COMPASSION FATIGUE, COPING AND EMOTIONAL INTELLIGENCE AMONG REHABILITATION PROFESSIONALS

Submitted to

THE TAMILNADU Dr.M.G.R. MEDICAL UNIVERSITY, CHENNAI

Submitted in partial fulfillment of the requirements for the degree of

M.Phil. in Clinical Psychology

September 2023

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I, **Haripriyaa V G**, hereby declare that the thesis titled **"Compassion Fatigue, Coping and Emotional Intelligence among Rehabilitation Professionals"**, was carried out by me at the National Institute for Empowerment of Persons with Multiple Disabilities (NIEPMD), Chennai, during the year 2021-2023, is an original research work carried out under the guidance and supervision of Ms. Srigowri Rajesh, Lecturer, Department of Clinical Psychology, NIEPMD, Chennai. This work has not formed the basis of award for any other degree.

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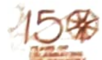

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This institute is a central body funded by Department of Empowerment of Persons with Disabilities (Divyangjan), Ministry of Social Justice & Empowerment, and Government of India. The MPhil programme offered at NIEPMD is recognized by Rehabilitation Council of India (RCI), New Delhi, and affiliated with the Tamil Nadu Dr M.G.R. Medical University

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ACKNOWLEDGEMENT

I express my sincere gratitude to the Associate Professor and Head, Department of Clinical Psychology, Dr. Karthikeyan S. for his guidance and assistance.

I would sincerely like to thank my guide, Ms. Srigowri Rajesh, Lecturer, for encouraging me and providing her support throughout the completion of this dissertation work and also Ms. P. Kalaivani (Assistant Professor), Mr. Kumaran Rajan (Former Lecturer), Ms. S.K. Anandhalakshmi (Lecturer), Department of Clinical Psychology for their constant guidance and support.

I would like to extend my thanks to Mr. Yogaraja, Ms. Merlin, and Mr. Amrudeen, Department of Clinical Psychology for their support.

I express my sincere gratitude to my friends Ms. Saranya, Ms. Vardhini, Ms. Nivetha, Mr. Harieharran; my junior Ms. Sherin Susan Suresh and family for their constant pillar of support and for providing me the appropriate resources needed for completion of this dissertation.

I extend my hearty thanks to the participants for their co-operation that made the process of this research work possible.

Finally, I would like to dedicate my work to my Late uncle Mr. K. Subramanian, who, although no longer with us, has always been a source of positivity and has showered lots of love on us.

HARIPRIYAA V G

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ABSTRACT

Working in rehabilitation setup entails taking responsibility for the well-being of others. Ironically, having empathy and compassion for others when under a lot of stress can lead to compassion fatigue. The study aimed to explore the relationship between compassion fatigue, emotional intelligence and coping among rehabilitation professionals. Data were collected from a sample of 121 rehabilitation professionals, who completed Professional Quality of Life scale (ProQOL-5), Brief COPE and Schutte's Self Report Emotional Intelligence Test (SSEIT) questionnaires. Pearson's correlation, Linear regression, Moderation analysis Chi-square test, t-test and one-way ANOVA were used to analyse the data. Major findings indicate that Emotional intelligence was a significant predictor of compassion fatigue and compassion satisfaction. While Emotion focused and Avoidant coping were significant predictors of Compassion Fatigue, Problem-focused coping was a significant predictor of compassion satisfaction. Furthermore, Emotion-focused, and Avoidant coping negatively moderated the relationship between emotional intelligence and compassion fatigue. Compassion fatigue decreased with increasing years of experience. Gender differences were reported in coping style as well. These findings shed light on the role of emotional intelligence and coping styles in the development of compassion fatigue among rehabilitation professionals. Enhancing emotional intelligence and fostering adaptive coping strategies can result in a higher professional quality of life for rehabilitation professionals. This, in turn, contributes to the delivery of better services to clients.

Keywords: compassion fatigue, emotional intelligence, problem-focused coping, emotion focused coping, avoidant coping, rehabilitation

CHAPTER I
INTRODUCTION

CHAPTER I

INTRODUCTION

1. Rehabilitation

Rehabilitation holds a vital role alongside the promotion of good health, disease prevention, treatment, and palliative care Within the framework of universal health coverage. Rehabilitation is defined as “a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment” (WHO, 2023). Currently, around 2.4 billion individuals worldwide are living with health conditions that could potentially benefit from rehabilitation. The global demand for rehabilitation is expected to rise, driven by shifts in population health and characteristics. While life expectancy has increased, the prevalence of chronic diseases and disabilities has also grown, contributing to the greater need for rehabilitation services (WHO, 2023).

The rehabilitation workforce comprises diverse healthcare professionals, such as physiotherapists, occupational therapists, speech and language therapists, audiologists, orthotists, prosthetists, clinical psychologists and among others. The professional services offered by rehabilitation professionals play a crucial role in enhancing the quality of life (QoL) for individuals with disabilities (Kim et al., 2020)

In the field of rehabilitation, professionals bear the responsibility of others' wellbeing. Despite the challenging working conditions in such professions, there is a notable interest from many individuals to work in this field. One possible reason for this attraction is the inherent joy and sense of significance that comes from helping others, as compassion is closely linked to positive emotions and prosocial behavior. Compassion, being an emotional response to witnessing suffering, involves recognizing another person's pain and possessing a genuine desire to aid them. It serves as a crucial tool and motivational force for professionals

in this line of work. The presence of compassion contributes significantly to ensuring satisfactory client care and enhances the overall well-being of the professionals themselves. Clients who perceive their clinicians as compassionate receive improved care (Sinclair et al., 2017), underscoring the significance of nurturing compassionate responses from rehabilitation professionals. Their role demands empathetic support for both the affected individuals and their caregivers.

Rehabilitation healthcare workers frequently encounter patients with complex trauma histories, life-threatening conditions, and chronic illnesses. While compassion is an essential quality for healthcare providers, those dealing with a high number of traumatic cases or displaying excessive compassion may be susceptible to developing compassion fatigue.

2. The Emergence of Compassion Fatigue as a Concept

The term "compassion fatigue" (CF) was first introduced in 1992 by Joinson to describe the condition experienced by nurses who were emotionally drained from dealing with daily hospital emergencies. Joinson identified CF as caregiver-specific burnout and emphasized its physical, emotional, and mental effects. The study stressed the need to raise awareness of CF signs among nurses and suggested self-care, emotional wellness, and stress management as essential interventions (Joinson, 1992). Compassion fatigue is defined as “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced or suffered by a person” (Figley C.R, 1995). It is characterized by profound physical, emotional, and spiritual exhaustion that arises from working in demanding caregiving environments on a daily basis (Figley & Roop, 2006). Rehabilitation professionals may experience compassion stress when they feel the pressure to be both compassionate and effective in their assistance, surpassing their natural capacity to provide help. This heightened

stress can lead to exhaustion or burnout, ultimately resulting in compassion fatigue, where the ability to be compassionate is depleted (Figley & Ludick, 2017).

2.1.1. Compassion Fatigue through the Lens of Professional Quality of Life

Compassion fatigue can be viewed in connection with professional quality of life, which reflects the satisfaction and challenges experienced in one's helping role. It encompasses both positive aspects (Compassion Satisfaction) and negative aspects (Compassion Fatigue) related to the job. Professionals with a positive ProQOL (Professional Quality of Life) deliver superior care and exhibit higher job retention compared to those with a lower ProQOL (McCammon, S. L., 1996). On a positive aspect, clinicians caring for suffering patients can also experience compassion satisfaction (CS), which encompasses the positive elements of their healthcare work. It is defined as the pleasure derived from helping others and has been linked to increased resilience – the capacity to cope, learn, and grow from difficult experiences (Burnett, 2015; Stamm, 2010). Professionals thrive when they feel a strong sense of morale and satisfaction, enabling them to deliver competent and compassionate care (Radey & Figley, 2007). To counteract the challenges of caregiving, a protective mechanism is essential (Collins & Long, 2003). Compassion satisfaction arises from empathetic altruism, leading to the relief of patient suffering and enabling the caregiver to manage the negative aspects of their work (Sacco & Copel, 2018). Additionally, this experience fosters hope, optimism, and a desire to continue in the caregiver role. Compassion fatigue, in turn, consists of two components: burnout and secondary traumatic stress.

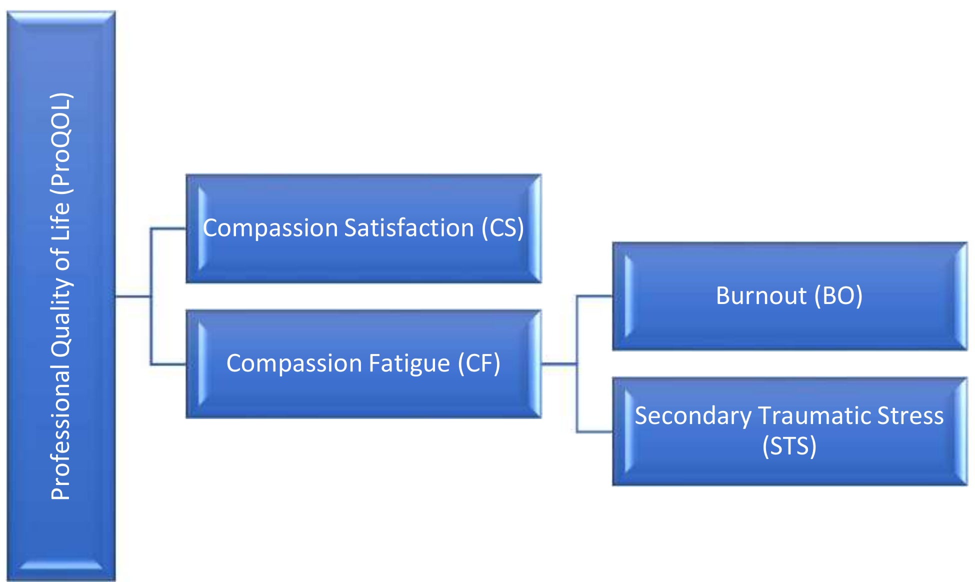
2.1.2. Compassion Fatigue: A Reflection of Secondary Traumatic Stress and Burnout

Beth Hudnall Stamm, an esteemed professor and researcher specializing in traumatic stress, suggests that compassion fatigue is considered an expression of both burnout and secondary traumatic stress (Figure 1.1). Burnout (BO) has been defined as “a syndrome of

emotional exhaustion and cynicism that occurs frequently among individuals who do ‘people-work’ of some kind” (Maslach et al., 1997). Burnout results from a chronic imbalance between job demands and available resources, leading to prolonged work-related stress (Freudenberger, 1974; Mastenbroek et al., 2014). The symptoms of burnout encompass a range of emotional and physical indicators, such as reduced empathy (decrease in caring), detachment from one's work or personal life (depersonalization), discouragement, persistent fatigue, emotional exhaustion, symptoms of depression, apathy, and a sense of detachment from one's surroundings or responsibilities (Harris & Griffin, 2015; Hunsaker et al., 2015). Research has demonstrated that burnout often results in various negative consequences, including an increased intention to quit one's job, higher levels of job dissatisfaction, more frequent absenteeism from work, and a tendency to neglect one's responsibilities and tasks at the workplace (Basar & Basim, 2016; McDermid et al., 2020).

Figure 1.1

Components of Professional Quality of Life



It also includes secondary traumatic stress (STS), which is the psychological distress arising from exposure to others' suffering (Figley, 1995). The condition is influenced by work-related stress and compassion stress, and primary traumatic stress from experiencing or witnessing traumatic events at work and in personal life can also heighten the risk of compassion fatigue. Individuals experiencing Secondary Traumatic Stress (STS) often display empathic concern for the traumatized person they are caring for. This empathic concern serves as the channel through which the emotions and experiences of the traumatized individual transfer to the caregiver, impacting their own emotional well-being and mental health (Sorenson et al., 2017).

3. Emotional Intelligence

Emotional intelligence serves as a key factor in understanding human functioning, individual performance, and personal well-being. Emotional Intelligence (EI) was initially conceptualized by Salovey and Mayer in 1990. This construct originated from and was closely linked to the concept of social intelligence, which entails the capacity to engage in relational interactions with others and effectively manage their responses in various social situations (Salovey & Mayer, 1990). Emotional Intelligence (EI), stemming from the broader concept of social intelligence, offers a deeper understanding of how individuals perceive, evaluate, and handle both their own emotions and the emotions of others. It emphasizes the use of these emotional insights to inform and make crucial decisions. Emotional intelligence is the capacity of individuals to recognize, utilize, comprehend, and positively regulate their emotions (Salovey & Mayer, 1990). This ability allows them to alleviate stress, communicate effectively, show empathy towards others, and effectively address challenges and resolve conflicts.

The Schutte Self-Report Emotional Intelligence Test (SSEIT) was developed based on the framework provided by the Salovey and Mayer models of Emotional Intelligence. It utilizes their concepts and theories as the foundation for assessing emotional intelligence in individuals. Emotional intelligence can be effectively understood as a trait or typical way of functioning. When employing a trait approach to assess emotional intelligence, information is collected through self-reports or reports from others, with a focus on how individuals typically exhibit emotional intelligence characteristics in their everyday lives. This approach looks at consistent patterns of emotional intelligence behavior over time (Schutte et al., 1998).

Professionals serving vulnerable populations require elevated levels of emotional intelligence to sustain personal well-being and optimal professional performance, enabling them to provide effective and efficient services to clients. Indeed, emotional intelligence plays a crucial role in how individuals manage stress in their daily lives, specifically in their ability to regulate and mitigate negative emotions. People with higher emotional intelligence are more attuned to their emotions and have better control over them, leading to reduced levels of distress and stress-related emotions, including compassion fatigue. By effectively managing their emotions, emotionally intelligent individuals are better equipped to navigate challenging situations and maintain their well-being in the face of stress (Salovey et al., 1999; Zeidner et al., 2009). Increased emotional intelligence is associated with positive traits like assertiveness, a willingness to seek social support, enhanced problem-solving abilities, adaptability, and reduced anxiety (Poret et al., 2010). Those with high emotional intelligence are less susceptible to work-related issues (Akbari & Tavassoli, 2011). Conversely, individuals with low emotional intelligence tend to experience higher work-related stress and may resort to self-destructive behaviours, such as alcohol consumption and smoking (Kun &

Demetrovics, 2010). Moreover, low emotional intelligence can contribute to compassion fatigue among psychotherapists (Gutierrez & Mullen, 2016).

4. Coping

Coping, in simple terms, refers to how an individual attempts to handle the stress they are experiencing. Effectively dealing with stress often depends on the person's ability to use effective coping skills. Conversely, if someone relies on ineffective coping strategies, they may struggle to manage stress effectively. It is an intentional and purposeful actions aimed at reducing the adverse consequences of a stressful situation, which may manifest as psychological, physical, or social challenges.

When individuals encounter the overwhelming emotions brought on by burnout or compassion fatigue, they employ diverse coping styles as a means of effectively addressing these challenges. Coping styles, akin to problem-solving approaches, serve as essential tools in managing and navigating through stressful experiences. Amidst the throes of stress, individuals resort to various approaches, encompassing both positive and negative strategies, as means of coping with the demanding circumstances they face. Lazarus and Folkman defined coping as “constantly changing cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984).

4.1. Types of Coping

Problem-focused coping revolves around taking action to modify the stressful situation, and it is generally regarded as an adaptive approach, often linked to positive adjustment following stressful events. Problem-focused coping entails recognizing the root cause of a problem with the goal of addressing or altering it. This coping approach involves taking charge of the stressful situation, gathering information about it, and assessing both its

positive and negative aspects. Strategies associated with problem-solving coping include time management, seeking support, reaching out for assistance from others, and creating plans, among others. It's a proactive approach to managing stress by directly addressing the underlying issues (Roncaglia, 2014).

On the other hand, emotion-focused coping targets the reduction of distress arising from the situation, encompassing both active strategies (like seeking social support and focusing on positive aspects of the situation) and avoidant strategies (such as denial and alcohol abuse) (Holahan & Moos, 1987). Emotion-focused coping is centered around the management of emotional responses triggered by stressful events. These coping strategies are designed to lessen and regulate the intensity of the negative and distressing emotions provoked by a stressful situation, rather than directly resolving the problem itself. In essence, emotion-focused coping seeks to alleviate emotional distress and help individuals cope with their feelings when confronting challenging circumstances (Fawzy, 1990). It focuses on alleviating the emotional burden and making the situation more bearable, even if the underlying problem is not immediately resolved. Although active emotion-focused coping is considered beneficial and adaptive, avoidant emotion-focused coping is seen as maladaptive (Penley et al., 2002) Importantly, these two coping styles can coexist and are not mutually exclusive (Lazarus, 1991).

Avoidant coping involves behaviours where individuals intentionally detach themselves from the task or situation they are facing. This coping strategy includes attempts to escape, avoid, or divert attention away from the stressful situation. It essentially entails avoiding direct confrontation with the stressor and seeking ways to distance oneself from it temporarily (Folkman & Moskowitz, 2004). Avoidance coping, while it may provide temporary relief from stress, can have negative consequences. It can lead to increased stress and anxiety over time, as well as a potential impact on an individual's self-confidence.

Avoidant coping involves avoiding behaviours and situations that may trigger negative memories or emotions. It can even result in individuals giving up on their goals if they encounter thoughts or situations that create anxiety or distress. In the long term, avoidance coping may hinder personal growth and problem-solving abilities (Boyles, 2013).

CHAPTER II
REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Ondrejkova & Halamova in 2022 conducted an online questionnaire-based study to determine the prevalence of compassion fatigue (CF) among various helping professions. The findings uncovered that the professions with the highest reported levels of compassion fatigue (CF) were doctors, pedagogues, home nurses, nurses, and psychologists. In contrast, psychotherapists and coaches had the lowest reported levels of CF, which could be attributed to their extensive long-term training, regular supervision, or their superior ability to cope with and process emotions. Psychotherapists and coaches, as well as priests and pastors, home nurses, nurses, and paramedics, experienced higher levels of compassion satisfaction (CS) compared to other helping professions (Ondrejková & Halamová, 2022).

A research study utilizing an online questionnaire was carried out to examine the psychological resilience and burnout in Occupational therapists. The findings revealed that a significant portion, accounting for 55%, of the surveyed occupational therapists experienced high levels of burnout, with the majority falling within the moderately high to high range (Katsiana et al., 2021).

An online survey of 76 occupational therapists was used to examine the prevalence of compassion fatigue among practitioners. High CS, low BO, and low STS were present in more than half of the subjects (52.6%, 60.5%, and 78.9%, respectively). Furthermore, no participant belonged to the high BO or low CS groups. These findings imply that most respondents were satisfied with their jobs (high to medium compassion satisfaction) and did not experience excessive compassion fatigue (low BO and low STS). Therefore, majority of them had a professional quality of life that was adequate to good (Chen, 2020).

A cross-sectional study conducted among 200 occupational therapists assessed the quality of life and its connection to the workplace environment. It involved 200 occupational therapists, utilizing a professional quality of life scale. The results showed that only 27.0% experienced high levels of compassion satisfaction (CS), while 80.5% and 74.5% experienced high or average levels of burnout (BO) and secondary traumatic stress (STS) associated with compassion fatigue (CF), respectively. Several factors were identified: CS was higher among temporary employees, CF was higher in females and those in their 30s, working at general hospitals; BO was higher in those with one to five years of clinical experience and regular employees, while STS was higher in the group without stable income. The study emphasized the importance of clinical experience in reducing BO and revealed that excessive workload outside of treatment negatively impacted the professional quality of life. (Chung, 2020).

Psychotherapists in northern Uganda were studied using a cross-sectional correlational research approach to see whether emotional intelligence and compassion fatigue are related. Nearly one-quarter of respondents, 23.7% (n=49), reported having an average degree of compassion fatigue, while 15.9% (n=33) had low levels. The majority of respondents, 60.4% (n=125), experienced high levels of compassion fatigue. The study also discovered significant relationships between all of the emotional intelligence and compassion fatigue dimensions (Kabunga et al., 2020).

Indian physiotherapists working in various settings participated in a descriptive cross-sectional comparative survey with the goal of determining their level of compassion fatigue. Physiotherapists working in a rehabilitation setting are more susceptible to compassion fatigue. Males experience compassion fatigue more than females do. Therapists with fewer than ten years of experience are more likely to feel compassion fatigue (T. et al., 2019)

A cross-sectional study conducted in a mental health facility in Nigeria with 234 mental health service workers sought to learn more about the relationship between coping mechanisms and compassion fatigue. 75.2 percent of those who provided mental health services were at risk of developing compassion fatigue. and coping techniques predicted compassion fatigue together. However, when each subgroup was examined separately, only the subgroups of emotional focused engagement coping and emotional focused disengagement coping strategies independently predicted compassion fatigue, respectively (Joyce et al., 2016).

The professional quality of life of audiologists and speech language pathologists was investigated through a web-based cross-sectional survey. High levels of compassion satisfaction, low levels of burnout, and low levels of secondary traumatic stress were reported by 48%, 60%, and 54% of the professionals, respectively. A significant inverse relationship between CS and burnout indicated that a decline in burnout causes an increase in CS and vice versa. Burnout and STS were found to have a mediocrely positive association (Ravi et al., 2016).

An online survey was carried out among 213 mental health counsellors to explore the various individual and environmental elements that may contribute to the development of compassion fatigue and burnout. Compassion fatigue and burnout were inversely correlated with the length of time working in the field; hence, the longer the counsellor had worked in the field, the less compassion fatigue and burnout was observed. Burnout was significantly predicted by maladaptive coping, meaning that respondents who supported substance use, denial, diversion, and self-blame were more prone to experience it. In addition, the degrees of burnout reported decreased the more counsellors supported the use of emotion-focused approaches (Thompson et al., 2014).

A cross-sectional study aimed to explore the personal and professional factors in compassion fatigue among 182 healthcare professionals (89 mental, 93 medical). It revealed that higher trait emotional intelligence and effective emotion management are linked to lower compassion fatigue, along with adaptive coping strategies. Problem-focused coping mediated the link between trait emotional intelligence and compassion fatigue. These findings emphasized the importance of emotional factors and coping styles in healthcare professionals' compassion fatigue (Zeidner et al., 2013).

A survey study explored the effects of implementing evidence-based practices on compassion fatigue, burnout, and compassion satisfaction in a randomly selected, nationwide group of individuals who identify themselves as trauma specialists. The study involved a sample of 532 participants. In this study, the researchers found that age and years of experience were significant predictors of certain outcomes among trauma specialists. Younger professionals tended to report higher levels of burnout, while more experienced providers reported higher levels of compassion satisfaction. Additionally, the use of evidence-based practices had a notable impact. It was associated with statistically significant reductions in both compassion fatigue and burnout, as well as an increase in compassion satisfaction. These findings suggest that adopting evidence-based practices can be an effective strategy for improving the well-being and job satisfaction of trauma specialists (Craig & Sprang, 2010).

An online-based survey aimed to shed light on the levels of CF, CS, and burnout in the general population of mental health professionals across the typical course of their professional practise. The CF subscale scores that are higher than the threshold (showing a considerable risk of CF) is a little lower than the rates noted in other investigations. Additionally, being female was linked to higher levels of CF, and trauma-trained therapists reported higher levels of CS than non-trained therapists (Sprang et al., 2007).

According to survey results from 280 trauma therapists in Canada (certified clinical counsellors, psychologists, psychiatrists, social workers, counsellors at community agencies, and others), compassion fatigue was more common among therapists who practised in community settings with increased caseloads of clients who had experienced trauma (Buchanan et al., 2006).

2.1 Need for the Study

The literature on compassion fatigue has traditionally centered on healthcare professionals in fields like medicine and nursing, leaving a gap in our understanding of how this phenomenon affects rehabilitation professionals. It is encouraging to see that studies on compassion fatigue among rehabilitation professionals are emerging, although they are still relatively limited in number.

Furthermore, it is worth noting that many of the existing studies have primarily focused on Western populations, and only a few have been conducted in the Indian context. This highlights the need for more comprehensive and culturally sensitive research to gain a deeper understanding of how compassion fatigue manifests across different regions and healthcare systems.

Most of the existing studies are at a preliminary level, often exploring the prevalence and sociodemographic factors related to compassion fatigue. While this foundational research is valuable, it is essential to transition toward investigating the causal aspects of compassion fatigue. Identifying the underlying causes and risk factors can help develop targeted interventions and support systems for healthcare and rehabilitation professionals.

Overall, the call to delve deeper into the causal aspects of compassion fatigue is indeed timely and essential to better address the well-being and mental health of professionals working in these critical fields.

CHAPTER III
METHODOLOGY

CHAPTER III

METHODOLOGY

3.1 Aim of the study

To analyze compassion fatigue, emotional intelligence, and coping style in rehabilitation professionals.

3.2 Objectives

1. To understand the relationship between emotional intelligence, coping styles, and compassion fatigue among rehabilitation professionals.

2. To understand the effects of emotional intelligence and coping styles on compassion fatigue

3. To understand the moderating effects of coping styles on relationship between emotional intelligence and compassion fatigue.

3.3 Hypothesis:

H1: There will be a significant relationship between emotional intelligence and compassion fatigue in rehabilitation professionals.

H2: There will be a significant relationship between emotional intelligence and compassion satisfaction in rehabilitation professionals.

H3: Emotional Intelligence will significantly predict compassion satisfaction and compassion fatigue among rehabilitation professionals.

H4: There will be a significant relationship between coping style and compassion fatigue in rehabilitation professionals.

a) There will be a significant relationship between problem focused coping and compassion fatigue.
b) There will be a significant relationship between emotion focused coping and compassion fatigue.
c) There will be a significant relationship between avoidant coping and compassion fatigue.

H5: Coping style will significantly predict compassion fatigue among rehabilitation professionals.

a) Emotion-focused coping will significantly predict compassion fatigue among rehabilitation professionals.
b) Avoidant coping will significantly predict compassion fatigue among rehabilitation professionals.

H6: Problem-focused coping will significantly predict compassion satisfaction among rehabilitation professionals.

H7: Emotional Intelligence, problem-focused coping, emotion-focused coping, and avoidant coping will significantly predict compassion fatigue in rehabilitation professionals.

H8: Coping style will moderate the relationship between emotional intelligence and compassion fatigue in rehabilitation professionals.

a) Problem-focused coping will moderate the relationship between emotional intelligence and compassion fatigue in rehabilitation professionals.
b) Emotion-focused coping will moderate the relationship between emotional intelligence and compassion fatigue in rehabilitation professionals.
c) Avoidant coping will moderate the relationship between emotional intelligence and compassion fatigue in rehabilitation professionals.

H8: There will be a significant relationship between years of experience and levels of Secondary Traumatic Stress in rehabilitation professionals.

H9: There will be a significant relationship between years of experience and levels of Burnout in rehabilitation professionals.

H10: There will not be any significant gender difference in compassion fatigue among rehabilitation professionals.

H11: There will not be any significant gender difference in secondary traumatic stress among rehabilitation professionals.

H12: There will not be significant gender difference in burnout among rehabilitation professionals.

H13: There will not be significant gender difference in compassion satisfaction among rehabilitation professionals.

H14: There will not be significant gender difference in emotional intelligence among rehabilitation professionals.

H15: There will be significant gender difference in coping styles among rehabilitation professionals.

a) There will not be significant gender difference in problem-focused coping among rehabilitation professionals.
b) There will not be significant gender difference in emotion-focused coping among rehabilitation professionals.
c) There will not be significant gender difference in avoidant focused coping among rehabilitation professionals.

H16: There will be a significant difference in the compassion fatigue among varying years of experience in rehabilitation professionals.

3.4 Sample

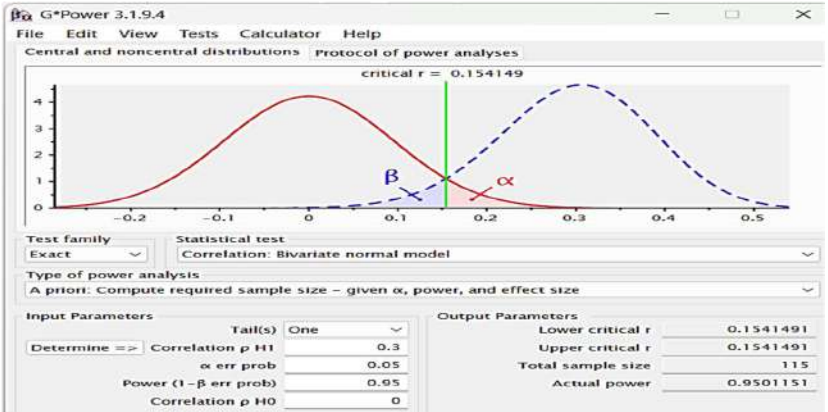
The methods followed in determining and recruiting the samples of the study are explained in the following subsections.

3.4.1 Sample Estimation Protocol

The priori analysis in G*Power 3.0 was done to estimate the sample size for the present study. The configuration was setup for Correlation: Bivariate normal model with $\alpha = 0.05$, $1\text{-}\beta = 0.95$.

Figure 3.1.

Results of the sample size estimation analysis



3.4.2 Sample Size - 115

3.4.3 Sampling Method – For the present study, purposive sampling was used.

3.4.4 Sampling Criteria

The following were the sampling criteria which were adopted in the present study.

Inclusion Criteria:

- Rehabilitation Professionals working as Clinical Psychologists, Rehabilitation Psychologists, Prosthetists and Orthotists, Audiologists & Speech Therapists, Physiotherapists, Occupational Therapists, and Special Educators
- Age Range – 30-55 years old
- Both Male and Female professionals
- Minimum Work Experience – 2 years

Exclusion Criteria:

- Currently suffering from any major physical illness.

3.5 Research Design

The present research follows cross-sectional research design.

3.6 Variables

The following are the variables considered in the study:

Independent Variable – Emotional Intelligence

Dependent Variable – Compassion Fatigue

Moderator Variable – Problem-focused coping, Emotion-focused coping, Avoidant coping

3.7 Tools of Assessment

In the following subsections, the description of the tools of assessment are discussed in detail along with their psychometric properties:

3.7.1 Socio-demographic Data sheet

Sociodemographic data sheet included basic demographic details such as age, gender, marital status, place, educational qualification, occupation, years of experience, daily hours of working, number of clients seen per day, whether currently having any chronic medical illness.

3.7.2 Professional Quality of Life (ProQOL) Version 5 is a self-report questionnaire developed by Stamm, B.H. in 2009. It has 30 Items in total. It comprises 3 Subscales – Compassion Satisfaction (CS); Burnout (BO); Secondary Traumatic Stress (STS). Compassion Fatigue (CF) has two components i.e., BO and STS. Each subscale has 10 items. The reliability of CS is 0.88, BO is 0.75 and CF is 0.81. The inter-scale correlations show 2% shared variance (r=-.23; co-σ = 5%; n=1187) with Secondary Traumatic Stress and 5% shared variance (r=.-.14; co-σ = 2%; n=1187) with Burnout. Responses are scored on a 5-point Likert scale with 1 being “Never” and 5 being “Very Often”. Items 1,4,15,17 and 29 are reverse scored. Score of 22 or less is interpreted as Low, 23 to 41 as Moderate and 42 or more as High under each subscale.

3.7.3 Brief COPE Inventory Brief COPE is a 28-item self-report questionnaire developed by Carver C.S in 1997 to measure coping styles. The scale has 3 subscales – Problem focused coping, Emotion-focused coping, and Avoidant coping. The Cronbach Alpha for the subscales range from 0.50 to 0.90. The responses are scored on a 4-point Likert scale with 1 being “I haven’t been doing this at all” and 4 being “I have been doing this a lot”. In addition to the subscales, it also consists of 14 facets such as active coping, use of informational support,

planning, and positive reframing subsumed under problem-focused coping; venting, use of emotional support, humour, acceptance, self-blame, and religion categorized by emotion-focused coping; self-distraction, denial, substance use, and behavioural disengagement included under avoidant coping. 2 items measure each facet.

3.7.4 Schutte's Self-report Emotional Intelligence Test (SSEIT) is a 33 item self-report questionnaire developed by Nicola Schutte to measure trait emotional intelligence. The reliability of the scale is Cronbach Alpha = 0.87 to 0.90. The items are measured on a 5-point Likert scale with 1 being "Strongly Disagree" and 5 being "Strongly Agree". Items 5, 8 and 23 are reverse coded while scoring. Scores can range from 33 to 165 with higher scores implying higher emotional intelligence.

3.8 Procedure

Initially the study was reviewed by the Department of Clinical Psychology, NIEPMD, followed by the Institute Ethics Committee (IEC). After the approval from the committee, permission to collect data at NIEPMD was obtained from the Director of NIEPMD. The participants who matched the criteria were identified and approached for the study both offline and online (using Google forms). They were explained about the purpose of the study and printed questionnaires were given to them for filling it and a link to fill the questionnaires were also sent to professionals approached through online platforms. Informed consent form was provided to all participants who matched the criteria and who were willing to participate in the study. Participants filled the three questionnaires, along with the socio-demographic form. There was a total of 125 responses obtained. The responses of participants who met the exclusion criteria were excluded from the study. There were 4 participants who reported experiencing chronic medical condition. Therefore, a total of 4 responses were excluded from the study. The

remaining 121 responses were taken for further analysis.

3.9 Ethical Considerations

- Informed consent was taken from all participants.
- Participation in the study was voluntary.
- Anonymity of the participants and the confidentiality of the data was maintained.
- The participants were not subjected to any physical or psychological harm.
- Tools used in the study were all either open source made publicly available for research under creative commons license and in the case of non-open-source tools, all necessary permission were obtained from the author.

3.10 Data Analysis

The data collected was analyzed in SPSS Version 20.0. The descriptive statistics were obtained for all the possible study measures and reported in the subsequent chapters. For inferential statistics, the data was tested for any outliers and normality analysis was done using Shapiro-Wilk statistic to meet the requirements of parametric statistics. The results showed that all the variables entered in the analysis was not significant indicating that the normality of the data was present. Consequently, Chi-square test of independence was performed to find the correlation between the categorial variables. Additionally, the homogeneity of variances was tested using Levene's test for equality of variances, in order to perform Independent Samples t-test. T-test was then used to compare the differences of scores within the group based on the gender. For variables having more than two groups, One-way ANOVA was used to check the significance of differences between the groups. Tukey's HSD was performed as the post-hoc analysis to understand which particular group has significant difference in comparison with other groups. Pearson correlation was performed to find the relationship between the continuous variables in the study. The data was tested using regression models (both simple and multiple linear models) in order to predict the effects of

the hypothesized independent variables over the dependent variable. The Hayes process macro plugin was added to the SPSS 20 and the built-in model 1 was used to find the moderating effects of the independent and moderating variables on the outcome variables in the study.

CHAPTER IV
RESULTS & DISCUSSION

CHAPTER IV

RESULTS AND DISCUSSION

As proposed in the previous chapters, the main aim of the research is to find out the relationship between compassion fatigue, emotional intelligence, and coping styles among rehabilitation professionals. The previous chapter laid out the methodology employed for the current study. This present chapter investigates the analysis of the result obtained.

The results of the study are presented in the following sections:

Section I: Shows the participants characteristics and descriptive statistics for the variables.

Section II: Shows the inferential statistics of the data collected from the sample.

4.1. Section I

Table 1

Participants' sociodemographic and other characteristics

Variables		Group	N	%	Mean ± SD
Age	i.	Males	60	49.6	36.36 ± 7.23
	ii.	Females	61	50.4	35.55 ± 7.30
	iii.	Combined	121	100	35.95 ± 7.25
Gender	i.	Males	60	49.6	-
	ii.	Females	61	50.4	-
Domicile	i.	Urban	97	80.2	-
	ii.	Rural	13	10.7	
	iii.	Semi-urban	11	9.1	-
Occupation	i.	Clinical Psychologists	20	16.5	-
	ii.	Rehabilitation Psychologists	16	13.2	-
	iii.	Prosthetists & Orthotists	16	13.2	-
	iv.	Audiologists	11	9.1	-
	v.	Speech Therapists	5	4.1	-
	vi.	Physiotherapists	18	14.9	-
	vii.	Occupational Therapists	16	13.2	-
	viii.	Special Educators	19	15.7	-
Years of Experience	i.	2-4	46	38	-
	ii.	5-7	30	24.8	-
	iii.	8-10	13	10.7	-
	iv.	10 Above	32	26.4	-
No. of Clients seen per day		-	121	-	9.46 ± 7.031
Daily Hours of working		-	121	-	7.88 ± 1.47

As it is given in Table 1, that out of the 121 participants, 49.6% were males and 50.4% were females. The mean age of males was 36.36 ± 7.23 years and 35.55 ± 7.30 years for females. The mean age of the overall sample was 35.95 ± 7.25 years. 80% (N=97) of the participants belonged to urban domicile, while 10.7 % (N=13) and 9.1% (N=11) were from rural and semi-urban domicile respectively. 16.5% (N=20) of the sample constituted clinical psychologists while 15.7% (N=19) were special educators. 14.9% (N=18) of the sample were

physiotherapists. Rehabilitation psychologists, prosthetist and orthotists and occupational therapists comprised 13.2% (N=16) each in the total sample. Audiologists and speech therapists made up 9.1% (N=11) and 4.1% (N=5) of the sample. The mean no. of clients seen per day is 9.46 ± 7.031. The mean daily hour of working is 7.88 ± 1.47 hours.

Table 2

Descriptive Statistics for the major study variables

Measure	N	Minimum Score	Maximum Score	Mean		SD Statistic	Variance Statistic
				Score	Std. Error		
CS	121	22	50	41.86	.438	4.821	23.29
BO	121	10	34	21.11	.494	5.434	29.53
STS	121	10	38	22.02	.565	6.214	38.61
CF	121	20	72	43.13	.935	10.29	105.87
EI	121	74	164	134.3	1.36	15.02	225.80
PB	121	14	34	24.40	.423	4.65	21.63
EMO	121	14	44	28.21	.631	6.93	48.15
AVO	121	8	26	14.08	.362	3.98	15.89

Note. CS= Compassion Satisfaction, BO= Burnout, STS= Secondary Traumatic Stress, CF=Compassion Fatigue (BO + STS), EI= Emotional Intelligence, PB=Problem-focused Coping, EMO= Emotion-focused coping, AVO= Avoidant coping

The Table 2 shows the descriptive statistics of the major study variables. The mean score of the Pro-QOL measures are as follows: Compassion Satisfaction (CS) was 41.86 ± 4.821, Burnout (BO) was 21.11 ± 5.434, Secondary Traumatic Stress (STS) was 22.02 ± 6.214. The mean score of Compassion Fatigue (CF) was calculated by adding both BO and STS scores which is 43.13 ± 10.28. The mean score of Emotional Intelligence (EI) is 134.3 ± 15.027. The mean score of the Brief-COPE measures are as follows: Problem-focused coping was 24.40 ± 4.650, Emotion-focused coping was 28.21 ± 6.939, Avoidant coping was 14.08 ± 3.987.

4.2 Section II

This following section shows the inferential statistical results of the samples taken for the study.

Table 3

Pearson Correlation statistic for the study variables

Variables	CS	CF	BO	STS	EI	PB	EMO	AVO
CS	-							
CF	-.417**	-						
BO	-.668**	.866**	-					
STS	-.105	.899**	.559**	-				
EI	.498**	-.319**	-.350**	-.223*	-			
PB	.339**	.135	-.026	-.247**	.475**	-		
EMO	.182	.369**	.127	.500**	.084	.672**	-	
AVO	.020	.379**	.188*	.463**	.014	.388**	.577**	-

*** Correlation is significant at the 0.01 level (2-tailed).*
** Correlation is significant at the 0.05 level (2-tailed).*
Note. CS= Compassion Satisfaction, BO= Burnout, STS= Secondary Traumatic Stress, CF=Compassion Fatigue (BO + STS), EI= Emotional Intelligence, PB=Problem-focused Coping, EMO= Emotion-focused coping, AVO= Avoidant coping.

Table 3 shows the correlation for the study variables. The findings of the analysis are discussed here. There was a significant negative correlation between Emotional Intelligence and Compassion Fatigue ($r = -.319, p < .01$); Burnout ($r = -.350, p < .01$) & Secondary Traumatic Stress ($r = -.223, p < .05$). There was a significant positive correlation between Emotional Intelligence and Compassion Satisfaction ($r = .498, p < .01$); Problem-focused coping ($r = .475, p < .01$). There was a significant positive correlation between Compassion Fatigue and Emotion-focused coping ($r = .369, p < .01$) and Avoidant coping (r = .379, p

<.01). There was a significant positive correlation between Secondary Traumatic Stress and Emotion-focused coping (r = .500, p < .01) & Avoidant coping (r = .463, p < .01). Secondary Traumatic Stress had a significant negative correlation with Problem focused coping (r = .247, p < .01). Problem-focused coping had a significant positive correlation with Compassion Satisfaction (r = .339, p < .01).

Table 4A

Linear Regression Model Summary for Compassion Fatigue

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	-.319[a]	.102	.094	9.79101	13.520	.000[b]

a. Predictors: (Constant), Emotional Intelligence
b. Dependent Variable: Compassion Fatigue

Table 4B

Linear Regression Coefficients Statistic for Compassion Fatigue

		Unstandardized Coefficients		Standardized Coefficients	t	Sig
	Model	B	Std. Error	Beta		
1	(Constant)	72.509	8.039		9.020	.000
	EI	-.219	.059	-31.9	-3.677	.000

The model summary of the linear regression (Table 4A) indicated that the variables entered in the model were a significant predictor of Compassion Fatigue, F (1, 119) = 13.520, p < 0.01 . The proportion of variance was estimated to be 10% which was explained by the predictors of the model. In this predictive model, Emotional Intelligence was the significant predictor of the dependent variable entered in the model. It was interpreted that emotional intelligence by one unit, the compassion fatigue indices decreased by -.219 units.

Table 5A

Linear Regression Model Summary for Compassion Satisfaction

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	.498[a]	.248	.241	4.199	39.187	.000[b]

a. Predictors: (Constant), Emotional Intelligence
b. Dependent Variable: Compassion Satisfaction

Table 5B

Linear Regression Coefficients Statistic for Compassion Satisfaction

		Unstandardized Coefficients		Standardized Coefficients	t	Sig
	Model	B	Std. Error	Beta		
1	(Constant)	20.412	3.447		5.921	.000
	EI	.160	.026	.498	6.260	.000

The model summary of the linear regression (Table 5A) indicated that the variables entered in the model were a significant predictor of Compassion Satisfaction, F (1, 119) = 39.187, p < 0.01. The proportion of variance was estimated to be 25% which was explained by the predictors of the model. In this predictive model, Emotional Intelligence was the significant predictor of the dependent variable entered in the model. It was interpreted that emotional intelligence by one unit, the compassion satisfaction indices increased by .160 units.

Table 6A

Linear Regression Model Summary for Compassion Fatigue

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	.369[a]	.136	.129	9.60404	13.520	.000[b]

a. Predictors: (Constant), Emotion-focused coping
b. Dependent Variable: Compassion Fatigue

Table 6B

Linear Regression Coefficients Statistic for Compassion Fatigue

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig
		B	Std. Error	Beta		
1	(Constant)	27.705	3.670		7.549	.000
	Emotion-focused coping	.547	.126	.369	4.328	.000

The model summary of the linear regression (Table 6A) indicated that the variables entered in the model were a significant predictor of Compassion Fatigue, F (1, 119) = 18.730, p < 0.01 . The proportion of variance was estimated to be 13% which was explained by the predictors of the model. In this predictive model, Emotional-focused coping was the significant predictor of the dependent variable entered in the model. It was interpreted that when emotional focused coping increased by one unit, the compassion fatigue indices increased by .547 units.

Table 7A

Linear Regression Model Summary for Compassion Fatigue

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	.379[a]	.144	.136	9.56130	19.964	.000[b]

a. Predictors: (Constant), Avoidant coping
b. Dependent Variable: Compassion Fatigue

Table 7B

Linear Regression Coefficients Statistic for Compassion Fatigue

	Model	Unstandardized Coefficients B	Std. Error	Standardized Coefficients Beta	t	Sig
1	(Constant)	29.356	3.203		9.164	.000
	EI	.978	.219	.379	4.468	.000

The model summary of the linear regression (Table 7A) indicated that the variables entered in the model were a significant predictor of Compassion Fatigue, F (1, 119) = 19.964, $p < 0.01$. The proportion of variance was estimated to be 14% which was explained by the predictors of the model. In this predictive model, Avoidant coping was the significant predictor of the dependent variable entered in the model. It was interpreted that avoidant coping by one unit, the compassion fatigue indices increased by .978 units.

Table 8A

Linear Regression Model Summary for Compassion Satisfaction

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	.339[a]	.115	.107	4.554	15.444	.000[b]

a. Predictors: (Constant), Problem-focused coping
b. Dependent Variable: Compassion Satisfaction

Table 8B

Linear Regression Coefficients Statistic for Compassion Satisfaction

	Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig
		B	Std. Error	Beta		
1	(Constant)	33.288	2.220		14.994	.000
	Problem-focused coping	.351	.089	.339	3.930	.000

The model summary of the linear regression (Table 8A) indicated that the variables entered in the model were a significant predictor of Compassion Satisfaction, F (1, 119) = 15.444, $p < 0.01$. The proportion of variance was estimated to be 12% which was explained by the predictor of the model. In this predictive model, Problem-focused coping was the significant predictor of the dependent variable entered in the model. It was interpreted that problem-focused coping increased by one unit, the compassion satisfaction indices increased by .351 units.

Table 9A

Multiple Regression Model Summary for Compassion Fatigue

R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
.546[a]	.298	.274	8.76	12.313	.000[b]

a. Predictors: (Constant), Emotional Intelligence, Problem-focused coping, Emotion-focused coping, and Avoidant coping
b. Dependent Variable: Compassion Fatigue

Table 9B

Multiple Regression Coefficients Statistics for Compassion Fatigue

Model	**Unstandardized Coefficients**		**Standardized**		
	B	**Std. Error**	**Coefficients**	**t**	**Sig.**
1 (Constant)	56.398	7.956		7.089	.000
Emotional Intelligence	-.261	0.65	-.381	-4.013	.000
Problem-focused coping	.189	.282	.086	.670	.504
Emotion-focused coping	.313	.185	.211	1.694	.093
Avoidant coping	.593	.246	.230	2.407	.018

The model summary of the multiple regression (Table 9A) indicated that the variables entered in the model were a significant predictor of Compassion Fatigue, F (4,116) = 12.313, p <0.01. The proportion of the variance were estimated to be 30% which was explained by the predictors in the model. In this predictive model, emotional intelligence and avoidant coping were the significant predictors of the dependent variable entered in the model. It was interpreted that when emotional intelligence increased by one unit, compassion fatigue indices were decreased by .261 units. It was interpreted that when avoidant coping increased by one unit, compassion fatigue indices were increased by .593 units. The final predictive model was: Compassion Fatigue = 56.398 + (-.261*Emotional Intelligence) + (.593*Avoidant coping).

Table 10A

Model Summary of Moderation analysis with moderator as Problem-focused coping

R	R^2	MSE	F	df1	df2	Sig.
.4824	.2327	83.3129	11.8280	3.00	117.00	.000

Table 10B

Coefficient Statistic of moderation analysis with outcome as Compassion Fatigue

Model	Coeff	SE	t	Sig.	LLCI	ULCI
Constant	128.6567	32.10	4.00	.0001	65.07	192.23
Emotional Intelligence	-.7730	.2343	-3.2995	.001	-1.23	-.309
Problem-focused Coping	-2.0040	1.484	-1.3504	.01795	-4.9430	.9349
Int_1	.0203	.0106	1.9216	.057	-.0006	.0412

Int_1: Emotional Intelligence x Problem-focused coping

Moderation analysis was conducted to test whether the effect of the independent variable (IV) i.e., Emotional Intelligence on the dependent variable (DV) i.e., Compassion Fatigue was moderated by the moderator variable (MV) i.e., Problem-focused coping. PROCESS macro (Hayes, 2022) was used to estimate the conditional effects of the IV on the DV at different levels of the MV. The results revealed that problem-focused coping did not emerge as a moderating factor in the relationship between Emotional intelligence and Compassion Fatigue, b = 0.2, SE = .0106, t (117) = 1.92, p > .05, 95% CI [-.0006, .0412].

Table 11A

Model Summary of Moderation analysis with moderator as Emotion-focused coping

R	R^2	MSE	F	df1	df2	Sig.
.5442	.2962	76.4229	16.4105	3.00	117.00	.000

Table 11B

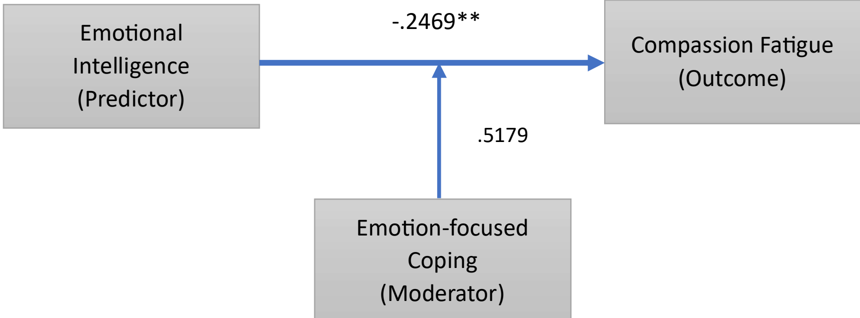
Coefficient Statistic of moderation analysis with outcome as compassion fatigue

Model	Coeff	SE	t	Sig.	LLCI	ULCI
Constant	42.9279	.7990	53.7239	.000	41.3454	44.5103
Emotional Intelligence	-.2469	.0533	-4.6281	.000	-.3525	-.1412
Emotion-focused Coping	.5179	.1191	4.3745	.000	.2820	.7539
Int_1	.0235	.0095	2.4638	.0152	.0046	.0424

Int_1: Emotional Intelligence x Emotion-focused coping

Figure 4.1

Proposed model of moderation effect of the study variable and Compassion Fatigue as the outcome

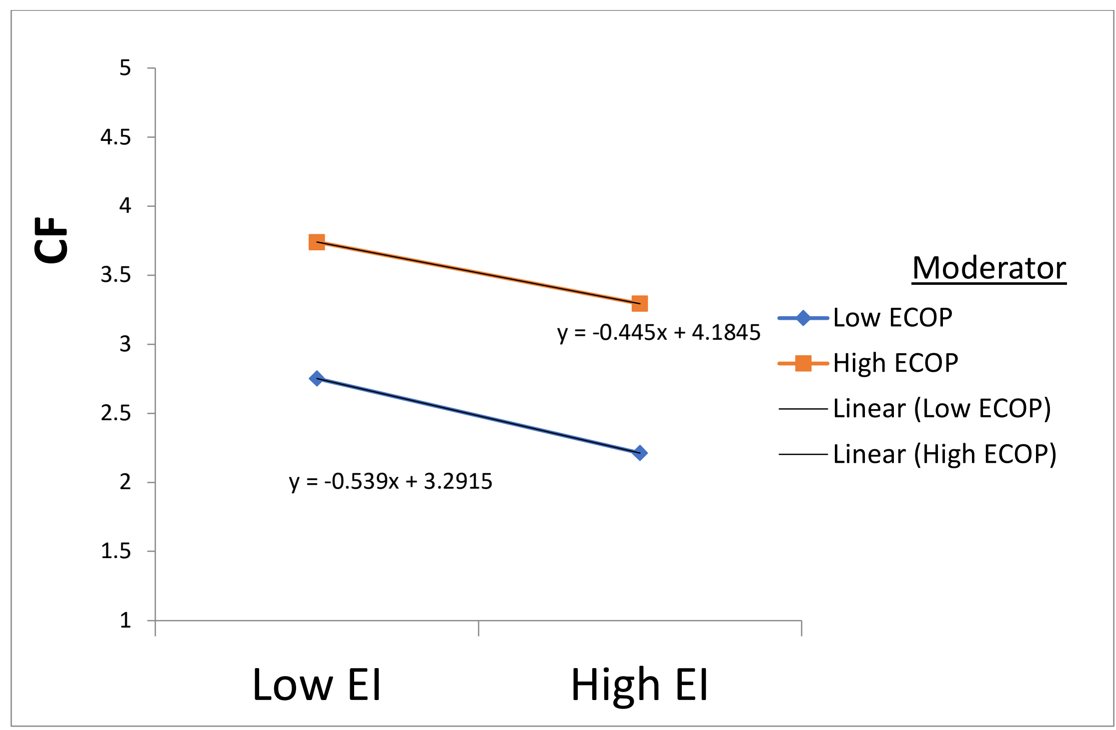


Moderation analysis was conducted to test whether the effect of the independent variable (IV) i.e., Emotional Intelligence on the dependent variable (DV) i.e., Compassion Fatigue was moderated by the moderator variable (MV) i.e., Emotion-focused coping. PROCESS macro (Hayes, 2022) was used to estimate the conditional effects of the IV on the DV at different levels of the MV. The results revealed a negative and significant moderating impact of Emotion-focused coping on the relationship between Emotional Intelligence and Compassion Fatigue. The results showed that the interaction between the IV and the MV was

significant, b = 0.02, SE = 0.09, t (117) = 2.46, p = 0.01, 95% CI [0.00, 0.04]. This indicated that the effect of the IV on the DV varied depending on the MV. Specifically, the effect of the IV on the DV was negative and significant when the MV was high, b = 0.51, SE = 0.11, t(117) = 4.34, $p < 0.001$, 95% CI [0.28, 0.75], but not when the MV was low, b = -0.04, SE = 0.10, t(198) = -0.40, p = 0.690, 95% CI [-0.24, 0.16]. Accordingly, when emotion-focused coping increases, the positive effect of emotional intelligence on compassion fatigue decreases (Figure 4.1)

Figure 4.2

Simple slope analysis for the moderator variable – Emotion-focused coping



Note. CF = Compassion Fatigue, EI = Emotional Intelligence, ECOP = Emotion-focused Coping

Table 12A

Model Summary of Moderation analysis with moderator as Avoidant Coping

R	R^2	MSE	F	df1	df2	Sig.
.5513	.3040	75.5724	17.0311	3.00	117.00	.000

Table 12B

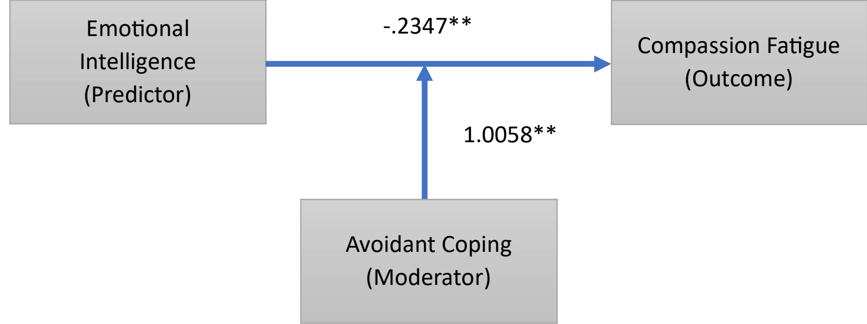
Coefficient Statistic of moderation analysis with outcome as compassion fatigue

Model	Coeff	SE	t	Sig.	LLCI	ULCI
Constant	43.0966	.7994	54.5249	.000	41.5313	44.6620
Emotional Intelligence	-.2347	.0530	-4.4310	.000	-.3396	-.1298
Avoidant Coping	1.0058	.1992	5.0506	.000	.6114	1.4002
Int_1	.0419	.0138	3.0339	.0030	.0146	.0693

Int_1: Emotional Intelligence x Avoidant coping

Figure 4.3

Proposed model of moderation effect of the study variable and Compassion Fatigue as the outcome

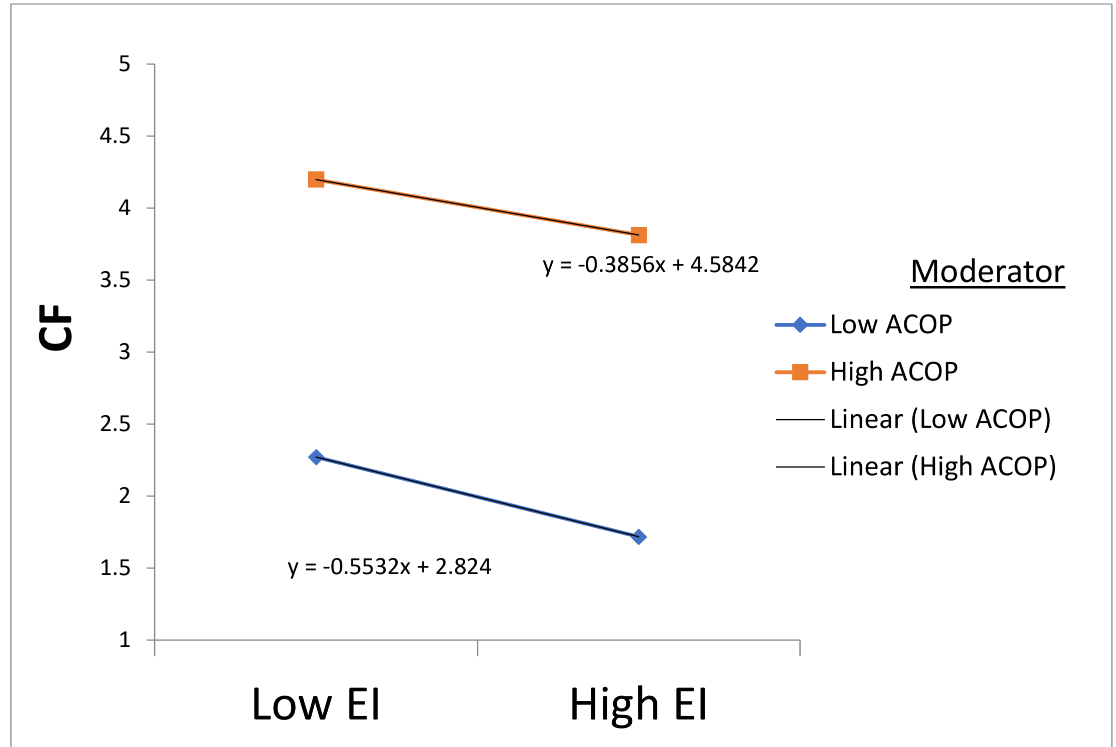


Moderation analysis was conducted to test whether the effect of the independent variable (IV) i.e., Emotional Intelligence on the dependent variable (DV) i.e., Compassion Fatigue was moderated by the moderator variable (MV) i.e., Avoidant coping. PROCESS macro (Hayes, 2022) was used to estimate the conditional effects of the IV on the DV at different levels of the MV. The results revealed a negative and significant moderating impact of avoidant coping on the relationship between Emotional Intelligence and Compassion Fatigue. The results showed that the interaction between the IV and the MV was significant, b = 0.041, SE = 0.013, t (117) = 3.033, p = 0.003, 95% CI [0.014, 0.069]. This indicated that the effect of the IV on the DV varied depending on the MV. Specifically, the effect of the IV

on the DV was negative and significant when the MV was low, b = -.40, SE = 0.07, t(117) = -5.06, p < 0.001, 95% CI [-.55, -.24], but not when the MV was high, b = -0.06, SE = 0.07, t(117) = -.92, p = 0.35, 95% CI [-0.21, 0.07]. Accordingly, when avoidant coping increases, the positive effect of emotional intelligence on compassion fatigue decreases (Figure 4.3)

Figure 4.4

Simple slope analysis for the moderator variable – Avoidant coping



Note. CF = Compassion Fatigue, EI = Emotional Intelligence, ACOP = Avoidant Coping

Table 13

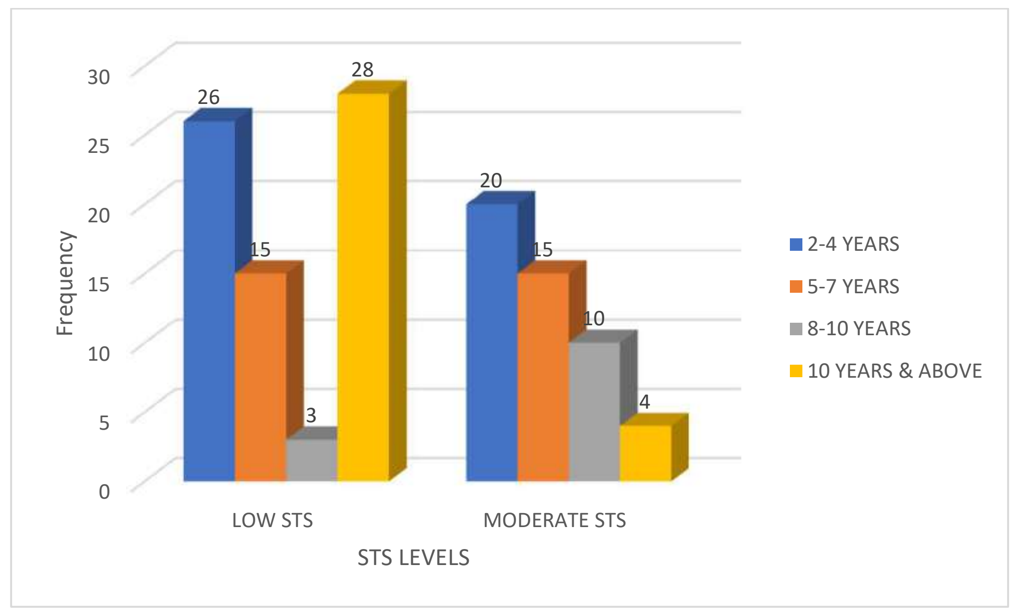
Chi-square statistic for levels of STS and years of experience

Variables	Pearson's Chi-square Likelihood Ratio	Df	Significance p<0.01
Levels of STS and years of experience	18.86	3	.000
Levels of BO and years of experience	22.49	3	.000

Note. STS = Secondary Traumatic Stress, BO = Burnout, df=Degrees of freedom

Figure 4.5

Levels of STS among various years of experience

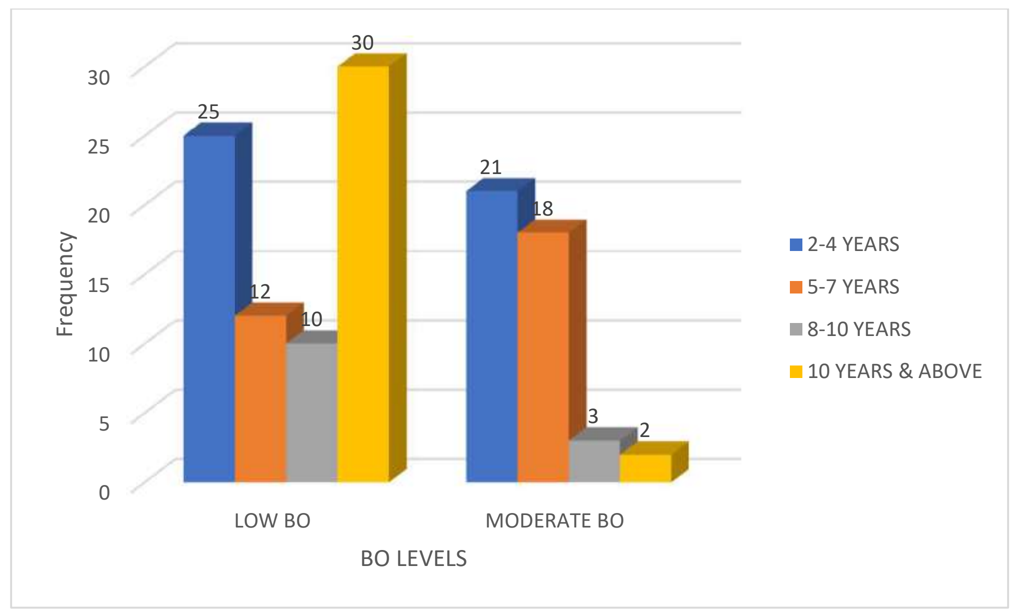


Note. STS = Secondary Traumatic Stress

A chi-square test of independence was performed to evaluate the relationship between the levels of STS and years of experience (Table 13). The relationship between these variables was significant, χ^2 (3, N = 121) = 18.861, p = .000.

Figure 4.6

Levels of BO among various years of experience



Note. BO = Burnout

A chi-square test of independence was performed to evaluate the relationship between the levels of BO and years of experience (Tabe 13). The relationship between these variables was significant, χ^2 (3, N = 121) = 22.49, p = .000.

Table 14

Group statistics for gender of the participants

Variables	Gender	N	Mean	Std. Deviation
CS	M	60	41	5.052
	F	61	42.70	4.462
STS	M	60	21.33	4.778
	F	61	20.88	6.041
BO	M	60	22.11	5.46
	F	61	21.93	6.915
CF	M	60	43.45	8.986
	F	61	42.81	11.49
EI	M	60	133.48	15.64
	F	61	135.15	14.47
PB	M	60	25.18	4.355
	F	61	23.62	4.834
EMO	M	60	29.93	6.295
	F	61	26.52	7.175
AVO	M	60	15.42	3.950
	F	61	12.77	3.593

Note. CS= Compassion Satisfaction, BO= Burnout, STS= Secondary Traumatic Stress, CF=Compassion Fatigue (BO + STS), EI= Emotional Intelligence, PB=Problem-focused Coping, EMO= Emotion-focused coping, AVO= Avoidant coping, M=Male, F=Female

Table 14 shows that the total number of Males and Females were 60 and 61 respectively. The results indicate differences in mean based on the gender of the professionals in each of the study variables. The mean values did not show a marked difference, however there is a slightly higher mean value for Males in scores of Emotion-focused and Avoidant Coping.

Table 15

Independent Samples t-test based on gender of the participants

Variables	t	df	Sig. (2-tailed)	Mean Difference
CS	-1.968	119	.051	-1.705
STS	.161	119	.873	.182
BO	.452	119	.652	.4480
CF	.336	119	.738	.6303
EI	-.607	119	.545	-1.664
PB	1.864	119	.065	1.560
EMO	2.776	119	.006*	3.409
AVO	3.856	119	.000*	2.646

** Indicates significance at 0.05 level.*
Note. CS= Compassion Satisfaction, BO= Burnout, STS= Secondary Traumatic Stress, CF=Compassion Fatigue (BO + STS), EI= Emotional Intelligence, PB=Problem-focused Coping, EMO= Emotion-focused coping, AVO= Avoidant coping

An independent samples t-test was conducted to compare the gender differences across the major study variables (Table 15). There was no significant gender difference in Compassion Satisfaction, Secondary Traumatic Stress, Burnout, Compassion Fatigue, Emotional Intelligence and Problem focused coping among the rehabilitation professionals. However, the results showed that there was significant difference in the scores of Emotion-focused among males (M=29.93, SD=6.295) than females (M=26.52, SD=7.715); t (119) = 2.776, p = 0.006. Statistically significant difference was also found in the scores of Avoidant coping among males (M=15.42, SD=3.950) than females (M=12.77, SD=3.593); t (119) = 3.856, p = .000

Table 16

ANOVA for Years of Experience

		Sum of Squares	df	Mean Square	F	Sig.
Compassion Fatigue	Between Groups	1624.611	3	541.537	5.719	.001*
	Within Groups	11079.273	117	94.695		
	Total	12703.884	120			

A one-way ANOVA was conducted to compare compassion fatigue among varying years of experience (Table 16). Years of experience was divided into four categories, namely 2-4 years, 5-7 years, 8-10 years and above 10 years. Compassion Fatigue varied with years of experience. The results indicate a significant effect, [F (3,117) = 5.719, p .001]. Post Hoc analysis was conducted using Tukey's HSD test. The multiple comparison revealed compassion fatigue was significantly different between 2-4 years of experience (M = 44.32, SD = 11.87), 5-7 years of experience (M = 46.43, SD = 9.54), 8-10 years of experience (M = 45.92, SD = 4.55) and above 10 years of experience (37.18, SD = 7.71), $p < 0.05$. The mean score of Compassion fatigue (CF) is higher in the group with 5-7 years of experience than 2-4 years of experience, 8-10 years of experience and above 10 years of experience.

Discussion

The study aimed at analysing the relationship between compassion fatigue, emotional intelligence, and coping style in rehabilitation professionals. The primary hypothesis of the study is to understand the nature of relationship between emotional intelligence and compassion fatigue among rehabilitation professionals. The results indicate that there is a significant negative correlation between emotional intelligence and compassion fatigue ($r = -.32$, $p < .01$). Emotional intelligence also turned out to be a significant predictor of compassion satisfaction. Indeed, managing one's emotions and having a deep understanding of the emotions of others are critical aspects of reducing the risk of experiencing compassion fatigue for rehabilitation professionals. Effective emotion management is especially vital as it can significantly contribute to mitigating the effects of compassion fatigue. This emotional self-regulation allows professionals to provide care and support to others while also safeguarding their own emotional well-being and preventing burnout. This pattern of results is consistent with the previous literature highlighting that emotional intelligence is a clear predictor of compassion fatigue (Amir et al., 2019; Maillet & Read, 2021; Ruiz Fernández et al., 2021).

In line with previous studies (Bae et al., 2020; Maillet & Read, 2021; Ruiz Fernández et al., 2021), another promising finding is that emotional intelligence had a significant positive correlation ($r = .49$, $p < .01$), with and significantly predicted compassion satisfaction. From these results, it is clear that emotional intelligence plays a dual role in the field of rehabilitation. It not only serves as a protective factor against the development of compassion fatigue but also contributes to the experience of compassion satisfaction. High emotional intelligence enables rehabilitation professionals to navigate the emotional challenges of their work more effectively, reducing the risk of burnout and compassion fatigue. Additionally, it enhances their ability to derive satisfaction and fulfilment from their

work by forging deeper connections with clients and experiencing a sense of accomplishment in helping others.

Coping strategies are indeed significantly related to compassion fatigue among individuals, especially those in rehabilitation professions. The ways in which individuals cope with the emotional demands of their work can influence their susceptibility to compassion fatigue. The results of this study support this notion as there is significant positive relationship between problem-focused coping and compassion satisfaction; whereas a negative correlation exists between compassion fatigue and emotion-focused, avoidant coping strategies. Problem-focused coping also significantly predicted compassion satisfaction (r = .33, p<.01). Problem-focused coping such as active coping, use of informational support, planning, and positive reframing which involves addressing and resolving the underlying issues or stressors, can contribute positively to compassion satisfaction. When individuals effectively manage the challenges, they face in their profession, they are more likely to experience a sense of accomplishment and fulfilment. Successfully solving such problems and making a positive impact on the well-being of others can enhance compassion satisfaction, as it reinforces a sense of purpose and efficacy in their work (Abou Hashish & Ghanem Atalla, 2023).

Emotion-focused coping such as venting, use of emotional support, humour, acceptance, self-blame, and religion which involves managing and regulating one's emotional responses to stress, can indeed be associated with compassion fatigue. This study revealed that emotion-focused coping was positively associated with compassion fatigue (r = .36, p <.01) and significantly predicted compassion fatigue. This result ties well with previous study conducted by Joyce et al in 2016 among mental health service workers and concluded that emotion-focused coping was a significant predictor of compassion fatigue (Joyce et al., 2016). When individuals repeatedly engage in emotion-focused coping without effectively

addressing the underlying issues or stressors in their caregiving or helping roles, it can lead to emotional exhaustion and burnout. Over time, constantly dealing with the emotional burden of others without finding constructive ways to alleviate it can contribute to compassion fatigue, as it may result in increased emotional distress and a sense of helplessness. Effective coping strategies often involve a balance between both problem-focused and emotion-focused approaches to mitigate the risk of compassion fatigue.

Avoidant coping strategies such as self-distraction, denial, substance use, and behavioural disengagement which involve distancing oneself from stressful situations or emotions, can indeed be associated with an increased risk of compassion fatigue, particularly among rehabilitation professionals. The result of this study provide evidence to this as avoidant coping is positively correlated with compassion fatigue ($r = .37, p < .01$) and significantly predicted compassion fatigue among rehabilitation professionals. Avoidance coping may provide temporary relief, but it often prevents individuals from directly addressing the emotional challenges and stressors inherent in their work. When individuals consistently use avoidant coping as their primary strategy, they may fail to process and manage their emotions effectively. This can lead to emotional exhaustion and detachment from their clients or patients. Over time, it can contribute to compassion fatigue, as caregivers may become less engaged, empathetic, and emotionally invested in their work. A similar conclusion was reached by Thompson et al., in 2014 who aimed to explore the individual factors leading to compassion fatigue among mental health counsellors. The results of their study demonstrated a significant positive correlation between compassion fatigue and avoidant coping strategies. Avoidant coping also significantly predicted counsellor's compassion fatigue. (Thompson et al., 2014).

Effective coping mechanisms can help reduce the risk, while less adaptive coping strategies may exacerbate the development of compassion fatigue. Therefore, understanding

and promoting healthy coping strategies is crucial in the prevention and management of compassion fatigue among professionals in emotionally demanding roles.

Previous literature has shown that avoidant coping acts as a moderator between compassion satisfaction and compassion fatigue among critical care nurses (Al Barmawi et al., 2019). The study hypothesized that coping style will moderate the relationship between emotional intelligence and compassion fatigue among rehabilitation professionals. The results led to a similar conclusion that emotion focused coping and avoidant coping served as moderators between emotional intelligence and compassion fatigue. Both these coping styles dampens the negative relationship between emotional intelligence and compassion fatigue. This means that there is an interaction between avoidant coping, emotional intelligence, and compassion fatigue. Specifically, as avoidant coping increases (meaning individuals are more inclined to distance themselves from stressors), the positive influence of emotional intelligence on reducing compassion fatigue diminishes. In other words, when individuals rely on avoidance strategies to cope with stress, having high emotional intelligence may be less effective in mitigating compassion fatigue.

The results of this study go beyond previous reports and highlighted that when individuals in rehabilitation professions rely more heavily on emotion-focused coping strategies, the positive impact of emotional intelligence on reducing compassion fatigue becomes less prominent. In other words, as individuals use more emotion-focused coping mechanisms to manage stress, without addressing the underlying stressors or problems, their emotional intelligence may have a reduced capacity to mitigate compassion fatigue. This finding suggests that the relationship between emotional intelligence and compassion fatigue may be influenced by the coping strategies employed, and a stronger reliance on emotion-focused coping may weaken the protective effect of emotional intelligence.

This underscores the importance of addressing coping strategies alongside emotional intelligence to prevent or manage compassion fatigue effectively.

The relationship between work experience and compassion fatigue is a complex and somewhat contradictory subject, as indicated by various studies. The current study revealed that levels of secondary traumatic stress and levels of burnout especially moderate level reduce with increasing years of experience among rehabilitation professionals. Compassion fatigue also decreased after 5 to 7 years of work experience ($F=5.17$, $p < .01$). Entering certain professions, such as healthcare and a rehabilitation setup can be quite overwhelming for individuals. They often find themselves dealing with a significant caseload, tight schedules, and the emotional toll of working with clients who have experienced trauma or distressing situations. It is common for those starting in these professions to feel the weight of these demands. They may struggle to manage their time effectively, maintain a healthy work-life balance, and find ways to cope with the emotional challenges of their work. Over time, typically spanning 5 to 7 years, professionals in these fields gain a deeper understanding of the nuances of their work. They become more adept at adapting to the demands of their profession. They learn how to manage their caseloads efficiently, organize their schedules, and develop coping strategies to navigate the emotional toll. This experience helps them become more effective in their roles and better equipped to provide support and care to their clients while also taking care of their own well-being. As highlighted by Kjellenberg et al. (2014), more years of work experience among trauma therapists have been correlated with higher levels of posttraumatic growth when working with trauma patients (Kjellenberg et al., 2014). A similar conclusion was reached by some studies, suggest that more experienced professionals tend to have lower rates of compassion fatigue (Sprang et al., 2007; Stamm, 2010; Thompson et al., 2014) These studies found that as years of experience in the mental health or rehabilitation field increased, compassion fatigue decreased.

This suggests that rehabilitation professionals with greater experience may have developed adaptive strategies for coping with the emotional strain of their work. It is possible that over time, experienced rehabilitation professionals develop a set of skills and coping mechanisms that enable them to navigate the challenges and emotional demands of their profession more effectively. These coping strategies may contribute to posttraumatic growth, as they learn to derive meaning and personal growth from their experiences of helping trauma patients.

The study hypothesized that there will not be any gender differences observed in compassion fatigue, compassion satisfaction, burnout, secondary traumatic stress, and emotional intelligence. The results of the study also supported the hypotheses and there were no significant gender differences observed in any of these constructs as supported by previous literature (Bethea et al., 2020; Samios, 2018). Goleman suggests that gender differences in emotional intelligence tend to diminish in certain work environments, indicating that people's behavior is more influenced by their surroundings rather than their gender (Pellitteri, 2022). Several studies have indicated that the gender of therapists may not necessarily correlate with the levels of compassion fatigue. These findings are supported by studies that found no significant relationship between a therapist's gender and their likelihood of experiencing compassion fatigue (Iliffe & Steed, 2000; Saleem & Hawamdeh, 2023; Stamm, 2010). This suggests that factors other than gender play a more significant role in the development of compassion fatigue among therapists.

Interestingly, it was found that there existed significant gender differences in coping styles, especially emotion-focused coping ($t = 2.77$, $p < .01$), and avoidant coping ($t = 3.85$, $p < .01$) more utilized by men. This contrasts with previous literature which has often shown that men tend to use more problem-focused coping strategies, which involve actively addressing and solving the source of stress, while women tend to use more emotion-focused

coping strategies and seek social support, which involve managing emotions and seeking help from others.

The shift toward more gender-neutral coping strategies among professionals could indeed reflect changing societal norms and expectations regarding gender roles and behavior. It may suggest that professionals are increasingly adopting coping strategies based on individual preferences and perceived effectiveness rather than adhering to traditional gender norms.

CHAPTER V
SUMMARY & CONCLUSION

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Rehabilitation healthcare workers frequently encounter patients with complex trauma histories, life-threatening conditions, and chronic illnesses. The study aimed to explore the relationship between compassion fatigue, emotional intelligence, and coping styles among rehabilitation professionals. The study hypothesized that there will be a significant relationship between the study variables and emotional intelligence and coping styles will predict compassion fatigue. It was also hypothesized that coping styles will moderate the relationship between emotional intelligence and compassion fatigue. It was also hypothesised that socio-demographic variables such as gender, years of working experience has its influence on the study variables.

The sample was chosen based on availability and the sample size was 121 which included both male and female participants. The findings include:

- Negative correlation between Emotional Intelligence and Compassion Fatigue
- Positive correlation between Emotional Intelligence and Compassion Satisfaction
- Emotional Intelligence positively predicted Compassion Satisfaction
- Emotional Intelligence negatively predicted Compassion Fatigue
- No significant relationship between Problem-focused coping and Compassion Fatigue.
- Positive correlation between Emotion-focused coping and Compassion Fatigue.
- Positive correlation between Avoidant coping and Compassion Fatigue.
- Emotion-focused coping negatively predicted Compassion Fatigue.
- Avoidant coping negatively predicted Compassion Fatigue.
- Problem focused coping positively predicted Compassion Satisfaction

- Emotional Intelligence and Avoidant Coping significantly predicted Compassion Fatigue.
- Problem-focused coping did not moderate the relationship between Emotional Intelligence and Compassion Fatigue.
- Emotion-focused coping moderated the relationship between Emotional Intelligence and Compassion Fatigue
- Avoidant coping moderated the relationship between Emotional Intelligence and Compassion Fatigue
- Significant relationship between years of experience and levels of Secondary Traumatic Stress.
- Significant relationship between years of experience and levels of Burnout.
- No significant gender difference in Compassion Fatigue.
- No significant gender difference in Secondary Traumatic Stress.
- No significant gender difference in Burnout.
- No significant gender difference in Compassion Satisfaction.
- No significant gender difference in Emotional Intelligence.
- No significant gender difference in Problem-focused coping
- Significant gender difference in Emotion-focused coping.
- Significant gender difference in Avoidant coping.
- Significant difference in Compassion Fatigue among years of experience.

The findings indicate the existing pattern of relationship among the major study variables and the socio-demographic factors. Thus, understanding the emotional intelligence and coping strategies adopted by rehabilitation professionals can help us buffer the effect of compassion fatigue.

5.1. Implications of the study:

- Identifying the early signs of compassion fatigue is crucial for several reasons. First and foremost, it enables us to address this issue proactively rather than waiting for it to escalate into a more severe problem. Compassion fatigue, if left unattended, can significantly impact the mental and emotional well-being of practitioners, leading to burnout, decreased job satisfaction, and reduced quality of care provided to clients.
- By recognizing these signs early on, we can offer professional help and support to practitioners in a timely manner. This might involve access to counselling, stress management programs, or other resources designed to help individuals cope with the emotional toll of their work. Providing assistance at this stage can prevent the situation from deteriorating and potentially allow practitioners to continue their important work with a renewed sense of resilience and well-being.
- Furthermore, addressing compassion fatigue early not only benefits the individuals but also contributes to the overall quality of services provided to clients. Practitioners who receive the necessary support and intervention are more likely to maintain their effectiveness, empathy, and commitment to their clients, ultimately ensuring better care and outcomes in rehabilitation profession.
- Understanding the emotional intelligence and coping strategies employed by rehabilitation professionals is vital for addressing and mitigating the impact of compassion fatigue in this field.
- By gaining insight into how these professionals manage their emotions and cope with the emotional demands of their work, organizations and support systems can take proactive measures to provide targeted assistance and develop strategies to alleviate compassion fatigue.

5.2. Limitations of the study:

- The study includes a smaller sample size due to the availability of sample and time. Thus, generalising the results to a greater population might be questioned.
- The study includes tools that are only self-report measures which may result in any discrepancies in the results.
- There was not equal representation of rehabilitation professionals in all the chosen categories.
- Type of work setting, place of working such as rural, urban, daily hours of working, no. of clients seen per day were not included in analysis.

5.3. Future Directions:

- Studies incorporating ability emotional intelligence, its components and facets of coping can be researched upon
- Mixed method studies can be carried out in the future to understand more about the professionals' experience of compassion fatigue, compassion satisfaction and their preferred ways of coping.
- Intervention studies such as incorporating Mindfulness can be carried out in the future to understand and modify the nature of compassion fatigue.

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APPENDICES

APPENDIX 1 – PERMISSION LETTER FROM NIEPMD

From
Ms. Haripriyaa V G
II M.Phil., Clinical Psychology Scholar
Dept. of Clinical Psychology
NIEPMD

16.06.2023
Chennai

Through
Dr. Karthikeyan (Head of the Department) & Ms. Srigowri Rajesh (Lecturer)
Dept. of Clinical Psychology
NIEPMD

To
The Director
NIEPMD

Respected Sir,

Subject: Letter of Permission for Data Collection

In partial fulfilment of our requirements for our Dissertation, I have proposed to conduct a research study entitled "Compassion Fatigue, Coping and Emotional Intelligence among Rehabilitation Professionals" under the guidance of Ms. Srigowri Rajesh, Lecturer, Dept. of Clinical Psychology.

In connection with this, I would like to request your permission to allow me collect data through paper-pencil mode in the form of questionnaires from Clinical staff of the Department of Clinical Psychology, The Department of Speech, Hearing and Communication, Department of Therapeutics (Occupational Therapy Unit and Physiotherapy Unit), Department of Medical Science (Prosthetic and Orthotic Unit) and Department of Special Education. The data collected will remain confidential and will be used for academic purposes only.

I request you to kindly grant me permission to collect data for the same. The details regarding the data collection is hereby annexed for your kind perusal.

Yours Sincerely

V G Haripriyaa
16/6/23
Haripriyaa V G

16/6/23
SRIGOWRI RA
(Guide)

Annexures Enclosed:

1. Ethical Committee Approval
2. Study Information Sheet & Questionnaires
3. Requirement of data

16/6/23

DR (Admin)

In-house study by the student at NIEPMD
Approved
19/6/23

APPENDIX 2 – PERMISSION FOR ProQOL 5

11/26/22, 8:51 PM Permission to Use the ProQOL

Permission to Use the ProQOL

Thank You!

Thank you for your interest in the ProQOL! We hope that you find it useful. You will receive an email from the ProQOL office that records your answers to these questions and provides your permission to use the ProQOL.

We invite any comments from you about the ProQOL and the experience of using it at proqol@cvt.org. Please also contact us if you have any questions about using the ProQOL, even if you noted them on this form. Note that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we greatly appreciate your engagement.

APPENDIX 3 – PERMISSION FOR BRIEF COPE

Make a Gift

(http://www.as.miami.edu)

Brief COPE

The items below are an abbreviated version of the COPE Inventory. We have used it in research with breast cancer patients, with a community sample recovering from Hurricane Andrew, and with other samples as well. The citation for the article reporting the development of the Brief COPE, which includes information about factor structure and internal reliability from the hurricane sample is below. The Brief COPE has also been translated into several other languages, which have been published separately by other researchers (see below).

We created the shorter item set partly because earlier patient samples became impatient at responding to the full instrument (both because of the length and redundancy of the full instrument and because of the overall time burden of the assessment protocol). In choosing which items to retain for this version (which has only 2 items per scale), we were guided by strong loadings from previous factor analyses, and by item clarity and meaningfulness to the patients in a previous study. In creating the reduced item set, we also "tuned" some of the scales somewhat (largely because some of the original scales had dual focuses) and omitted scales that had not appeared to be important among breast cancer patients. In this way the positive reinterpretation and growth scale became positive reframing (no growth); focus on and venting of emotions became venting (focusing was too tied to the experiencing of the emotion, and we decided it was venting we were really interested in); mental disengagement became self-distraction (with a slight expansion of mentioned means of self-distraction). We also added one scale that was not part of the original inventory--a 2-item measure of self-blame--because this response has been important in some earlier work.

You are welcome to use all scales of the Brief COPE, or to choose selected scales for use. Feel free as well to adapt the language for whatever time scale you are interested in.

Citation: Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, 4, 92-100. [abstract (http://www.psy.miami.edu/faculty/ccarver/abstracts/AbBrCOPE.html)]

Following is the BRIEF COPE as we are now administering it, with the instructional orientation for a presurgery interview (the first time the COPE is given in this particular study). Please feel free to adapt the instructions as needed for your application.

Scales are computed as follows (with no reversals of coding):

Self-distraction, items 1 and 19
Active coping, items 2 and 7
Denial, items 3 and 8
Substance use, items 4 and 11
Use of emotional support, items 5 and 15
Use of instrumental support, items 10 and 23
Behavioral disengagement, items 6 and 16
Venting, items 9 and 21
Positive reframing, items 12 and 17
Planning, items 14 and 25
Humor, items 18 and 28
Acceptance, items 20 and 24
Religion, items 22 and 27
Self-blame, items 13 and 26

I have had many questions about combining scales into "problem focused" and "emotion focused" aggregates, or into an "overall" coping index. I have never done that in my own use of the scales. There is no such thing as an "overall" score on this measure, and I recommend no particular way of generating a dominant coping style for a give person. Please do NOT write to me asking for instructions to for "adaptive" and "maladaptive" composites, because I do not have any such instructions. I generally look at each scale separately to see what its relation is to other variables. An alternative is to create second-order factors from among the scales (see the 1989 article) and using the factors as predictors. If you decide to do that, I recommend that you use your own data to determine the composition of the higher-order factors. Different samples exhibit different patterns of relations.

If you can not figure out from these instructions how to examine your data, please consult with your own statistical person rather than sending me questions.

APPENDIX 4 – PERMISSION FOR SSEIT

From: Nicola Schutte
Sent: 16 February 2023 07:00 AM
To: HARIPRIYAA V G - 191199007
Subject: RE: Requesting Permission to use Schutte Self-Report Emotional Intelligence test (SSEIT)

Thank you for your message.

You are welcome to use the scale. Please see below a link to the manuscript copy of a published chapter that provides more information, including the scale and scoring instructions.

https://www.researchgate.net/publication/216626162_The_Assessing_Emotions_Scale

Kind regards, Nicola Schutte

From: HARIPRIYAA V G - 191199007 <haripriyaa.g@learner.manipal.edu>
Sent: Wednesday, 15 February 2023 5:53 AM
To: Nicola Schutte <nschutte@une.edu.au>
Subject: Requesting Permission to use Schutte Self-Report Emotional Intelligence test (SSEIT)

Respected Madam,

I am Haripriyaa V G, Clinical Psychology Scholar from India. As a part of our academic curriculum, I'm doing a research dissertation in which I would like to use your "The Schutte Self-Report Emotional Intelligence Test (SSEIT)" I request your permission for the same.

I would greatly appreciate your consent to my request. It would be extremely helpful if you could attach the manual with its subscale items, scoring, norms, interpretation of the total score as well. Hoping for a positive response.

Thanks in advance!

Yours Sincerely,

Haripriyaa V G

Sent from Mail for Windows

Disclaimer: This email and any files transmitted with it are privileged and confidential material of Manipal Academy of Higher Education (MAHE). They are intended to named recipient(s) only. If you are not the intended recipient of this message, please contact the sender and delete the message. This Email message including attachment(s), if any, is believed to be free of any virus. However, it is the responsibility of the recipient to ensure that it is virus-free, and MAHE accepts no liability for any loss or damage arising in any way from its use. Please consider the environment before printing this email.

APPENDIX 5 – DATA COLLECTION FORM

RESEARCH FORM NO: _____

National Institute for Empowerment of Persons with Multiple Disability (NIEPMD)
Ministry of Social Justice and Empowerment, Govt. of. India
Muttukadu, ECR Road, Chennai – 603 112
NIEPMD PHONE NO. 044-27472113, 27472046; E-mail: niepmd@gmail.com

COMPASSION FATIGUE, COPING AND EMOTIONAL INTELLIGENCE AMONG REHABILITATION PROFESSIONALS

Researcher : Ms. Haripriyaa V G, II M.Phil., Clinical Psychology Scholar, Dept. of Clinical Psychology

Guide : Ms. Srigowri Rajesh, Lecturer, Dept. of Clinical Psychology

STUDY INFORMATION SHEET

Purpose of the Study: Working in rehabilitation setup entails taking responsibility for the well-being of others. Ironically, having empathy and compassion for others when under a lot of stress can lead to compassion fatigue. Experts acknowledge that compassion fatigue exists and that it can be an unrecognized work danger for service providers. However, not much has been spoken about the positive protective factors that need to be promoted to help rehabilitation professionals cope with the issues. This study investigates these protective factors like emotional intelligence and coping styles which may help reduce compassion fatigue. This would help in introducing awareness programme modules and techniques to help promote these protective factors among rehabilitation professionals.

Participants: Rehabilitation professionals such as Clinical Psychologists, Rehabilitation Psychologists, Prosthetists and Orthotists, Audiologists & Speech Therapists, Physiotherapists, Occupational Therapists, and Special Educators in the age range of 30-55 years with minimum 2 years of work experience are eligible to participate in this study.

Benefits: There will be no direct benefit to you, but your participation is likely to help us find out more about identifying the level of compassion fatigue and the protective factors that can be employed to help rehabilitation professionals emerge out of these difficulties to feel better and to help cope with such instances in a better way.

Expenses: This study does not involve any expenses.

Legal Enforcement: This is not a legally binding document. It is a research document.

Risks: Your participation in this study will not lead to any negative consequences.

Incentives for Participation: You will not be provided any incentive to take part in this study. This study is conducted only for academic purpose and there is no increment or promotion for taking part in this study.

Requirements: If you agree to consent to the study, you would be required to fill the questionnaires which would take around 10 to 15 mins.

Voluntary Participation: Your participation in this study is completely voluntary and you can refuse to participate.

Withdraw from the study: You are free to choose whether you want to be a part of this study. Saying "NO" will not affect your relationship with the researcher or the institute.

Confidentiality: The personal information given by you will be kept confidential. Only members of the research team will know your name and details. Your name will not appear in any report or publication. However, the overall results of the study will be published in the research journals.

Mode of session & Video Recording: Data will be collected in a room setting. The session will not be audio or video recorded.

Undertaking by the Researcher: Your consent to participate in the above research by Ms. Haripriyaa V G, II M.Phil., Clinical Psychology Scholar under the guidance of Ms. Srigowri Rajesh, Lecturer in Dept. of Clinical Psychology, NIEPMD is sought. If you have any doubts about the research, please feel free to contact the Researcher Ms. Haripriyaa V G (Ph: +91 95516 00969 / priyayer166@gmail.com) or the Guide (Ph: +91 63743 80854/ gowrirajesh30@gmail.com) and clarify the same.

---------------------------------------**CONSENT TO PARTICIPATE**-----------------------------------

I confirm that I have read and understood the Study Information Sheet for this study and have had the opportunity to ask questions. I understand that my participation in this study is voluntary and I can decline participation without giving any reason. I consent to take part in this study.

Name of the Participant: ______________________ Signature: ________________ Date: _____________

Name of the Researcher: ______________________ Signature: ________________ Date: _____________

SOCIO-DEMOGRAPHIC DATA SHEET

Name (Optional) or Initials : ________________

Age : _________

Gender : ☐ Male ☐ Female

Marital Status : ☐ Unmarried ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

City : ________________

State : ________________

Domicile : ☐ Urban ☐ Rural ☐ Semi-urban

Educational Qualification : ________________________

Occupation : ☐ Clinical Psychologist ☐ Rehabilitation Psychologist ☐ Prosthetist & Orthotist
☐ Audiologist & Speech Therapist ☐ Physiotherapist ☐ Occupational Therapist
☐ Special Educators

Years of Experience : ☐ 2- 4 years ☐ 5-7 years ☐ 8-10 years ☐ 10 years & above

Work Settings : ☐ Hospital (Govt / Private) ☐ Institution (Govt / Private)
☐ Private Practice ☐ School set-up (Govt / Private) ☐ Others

Daily hours of Working : ____________

No. of clients per day (approx.) : ______________

Are you currently suffering from any chronic medical illness? ☐ Yes ☐ No

If Yes, what medical illness? ___________________

பங்கேற்பதற்கான ஊக்கத்தொகைகள்: இந்த ஆய்வில் பங்கேற்க உங்களுக்கு எந்த ஊக்கத்தொகையும் வழங்கப்படாது.

உங்கள் பங்கேற்பின் விவரம்: இதில் நீங்கள் பங்கேற்க சம்மதம் தெரிவித்தால் சில வினாப்பட்டியல்களை உங்களிடம் கொடுத்து அதை நிரப்பும்படி கேட்பேன். இதற்கு சுமார் 10 முதல் 15 நிமிடங்கள் தேவைப்படும்.

தன்னார்வ பங்கேற்பு: இந்த ஆராய்ச்சியில் உங்கள் பங்கேற்பு முற்றிலும் தன்னார்வமானது மற்றும் நீங்கள் பங்கேற்க மறுக்கலாம்.

ஆராய்ச்சியில் இருந்து விலகிக்கொள்ளுதல்: நீங்கள் இந்த ஆய்வின் ஒரு பகுதியாக இருக்க விரும்புகிறீர்களா என்பதைத் தேர்வுசெய்ய உங்களுக்கு சுதந்திரம் உள்ளது. "இல்லை" என்று சொல்வது ஆராய்ச்சியாளர் அல்லது நிறுவனத்துடனான உங்கள் உறவை பாதிக்காது.

ரகசியத்தன்மை: ஆராய்ச்சிக் குழுவின் உறுப்பினர்களுக்கு மட்டுமே உங்கள் பெயர் மற்றும் விவரங்கள் தெரியும். உங்கள் பெயர் எந்த அறிக்கை அல்லது வெளியீட்டிலும் இடம்பெறாது. இருப்பினும், ஆய்வின் ஒட்டுமொத்த முடிவுகள் ஆராய்ச்சி இதழ்களில் வெளியிடப்படும்.

தகவல் சேகரிக்கும் முறை: உங்களிடமிருந்து சேகரிக்கும் தகவல் அனைத்தும் ஆடியோ அல்லது வீடியோ பதிவு செய்யப்படாது

ஆராய்ச்சியாளரின் உறுதிமொழி: சென்னையில் உள்ள NIEPMD இல் மருத்துவ உளவியல் துறை தத்துவப்படிப்பு (M.Phil. Clinical Psychology) இரண்டாம் ஆண்டு ஆராய்ச்சியாளரான செல்வி. ஹரிப்ரியா வி. க. வின் மேற்கண்ட ஆராய்ச்சியில் பங்கேற்க உங்கள் ஒப்புதல் கோரப்படுகிறது. ஆராய்ச்சி குறித்து உங்களுக்கு ஏதேனும் சந்தேகங்கள் இருந்தால், ஆராய்ச்சியாளர் செல்வி. ஹரிப்ரியா வி. க. (தொலைபேசி: +91 95516 00969 / மின்னஞ்சல்: priyayer166@gmail.com) அல்லது ஆராய்ச்சியாளரின் வழிகாட்டி திருமதி. ஸ்ரீகௌரி ராஜேஷ் (தொலைபேசி: +91 63743 80854 / மின்னஞ்சல்: gowrirajesh30@gmail.com) ஆகியோரைத் தொடர்பு கொள்ளலாம்.

-------------ஆராய்ச்சியில் பங்கேற்க ஒப்புதல் அளித்தல் -------------

இந்த ஆராய்ச்சிக்கான ஆராய்ச்சி தகவல் படிவத்தை படித்துப் புரிந்துகொண்டேன் என்பதையும் கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு கிடைத்தது என்பதையும் நான் உறுதிப்படுத்துகிறேன். இந்த ஆய்வில் நான் பங்கேற்பது தன்னார்வமானது என்பதை நான் புரிந்துகொண்டேன், மேலும் எந்த காரணமும் கூறாமல் பங்கேற்பை நான் மறுக்க முடியும். இந்த ஆய்வில் பங்கேற்க நான் ஒப்புக்கொள்கிறேன்.

பங்கேற்பாளரின் பெயர்: ______________ தேதி ________ கையொப்பம் ________

ஆராய்ச்சியாளர் பெயர்: ______________ தேதி ________ கையொப்பம் ________

ஒன்றுக்கும் மேற்பட்ட ஊனமுற்றோரின் மேம்பாட்டிற்கான தேசிய நிறுவனம்
(NIEPMD)
சமூக நீதி மற்றும் அதிகாரம் வழங்கல் அமைச்சகம், இந்திய அரசு
முட்டுக்காடு, கிழக்கு கடற்கரை சாலை, சென்னை - 603 112
தொலைபேசி எண்: 044-27472113, 27472046; **மின்னஞ்சல்:** niepmd@gmail.com

மறுவாழ்வு நிபுணர்களிடையே இரக்க சோர்வு, சமாளித்தல் மற்றும் உணர்ச்சி நுண்ணறிவு

ஆராய்ச்சியாளர் : செல்வி. ஹரிப்ரியா வி. க. இரண்டாம் ஆண்டு எம்.பில்., மருத்துவ உளவியல் அறிஞர், மருத்துவ உளவியல் துறை

வழிகாட்டி : திருமதி. ஸ்ரீகௌரி ராஜேஷ், விரிவுரையாளர், மருத்துவ உளவியல் துறை

ஆராய்ச்சி தகவல் படிவம்

ஆராய்ச்சியின் நோக்கம்: புனர்வாழ்வு அமைப்பில் பணிபுரிவது என்பது மற்றவர்களின் நல்வாழ்விற்கான பொறுப்பை எடுத்துக்கொள்வதை உள்ளடக்குகிறது. முரண்பாடாக, நிறைய மன அழுத்தத்தில் இருக்கும்போது மற்றவர்களிடம் பச்சாத்தாபம் மற்றும் இரக்கம் இருப்பது இரக்க சோர்வுக்கு வழிவகுக்கும். இரக்க சோர்வு இருப்பதாகவும், இது சேவை வழங்குநர்களுக்கு அங்கீகரிக்கப்படாத வேலை அபாயமாக இருக்கலாம் என்றும் நிபுணர்கள் ஒப்புக்கொள்கிறார்கள். இருப்பினும், புனர்வாழ்வு வல்லுநர்கள் பிரச்சினைகளைச் சமாளிக்க உதவ ஊக்குவிக்கப்பட வேண்டிய நேர்மறையான பாதுகாப்பு காரணிகளைப் பற்றி அதிகம் பேசப்படவில்லை. இந்த ஆய்வு உணர்ச்சி நுண்ணறிவு மற்றும் சமாளிக்கும் பாணிகள் போன்ற இந்த பாதுகாப்பு காரணிகளை ஆராய்கிறது, இது இரக்க சோர்வைக் குறைக்க உதவும். புனர்வாழ்வு நிபுணர்களிடையே இந்த பாதுகாப்பு காரணிகளை மேம்படுத்த உதவும் விழிப்புணர்வு திட்ட தொகுதிகள் மற்றும் நுட்பங்களை அறிமுகப்படுத்த இது உதவும்.

பங்கேற்பாளர்கள்: மருத்துவ உளவியலாளர்கள், புனர்வாழ்வு உளவியலாளர்கள், புரோஸ்டெட்டிஸ்ட்கள் மற்றும் ஆர்த்தோடிஸ்டுகள், பிசியோதெரபிஸ்ட்கள், தொழில்சார் சிகிச்சையாளர்கள் மற்றும் சிறப்பு கல்வியாளர்கள் குறைந்தபட்சம் 2 ஆண்டுகள் பணி அனுபவம் கொண்ட 30-55 வயதிற்குட்பட்ட போன்ற புனர்வாழ்வு வல்லுநர்கள் இந்த ஆராய்ச்சியில் பங்கேற்க தகுதியுடையவர்கள்.

பலன்கள்: இதில் பங்கேற்பதால் உங்களுக்கு நேரடியாக எந்த பலனும் இல்லை என்ற போதும், உங்கள் பங்கேற்பு இரக்க சோர்வின் அளவை அடையாளம் காண்பது மற்றும் மறுவாழ்வு வல்லுநர்கள் இந்த சிரமங்களிலிருந்து மீண்டு வர உதவக்கூடிய பாதுகாப்பு காரணிகளைப் பற்றி மேலும் அறியவும், அத்தகைய நிகழ்வுகளை சிறந்த முறையில் சமாளிக்கவும் உதவும்.

செலவுகள்: இந்த ஆராய்ச்சியில் பங்கேற்பதற்கு எந்த கட்டணமும் இல்லை.

சட்ட அமலாக்கம்: இது சட்டரீதியாக பிணைக்கப்பட்ட ஆவணம் அல்ல. இது ஒரு ஆராய்ச்சி ஆவணம்.

ஆபத்து மற்றும் அசௌகரியம்: இதில் பங்கேற்பதால் உங்களுக்கு எந்த விதமான ஆபத்தும் இல்லை.

பங்கேற்பதற்கான ஊக்கத்தொகைகள்: இந்த ஆய்வில் பங்கேற்க உங்களுக்கு எந்த ஊக்கத்தொகையும் வழங்கப்படாது.

உங்கள் பங்கேற்பின் விவரம்: இதில் நீங்கள் பங்கேற்க சம்மதம் தெரிவித்தால் சில வினாப்பட்டியல்களை உங்களிடம் கொடுத்து அதை நிரப்பும்படி கேட்பேன். இதற்கு சுமார் 10 முதல் 15 நிமிடங்கள் தேவைப்படும்.

தன்னார்வ பங்கேற்பு: இந்த ஆராய்ச்சியில் உங்கள் பங்கேற்பு முற்றிலும் தன்னார்வமானது மற்றும் நீங்கள் பங்கேற்க மறுக்கலாம்.

ஆராய்ச்சியில் இருந்து விலகிக்கொள்ளுதல்: நீங்கள் இந்த ஆய்வின் ஒரு பகுதியாக இருக்க விரும்புகிறீர்களா என்பதைத் தேர்வுசெய்ய உங்களுக்கு சுதந்திரம் உள்ளது. "இல்லை" என்று சொல்வது ஆராய்ச்சியாளர் அல்லது நிறுவனத்துடனான உங்கள் உறவை பாதிக்காது.

ரகசியத்தன்மை: ஆராய்ச்சிக் குழுவின் உறுப்பினர்களுக்கு மட்டுமே உங்கள் பெயர் மற்றும் விவரங்கள் தெரியும். உங்கள் பெயர் எந்த அறிக்கை அல்லது வெளியீட்டிலும் இடம்பெறாது. இருப்பினும், ஆய்வின் ஒட்டுமொத்த முடிவுகள் ஆராய்ச்சி இதழ்களில் வெளியிடப்படும்.

தகவல் சேகரிக்கும் முறை: உங்களிடமிருந்து சேகரிக்கும் தகவல் அனைத்தும் ஆடியோ அல்லது வீடியோ பதிவு செய்யப்படாது

ஆராய்ச்சியாளரின் உறுதிமொழி: சென்னையில் உள்ள NIEPMD இல் மருத்துவ உளவியல் துறை தத்துவப்படிப்பு (M.Phil. Clinical Psychology) இரண்டாம் ஆண்டு ஆராய்ச்சியாளரான செல்வி. ஹரிப்ரியா வி. க. வின் மேற்கண்ட ஆராய்ச்சியில் பங்கேற்க உங்கள் ஒப்புதல் கோரப்படுகிறது. ஆராய்ச்சி குறித்து உங்களுக்கு ஏதேனும் சந்தேகங்கள் இருந்தால், ஆராய்ச்சியாளர் செல்வி. ஹரிப்ரியா வி. க. (தொலைபேசி: +91 95516 00969 / மின்னஞ்சல்: priyayer166@gmail.com) அல்லது ஆராய்ச்சியாளரின் வழிகாட்டி திருமதி. ஸ்ரீகௌரி ராஜேஷ் (தொலைபேசி: +91 63743 80854 / மின்னஞ்சல்: gowrirajesh30@gmail.com) ஆகியோரைத் தொடர்பு கொள்ளலாம்.

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இந்த ஆராய்ச்சிக்கான ஆராய்ச்சி தகவல் படிவத்தை படித்துப் புரிந்துகொண்டேன் என்பதையும் கேள்விகளைக் கேட்க எனக்கு வாய்ப்பு கிடைத்தது என்பதையும் நான் உறுதிப்படுத்துகிறேன். இந்த ஆய்வில் நான் பங்கேற்பது தன்னார்வமானது என்பதை நான் புரிந்துகொண்டேன், மேலும் எந்த காரணமும் கூறாமல் பங்கேற்பை நான் மறுக்க முடியும். இந்த ஆய்வில் பங்கேற்க நான் ஒப்புக்கொள்கிறேன்.

பங்கேற்பாளரின் பெயர்: ______________ தேதி ________ கையொப்பம் ________

ஆராய்ச்சியாளர் பெயர்: ______________ தேதி ________ கையொப்பம் ________

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you [help] people, you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the option that honestly reflects how frequently you experienced these things in the last 30 days.

S.NO	ITEMS	Never	Rarely	Sometimes	Often	Very Often
1	I am happy.					
2	I am preoccupied with more than one person I [help].					
3	I get satisfaction from being able to [help] people.					
4	I feel connected to others.					
5	I jump or am startled by unexpected sounds.					
6	I feel invigorated after working with those I [help].					
7	I find it difficult to separate my personal life from my life as a [helper].					
8	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
9	I think that I might have been affected by the traumatic stress of those I [help].					
10	I feel trapped by my job as a [helper].					
11	Because of my [helping], I have felt "on edge" about various things.					
12	I like my work as a [helper].					
13	I feel depressed because of the traumatic experiences of the people I [help].					
14	I feel as though I am experiencing the trauma of someone I have [helped].					
15	I have beliefs that sustain me.					
16	I am pleased with how I am able to keep up with [helping] techniques and protocols.					

S.NO	ITEMS	Never	Rarely	Sometimes	Often	Very Often
17	I am the person I always wanted to be.					
18	My work makes me feel satisfied.					
19	I feel worn out because of my work as a [helper].					
20	I have happy thoughts and feelings about those I [help] and how I could help them.					
21	I feel overwhelmed because my case [work] load seems endless.					
22	I believe I can make a difference through my work					
23	I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
24	I am proud of what I can do to [help].					
25	As a result of my [helping], I have intrusive, frightening thoughts.					
26	I feel "bogged down" by the system.					
27	I have thoughts that I am a "success" as a [helper].					
28	I cannot recall important parts of my work with trauma victims.					
29	I am a very caring person.					
30	I am happy that I chose to do this work.					

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/www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

BRIEF COPE

These items deal with ways you have been coping with the stress in your life. Read the statements and indicate how much you have been using each coping style by putting a tick mark in the respective column. Make your answers as true FOR YOU as you can.

S.NO	ITEM	I have not been doing this at all	I have been doing this a little bit	I have been doing this a medium amount	I have been doing this a lot
1	I have been turning to work or other activities to take my mind off things.				
2	I have been concentrating my efforts on doing something about the situation I am in.				
3	I have been saying to myself "this isn't real.".				
4	I have been using alcohol or other drugs to make myself feel better.				
5	I have been getting emotional support from others.				
6	I have been giving up trying to deal with it.				
7	I have been taking action to try to make the situation better.				
8	I have been refusing to believe that it has happened.				
9	I have been saying things to let my unpleasant feelings escape.				
10	I have been getting help and advice from other people.				
11	I have been using alcohol or other drugs to help me get through it.				
12	I have been trying to see it in a different light, to make it seem more positive.				
13	I have been criticizing myself.				
14	I have been trying to come up with a strategy about what to do.				
15	I have been getting comfort and understanding from someone.				

S.NO	ITEM	I have not been doing this at all	I have been doing this a little bit	I have been doing this a medium amount	I have been doing this a lot
16	I have been giving up the attempt to cope.				
17	I have been looking for something good in what is happening.				
18	I have been making jokes about it.				
19	I have been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20	I have been accepting the reality of the fact that it has happened.				
21	I have been expressing my negative feelings.				
22	I have been trying to find comfort in my religion or spiritual beliefs.				
23	I have been trying to get advice or help from other people about what to do.				
24	I have been learning to live with it.				
25	I have been thinking hard about what steps to take.				
26	I have been blaming myself for things that happened.				
27	I have been praying or meditating.				
28	I have been making fun of the situation.				

SCHUTTE SELF-REPORT EMOTIONAL INTELLIGENCE TEST (SSEIT)

Directions: Each of the following items asks you about your emotions or reactions associated with emotions. After deciding whether a statement is generally true for you, use the 5-point scale to respond to the statement. There are no right or wrong answers. Please tick the response that best describes you.

S.NO	ITEMS	Strongly Disagree	Somewhat Disagree	Neither agree nor disagree	Somewhat Agree	Strongly Agree
1	I know when to speak about my personal problems to others.					
2	When I am faced with obstacles, I remember times I facedsimilar obstacles and overcame them.					
3	I expect that I will do well on most things I try.					
4	Other people find it easy to confide in me.					
5	I find it hard to understand the non-verbal messages of other people.					
6	Some of the major events of my life have led me to re-evaluate what is important and not important.					
7	When my mood changes, I see new possibilities.					
8	Emotions are one of the things that make my life worth living.					
9	I am aware of my emotions as I experience them.					
10	I expect good things to happen.					
11	I like to share my emotions with others.					
12	When I experience a positive emotion, I know how to make it last.					
13	I arrange events others enjoy.					
14	I seek out activities that make me happy.					
15	I am aware of the non-verbal messages I send to others.					
16	I present myself in a way that makes a good impression on others.					
17	When I am in a positive mood, solving problems is easy for me.					

S.NO	ITEMS	Strongly Disagree	Somewhat Disagree	Neither agree nor disagree	Somewhat Agree	Strongly Agree
18	By looking at their facial expressions, I recognize the emotions people are experiencing.					
19	I know why my emotions change.					
20	When I am in a positive mood, I am able to come up withnew ideas.					
21	I have control over my emotions.					
22	I easily recognize my emotions as I experience them.					
23	I motivate myself by imagining a good outcome totasks I take on.					
24	I compliment others when they have done something well.					
25	I am aware of the non-verbal messages other people send.					
26	When another person tells me about an important event in his or her life, I almost feel as though I experienced this event myself.					
27	When I feel a change in emotions, I tend to come upwith new ideas.					
28	When I am faced with a challenge, I give up becauseI believe I will fail.					
29	I know what other people are feeling just by looking at them.					
30	I help other people feel better when they are down.					
31	I use good moods to help myself keep trying in the face of obstacles.					
32	I can tell how people are feeling by listening to the tone of their voice.					
33	It is difficult for me to understand why people feel the way they do.					

-----------------------------------*Thank you for participating in this study!!*-----------------------------------

Document Information

Analyzed document	CHAPTER IV.docx (D174613803)
Submitted	2023-09-26 12:32:00
Submitted by	Haripriyaa
Submitter email	priyaiyer166@gmail.com
Similarity	7%
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Sources included in the report

	Source		
SA	**Jenifer- Final.docx** Document Jenifer- Final.docx (D50005163)	田	7
SA	**Psychology department- Comparative study of Compassion satisfaction, Compassion Fatigue and Burnout between Selected mental health professional Groups- Deena Merin Sam-17COB25.pdf** Document Psychology department- Comparative study of Compassion satisfaction, Compassion Fatigue and Burnout between Selected mental health professional Groups- Deena Merin Sam-17COB25.pdf (D49693777)	田	4
SA	**AMIRA PV DISSERTATION.pdf** Document AMIRA PV DISSERTATION.pdf (D172988009)	田	1
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SA	**Final Draft -Apsana Nasrin .B 20ppy002 .docx** Document Final Draft -Apsana Nasrin .B 20ppy002 .docx (D135129684)	田	1
SA	**7. CHAPTER V_ Reselts and Discussion.docx** Document 7. CHAPTER V_ Reselts and Discussion.docx (D61544376)	田	8
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