates predictable parameters					95% C.I. for EXP(B)		
		B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Step	VPTG	.547	.254	4.649	1	.031	1.728	1.051	2.841
1 ^a	Constant	-1.453	.652	4.965	1	.026	.234		

a. Variable(s) entered on step 1: Classification (Levels) of VPTG.

As shown on the Table, findings indicate that practicing balanced self-care is a predictor of higher VPTG (AOR: 1.73; CI 95%: 1.051-2.841. $p = 0.031$). This implies that the balanced self-care has the 1.73 times likelihood of predicting experiencing higher level of vicarious posttraumatic growth.

Figure 6: The logistic regression showing the relationship between practicing balanced self-care and higher level of VPTG.

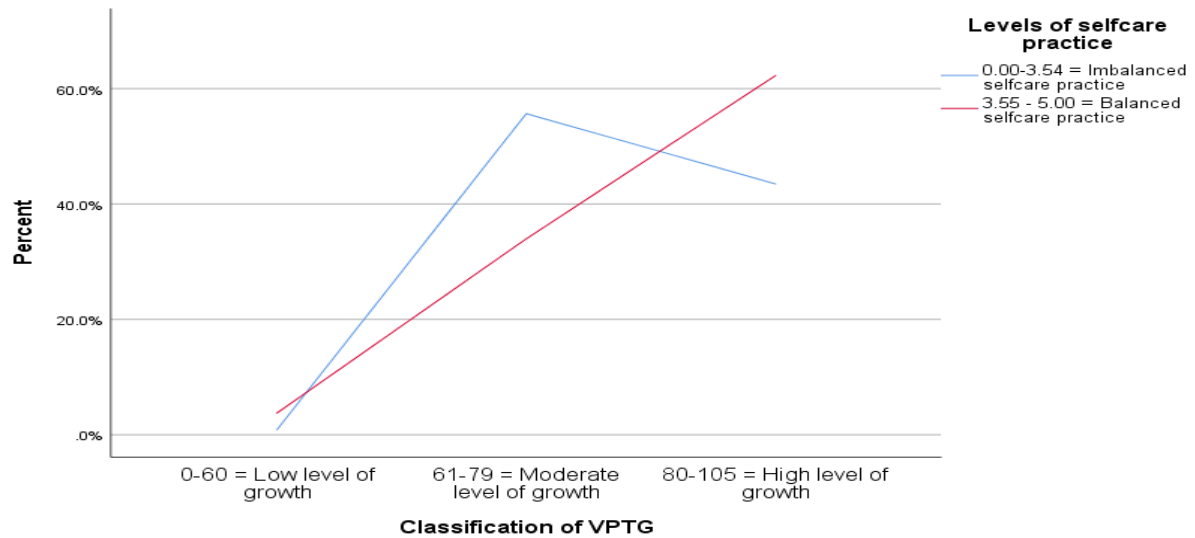


Figure 6 shows the graphic representation of logistic regression. It shows the connection and relationship between the balanced self-care practice and high level of growth. In other words, significant relationship exists between balanced self-care practice and high level of growth. Similarly, levels of relationship also exist between imbalanced self-care practice and moderate level of growth. The balanced and imbalanced curves intersect at two points. At lower levels of growth, the rate of increase of imbalanced self-care is higher than that of balanced self-care. The proportion of the participants with imbalanced self-care begins to decline once the participants reach the moderate level of growth (61-79). The proportion of the participants exhibiting balanced level of growth increases consistently during the period across the low, moderate and high levels of growth.

4.10. Limitations of the Study

This study was a cross-sectional study design, this being the case the results was difficult to interpret as they only identify relationships between the variables and not cause and effect. To accurately assess a cross sectional study’s findings, further research is called for.

Additionally, to accurately represent a population, cross sectional studies require a large sample size which was difficult to achieve thus making the study less reliable.

Another limitation is that, the quantitative research paradigm overlooks the respondents' experiences and perspectives in highly controlled settings, because there lacks a direct connection between researchers and the participants when collecting data.

Further, the instruments used were administered online and therefore a likely challenge of self-selection bias where only those interested or motivated responded to the questionnaire. Additionally technical issues such as poor internet connectivity or compatibility problems may have led to incomplete responses as was the case for this study.

Despite the few limitations which have been noted in this study, the methods used for data analysis were found to be satisfactory and they effectively helped the researcher to meet the objectives of the study.

4.11 Chapter Summary

This quantitative research sought to examine the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County. This chapter presented various findings from the socio-economic demographic questionnaire, the Self-Care Assessment Worksheet (SCAW), which assesses six dimensions of self-care such as physical care, psychological care, emotional care, spiritual care, professional/workplace self-care, and balanced self-care. Also, Vicarious Posttraumatic Growth (PTG) Inventory, which assesses levels of growth: low, moderate, and high levels of growth. Data collected using both the researcher-generated sociodemographic questionnaire and the standardized instruments were presented, analysed, and interpreted. The next chapter, discusses the key findings, concludes, and provides recommendations for further studies.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

The chapter provides a discussion of study results while comparing them with key findings of similar studies worldwide. The discussion addressed the associated three objectives of the study as well as the socio-demographic characteristics of respondents' age categories, gender, highest level of education attained, religious affiliation, highest professional training, and years of work experience. Further, in this chapter the conceptual framework was revisited to assess relationship among the variables of the study topic.

5.2 Demographic Characteristics

The respondents were male and female adults working as counsellors in Nairobi country. The response rate was found to be 81.4% (n = 249) and this can be justified in comparison with other similar study done in other places among the medical study (Kadel & Bhandari, 2018). Most of the KCPA registered counsellors that participated in this study were aged above 21 years with majority being 41-50 years old at 36.7% (n = 81). This was expected to be due to the fact that the majorities of practicing counsellors are of middle adulthood age bracket.

With reference to the respondent's years of work experience, findings indicate that the respondents who had worked for over 16 years was higher 35.7% (n = 79) as against those who have worked for less than 5 years (35, 15.8%), 6-10 years (60, 27.1%), and 11-15 years (47, 21.3%). Therefore, majority of respondents had been exposed to higher trauma incidences necessary for answering questionnaire prompts and meeting the study's set objectives.

Findings on gender representation did not attain gender balance with female participants representing the majority 70.1% (n = 155) which could present challenges in study findings' practical representativeness and generalizability. However, Dickinson et al. (2012)

states that the resulting sample size might be imbalanced in terms of gender but representative due to its approximation of the gender groups' sizes in the counselling profession in Nairobi County with more KCPA registered women counsellors. Considering the argument on representativeness with a potential for minimised bias, the results would be generalizable for empirical research, informing counselling practice, and in policy formulation.

Findings on professional training, indicated that all the respondents had relevant professional training, ranging from diploma to postgraduate but those with undergraduate qualification were the highest 57.9% (n = 128) compare to others.

5.3 Level of Self-Care Practices Among Counsellors in Nairobi County

The first objective was to investigate the levels of self-care practices among the counsellors in Nairobi County. Nairobi County counsellors are set to benefit from having an awareness regarding their levels of self-care practices and attempting to attain a healthy self-care routine by successfully achieving the requirements for high levels of all the self-care practices' dimensions (Lin & Wilson, 2019; Uche, 2022). This section discusses salient findings established on the various levels of physical, psychological, emotional, spiritual, professional/workplace, and balanced self-care practices while comparing them with other key findings in renowned studies around the world.

The study established that low levels of physical self-care were higher at 62% (n = 138) as opposed to high levels of physical self-care at 37.6%. (n = 83). The counsellors indicated to practice physical self-care much less in their daily activities. As proclaimed by VanKim and Nelson (2013), the counsellors that engaged themselves in regular physical activities experienced reduced stress, anxiety, and depression. Therefore, the general outlook of low awareness in the benefits associated with physical self-care meant that Nairobi Counsellors had inadequate physical fitness required for improved mental activity.

On the other hand, the study findings indicated prevalence of high levels of psychological self-care practices being slightly higher at 51% (n = 113) as opposed to low level of psychological self-care practices at 49% (n = 108). Coleman et al. (2021) suggests that high psychological self-care is essential for positively altering affect regulation, perception, sense of self, consciousness, systems of meaning, and relating with other professionals. These findings establish a connection between psychological self-care and emotional self-care practices which are meant to be responsive calls for the counsellors' sphere of influence. Additionally, these findings concur with Orem's theory of self-care that asserts that, thoughtful self-care undertakings have to be conducted for the sustenance of the counselors' well-being. Orem's self-care theory is based on the assumption that people take responsibility of their well-being and actively initiate activities that preserve that well-being (Orem, 2001). Thus, the increased prevalence of moderate and high level of self-care practices indicate that the counsellors in Nairobi County understand the need to preserve their functioning and well-being, which inspires them to undertake self-care activities.

Since the proportion of low level of emotional self-care practices were found to be higher at 55.7% (n = 123) as compared to higher level at 44.3% (n = 98), it meant that counsellors in moderately practiced learning, growth, and thinking activities that enhances personal and development (Baker & Gabriel, 2021). The study findings established that there was a slight difference between low level of spiritual self-care practices at 55.7% (n = 123) and high level of spiritual self-care practices at 44.3% (n = 98). Even though the counsellors involved in the study indicated to have awareness on the importance of integrating spiritual self-care practices for enhanced health and wellbeing their level of engagement was moderate in their professional and personal lives. Spiritual and religious competency is required for a counsellor to embrace diversity and as a resource for burnout prevention which is a form of self-care in practice (Giles, 2013). McGrath (2011) asserts that spiritual growth was important

for supported personal resilience. However, the low levels demonstrated by this study's respondents indicated restrained positivity and openness in state of mind which could encourage empathy overload and hinder looking after the clients' needs.

The study found out that the proportion of high level of professional workplace self-care was higher at 56.1% (n = 124) compared to low level of professional workplace self-care at 43.9%. (n = 97). The study indicated that respondents were trained on self-care strategies necessary for overcoming hazards in the profession (Thériault et al., 2015). The key findings from the study appeared to be in harmony with assertions in Thériault et al. (2015), that there was no unequivocal quest for incorporating self-care practices in the counsellors' professional workplace which made them to sparingly address the workplace hazards associated with intensive counselling. However, it is notable that a slightly higher population of Nairobi Counsellors have integrated self-care strategies into their professional workplace for enhanced wellbeing.

Finally, this study found the prevalence of balanced self-care practices at 48% (n = 106), slightly above half of the respondents at 52%, (n = 115) had imbalanced self-care practices. Posluns and Gall (2020) expressed the need for a balance in attending to physical, psychological, emotional, spiritual, and workplace/professional self-care practices. The sense of equilibrium emanating from shared experiences would have a positive impact on the general wellbeing of the counsellor. Exploring a wide variety of interventions that promote holistic, balanced individuals is fundamental to the profession of counselling. With a majority of respondents having worked for more than 16 years, the findings were in harmony with assertions by Rivera-Kloeppel and Mendenhall (2023) who stated that experienced professionals were more aware regarding their workplace hazards which enhanced their propensity to engage in self-care practices meant to improve their wellbeing.

5.4 Level of Vicarious Posttraumatic Growth Among Counsellors in Nairobi County

The second objective in this study sought to measure the level of vicarious posttraumatic growth among the respondents. Vicarious Posttraumatic Growth (PTG) Inventory was used to realize this second objective. VPTG is a 21-item Likert scale that measures trauma victims' posttraumatic growth, the possible minimum possible score is 0 while the maximum possible score is 105.

The key findings of this study established high level of vicarious posttraumatic growth among counsellors in Nairobi County to be slightly higher at 52.5% (n = 116) compared to moderate level of growth at 45.2%,(n = 100) and low level of growth at 2.3% (n = 5). The study findings confirmed the assertions by Long (2020), Slade et al. (2019), and Zieba et al. (2019) that an experience of vicarious trauma resulted in an intrinsically motivated sense of perceived life importance, improved personal relationships and spiritual engagements, as well as feelings of self-control over an individual's self-management. According to Sui and Padmanabhanunni (2016, p.1), long exposure to vicarious trauma disrupted the counsellors' cognitive schemas but eventually resulted in an "enhanced sense of personal interconnectedness and positive changes in their philosophy of life and self-perceptions." As the counsellors tried to rebuild the assumptive world they formed during high trauma level exposure, they re-examined their numerous life aspects while making meaning out of the survived episode of vicarious trauma.

The research evidence by Tsirimokou et al. (2023) and Sui and Padmanabhanunni (2016) confirms that long exposure to vicarious trauma and lived experiences through the years meant that practitioners that were older could effectively and efficiently applied positivity in their general outlook to life and connectedness to self, others, nature, and spirituality. Therefore, the study's key findings of moderate level of growth being higher among the respondents aged 41-50 years at 16.3%, (n = 36) and high level of growth being higher among

the respondents' aged 41-50 years at 16.7% (n = 37), was confirmed by studies conducted by Manning-jones et al. (2017) and Sui and Padmanabhanunni (2016). The older practitioners were more likely to experience a renewed sense of personal strength and resilience that is critical to high level of vicarious posttraumatic growth as evidenced by Tsirimokou et al. (2023) and Hyun et al. (2021). The key findings were in agreement that there was improved development of strength and resilience in terms of persistence, optimism, hardiness, and support with increased exposure to vicarious trauma and the progression of practitioner age.

The study's key findings regarding gender vicarious posttraumatic growth levels were in harmony with research evidence that the female gender exhibited higher resilience and strength levels that had significant relationship with vicarious posttraumatic growth when compared to their male counterparts (Hyun et al., 2021). The study by Hyun et al. (2021) states that women were more willing to endure to fulfil the job and engage in 'circumspect thinking' while tolerating negative effect through hardiness and persistence. As established by the study's key findings in terms of gender distribution, moderate growth was high among the female respondents at 29% (n = 64) as well as high level of growth among the female respondents at 39.5% (n = 88) as opposed to the male respondents. The female counsellors had a higher capability for applying positivity through enhanced sense of connectedness to self, others, nature, and spirituality which have a positive associative impact on vicarious posttraumatic growth (Hyun et al., 2021; Sui & Padmanabhanunni, 2016). The study by Zieba et al. (2019) mostly consisted of female students and it established that majority experienced significantly high levels of posttraumatic growth associated with the dimensions of personal strength, relating to others, appreciation of life, new possibilities, and spiritual as well as existential change.

With reference to level of education, the findings indicated moderate and high levels of growth to be higher among the respondents whose levels of education was diploma/bachelor's

degree at 33% (n = 73) respectively. The key findings pointed out level of education as another vital factor that could be used in predicting vicarious posttraumatic growth among counsellors in Nairobi County. Counsellors with diploma/bachelor's as their highest level of education signified a high predictive power whereby they demonstrated high level competence in factors regarding cognitive, interpersonal, psychological, behavioural, and other external factors that are critical towards vicarious posttraumatic growth (Tsirimokou et al., 2023). The study's key findings regarding the factor of highest level of education attained meant that professionals who held a diploma/degree qualification engaged in meaning making better as they changed their sense of worldview after exposure to vicarious trauma compared to others.

Finally, this study found the frequency of moderate level of VPTG to be higher among the respondents who had worked for 16 years and above at 16.7% (n = 37). The socio-demographic characteristic associated with a counsellor's years of work experience denoted that increased exposure levels had the capability of recognizing importance of their role, stronger sense of self, finding meaning in their own life, and more appreciation for their own personal circumstances (Tsirimokou et al., 2023). This study's findings were consistent with the study by Ben-Porat (2015) that higher vicarious posttraumatic growth was experienced by social service therapists as their years of experience increased. More than 16 years working experience made certain that the counsellors in Nairobi County developed more flexibility to accommodate new information regarding the worldview and increased effort towards finding meaning which offered them more opportunity for vicarious posttraumatic growth. The assertion is in agreement with Organismic valuing theory that cumulative and transforming effects of working with survivor clients could lead to cognitive shifts with pervasive effects on therapists' cognitive schemas, such as identity, world view, beliefs and psychological needs.

5.5 Relationship Between Self-Care Practices and Vicarious Posttraumatic Growth among counsellors in Nairobi County

The third objective of this study was to measure whether there was a significant relationship between self-care practices and vicarious posttraumatic growth among the participants. To determine whether there is a relationship between the two variables, Pearson's correlation was applied to determine whether the correlation is positive or negative. Further, to determine the degree of correlation, (Pearson's 'r' Coefficient p-value) was applied. Linear regression test was also done to determine the relationship between the two variables.

According to the study's key findings, there existed significant positive correlations within the dimensions of self-care. The significant associative impacts within the self-care dimensions signified an automatic increase in other self-care dimensions when one of the self-care dimensions was enhanced through associated practices. The study's key findings were consistent with research conducted by Zahniser et al. (2017) which state that self-care served to safeguard against harmful stress inherent impact while enhancing great personal wellbeing and improved self-reported progress. The assertions by Zahniser et al. (2017) were consistent with the study's arguments that a counsellor who is strong-willed towards improving a specific self-care dimension as a professional support system was capable of preserving the sustained awareness of their reactions and needs with a high susceptibility towards engaging in further self-care practices. This implied that causal and effect relationship existed within and between the variables.

Therefore, encouraged self-care among counsellors could result in significant positive results towards other self-care practices due to the trickle-down effect associated with being committed to a particular self-care practice. For instance, the study's key findings indicated a very strong correlation between spiritual self-care practices and emotional self-care practices ($r = .652$; $p = 0.01$). The interpretation established that the strong associative impact between

emotional self-care practices and spiritual self-care practices meant that counsellors that invested in cultivating their spiritual life reaped massively from enhanced mental health benefits which were considered an indicator for improved personal wellbeing. The findings reflect the tenets of Linley and Joseph's Valuing Theory, which state that human beings are constantly striving towards higher levels of psychological functioning by adopting activities that enhance that wellbeing. Based on the evaluation of their experience, they get motivated to execute actions that can enhance their experience (Joseph & Linley, 2008). It seems that the participants evaluated their vicarious posttraumatic growth and sensed that whatever they were doing was not fulfilling their needs, which motivated them to adopt particular self-care practices to improve their psychological functioning and wellbeing.

The key findings of the study established that there were contingency coefficients significant relationship between higher level of emotional self-care practices and higher level of vicarious posttraumatic growth ($p = 0.00$). The result was consistent with the findings in the study conducted by Sadeghpour et al. (2020) which state that vicarious posttraumatic growth relates with personal strength, appreciation of life, new possibilities, spiritual change, and relating to others was attributed to positive and significant variations in emotional self-care ability. These statements shared similarities with the study's findings regarding the Pearson correlation test which revealed a positive strong correlation between emotional self-care and VPTG. The study by Sadeghpour et al. (2020) and Deaton (2020, p.2) relates vicarious posttraumatic growth with positive psychological changes that include "being more expressive emotionally in personal relationships, and a newfound purpose and meaning to the trauma work" which was a dependable unit of information applicable to the current study's key findings. Therefore, counsellors that were highly susceptible towards maintaining a compassionate and positive view of self and capable of positively negotiating internal and

external demands to cope with tough situations, calm their nervous system, and boost their mood would experience high levels of vicarious posttraumatic growth after exposure.

On the other hand, the study's key findings found out that there was a significant linear relationship between the higher levels spiritual self-care and higher level of vicarious posttraumatic growth ($p = 0.00$). The key finding shared similarity with the study by Deaton (2020, p.5) that confirmed spiritual change or spirituality as "a domain acknowledging an individual's experience of positive change through an existential lens" and was an area recognised for its posttraumatic growth. This was consistent with this study's key finding regarding Pearson correlation test that revealed a positive and strong correlation between levels of spiritual self-care and VPTG. Positive changes in Nairobi Counsellors' view of spirituality included changes in cognitive schemas since most of them indicated to strengthen their increased sense of intimacy, control, and finding meaning in the emotional context (Deaton, 2020). The finding's understanding is that there was a very strong positive correlation between spiritual self-care practices and emotional self-care practices ($r = .652$; $p = 0.01$) as emphasized by Deaton (2020). Spirituality was acknowledged as a therapeutic resource capable of enhancing vicarious posttraumatic growth.

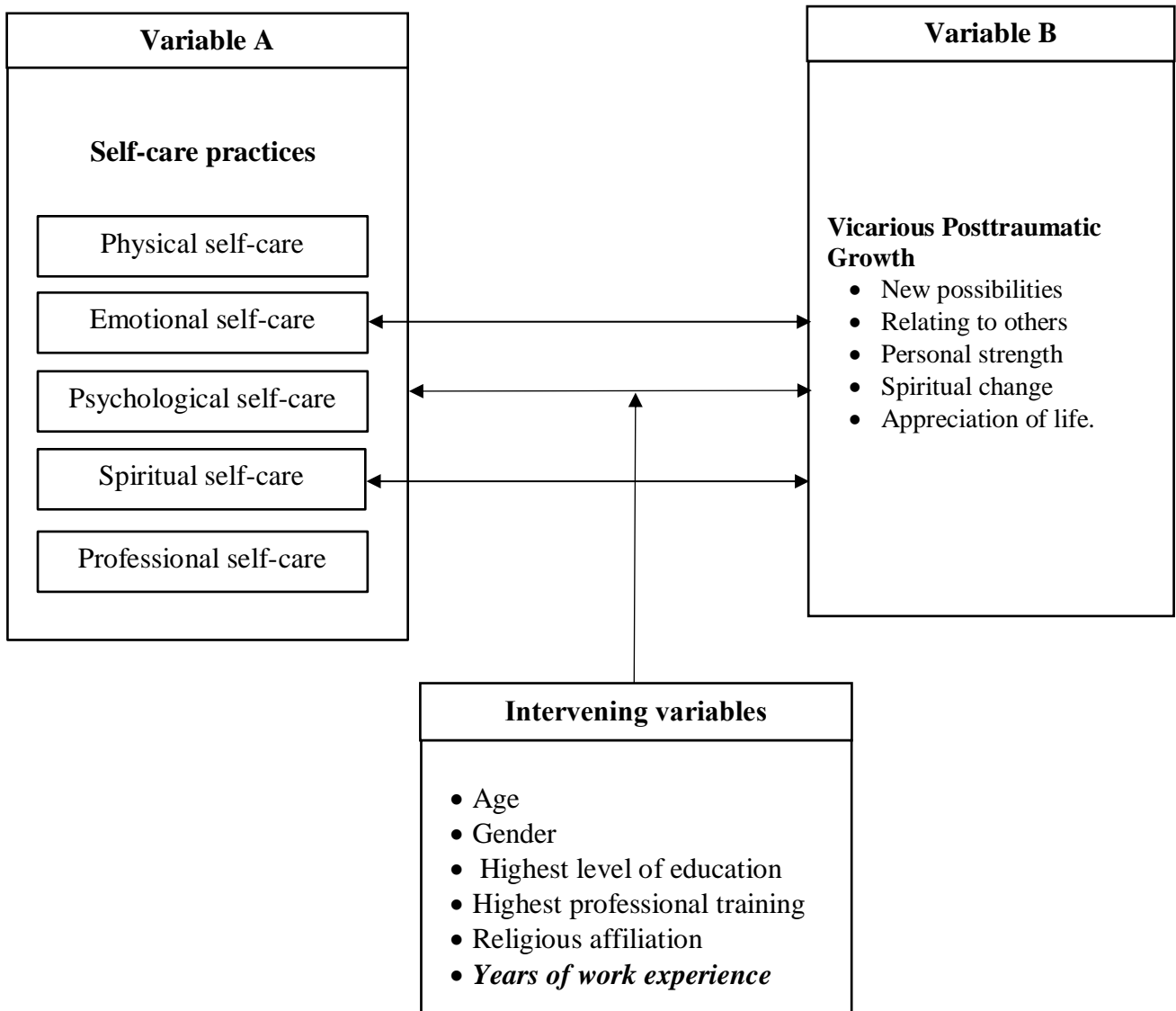
Finally, the implication of the study's findings suggested that the higher the levels of self-care, the higher the VPTG. In terms of predictive relationship, this study found that practicing balanced self-care had a 1.73 times likelihood to experience higher levels of vicarious posttraumatic growth. Study findings by Sawyer (2023), Kinsella et al. (2020) as well as Trowbridge and Mische Lawson (2016) acknowledged that mindfulness had the capacity for developing professional practice placement and enhancing a balance in self-care practices. Therefore, a balance in self-care practices strengthened the capability towards accepting present moments, enhanced the counsellors' capacity for concentration and attention, and increased the professionals' self-regulation capacities hence enabling a possession of greater

compassion and self-awareness (Sawyer, 2023). Cuartero and Campos-Vidal (2019) confirmed that balanced practicing of professional and personal self-care reduced the levels of compassion fatigue and increased levels of satisfaction among practitioners hence would be considered beneficial to Nairobi Counsellors. As a validation, research findings were consistent with the study's hypothesis testing results which found evidence to reject the null hypothesis and assert that there was a significant relationship between self-care practices and vicarious posttraumatic growth among Nairobi County counsellors.

5.6 Re-visiting Conceptual Framework

Figure 6, presents the revisited conceptual framework of this study showing the relationship between self care practices and vicarious posttraumatic growth among respondents. The aim of revisiting conceptual framework is to determine whether the variables being studied have remained the same or whether has changed during the course of study or even after the study. Figure 6 shows the reconstructed conceptual framework after the data analysis.

Figure 7: Relationship between self-care practices and vicarious post traumatic growth.



Source: Author (2023)

Figure 6 above depicts the recreated conceptual framework after the data analysis and testing for the relationship between the variables. Test of linear relationship between self-care relationship and vicarious posttraumatic growth showed that only emotional self-care practices (sig.= 0.00; $p < 0.05$) and spiritual self-care practices (sig.= 0.00; $p < 0.05$) had a significant relationship with vicarious posttraumatic growth. However, an overall two-tailed test showed there is a significant relationship between self-care practices and vicarious posttraumatic

growth among the counselors in Nairobi County. The two-way arrow touching the outer box depicts the overall relationship based on the two-tailed test while the two thin two-way arrows that originate from the inner boxes depict the linear relationship tested for each practice independently.

The only demographic variable that had a significant effect on the relationship between self-care practices and vicarious posttraumatic growth is respondents' years of work experience (sig.=0.048). All other demographic variables were not significant intervening variables. Thus, in overall, the conceptual framework illustrates that the vicarious posttraumatic growth elements of new possibilities, relating to others, personal strength, spiritual change, and appreciation for life were attributed to high levels of physical, emotional, psychological, spiritual, and professional dimensions.

5.7 Chapter Summary

The chapter has presented a discussion of the findings with reference to existing literature. The sample was imbalanced but representative of the group sizes in the counseling profession for Nairobi County. The chapter confirmed a consistency between the current study's findings and past studies in other contexts, confirming the hypothesis that counselors in Nairobi County practice self-care practices. Moreover, past studies support the current study's findings by revealing that self-care practices are related to posttraumatic growth among the counselors in Nairobi County. The findings were further supported by Dorothea Orem's self-care theory, which emphasizes the need for self-care as an ingredient for positive life outcomes.

CHAPTER SIX

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.1 Introduction

This chapter presents a summary of the study's findings, conclusion, and recommendations that are derived from the research study. The chapter also makes recommendations for future research on the topic.

6.2 Summary

The findings of this study established that the prevalence of balanced self-care practices at 48% (n = 106). This means that slightly above half of the respondents at 52% (n = 115) have imbalanced self-care practices. This can be considered a general outlook as far as how well counsellors in Nairobi country exercise self-care practices. More so, respondents aged 41-50 years practice more of balanced self-care practices when compared to other age categories. Also, female respondents were found to exhibit more of balanced self-care practices at 30.9% (n = 68) as opposed male respondents at 17.3% (n = 38). Christians were noticed to display more of balanced self-care practices 46.2% (n = 102) as opposed other religious affiliations. In terms of the respondent's years of work experiences this study found that higher frequency of balanced self-care practices was among the respondents who had worked for more than 16 years at 15.8% (n = 35) compared to other categories.

Key findings regarding various dimensions of self-care practices stated that prevalence of high levels were on psychological self-care practices slightly higher at 51% (n = 113), and professional workplace self-care was higher at 56.1% (n = 124) compared to other categories. It was commendable that a slightly higher population of Nairobi Counsellors had integrated self-care strategies into their professional workplace for enhanced wellbeing. The study also found out that there exists significant positive correlations within the dimensions of self-care.

As such, the study's key findings ($r = .652$; $p = 0.01$) indicated a very strong correlation between spiritual self-care practices and emotional self-care practices.

Regarding levels of vicarious posttraumatic growth, slightly higher levels were recorded at 52.5% ($n = 116$) in comparison to 45.2% ($n = 100$) of moderate level of growth and 2.3% ($n = 5$) of low level of growth. Notably high level of growth was higher among the respondents' aged 41-50 years at 16.7% ($n = 37$) compared to other categories. These findings were consistent with empirical evidence that improved development of strength and resilience in terms of persistence; optimism, hardiness, and support were linked to longer exposure to vicarious trauma experiences with the older generation of counsellors being responsive to high level vicarious posttraumatic growth. Similarly, the frequency of moderate level of VPTG was higher among the respondents who had worked for 16 years and above at 19% ($n = 42$). This indicates that counsellors with presumably more exposure to traumatic experiences have over the year's learnt how to navigate these occupational hazards and therefore stand better chances of converting these negative encounters into beneficial outcomes.

The key findings established that moderate growth was high among the female respondents at 29% ($n = 64$) as well as high level of growth among the female respondents at 39.5% ($n = 88$), as opposed to the male respondents. Also, moderate and high levels of growth were higher among the respondents whose level of education was diploma/bachelor's degree at 33% ($n = 73$). The outlined sociodemographic characteristics of female counsellors, older counsellors between 41-50 years, and with more than 16 years counselling experience were established to hold more predictive power for vicarious posttraumatic growth. Also, the contingency coefficients demonstrated a significant relationship ($p=0.000$) between higher level of emotional self-care practices and higher level of vicarious posttraumatic growth.

The study comprehensively addressed the third research objective with the key finding showing a positive correlation between emotional self-care practices and VPTG at 2-tailed

significant level ($r = .264$; $p = 0.01$). A positive correlation in this data implies that the two variables move in the same direction. This means that increase in the level of emotional self-care practices also increases the level of VPTG. Furthermore, this study found a positive correlation between levels of spiritual self-care practices and levels of VPTG at 2 tailed ($r = .264^{**}$; $p = 0.01$). Positive correlation from this data implies that as the level of spiritual self-care practices increases, the level of VPTG also increases. Therefore, spiritual change through high level spiritual self-care practices as a therapeutic resource was acknowledged as a vital measure for vicarious posttraumatic growth among Nairobi County counsellors.

The predictive relationship between self-care practices and posttraumatic growth among counsellors in Nairobi County stated that there was a 1.73 times likelihood to experience higher levels of vicarious posttraumatic growth by practising balanced self-care. Also, the study found adequate evidence through hypothesis testing to reject the null hypothesis and confirm that there was a significant relationship between self-care practices and vicarious posttraumatic growth among Nairobi County counsellors.

6.3 Conclusion

The key findings in this study were consistent with empirical evidence from previous studies which established that there was a significant linear relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County. Generally, the counsellors were found to engage in moderate levels of self-care practices with the prevalence of high levels of psychological self-care practices being slightly higher as compared to emotional, spiritual, physical, and workplace self-care practices. In addition, the counsellors exhibited lower level physical self-care practices.

The study's findings established that most counsellors in Nairobi County experienced moderate levels of vicarious posttraumatic growth. The study showed that most of the participants experienced a high level of VPTG compared to those experiencing moderate and

low levels of growth. High and moderate levels of VPTG are dominant among the respondents aged 41-50 years. Most females exhibit moderate growth compared to males. Moreover, moderate and high levels of growth to be higher among the respondents whose levels of education was diploma/bachelor's degree. Years of practice influence the counsellors' VPTG, as evidenced by the study results showing that moderate level of VPTG is higher among the respondents who had worked for 16 years and above.

Thirdly the findings on contingency coefficients signified a positive relationship between higher level self-care practices and posttraumatic growth among the counselling professionals in the study region. Remarkably, there was a significant relationship between higher level of emotional self-care practices and higher level of vicarious posttraumatic growth. Also, higher levels of spiritual self-care had a significant relationship with higher level of vicarious posttraumatic growth. The two dimensions of emotional self-care and spiritual self-care demonstrated a strong and positive between dimension correlation which can explain their significant influence on higher-level posttraumatic growth among counsellors in Nairobi County. Also, a balance in self-care practices resulted in increased likelihood to experience higher level posttraumatic growth. Therefore, the higher the level of self-care practices, the higher the level of posttraumatic growth among counsellors.

6.4 Recommendations

The study established that there was a relationship between self-care practices (emotional, psychological, physical, spiritual, and workplace/professional self-care practices) and vicarious posttraumatic growth among counsellors in Nairobi County. Based on the study findings, the researcher provided recommendations for the counselling professionals/practitioners in Nairobi County, the counselling discipline/industry, counsellor training/educational institutions, and policymakers.

The counselling professionals/practitioners in Nairobi County should engage themselves more in self-care practices to enhance their personal strength and resilience required for their improved health and wellbeing in the profession. The study established that higher level self-care practices significantly influenced higher level vicarious posttraumatic growth among counsellors. Furthermore, the key findings indicated that majority of the counsellors focused on higher levels of psychological self-care while engaging in lower levels of physical self-care. The researcher considers the key finding of having a balance in self-care practices resulting in increased likelihood to experience higher level posttraumatic growth as a solid recommendation for the counselling profession in Nairobi County.

The counselling discipline/industry should consider providing opportunities for counsellors to practice self-care. The study findings showed that emotional self-care and spiritual self-care had positive and significant associative impacts on each other. Therefore, the supervisory personnel and counselling organizations in Nairobi County should establish best practices for active integration of balanced self-care practices that could result in positive and significant posttraumatic growth rather than a skewed focus on a limited number of practices.

Counsellor training/educational institutions should integrate sensitisation activities into education facilities could increase the likelihood of practising self-care practices for professionals with less than 16 years' work experience and who might be young in age (fresh from learning institutions). The study findings have contributed to the existing literature about the relationship between self-care practices and vicarious posttraumatic growth. Learning institutions should consider integrating the findings into the counsellors' academic curriculum to keep them informed on the practices that they should engage in to enhance their vicarious posttraumatic growth once they start practicing.

Policymakers should formulate policies encouraging reduced vulnerability, spiritual advancement, and religious competency within the counselling practice and also be integrated

into education establishments' curriculum. The study's key findings established that there was a significant relationship between higher level of emotional self-care practices and higher level of vicarious posttraumatic growth. Also, it was established that higher levels of spiritual self-care had a significant relationship with higher level of vicarious posttraumatic growth. The policies can help enhance spiritual and emotional self-care practices since the counsellors would have been sensitized on the significance levels of the self-care practices. On the wider perspective, the national policy actors have been informed of the significant relationship between higher level self-care practices and higher level vicarious posttraumatic growth. Therefore, a favourable policy formulated to encourage balanced self-care practices among counselling professionals will guarantee improved vicarious posttraumatic growth results without a primary reliance on learned experiences of being exposed to prolonged vicarious trauma.

6.5 Recommendations for Further Research

Despite the robustness of the findings generated from this study, some limitations were recognised, which can be addressed in future research. First, the academic communities and the body of empirical could expand on the current gaps associated with the self-care practices that did not ascertain a significant relationship with vicarious posttraumatic growth. The researcher recommends future studies to direct more emphasis towards expounding on physical, psychological, and workplace/professional self-care practices and their impact on vicarious posttraumatic growth among professional counsellors in Nairobi County.

Second, the current study utilised a correlational survey design whereby the researcher focused on testing if all the variables changed together without the opportunity of checking the impact of one variable on the other since they were measured without being manipulated. Perhaps, future studies could utilise experimental survey design whereby the researcher can

manipulate single independent variables including self-care practices while measuring their impact on levels of posttraumatic growth (dependent variable) among counsellors in the region.

Third, future researchers may consider replicating the current study using mixed methods to populations of counsellors in Nairobi County. The current study utilized structured tools, which led to the collection of numeric data. The limitation of numeric data is that it does not provide for participants' expression of their responses, which is instrumental in making meaning of the quantitative data. Future research may consider adopting mixed method designs, which allow for collection of qualitative data from a subset of the sample to improve the meaning and quality of the findings. The study may also be replicated to other counties in Kenya to investigate if self-care practices have the same effect on the vicarious posttraumatic growth and explain consistencies/inconsistencies in the comparative results.

6.6 Chapter Summary

Chapter six of the dissertation focuses on summarizing the study's findings, drawing conclusions, and providing recommendations. The study reveals that 48% of counselors in Nairobi practice balanced self-care, while 52% exhibit imbalanced practices. Various factors such as age, gender, religious affiliation, and years of work experience influence self-care practices. High levels of vicarious posttraumatic growth (VPTG) are observed, particularly among older counselors with more experience. Significant positive correlations are found between spiritual and emotional self-care practices. The study concludes that balanced self-care practices increase the likelihood of higher VPTG. Recommendations include promoting balanced self-care in counseling professionals, integrating self-care into training programs, and formulating policies to support spiritual and emotional well-being. Suggestions for future research involve exploring the impact of specific self-care practices on VPTG and employing experimental survey designs.

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APPENDIX A

Introduction letter

Dear participant,

RE: REQUEST TO PARTICIPATE IN A RESEARCH STUDY

My name is **Joyce Waweru**, a student at Tangaza University College University undertaking a Master's degree in **Counselling psychology**. I am undertaking a study, on **relationship between self-care practices and Vicarious Posttraumatic Growth among counsellors in Nairobi County**.

Being a counsellor practicing in Nairobi County you have been chosen as one of the respondents. In this regard, I am requesting you to dedicate some time to participate in this exercise. Your involvement in this exercise is invaluable to our work and the advancement of the knowledge in this field. Kindly read and understand the instructions before responding. Participation in this exercise is voluntary with no monetary rewards. I will observe anonymity and information provided will be strictly confidential.

Thank you.

Yours sincerely

Joyce Waweru

MA Student

APPENDIX B

Participant Consent Form

Participant Consent Form
CUEA – Tangaza University College
Title of Research: Relationship between Self-Care Practices and Vicarious Posttraumatic Growth among Counsellors In Nairobi County, Kenya
<ul style="list-style-type: none">• This study is being conducted as the requirement for MA Proposal in Counselling Psychology at Tangaza University College.• It has been approved by the supervisors (contact:iysba@tangaza.org) This study involves not known risk to participants and contains no deception. It takes approximately 15-30 minutes to take part in the present phase of the study.• The task requires a participant to answer a series of questions.• All respondents are treated as strictly confidential. No participant’s results will be presented individually but only in aggregate form.• Participation in this study is voluntary and there is no monetary or any other kind of compensation. Withdrawal from participation in the study will not lead to any individual to be penalized in any way, and all participants have the right to withdraw themselves and their data from the study at any time.
Name of the researcher: JOYCE WAWERU
Position of the researcher: STUDENT IN MA PROGRAMME
Address of the University College: Tangaza University College, Langata, Nairobi, Kenya, 15055-00509,
Signed by researcher.....Date.....
Statement to be signed by the participant
I confirm that the organizer has explained fully the nature of the project and the range of activities which I am asked to undertake and that I have received an information sheet. I confirm that I have had adequate opportunity to ask questions about this project. <ul style="list-style-type: none">• I understand that my participation is voluntary and that I may withdraw at any time during the project, without having to give a reason• I agree to take part in this project, by participating in the interviews
Signed by participant.....Date.....

APPENDIX C

Questionnaire for participants

Section A: Demographic characteristics of participants

1. Your age:

2. Your Gender (M/F)

3. Highest Educational Level attained:

- Primary school.....
- Form IV.....
- Diploma/Bachelor
- PG Diploma/Masters
- PhD

4. Religious affiliation:

- Christian
- Islamic.....
- Hinduism.....
- Other religious affiliation

5. Highest professional training:

- Diploma/Higher Diploma..........
- Undergraduate
- Postgraduate

6. Years of work experience:

- Under 5 years.....
- 5 to 10 years
- 10 to 15 years
- Above 15 years

Section B: Self-care practices Scale

7. Do you engage in activities that can be considered as Self-care practices? Yes No

For each of the following statements and/or questions, please circle the point on the scale that you feel is most appropriate in describing you. 1 = Not at all, 2= Rarely, 3= Sometimes, 4 = Often, 5 = Very often

EXPOUNDING SELF CARE PRACTICES

Rating scale

<i>Physical self-care</i>						
8	Eat regularly	1	2	3	4	5
9	Eat healthy	1	2	3	4	5
10	Exercise or go to the gym	1	2	3	4	5
11	Life weights	1	2	3	4	5
12	Practice martial arts	1	2	3	4	5
13	Take time off when sick	1	2	3	4	5
14	Get massages	1	2	3	4	5
15	Dance, swim, walk, run, play sports, sing, or do some other fun physical activity	1	2	3	4	5
16	Take time to be sexual - with yourself, with a partner	1	2	3	4	5
17	Get enough sleep	1	2	3	4	5
<i>Psychological self-care</i>						
18	Take day trips or mini-vacations	1	2	3	4	5
19	Make time away from telephones, email, and the Internet	1	2	3	4	5
20	Make time for self-reflection	1	2	3	4	5
21	Notice my inner experience - listen to my thoughts, beliefs, attitudes, feelings	1	2	3	4	5
22	Have my own personal therapy	1	2	3	4	5
23	Write in a journal	1	2	3	4	5
24	Read literature that is unrelated to work	1	2	3	4	5
25	Do something at which I am not expert or in charge	1	2	3	4	5
26	Attend to minimizing stress in my life	1	2	3	4	5

27	Engage my intelligence in a new area, e.g., go to an art show, sports event, theatre	1	2	3	4	5
28	Practice receiving from others	1	2	3	4	5
29	Be curious	1	2	3	4	5
30	Say no to extra responsibilities sometimes	1	2	3	4	5
31	Spend time outdoors	1	2	3	4	5
	<i>Emotional Self-care</i>					
32	Spend time with others whose company you enjoy	1	2	3	4	5
33	Stay in contact with important people in life	1	2	3	4	5
34	Treat myself kindly (for example, by using supportive inner dialogue or self-talk)	1	2	3	4	5
35	Feel proud of myself	1	2	3	4	5
36	Reread favorite books and see favorite movies again	1	2	3	4	5
37	Identify comforting activities, objects, people, relationships, and places, and seek them out	1	2	3	4	5
38	Allow yourself to cry	1	2	3	4	5
39	Find things that make you laugh	1	2	3	4	5
40	Express your outrage in a constructive way	1	2	3	4	5
41	Play with children	1	2	3	4	5
	<i>Spiritual self-care</i>					
42	Make time for prayer, meditation and reflection	1	2	3	4	5
43	Spend time in nature	1	2	3	4	5
44	Participate in a spiritual gathering, community or group	1	2	3	4	5
45	Am open to inspiration	1	2	3	4	5
46	Cherish optimism and hope	1	2	3	4	5
47	Am aware of nontangible (nonmaterial) aspects of life	1	2	3	4	5
48	Am open to mystery, to not knowing	1	2	3	4	5
49	Identify what is meaningful and notice its space in my life	1	2	3	4	5
50	Sing	1	2	3	4	5

51	Express gratitude	1	2	3	4	5
52	Celebrate milestones with rituals that are meaningful to me	1	2	3	4	5
53	Remember and memorialize loved ones who have died	1	2	3	4	5
54	Nurture others	1	2	3	4	5
55	Have awe filled experiences	1	2	3	4	5
56	Contribute to or participate in causes I believe in	1	2	3	4	5
57	Read/listen to inspiring music	1	2	3	4	5
		1	2	3	4	5
	<i>Professional/workplace self-care</i>					
58	Take time to eat lunch	1	2	3	4	5
59	Take time to chat with co-workers	1	2	3	4	5
60	Make time to complete tasks	1	2	3	4	5
61	Identify projects/tasks that are exciting, growth promoting and rewarding for me	1	2	3	4	5
62	Pursue regular learning and professional development	1	2	3	4	5
63	Get support from colleagues	1	2	3	4	5
64	Negotiate for my needs	1	2	3	4	5
65	Have a peer support group	1	2	3	4	5

Adapted from Transforming the Pain: A Workbook on Vicarious Traumatization by Karen Saakvitne and Laurie Anne Pearlman, published in 1996 by TSI Staffsect

Section C: Vicarious Posttraumatic Growth Scale

66. Do you experience changes when working with trauma clients? Yes No

For each of the following statements and/or questions, please circle the point on the scale that you feel is most appropriate in describing your experiences of change. 0=I did not, 1= a very small degree, 2 = a small degree, 3 = a moderate degree, 4 = to a great degree, 5 = to a very great degree

Vicarious PTG Indicators

Rating scale

67	I changed my priorities about what is important in life.	0	1	2	3	4	5
68	I have a greater appreciation for the value of my own life	0	1	2	3	4	5
69	I have developed new interests	0	1	2	3	4	5
70	I have a greater feeling of self-reliance.	0	1	2	3	4	5
71	I have a better understanding of spiritual matters.	0	1	2	3	4	5
72	I more clearly see that I can count on people in times of trouble.	0	1	2	3	4	5
73	I established a new path for my life	0	1	2	3	4	5
74	I have a greater sense of closeness with others.	0	1	2	3	4	5
75	I am more willing to express my emotions.	0	1	2	3	4	5
76	I know that I can handle difficulties.	0	1	2	3	4	5
77	I can do better things with my life.	0	1	2	3	4	5
78	I am better able to accept the way things work out.	0	1	2	3	4	5
79	I can better appreciate each day.	0	1	2	3	4	5
80	New opportunities available which wouldn't have been	0	1	2	3	4	5
81	I have more compassion for others	0	1	2	3	4	5
82	I put more effort into my relationships.	0	1	2	3	4	5
83	I am more likely to try to change things that need changing.	0	1	2	3	4	5
84	I have stronger religious faith.	0	1	2	3	4	5
85	I discovered that I'm stronger than I thought I was.	0	1	2	3	4	5
86	I learned a great deal about how wonderful people are.	0	1	2	3	4	5
87	I better accept needing others	0	1	2	3	4	5


APPENDIX D

Request for Permission to Use VPTG Scales

Request to use PTG inventory

Add label

☆

 **joyce waweru** 19:07
to info ^

← ⋮

From joyce waweru • 2000923@tangaza.ac.ke
To info@istss.org
Date Apr 15, 2023, 19:07
[View security details](#)

I am a student at Tangaza University college in Nairobi Kenya. I am writing a study for my Masters programme on Relationship between Self-care practices and vicarious posttraumatic growth among counsellors in Nairobi.
I hereby request permission to use the PTG inventory in my study.

I look forward to hearing from you

Yours sincerely

Joyce Waweru
20/00923 Tangaza University

APPENDIX E

Scoring of scales

Self-Care Assessment Worksheet (SCAW)

The SCAW is a 70-item scale that provides an overview of effective strategies that help to maintain self-care. As a multidimensional tool for assessing self-care, the SCAW seeks to gauge six dimensions, with each dimension having a different number of items: physical care (15 items), psychological care (13 items), emotional care (11 items), spiritual care (17 items), workplace self-care (12 items), and balance (2 items). The SCAW scales are gauged on a five-point Likert scale and are scored using five real numbers, which are 1-it never occurs, 2-never, 3-rarely, 4-occasionally, and 5-frequently. After rating the dimensions of the scale, the scores for all 70 items are summed up. The highest score is 350 while the minimum possible score is 70.

Vicarious Posttraumatic Growth (PTG)

Vicarious Posttraumatic Growth (PTG) Inventory is a 21-item Likert scale that measures trauma victims' posttraumatic growth. The dimensions of the PTG include New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. The scale requires participants to rate the extent to which they have experienced the growth described in each item on a 6-point scale. The minimum possible score is 0 while the maximum possible score is 105. Scores below 60 indicate a low level of growth. Scores between 60 and 79 indicate a moderate level of growth. Scores of 80 and above indicate a high level of growth.

APPENDIX F

Debrief form

Thank you for participating in this study. The purpose of the study is to examine the relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County, Kenya. Your participation will assist the researcher ascertain the possible relationship between the two variables and help in formulating policies on promotion of self-care practices to facilitate vicarious posttraumatic growth among counsellors.

If the study causes any discomfort, please feel free to contact the researcher using the contact and email below.

Kind regards

Joyce Waweru

Mobile Contact: 0720908213

Email: joicweru@gmail.com

APPENDIX G

Tangaza University Research Permit



TANGAZA UNIVERSITY COLLEGE

The Catholic University of Eastern Africa

OFFICE OF THE DIRECTOR OF RESEARCH & POST GRADUATE STUDIES

E-mail: djr.pgsr@tangaza.ac.ke Website: www.tangaza.ac.ke

OUR Ref: DPGSR/ER/06/2023

Date: 21st June 2023

To The Commission Secretary,
National Commission for Science, Technology and Innovation
P.O. Box 30623,
Nairobi – Kenya.

Dear Sir/Madam,

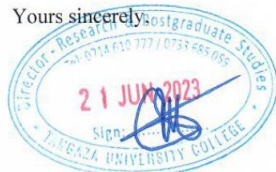
Re: Research Permit for Joyce Waweru

This is to confirm that the person named in this letter is a student at Tangaza University College (TUC). She is registered in the Institute for Youth Studies (Reg. No. 20/00923) and she is pursuing M.A degree in Counselling Psychology.

Joyce has met all our provisional academic requirements leading to data collection. However, she cannot proceed to the field before getting a Research Permit from the National Commission for Science, Technology and Innovation (NACOSTI). Kindly assist her to process the permit for data collection for her M.A. Thesis.

Thanking you in advance for your cooperation

Yours sincerely,



Dr. Daniel M. Kitonga (Ph.D.)
Director, Research & Post-Graduate Studies

CC:

Dr. Alice Nzangi – Programme Leader, M. A. Counselling Psychology (IYS)

APPENDIX H

Tangaza University Ethics Clearance



TANGAZA UNIVERSITY COLLEGE

The Catholic University of Eastern Africa

OFFICE OF THE DIRECTOR OF RESEARCH & POST-GRADUATE STUDIES

E-mail: dir.pgsr@tangaza.ac.ke

Website: www.tangaza.ac.ke

OUR Ref: DPGSR/ER/06/2023

Date: 21st June 2023

Joyce Waweru
Institute for Youth Studies
School of Arts & Social Sciences
Tangaza University College

Dear Waweru,

RE: ETHICS CLEARANCE FOR JOYCE WAWERU, REG. NO. 20/00923

Reference is made to your letter dated 8th June 2023 requesting for ethical clearance of your research proposal to carry out a study on "*Relationship between self-care practices and vicarious posttraumatic growth among counsellors in Nairobi County*".

I am pleased to inform you that, your research proposal has been reviewed and you can apply for research permit from the National Commission for Science, Technology and Innovation (NACOSTI). This should be done before commencing the data collection. You are also advised to adhere to the code of ethics as regards the protection of human subjects during the entire process of your study.

This approval is valid for one year from **21st June 2023**.

Please, ensure that after the data analysis and final write up, you submit a soft copy of the thesis to the Director of Research & Post-Graduate Studies – Tangaza University College for records purposes.

Yours sincerely,

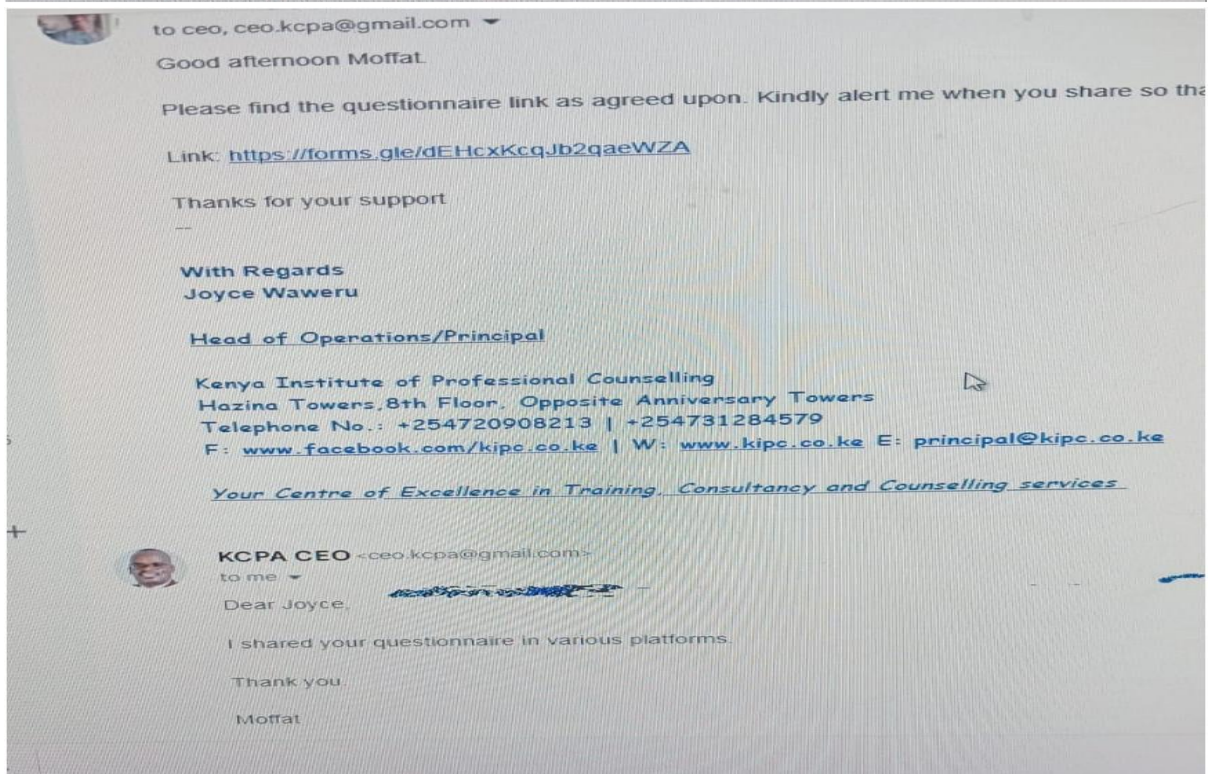
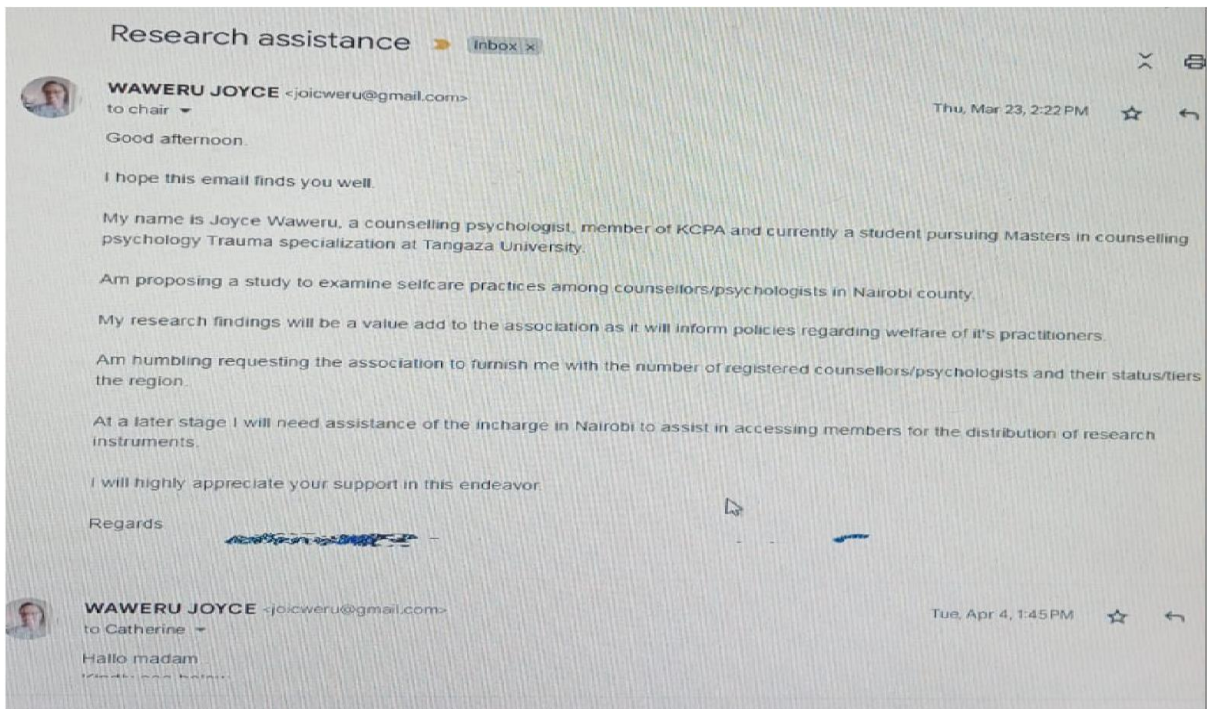


DR. DANIEL M. KITONGA (Ph.D.)
Director, Research & Post-Graduate Studies
Tangaza University College

CC: **Dr. Alice Nzangi** – Programme Leader, M.A. Counselling Psychology (IYS)

APPENDIX I

Permission to Conduct Research in KCPA



APPENDIX J

NACOSTI Research License



REPUBLIC OF KENYA



NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION

RefNo: 502848

Date of Issue: 02/July/2023

RESEARCH LICENSE



This is to Certify that Miss.. Waweru Wairimu Joyce of Tangaza University College, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: RELATIONSHIP BETWEEN SELF-CARE PRACTICES AND VICARIOUS POST-TRAUMATIC GROWTH AMONG COUNSELORS IN NAIROBI COUNTY, KENYA for the period ending : 02/July/2024.

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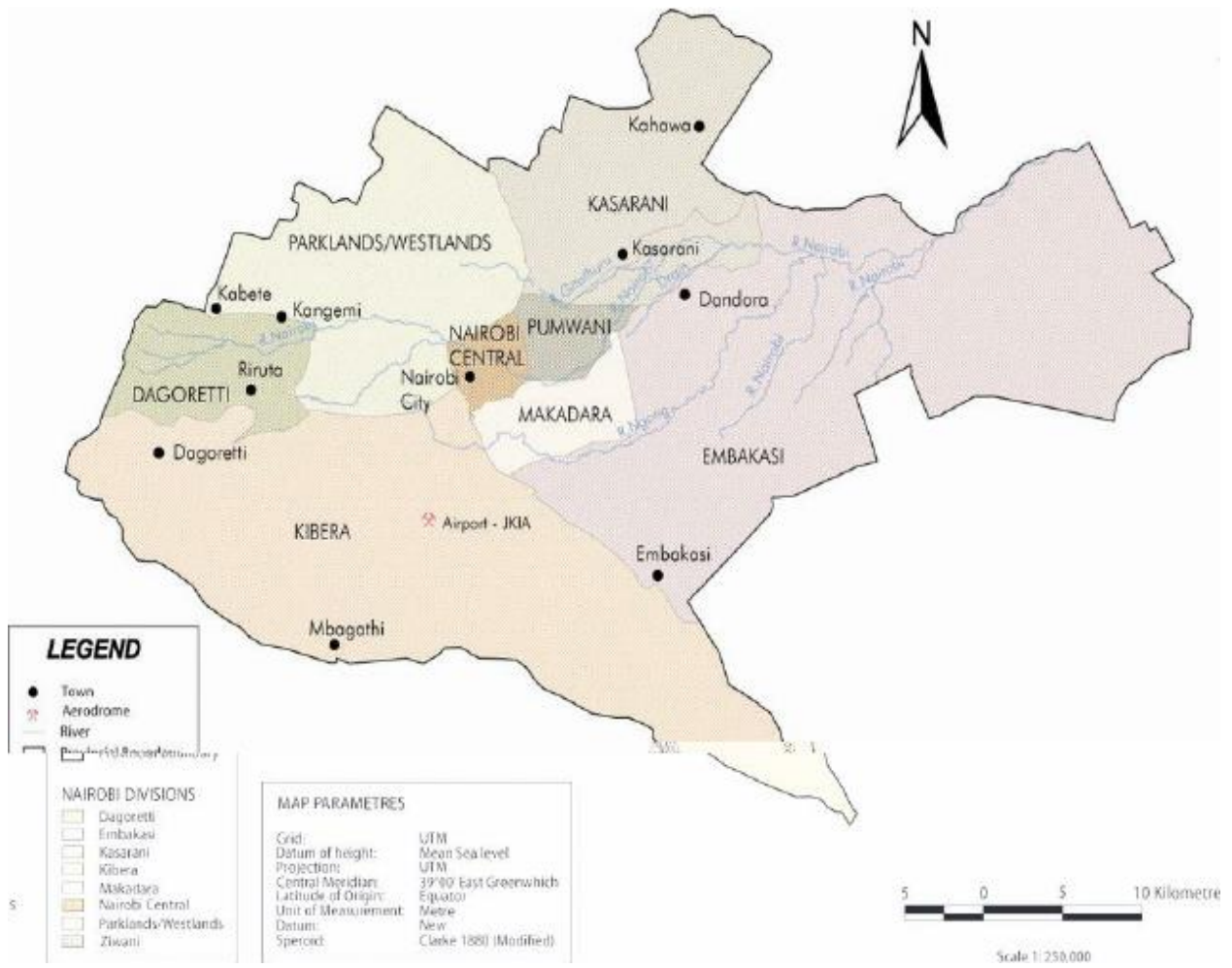


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APPENDIX K

Map of Nairobi County



APPENDIX L

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