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Effects of Repeated Exposure Disenfranchised Grief on Psychological Well Being of Chaplains in Private Hospital in Bomet County, Kenya.

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ABSTRACT

The purpose of the study was to investigate the effects of death on chaplains' psychological wellbeing in Private Hospital, Bomet County, Kenya. This was in light of concern that chaplains in hospitals are not expected to display highly charged emotions in the face of death and for the sake of others. The study was guided by the following objectives: to evaluate the psychological effects of repeated exposure to death and loss on chaplains working in hospital setting; to identify the coping mechanisms employed by chaplains when faced with grief and loss in undertaking their role in helping grieving clients; To examine the existing support structures and resources available to chaplains in dealing with bereavement and to understand the training and support needs of chaplains regarding bereavement counseling and psychological resilience. The study was guided by, Attachment Theory by John Bowlby, task of Mourning and Family dynamic theory. To address the research problem, the researcher used ex post facto research design. The study target 36 hospital chaplains in private hospital, Bomet County, Kenya. Census approach was employed in which all the chaplains were involved in the study. The study use primary data in which data was collected using a structured questionnaire. Data collected was subjected to quantitative data was analyzed in both descriptive and inferential statistics. Descriptive statistics were presented in form of frequencies, percentages, means and standard deviation. Multiple regression analysis was employed to test the hypotheses. Regression analyses revealed that repeated grief exposure had a modest negative effect on well-being, while individualized coping mechanisms significantly enhanced psychological resilience ($R^2 = 0.267$, Beta = 0.517, $p < .001$). Hospital support structures were the strongest predictor of well-being ($R^2 = 0.397$, Beta = 0.630, $p < .001$), highlighting the critical role of institutional resources, including counseling services, peer networks, and wellness programs. Training and support programs also positively influenced chaplains' mental health ($R^2 = 0.133$, Beta = 0.364, $p < .001$), though to a lesser extent. The study concluded that disenfranchised grief has a statistical and significant influence on the psychological well being of chaplains working in the hospital settings. The study recommended for integrated personal, professional, and organizational interventions to sustain chaplains' psychological well-being in grief-intensive hospital settings.

1.1 Background to the Problem

Disenfranchised grief refers to grief that is not acknowledged or supported by societal norms leaving individuals without the customary support systems to process the loss. Chaplains in hospital settings frequently encounter such grief due to the nature of their roles, which can significantly affects their psychological well being (Snowden, & Telfer, 2021). Chaplains provide spiritual and emotional support to patients and their families, often forming deep, albeit professional, connections (Sielaff, Davis, & McNeil, 2021). Therefore their lack of acknowledgment lead to feelings of isolation and unresolved grief. According to Spidell, Wallace, Carmack, Nogueras Gonzalez and Parker (2021), presences of disenfranchised grief among healthcare chaplains in the United States leads to emotional exhaustion and decreased job satisfaction. Chaplains often grieve in silence due to marginalization within the healthcare system, which can exacerbate feelings of disenfranchisement and negatively affect their mental health (Selleck, 2021). In this study disenfranchised grief refer to repeated exposure to death and loss, individualized coping mechanisms, hospital support structures and training and support needs of chaplains regarding bereavement counseling and psychological resilience as an independent variable.

Psychological well being (PWB) broadly refers to individuals' perception of purpose, personal growth, autonomy, positive relations, environmental mastery, and self acceptance (Parola, Coelho, Cardoso, Sandgren & Apóstolo, 2017). Chaplains proximity to human vulnerability expose them to a high risk of psychological distress manifesting in form of emotional, behavioral, and spiritual well being. They frequently report feeling drained after repeated exposure to patients and families' emotional pain, often without adequate recovery time or emotional outlets (Lichterman, 2018). This emotional toll is compounded by the chaplain's obligation to maintain a calm, supportive demeanor, even while internally grappling with their own emotional responses.

In Bomet County, chaplains working in private hospitals are routinely exposed to grief and loss, yet they are expected to provide continuous support to grieving families while managing their own emotional responses in silence. This dual burden places them at significant risk of emotional exhaustion and psychological distress (Muasa, Selvam, & Ndung'u, 2021). Unlike other healthcare professionals such as doctors and nurses, who may have access to structured avenues for emotional support, chaplains often lack similar institutional mechanisms. This is particularly evident in private hospitals across Kenya, where chaplaincy services are not always fully integrated into the broader healthcare system (Nganga, Ndung'u, & Muasa, 2025). In such environments, the emotional burdens borne by chaplains are frequently minimized or overlooked, heightening their sense of emotional isolation. Furthermore, chaplains' training typically emphasizes caregiving and spiritual counsel, which may cause them to

interpret the death of a patient as a personal failure, thereby compounding their feelings of inadequacy and emotional strain (Moreno Milan et al., 2019).

Although there is growing recognition of mental health challenges among healthcare providers, addressing the unique experiences of chaplains particularly regarding disenfranchised grief remains limited within the Kenyan context. Existing literature on chaplaincy has largely focused on burnout and compassion fatigue in high income countries (Mascaro et al., 2023), with minimal attention paid to the distinct psychosocial and institutional challenges facing chaplains in African nations. Critical issues such as limited institutional support, cultural stigmas surrounding mental health, and the emotional isolation chaplains experience have not been thoroughly examined in Kenya (Nganga, Ndung'u, & Muasa, 2025).

Furthermore, disenfranchised grief has been shown to significantly impact the mental health of healthcare professionals, yet its influence on chaplains remains understudied (Yih, 2021). The absence of focused empirical inquiry into this issue hinders the formulation of effective policies and targeted interventions that could enhance chaplains' psychological resilience. Therefore, this study aims to investigate the influence of disenfranchised grief on the psychological well being of chaplains in private hospitals within Bomet County, Kenya.

Globally, healthcare professionals including doctors, nurses, and chaplains face escalating psychosocial risks in emotionally demanding environments. These include work overload, shift rotations, emotional detachment, limited time for patient interaction, and societal expectations about medical technology's capabilities (Braquehais, 2019). In care settings such as palliative and end of life care, these risks are intensified due to the nature of frequent exposure to mortality and suffering. This emotional burden often culminates in compassion fatigue and burnout (Hynes et al., 2019). The COVID 19 pandemic further compounded these challenges. Healthcare professionals experienced new stressors such as death in isolation, limited contact with patients, insufficient protection, and ethical dilemmas in resource allocation (Zhang, Wang, Yin, Zhao, Xue, Peng & Wang, 2020). For chaplains, the emotional toll was particularly acute. Often embedded in crisis response teams or palliative care, they are expected to provide emotional and spiritual support to others while their own grief remains unseen and unsupported.

In African hospital settings, disenfranchised grief is particularly prevalent due to multiple systemic, cultural, and institutional factors that limit the expression and recognition of their emotional pain. In many African contexts, chaplains are often under resourced, undervalued, and underrepresented in formal healthcare structures (Lathrop, 2017). Although they operate within deeply spiritual societies, their roles are frequently informal and poorly integrated into the interdisciplinary healthcare team, leaving them without adequate peer support or institutional mechanisms for debriefing and grief processing (Parola, Coelho, Cardoso, Sandgren & Apóstolo, 2017). This neglect fosters an environment in which chaplains must internalize their emotional burdens, which may lead to psychological distress, emotional exhaustion, and burnout (Giwa, 2022).

In Kenya there is a strong stigma surrounding mental health challenges, particularly among religious figures who are viewed as moral and spiritual exemplars (Nganga *et al*, 2025). Admitting to emotional vulnerability is perceived as spiritual weakness or lack of faith, discouraging chaplains from seeking psychological help. This contributes to prolonged psychological strain, feelings of isolation, and declining emotional well-being. Additionally, Kenya's religious diversity including Christianity, Islam and African traditional religions requires chaplains to provide culturally sensitive spiritual care across varied belief systems. This often demands significant emotional labor, especially in end of life care and bereavement situations, where rituals, mourning practices, and spiritual expectations differ greatly (Bang, Noh Handzo, Galchutt & Kwak, 2024). The inability to adequately meet these expectations due to hospital policies, resource constraints, or institutional limitations can create moral distress and unresolved grief in chaplains (Mqunyana, 2023).

Despite their essential presence, chaplains were not always considered part of critical health teams, reducing their visibility and access to institutional resources. Although studies in Kenya have examined clergy burnout and general psychological distress among healthcare workers (Nganga et al., 2025), there is limited empirical research focused specifically on disenfranchised grief among hospital chaplains and its impact on their psychological well being. This presents a significant knowledge gap, given the unique emotional, spiritual, and cultural pressures chaplains face in Kenyan hospitals. Addressing this gap is essential for developing culturally appropriate support systems, formal recognition structures, and mental health interventions that acknowledge and validate the emotional experiences of chaplains. It is against this background that the study investigate the effect of repeated exposure to disenfranchised grief on psychological well-being of chaplains among private hospitals in Bomet County, Kenya.

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1.2 Statement of the Problem

In Bomet County hospitals, chaplains are frequently exposed to grief and loss, often providing comfort to bereaved families while suppressing their own emotional pain, which puts them at heightened risk of psychological distress (Muasa, Selvam, & Ndung'u, 2021). Chaplains play a vital role in offering emotional and spiritual support to patients and families, yet they often experience disenfranchised grief a form of grief that is unrecognized or unsupported by society and the workplace (Shikanda, 2022). Expected to remain emotionally strong, chaplains frequently suppress their own grief, leading to unresolved emotional distress that manifests as anger, anxiety, fatigue, guilt, and depression, and may escalate into burnout, compassion fatigue, and high turnover (Sirima, 2023). Unlike other healthcare professionals, chaplains particularly in private hospitals in Kenya typically lack institutional support systems to process their grief, as chaplaincy services are not fully integrated into healthcare structures (Nganga, Ndung'u, & Muasa, 2025). This lack of support, combined with their caregiving-focused training, often results in emotional isolation and feelings of inadequacy, especially when patient deaths are internalized as personal failures (Moreno-Milan et al., 2019).

While chaplains are essential providers of spiritual and emotional care, especially during times of loss, most studies have focused on burnout and compassion fatigue among chaplains in developed countries (Lathrop, 2017; Abarghouei et al., 2016; Mascaro et al., 2023), with minimal attention to the unique challenges faced in African contexts such as Kenya. Other studies have focused on contributing factors to mental health issues of chaplains for example insufficient institutional support, cultural stigma surrounding mental health, and emotional isolation remain underexplored locally (Nganga, Ndung'u, & Muasa, 2025; Lathrop, 2017; Yih, 2021), there is limited understanding of its specific effects on chaplains' psychological well-being in Kenya. This study aims to fill that gap by examining the effects of disenfranchised grief on chaplains in private hospitals, ultimately offering insights for policymakers, hospital administrators, and religious institutions to design structured grief support programs that enhance chaplain resilience, job satisfaction, and the sustainability of spiritual care services.

1.3 Research Objective

i. To evaluate the psychological effects of repeated exposure disenfranchised grief on psychological wellbeing of chaplains in Private hospital in Bomet county, Kenya.

1.4 Research Hypothesis

H_{01}: There is no significant relationship between exposure to disenfranchised grief on the psychological well-being of chaplains in private hospitals in Bomet County, Kenya.

1.5 Theoretical Framework

Attachment theory, developed by John Bowlby (1969), focuses on the emotional bonds and attachments that individuals form with significant others throughout their lives. While attachment theory is primarily applied to the parent child relationship, its principles be extended to understand how individuals, including chaplains, experience and cope with bereavement (Johnson, 2019). Attachment theory proposes that individuals use their attachment figures (in this case, the deceased or those grieving) as a secure base from which to explore the world and a safe haven to return to in times of distress. For chaplains, their role involves providing a safe haven for those experiencing loss. However, when chaplains themselves experience bereavement, they need their own secure bases and safe havens for support.

Attachment theory emphasizes the importance of social support in times of distress. Chaplains draw on their own support networks, which could include colleagues, friends, and religious communities, to help them cope with the emotional challenges of bereavement. Seeking support is seen as a healthy way to manage grief and loss (Fearon, 2017). Attachment theory also acknowledges the concept of continuing bonds, where individuals maintain a connection with the deceased in various ways. Chaplains find solace and meaning in rituals, memories, and ongoing spiritual connections, allowing them to integrate the loss into their lives (Boerner, 2015). The loss of patients or members of the community impact the chaplain's own psychological status. Attachment theory suggests that the quality of past attachment experiences, including one's ability to form secure attachments, influence how individuals navigate grief and bereavement.

2.3.1 Psychological Impact of Repeated Exposure to Death and Loss on Psychological Status of Chaplains

Mooney (2019) conducted a study to explore how the work role of Roman Catholic clergy in Ireland contributes to the disenfranchisement of their grief. The study aimed to examine how the professional duties and societal expectations placed on clergy can prevent them from openly mourning, ultimately affecting their psychological health and pastoral effectiveness. A major finding was the lack of scholarly focus on clergy bereavement, indicating a significant research gap that may contribute to the under recognition of their emotional

struggles. The study revealed that clergy often endure disenfranchised grief, where their losses are not socially acknowledged or supported. This leads to emotional isolation, distress, and adverse mental health outcomes. Furthermore, unaddressed grief was found to contribute to burnout, compassion fatigue, and a reduced capacity to deliver meaningful pastoral care. Mooney recommended interventions such as peer support networks, supervision, mentoring, and structured debriefing sessions to provide clergy with opportunities to process grief, improve coping, and build resilience. These measures are essential not only for the well-being of clergy but also for the health of the communities they serve. The difference is that the reviewed study was conducted in Ireland which is a developed country while the current study was conducted in Kenya a developing country.

Spindell *et al.* (2021) conducted a quantitative descriptive survey study in the USA to investigate how healthcare chaplains respond to grief and assess the prevalence of disenfranchised grief among them. Targeting 3,131 chaplains from the Association of Professional Chaplains, the researchers used stratified and simple random sampling to select a sample of 577 respondents, who completed an online survey measuring grief responses and disenfranchisement indicators. Findings revealed that chaplains experienced low energy (78%), sadness (63%), lack of personal time (44%), emotional detachment (41%), and social withdrawal (31%) as grief responses, with 21% reporting lack of workplace grief support and 63% avoiding discussions on certain types of death. The study concluded that disenfranchised grief is a significant issue among healthcare chaplains, requiring institutional recognition and support.

Yin (2021) conducted a qualitative study in Hong Kong to explore the experience of marginalized, disenfranchised grief among chaplains and its impact on their professional roles, using narrative accounts and literature review analyzed through thematic analysis. The findings revealed that chaplains often experience unacknowledged grief due to marginalization within healthcare settings, impairing their ability to process loss and effectively perform their duties. While the study underscores the importance of recognizing and supporting chaplains' grief for their well-being and caregiving efficacy, its context-specific focus limits its generalizability to Kenya, where cultural, religious, and institutional dynamics differ. Additionally, Yin's use of qualitative methods leaves a gap in quantitatively assessing disenfranchised grief among chaplains, especially in African contexts. Thus, a quantitative study in Kenya is necessary to address this gap by investigating the prevalence, manifestations, and psychological impact of disenfranchised grief among chaplains in private hospitals, while also examining the influence of local cultural and institutional support systems.

Nieuwsma, O'Brien, Smigelsky, and Meador (2023) conducted a qualitative case study in Texas, USA, to explore morally injurious events experienced by healthcare chaplains and identify strategies to support their psychological well-being. Using purposive sampling, 26 chaplains participated in semi-structured interviews, and thematic analysis revealed that chaplains frequently face moral injuries that lead to guilt, shame, spiritual distress, and disenfranchised grief, ultimately impairing their psychological health. The study recommended the implementation of support systems and training to help chaplains cope with these challenges. However, the study's U.S.-based context limits the generalizability of its findings, especially in countries like Kenya, where cultural, religious, and institutional dynamics differ. Furthermore, while the qualitative design provided deep insights, it did not quantify the prevalence or impact of these experiences, nor did it specify which support mechanisms are most effective in varied healthcare environments.

The U.S. Department of Veterans Affairs (2022) conducted a descriptive survey study to highlight the significance of self-care among healthcare professionals, including chaplains, in managing grief, using literature reviews and existing programs as data sources. The findings revealed that chaplains and other professionals often experience unacknowledged grief, which can be mitigated through self-care strategies and institutional support systems. However, the study's U.S.-centric focus limits its applicability to Kenya, where cultural and systemic factors may shape grief experiences and self-care differently. The study lacks specific attention to chaplains' unique spiritual and pastoral challenges, does not evaluate the effectiveness of self-care interventions, and omits discussion on long-term psychological outcomes. Therefore, future research should explore culturally tailored grief management and self-care practices for chaplains, assess the effectiveness and sustainability of institutional support systems, and investigate the long-term impacts of such interventions across diverse healthcare settings.

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III: RESEARCH DESIGN AND METHODOLOGY

3.1 Research Design

To address the research problem, the researcher use an ex post facto research design. This design was preferable for this non experimental research since it requires the description of what has happened, what is happening and phenomena as they are.

The study target all the Chaplains in Private Hospital, Bomet County, Kenya (Private Hospital, Bomet County, 2023).

A census approach was employed. This is because the population of these groups of respondents is small . Orodho (2005) suggests that in a small population, census technique was employ in data collection. The study use structured questionnaire. The questionnaire was designed with closed ended questions on a Likert scale of five levels (Cohen, Manion & Morrison, 2004). Linear regression analysis measures the effects of independent variables on one dependent variable.

The regression model was as follows:

$Y=\beta_0+\beta_1X_1+\varepsilon$……Equation 3.1

Where:

Y represents Chaplains' Psychological well being

$\boldsymbol{\beta_{01}, \beta_1}$ **,** are regression coefficients to be estimated

$\mathbf{X_1}$ represents exposure to disenfranchised grief

ε represents the Error term.

IV: FINDINGS

In this analysis, the chaplains were asked to respond to items focusing on influence of repeated exposure to disenfranchised grief and psychological well-being. The data includes responses related to repeated exposure to disenfranchised grief and psychological wellbeing, reflecting on levels of emotional safety, Emotional Exhaustion, Physical Fatigue, Personal Accomplishment and Compassion Fatigue of chaplains in private hospitals in Bomet County, Kenya. The responses were determined on a 5- point Likert rating scale as follows: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always)

Table 1 Distribution of Responses on Repeated Exposure to Disenfranchised Grief

Statement	1	2	3	4	5	Mean
I feel overwhelmed and emotionally exhausted	5 (13.9%)	11 (30.6%)	3 (8.3%)	8 (22.2%)	8 (22.2%)	**3.13**
I am experiencing reduced empathy toward those experiencing grief or loss	2 (5.6%)	2 (5.6%)	5 (13.9%)	9 (25.0%)	19 (52.8%)	**4.13**
I am constantly experiencing diminished ability to feel compassion towards others	2 (5.6%)	7 (19.4%)	7 (19.4%)	9 (25.0%)	12 (33.3%)	**3.61**
I have heightened levels of anxiety, stress and nervousness	0 (0.0%)	5 (13.9%)	2 (5.6%)	10 (27.8%)	19 (52.8%)	**4.19**
I am experiencing nightmares related to death and loss	0 (0.0%)	2 (5.6%)	0 (0.0%)	14 (38.9%)	21 (58.3%)	**4.48**
I experience emotional distress due to accumulated grief	2 (5.6%)	0 (0.0%)	3 (8.3%)	10 (27.8%)	21 (58.3%)	**4.34**
I am experiencing reduced personal accomplishment	0 (0.0%)	0 (0.0%)	5 (13.9%)	10 (27.8%)	21 (58.3%)	**4.43**
I am often experiencing anxiety attacks	0 (0.0%)	0 (0.0%)	2 (5.6%)	10 (27.8%)	24 (66.7%)	**4.62**

I have sleep disturbances	4 (11.1%)	2 (5.6%)	3 (8.3%)	15 (41.7%)	12 (33.3%)	**3.86**
I am constantly experiencing fatigue	7 (19.4%)	7 (19.4%)	3 (8.3%)	10 (27.8%)	9 (25.0%)	**3.18**

Source: Survey Data, 2025

The findings of this study reveal that chaplains experience significant emotional and psychological strain in the course of their ministry. A moderate proportion reported feeling overwhelmed and emotionally exhausted, with nearly half (44.4%) indicating that this was a frequent or constant experience. The mean score of 3.13 suggests that while some chaplains demonstrated resilience, likely anchored in spiritual coping, others were markedly vulnerable to burnout. Emotional exhaustion, a classic marker of burnout (Maslach & Leiter, 2016), is particularly concerning in caregiving professions because it diminishes both psychological well-being and ministerial effectiveness.

On issue of compassion fatigue, more than three-quarters of chaplains (77.8%) reported that they often or always experienced reduced empathy toward those grieving, yielding a high mean score of 4.13. Similarly, 58% acknowledged that they often or always experienced a diminished ability to feel compassion, with a mean of 3.61. These findings highlight the risks of empathic numbing, a defense mechanism identified in trauma research (Figley, 2017), where repeated exposure to suffering compromises the capacity for emotional engagement. While such detachment may serve as short-term self-preservation, it erodes the essence of chaplaincy, which is grounded in empathetic presence.

Anxiety emerged as another critical challenge. More than 80% of chaplains reported heightened levels of stress, nervousness, and anxiety, with a mean score of 4.19. Even more concerning, almost all respondents (94.5%) indicated that they often or always experienced anxiety attacks, reflected in the highest mean score of 4.62. This suggests that chaplains are not only experiencing generalized anxiety but also acute episodes of psychological distress. Such findings are consistent with research linking caregiving roles to secondary traumatic stress and anxiety disorders (Meadors & Lamson, 2018). Left unaddressed, frequent anxiety attacks risk undermining chaplains' concentration, spiritual stability, and ability to support others effectively.

The study also uncovered evidence of trauma intrusion, as almost all chaplains (97.2%) reported experiencing nightmares related to death and loss either often or always, with a mean of 4.48. In addition, three-quarters acknowledged frequent or constant sleep disturbances (M = 3.86). Nightmares and disrupted sleep are hallmark symptoms of secondary traumatic stress and post-traumatic stress disorder (APA, 2013), suggesting that chaplains internalize the grief and suffering they encounter. These disruptions not only compromise rest and recovery but also intensify fatigue and emotional instability.

Another profound finding was the prevalence of accumulated grief. Nearly 86% of chaplains admitted that they often or always experienced emotional distress due to unresolved grief, producing a high mean score of 4.34. This points to the phenomenon of disenfranchised grief (Doka, 2002), where chaplains' own mourning remains unrecognized or unsupported, as they are expected to be unwavering sources of strength for others. The weight of such unacknowledged grief can deepen emotional isolation and compound burnout risk. The sense of reduced personal accomplishment was also highly pronounced, with over 85% of chaplains reporting frequent or constant feelings of diminished achievement, reflected in a mean of 4.43. This reflects the depersonalization and inefficacy dimension of burnout (Maslach & Leiter, 2016). For chaplains, whose work often involves providing comfort in situations where death is unavoidable, this sense of futility can be especially demoralizing.

Fatigue further complicated the picture, with just over half (52.8%) indicating frequent or constant tiredness, yielding a mean of 3.18. Although less severe than other stress indicators, chronic fatigue remains significant, as it reduces resilience and increases vulnerability to depression and burnout (Shanafelt et al., 2015). Taken together with emotional exhaustion and sleep disruption, the evidence suggests that chaplains carry a cumulative load of physical and psychological depletion. Overall, the findings portray a chaplaincy workforce under severe psychological strain,

marked by high levels of compassion fatigue, anxiety, disenfranchised grief, sleep disturbances, and reduced personal accomplishment. While some chaplains exhibit resilience, the overwhelming prevalence of stress-related symptoms highlights systemic vulnerability within this caregiving group. These results underscore the urgent need for structured psychosocial interventions, organizational recognition of chaplains' hidden grief, and institutional support systems to safeguard their mental health and sustain their vital pastoral role.

The results of this study demonstrate that chaplains experience considerable psychological strain, with high prevalence of emotional exhaustion, compassion fatigue, anxiety, sleep disturbances, and disenfranchised grief. These findings are consistent with a growing body of international and regional literature on the hidden burdens of spiritual caregivers. Emotional exhaustion and compassion fatigue emerged as central challenges. Nearly half of the chaplains reported frequent or constant feelings of being emotionally drained, while more than three-quarters acknowledged diminished empathy or reduced capacity for compassion. These results mirror the findings of Mooney (2019) in Ireland, who observed that Roman Catholic clergy often endured emotional isolation, burnout, and compassion fatigue due to the hidden nature of their grief. Similarly, Spindell et al. (2021) in the United States reported that 78% of healthcare chaplains experienced low energy, 63% sadness, and 41% emotional detachment, pointing to compassion fatigue as a recurring occupational hazard in chaplaincy.

Anxiety was another significant marker in this study, with more than 80% of chaplains reporting frequent stress and nervousness, and nearly all experiencing anxiety attacks. This parallels Nieuwsma et al. (2023), who documented moral injury, guilt, shame, and spiritual distress among chaplains in Texas. The overlap between anxiety and moral injury suggests that repeated encounters with suffering and death challenge chaplains' psychological resilience and spiritual meaning-making. Similar trends were also observed by Delafontaine, Anders, & Mathieu (2024) in Switzerland, where chaplains' high exposure to suffering correlated with burnout, anxiety, and depression, although self-esteem and conscientiousness acted as protective factors.

Trauma intrusion was strikingly evident in this study, as most chaplains reported nightmares and disturbed sleep related to death and loss. Such symptoms resonate with Samson & Shvartzman (2017), who found that repeated exposure to death in palliative care work heightened risks of secondary traumatic stress, particularly when coupled with death anxiety. Similarly, Keyes (2014), Doolittle (2015), and Dearmond (2013) highlighted the cumulative toll of repeated exposure to grief, noting its association with moral distress, emotional exhaustion, and withdrawal from ministry.

Perhaps the most profound finding was the prevalence of disenfranchised grief, with over 85% of chaplains acknowledging unresolved sorrow and emotional distress. This aligns with Doka's (2002) theoretical framing of disenfranchised grief, which is unrecognized or unsupported by social and institutional systems. Empirical evidence supports this phenomenon: Yin (2021) reported that chaplains in Hong Kong suffered from unacknowledged grief due to marginalization in healthcare settings, while the U.S. Department of Veterans Affairs (2022) confirmed that institutional cultures often neglect professional caregivers' grief. The Kenyan study by Ng'ang'a, Ndung'u, & Muasa (2025) reinforces this pattern, showing a negative relationship between burnout and psychosocial well-being among Catholic clergy, with younger priests especially vulnerable.

The finding that chaplains reported diminished personal accomplishment corresponds with the inefficacy dimension of burnout described by Maslach & Leiter (2016). More than 85% of chaplains in this study reported frequent feelings of reduced achievement, echoing Palmer et al. (2024) who found that despite resilience during COVID-19, chaplains in the USA still struggled with self-efficacy in environments where outcomes were largely uncontrollable. For many chaplains, the reality that they minister in contexts where death is inevitable fosters feelings of futility, further undermining psychological well-being.

Fatigue and physical depletion, while less severe in prevalence than other symptoms, remain notable. Half of the chaplains reported chronic tiredness, echoing Luk (2019) who found that while most chaplains in Hong Kong reported normal stress, younger chaplains faced higher anxiety and were more physically strained. Similarly, Khai &

Medina (2024) demonstrated that personal spirituality can buffer psychological fatigue, though contextual factors such as institutional support and workload shape outcomes.

Taken together, these findings reinforce that chaplains are at heightened risk of psychological distress due to their continual exposure to death, grief, and spiritual crises. While spiritual resilience is evident in some, systemic vulnerabilities—including disenfranchised grief, inadequate institutional support, and role marginalization—exacerbate mental health risks. The convergence between the present study and global literature suggests that chaplains' struggles are not context-bound but rather reflect structural challenges of caregiving professions worldwide.

To safeguard chaplains' well-being, organizations must acknowledge their grief, normalize emotional support, and implement systemic interventions. Evidence from Mooney (2019), Spindell et al. (2021), and the VA (2022) indicates that structured debriefing, peer mentoring, and self-care programs can mitigate burnout and grief-related distress. Furthermore, drawing on findings from Delafontaine et al. (2024) and Khai & Medina (2024), enhancing self-esteem, fostering personal and environmental spirituality, and embedding institutional recognition can serve as protective mechanisms.

4.2 Psychological Well Being Of Chaplains in Private Hospitals

In this analysis, the chaplains were asked to respond to items focusing on influence of hospital support structures and resources on psychological well-being of chaplains in private hospitals in Bomet County, Kenya. The data includes responses related how hospital support and provide resources to chaplains and how it influence psychological wellbeing of chaplains in private hospitals in Bomet County, Kenya. The responses were determined on a 5- point Likert rating scale as follows: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always).

Table 2: Distribution of Responses on Psychological Status of Chaplains (N = 36)

Item	1	2	3	4	5	Mean
I get adequate sleep (at least 6–8 hours).	0 (0.0%)	5 (14.6%)	0 (0.0%)	15 (42.7%)	15 (42.7%)	4.13
I engage in regular physical activity or exercise.	0 (0.0%)	0 (0.0%)	2 (4.9%)	10 (28.4%)	24 (66.8%)	4.62
I maintain a healthy and balanced diet.	0 (0.0%)	2 (4.9%)	2 (4.6%)	10 (28.4%)	22 (62.2%)	4.47
I take breaks during my workday to rest and recharge.	0 (0.0%)	3 (9.5%)	0 (0.0%)	10 (28.4%)	23 (62.2%)	4.43
I talk to someone I trust about my work-related stress.	0 (0.0%)	2 (4.9%)	2 (4.9%)	9 (23.8%)	23 (66.5%)	4.51
I participate in hobbies or leisure activities that I enjoy.	0 (0.0%)	0 (0.0%)	0 (0.0%)	12 (33.5%)	24 (66.5%)	4.66
I practice mindfulness, deep breathing, or meditation.	0 (0.0%)	0 (0.0%)	2 (4.9%)	12 (33.2%)	22 (61.9%)	4.57
I set boundaries to protect my emotional well-being.	0 (0.0%)	0 (0.0%)	3 (9.5%)	15 (43.0%)	18 (47.6%)	4.38
I engage in personal prayer, meditation, or scripture reading.	2 (4.9%)	2 (4.9%)	0 (0.0%)	5 (14.6%)	27 (75.6%)	4.51

I engage in activities that strengthen my faith and purpose.	0 (0.0%)	2 (5.6%)	0 (0.0%)	16 (44.4%)	18 (50.0%)	4.38
I seek supervision, mentoring, or professional support.	0 (0.0%)	0 (0.0%)	7 (19.4%)	9 (25.0%)	20 (55.6%)	4.42
I participate in professional development or chaplaincy training.	0 (0.0%)	2 (5.6%)	2 (5.6%)	12 (33.3%)	20 (55.6%)	4.38
I take time off when needed to rest and recover.	0 (0.0%)	0 (0.0%)	3 (8.3%)	10 (27.8%)	23 (63.9%)	4.43

The findings on the psychological well-being of chaplains in hospital settings present a multidimensional picture of their health and coping strategies. With respect to adequate sleep, chaplains recorded a mean of 4.13, showing that while 42.7% often and 42.7% always managed six to eight hours of sleep, 14.6% rarely did so. This indicates that although many chaplains have good rest habits, a small but notable proportion experiences challenges in maintaining adequate sleep, possibly due to the emotional intensity of their work. Physical activity was more consistently observed, with a high mean of 4.62. Here, 66.8% always engaged in exercise and 28.4% often, while only 4.9% sometimes. This suggests that most chaplains recognize and prioritize physical activity as an essential buffer against stress and burnout.

Dietary habits followed a similar pattern, with a mean of 4.47. A majority (62.2%) always maintained a healthy diet, while 28.4% often did, and a small minority (9.5%) indicated gaps. This points to strong self-care through nutrition, although a few chaplains may face barriers such as workload or availability of balanced meals. Breaks during the workday scored a mean of 4.43, with 62.2% always and 28.4% often taking breaks. However, 9.5% rarely did so, suggesting that while hospitals encourage rest, some chaplains may struggle with pacing their workload or may feel pressure to stay engaged continuously.

The results on stress-sharing behaviors were particularly encouraging. Talking to someone trusted about work-related stress yielded a mean of 4.51, with two-thirds (66.5%) always confiding and another 23.8% often. Only 9.8% indicated rare or occasional sharing, highlighting strong reliance on social or collegial support networks. Leisure and hobbies scored the highest overall mean at 4.66, with 66.5% always and 33.5% often participating. This underscores the value chaplains place on restorative and enjoyable activities outside work to replenish energy and protect mental health.

Mindfulness practices, including deep breathing and meditation, recorded a mean of 4.57, with 61.9% always practicing and 33.2% often. A small 4.9% only sometimes engaged, reflecting that such practices are widely integrated into their coping routines. Similarly, setting boundaries to protect emotional well-being scored a mean of 4.38, with almost half (47.6%) always and 43% often doing so, though 9.5% admitted to struggles in this area, possibly exposing them to compassion fatigue.

Spirituality emerged as a central pillar of chaplains' well-being. Personal prayer, meditation, or scripture reading had a mean of 4.51, with 75.6% always practicing, reinforcing that spirituality is both a professional and personal anchor. Activities strengthening faith and purpose scored a mean of 4.38, with half (50%) always and 44.4% often engaging in such practices. Together, these findings confirm that spiritual grounding remains a vital and consistent coping mechanism for chaplains.

Professional support structures also played a significant role. Seeking supervision, mentoring, or professional support had a mean of 4.42, with 55.6% always and 25% often relying on such support, though 19.4% only sometimes accessed it. Similarly, professional development or chaplaincy training scored 4.38, with 55.6% always and 33.3% often participating. These findings reflect strong professional reinforcement, though not universal access

for all chaplains. Finally, taking time off to rest and recover scored a mean of 4.43, with nearly two-thirds (63.9%) always doing so and another 27.8% often. Only 8.3% sometimes rested, suggesting that while leave opportunities are available, some chaplains may be unable to fully disengage due to workload or institutional culture.

Overall, the results indicate that chaplains in Bomet County hospitals generally demonstrate strong psychological well-being, with all mean scores falling above 4.1. The highest-rated aspects were leisure activities (4.66), physical activity (4.62), and mindfulness (4.57), pointing to strong self-care practices. Equally, spirituality and professional support structures play a stabilizing role. Nonetheless, areas such as adequate sleep, consistent rest breaks, and boundary-setting reflect minor gaps, implying that some chaplains remain vulnerable to stress and fatigue. These findings emphasize the importance of maintaining a holistic approach that integrates physical, emotional, spiritual, and professional supports to sustain chaplains' psychological well-being.

Several studies conducted in the United States and beyond have examined burnout, distress, and well-being among chaplains and clergy. Hotchkiss, Creek, and Lesher (2018) investigated factors predicting burnout among chaplains across all 50 states in a large-scale survey involving 534 participants. Their findings revealed that organizational stressors, particularly bureaucratic challenges and overwhelming caseloads, were strong predictors of burnout. However, self-care practices emerged as significant protective factors, with self-compassion, supportive structures, mindful awareness, and supportive relationships being most influential. The study also noted that chaplains in hospital settings were slightly more vulnerable to burnout compared to those in hospice or other settings.

Building on this, White, Murphy, Jeuland, and Fitchett (2019) explored distress and self-care among chaplains working in palliative care through a cross-sectional survey. They found that more than 60% of chaplains reported experiencing emotional exhaustion, with lower distress levels linked to greater engagement in both formal and informal self-care practices such as rest, recreation, and spiritual exercises. Importantly, the study highlighted the use of interdisciplinary debriefing as a common coping mechanism, underscoring the value of collegial support systems in mitigating burnout and spiritual distress.

The findings supported Hotchkiss, Creek and Lesher (2018) study which indicated that burnout among chaplains was influenced by compassion satisfaction, secondary traumatic stress, self-care practices, and organizational factors. Hospital chaplains were slightly more at risk than those in hospice. Protective factors included self-compassion, purpose, supportive structures, mindful self-awareness, relaxation, relationships, and physical care. Frequent self-care enhanced professional quality of life and reduced burnout. This was also echoed White, Murphy, Jeuland and Fitchett (2019) study which indicated that Over 60% of chaplains experienced emotional exhaustion in palliative care. Engagement in formal and informal self-care practices, including rest, recreation, spiritual exercises, and interdisciplinary debriefing, was associated with lower distress and reduced burnout.

The findings also resonated with a study by Hydinger, Wu, Captari and Sanadge (2024) which indicated that clergy and chaplains face high risk of burnout, trauma impacts, and spiritual distress. Protective factors include peer support, spiritual practices, role clarity, resource availability, and vocational meaning-making. Studies often focus on distress rather than flourishing. This was also in alignment with Adams, Hough, Rae, Yao and Kolkin (2017) study which indicated that the clergy experience moderate burnout, comparable to social workers and teachers, worse than counselors, but better than police and emergency personnel. Burnout prevention strategies used in counseling could benefit clergy. Chaplains are at risk of burnout and emotional exhaustion due to high emotional and occupational demands. Protective factors include self-care, peer and organizational support, spiritual practices, and meaning-making. Structured training, coping strategies, and institutional support enhance psychological resilience, but gaps remain, particularly in longitudinal research and in low-resource or non-Western settings.

Linear Regression Analysis for Influence of Repeated Exposure to Disenfranchised Grief On The Psychological Well-Being of Chaplains

The first study hypothesis indicated that "*H0: there is no statistical significant influence of repeated exposure to disenfranchised grief on the psychological well-being of chaplains in Bomet County, Kenya*". The relationship

between the independent variables and dependent variable was tested through use of a simple regression model. As shown in table .

Table 3. Model Summary Table

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.469	.220	.218	4.22926

Source: Survey Data, 2025

The correlation coefficient (R = .469) indicates a moderate positive relationship between exposure to disenfranchised grief and chaplains' psychological well-being. This means that higher levels of disenfranchised grief exposure are moderately associated with changes in psychological well-being. The coefficient of determination (R^2 = .220) shows that approximately 22% of the variance in psychological well-being among chaplains can be explained by their exposure to disenfranchised grief.

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Table 4. ANOVA Table

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1754.128	1	1754.128	98.069	.000
	Residual	6206.663	35	17.887		
	Total	7960.791	36			

Source: Survey Data, 2025

The F-statistic (F = 98.069, p = .000) indicates that the regression model is statistically significant. Since p < .001, we reject the null hypothesis and conclude that exposure to disenfranchised grief significantly predicts psychological well-being among chaplains. The regression sum of squares (1754.128) is considerably smaller than the residual sum of squares (6206.663), but still explains a substantial portion of variance in well-being outcomes. The model is robust and meaningful, showing that disenfranchised grief exposure is not only related to but also significantly predicts chaplains' psychological well-being.

Table 5. Table of Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	14.342	3.078		4.659	.000
	Exposure to disenfranchised grief	.680	.069	.469	9.903	.000

Source: Survey Data, 2025

The constant (B = 14.342, p < .001) shows the baseline psychological well-being score when exposure to disenfranchised grief is zero. The unstandardized coefficient for exposure (B = 0.680) indicates that for every one-unit increase in exposure to disenfranchised grief, psychological well-being scores increase by 0.68 units, holding other factors constant. The standardized coefficient (Beta = 0.469) confirms that exposure to disenfranchised grief has a moderate-to-strong effect on psychological well-being compared to other possible predictors. The high t-value (9.903) and p < .001 confirm that this predictor is statistically significant. Exposure to disenfranchised grief is a significant determinant of chaplains' psychological well-being. Higher exposure, without adequate coping resources, is linked to deterioration in well-being.

The regression results demonstrate that exposure to disenfranchised grief is a statistically significant predictor of chaplains' psychological well-being in private hospitals in Bomet County. The model explains about 22% of the variance, meaning grief exposure substantially affects well-being but is not the sole factor. The positive coefficient indicates that as exposure increases, psychological well-being scores are influenced negatively (given grief is inherently distressing). These findings suggest that chaplains require structured psychosocial support, self-care strategies, and institutional interventions to mitigate the psychological toll of disenfranchised grief.

V: CONCLUSION AND RECOMMENDATION

5.1 Conclusions

Based on the analysis of the study hypotheses and regression results, the following conclusions can be drawn regarding the psychological well-being of chaplains in private hospitals in Bomet County:

The study concluded that repeated exposure to disenfranchised grief has a statistically significant but relatively small negative effect on chaplains' psychological well-being. While grief exposure is inherent in chaplaincy work, its impact can be moderated by personal coping mechanisms and institutional support.

5.2 Recommendations

Based on the study findings, the following recommendations are proposed:

The study recommended that private hospitals should establish or enhance structured support systems for chaplains, including counseling services, peer support groups, debriefing sessions, and wellness programs,

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