NIGERIAN JOURNAL OF PSYCHOLOGY

Volume 26, No. 2, 2026 ISSN: 0331-0574 (Print), 2635-3806 (Online)
Published by the Nigerian Psychological Association
NPA JOURNALS - www.npa-journals.org/journals/njp

Empathy Domains And Secondary Traumatic Stress Among Mental Health Professionals: a Cross-Sectional Study Of a Nigerian Federal Neuro-Psychiatric Hospital

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Article's History
Received: 30 June 2026;
Revised: 18 August 2026;
Accepted: 20 August 2026;
Published: October 2026

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ABSTRACT

Background: Secondary traumatic stress (STS) is a significant occupational hazard among mental health professionals in high-trauma settings, yet the role of empathy in determining differential vulnerability remains insufficiently understood, particularly within Nigerian psychiatric contexts.

Objective: This study examined cognitive and affective empathy domains as predictors of secondary traumatic stress among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria.

Method: A cross-sectional survey design was employed among 150 mental health professionals (74.7% female; *M*age = 40.49 years, *SD* = 9.14) recruited using proportionate quota sampling. Data were collected using the Secondary Traumatic Stress Scale (STSS) and the Interpersonal Reactivity Index (IRI). Hierarchical multiple regression analysis was conducted, with demographic variables entered in Step 1 and the two empathy dimensions entered in Step 2.

Results: The hypothesis that empathy would significantly predict STS was partially supported. Affective empathy significantly predicted STS, whereas cognitive empathy did not. Together, the empathy dimensions accounted for an additional 13.0% of the variance in STS beyond demographic controls.

Conclusion: Affective empathy, rather than empathy broadly defined, constitutes the primary empathy-related risk factor for secondary traumatic stress among mental health professionals in this setting, whereas cognitive empathy appears unrelated to STS risk. These findings underscore the importance of interventions that help clinicians regulate emotional absorption while preserving empathic engagement in trauma-focused practice.

Keywords: Affective, cognitive, empathy domains, mental health professionals, neuropsychiatry, secondary traumatic stress.

Introduction

Mental health professionals are often exposed to the raw pain of human suffering. Through repeated listening to graphic accounts of violence, sexual abuse, loss, torture and severe mental illness, clinicians become indirectly exposed to traumatic material (Ludick & Figley, 2017). This exposure can produce a cluster of stress reactions in the helper that closely mirrors the symptoms of posttraumatic stress disorder (PTSD) experienced by primary victims (Butler et al., 2017). This phenomenon is known as secondary traumatic stress (STS; Ludick & Figley, 2017). Secondary traumatic stress refers to the natural consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other and the stress resulting from helping or wanting to help a traumatised person (Figley, 1995). Its symptom profile includes intrusive imagery, distressing dreams, avoidance of trauma-related reminders, hyperarousal, negative alterations in cognition and mood, and clinically significant impairment in social, occupational or other important areas of functioning (American Psychiatric Association, 2013; Bride, 2007). In severe cases, STS meets full diagnostic criteria for PTSD under DSM-5 Criterion A4 – "experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (American Psychiatric Association, 2013).

STS is a common occupational hazard among trauma-exposed mental health professionals. Bride (2007) found that among a sample of 282 social workers, 70% reported at least one STS symptom in the preceding week and 15% met full diagnostic criteria for PTSD secondary to their clinical duties, while a later meta-analysis estimated a pooled prevalence of moderate-to-severe STS of approximately 26% among mental health professionals working with trauma survivors (Hensel et al., 2015). A more recent meta-analysis of observational studies confirms that STS remains highly prevalent among trauma-exposed clinical populations, with pooled estimates of 57.3% in nurses (You et al., 2026). These figures indicate that STS is a recurrent feature of trauma-adjacent work, with downstream consequences that extend beyond the individual clinician to the systems in which they operate, including impaired decision-making, desensitisation to traumatic content, and elevated staff turnover (Şişman et al., 2025). Because STS compromises the very workforce responsible for delivering trauma-informed care, understanding what places clinicians at risk is a precondition for protecting both staff wellbeing and the quality of services patients receive.

A substantial body of international evidence identifies empathy as the central mechanism through which STS develops. Empathy which is defined as the capacity to understand and share the feelings of another (Chrysikou & Thompson, 2016), has consistently been regarded as a cornerstone of therapeutic practice (Ho, 2023; Irarrázaval & Kalawski, 2022). In trauma-focused work, it allows clinicians to enter the client's internal world, foster trust, and facilitate healing. Paradoxically, research has shown this same empathic engagement to be a pathway through which secondary traumatic stress develops (Ludick & Figley, 2017). The picture sharpens considerably once empathy is treated as a multidimensional rather than unitary construct. Across diverse occupational samples, affective empathy components — particularly personal distress — emerge repeatedly as the strongest predictors of STS, while cognitive empathy components such as perspective-taking show weak, null, or even protective associations (Kitano et al., 2023; Juczyński et al., 2022; Ogińska-Bulik & Bak, 2025). A recent meta-analysis of the broader literature corroborates this pattern, finding that affective empathy subdomains are consistently associated with elevated burnout symptoms, whereas cognitive empathy subdomains such as perspective-taking show weak protective or null associations (Maximiano-Barreto et al., 2026). This differentiation holds across markedly different professional groups and national contexts: among Polish therapists, personal distress accounted for 20% of variance in STS, eclipsing maladaptive coping strategies (Juczyński et al., 2022); among Polish police officers, personal distress emerged as the single strongest predictor of STS while other empathy dimensions showed weaker or non-significant relationships (Ogińska-Bulik & Bak, 2025); and structural equation modelling with

medical professionals showed affective empathy exerting a significant indirect positive effect on burnout through elevated STS, while cognitive empathy instead operated protectively via reduced STS and enhanced compassion satisfaction (Dawkins & Seo, 2025). This literature suggests that the risk empathy poses in trauma-exposed work is not a function of empathic capacity in general, but specifically of the tendency to emotionally absorb, rather than cognitively understand, another's suffering.

The theoretical basis for this differentiation is provided by the Compassion Fatigue Resilience Model (Ludick & Figley, 2017), which builds on Figley's (1995) earlier Trauma Transmission Model to explain why some professionals develop secondary traumatic stress while others remain resilient. Central to the model is the concept of emotional reactivity which determines whether empathic engagement leads toward psychological harm or toward resilience and compassion satisfaction. When clinicians emotionally absorb the traumatic material of their clients, the model predicts an escalating pathway from compassion stress to secondary traumatic stress, characterised by intrusion, avoidance, and arousal symptoms that mirror those of primary trauma victims (Ludick & Figley, 2017). Critically, this risk is not inherent to empathy as a whole: it is most acute when empathic engagement is affective in character, involving emotional contagion and vicarious arousal, rather than cognitive, involving understanding without emotional absorption. The Compassion Fatigue Resilience Model therefore provides a theoretically coherent basis for expecting that affective and cognitive empathy will show divergent relationships with STS, and it is within this framework that the present study's hypotheses are situated.

This differentiated empathy–STS relationship has not been empirically tested among mental health professionals in Nigerian psychiatric hospital settings, a gap that is consequential rather than incidental. Nigerian clinicians in federal psychiatric facilities manage patients presenting with extraordinarily high rates of trauma exposure, including conflict displacement, insurgency-related violence, and ritual abuse (Abdulmalik et al., 2019), against a backdrop of severe systemic resource constraints — only ten federal specialist psychiatric hospitals serve a population exceeding 200 million (National Bureau of Statistics, 2023; Federal Ministry of Health and Social Welfare, 2025). Yet, no study has examined whether the same differentiation between affective and cognitive empathy observed internationally holds within a Nigerian psychiatric hospital workforce, where chronic underresourcing and an exceptionally high local burden of trauma-related illness may plausibly intensify the pathways linking empathic engagement to psychological harm. Establishing whether this pattern replicates, or instead diverges, in a high-trauma, low-resource Nigerian setting is therefore essential to determining whether intervention strategies developed elsewhere are appropriately targeted for this context.

The present study addresses this gap through a cross-sectional survey of mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, examining cognitive and affective empathy domains as predictors of secondary traumatic stress. It was hypothesised that empathy domains (cognitive and affective) would significantly predict secondary traumatic stress among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State.

Method

Design

This study employed a cross-sectional survey design, allowing simultaneous examination of the relationship between empathy and secondary traumatic stress at a single point in time.

Setting

The study was conducted at the Federal Neuro-Psychiatric Hospital (FNPHK), Barnawa, Kaduna State, Nigeria, one of the country's ten federal specialist psychiatric institutions. FNPHK serves as the primary specialist referral centre for Kaduna State and the wider northwestern region, with a multidisciplinary clinical workforce engaged in sustained, trauma-adjacent patient care.

Sampling

The target population comprised 228 licensed mental health professionals engaged in direct patient care at FNPHK. Sample size was calculated using Yamane's (1967) formula for finite populations. The calculation yielded a minimum required sample of 145 at a 95% confidence level; the study targeted 150 to allow for non-response. To supplement this and evaluate adequacy for the study's inferential analyses, an a priori power analysis was also conducted using G*Power (Version 3.1.9.7; Faul et al., 2009) for the hierarchical multiple regression model. With seven predictors in total (five demographic control variables entered in Step 1, and two empathy subscales entered in Step 2), $\alpha = .05$, and power = .80, a medium effect size ($f^2 = 0.15$) required a minimum of 103 participants to detect the overall model effect, and 73 participants to detect the R^2 increase attributable to the empathy predictors specifically. The achieved sample of 150 exceeded both thresholds, supporting the adequacy of the sample for the analyses.

Proportionate quota sampling was used, with quotas allocated by professional cadre (psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, medical social workers) in proportion to their representation in the population, to ensure adequate representation of smaller cadres alongside the numerically dominant nursing workforce.

Table 1: Quota Allocation for Each Professional Cadre

Profession	Population (N = 228)	Percentage	Target Quota (n = 150)
Psychiatrists	45	19.74%	30
Clinical Psychologists	7	3.07%	5
Psychiatric Nurses	150	65.79%	98
Medical Social Workers	14	6.14%	9
Occupational Therapists	12	5.26%	8
Total	**228**	**100.00%**	**150**

Participants

Participants were recruited through proportionate quota sampling from mental health professionals employed at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria. Eligibility was restricted to psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers/medical social officers who were licensed with the relevant Nigerian regulatory bodies and engaged in direct, recurring patient contact; non-clinical staff, short-term interns or NYSC personnel posted for less than six months, and staff on leave during data collection were excluded.

In total, 150 valid responses were obtained, with ages ranging from 25 to 58 years ($M = 40.49$, $SD = 9.14$). Most of the sample identified as female (74.7%), compared with male (25.3%). Regarding marital status, most participants were married (68.7%), followed by single (16.0%), separated (8.7%), and divorced or widowed (3.3% each). The sample was predominantly composed of psychiatric nurses (65.3%), followed by psychiatrists (20.0%), medical social workers (6.0%), occupational therapists (5.3%), and clinical psychologists (3.3%). Regarding professional tenure, 28.7% of participants had more than 20 years of post-qualification experience, while 19.3% had less than five years. All 150 participants provided complete data on the empathy and secondary traumatic stress measures, and this N = 150 constitutes the analytic sample for all regression analyses.

Table 2: Demographic Characteristics of the Sample

	Category	n	%
Gender	Female	112	74.7
	Male	38	25.3
Marital Status	Single	24	16.0
	Married	103	68.7
	Divorced	5	3.3
	Widowed	5	3.3
	Separated	13	8.7
Professional Cadre	Psychiatrist	30	20.0
	Clinical Psychologist	5	3.3
	Psychiatric Nurse	98	65.3
	Medical Social Worker	9	6.0
	Occupational Therapist	8	5.3
Years of Post-Qualification Experience	Less than 5 years	29	19.3
	5–10 years	23	15.3
	11–15 years	25	16.7
	16–20 years	30	20.0
	More than 20 years	43	28.7

Instruments

Secondary Traumatic Stress Scale (STSS; Bride et al., 2004)

The 17-item STSS assesses the frequency of intrusion, avoidance, and arousal symptoms arising from indirect exposure to clients' traumatic material. Participants rate items such as "*I felt emotionally numb*" on a 5-point Likert scale from 1 (never) to 5 (very often), based on the past seven days. Items are summed to yield a total score ranging from 17–85, with higher scores indicating greater severity of secondary traumatic stress. In the present sample, internal consistency was good (Cronbach's $\alpha = .94$).

Interpersonal Reactivity Index (IRI; Davis, 1983)

The 28-item IRI assesses empathy across four subscales: perspective-taking, fantasy, empathic concern, and personal distress. Consistent with evidence that these subscales differentiate into two broader empathy dimensions (Lai et al., 2021; Ogińska-Bulik & Michalska, 2024), perspective-taking and fantasy were combined to form a cognitive empathy composite, while empathic concern and personal distress were combined to form an affective empathy composite. Participants rate items such as "*I sometimes try to understand my friends better by imagining how things look from their perspective*" on a 5-point Likert scale from 0 (does not describe me well) to 4 (describes me very well). Each composite comprises 14 items, yielding scores ranging from 0–56, with higher scores reflecting greater empathic disposition on that dimension. In the present sample, internal consistency was good for both cognitive empathy ($\alpha = .85$) and affective empathy ($\alpha = .82$).

Procedure

Ethical clearance was obtained from the Research and Ethics Committee of FNPHK prior to data collection, following institutional permission secured through the Medical Director's office. Data collection took place between May and June 2026. Within each professional cadre, participants were selected using consecutive sampling, whereby every eligible professional encountered during the data collection period was invited to participate until the cadre's quota was reached, with recruitment distributed across morning, afternoon, and night shifts. Questionnaires were distributed immediately after daily multidisciplinary ward rounds; eligible professionals were briefed on the study and, after providing written informed consent, completed the questionnaire on the spot in a nearby quiet location. Completed questionnaires were returned immediately in sealed envelopes collected by the researcher or research assistant. No incentives were offered, and participation was entirely voluntary.

Ethical Considerations

This study was conducted in accordance with the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 2017). Formal ethical clearance was obtained from the Research and Ethics Committee of FNPHK prior to data collection. All participants received a participant information sheet detailing the study's purpose, voluntary nature, right to withdraw without consequence, and confidentiality safeguards, and written informed consent was obtained before questionnaire administration. Participation involved no incentives or coercion, and questionnaires were entirely anonymous, with no names or staff identifiers recorded. Electronic data were password-protected and stored on an encrypted drive. The risk of emotional discomfort from completing the STS items was judged minimal and no greater than that encountered in routine clinical practice.

Data Analysis

Data were analysed using IBM SPSS Statistics Version 23. Preliminary screening was performed to check for missing values, outliers, and normality assumptions. Descriptive statistics (means, standard deviations, frequencies, percentages) were computed for all study variables, and Pearson zero-order correlations were examined among cognitive empathy, affective empathy, secondary traumatic stress, and relevant control variables (age, gender, marital status, professional cadre, years of experience). The hypothesis that empathy (cognitive and affective) would significantly predict secondary traumatic stress was tested using hierarchical multiple regression, with control variables entered in the first block and the two empathy subscales entered simultaneously in the second block. The significance level was set at $p < .05$ (two-tailed).

Results

Descriptive Statistics and Intercorrelations

Participants had a mean age of 40.49 years (SD = 9.14). The mean score on cognitive empathy was 29.56 (SD = 8.60), and the mean score on affective empathy was 31.21 (SD = 7.30). The mean score on secondary traumatic stress (STS) was 37.88 (SD = 10.05). Means, standard deviations, and intercorrelations among study variables are presented in Table 3.

Table 3

Means, Standard Deviations, and Correlations for Demographic Variables, Empathy (Cognitive and Affective), and Secondary Traumatic Stress

	Variable	*M*	*SD*	1	2	3	4	5	6	7	8
1	Age	40.49	9.14								

	Variable	*M*	*SD*	1	2	3	4	5	6	7	8
2	Gender	—	—	.26**							
3	Marital Status	—	—	.23**	-.11						
4	Prof. Cadre	—	—	-.22**	-.28**	-.02					
5	Years of Exp.	—	—	.93**	.15	.23**	.03				
6	Cognitive Empathy	29.56	8.60	.05	-.10	.01	.05	.10			
7	Affective Empathy	31.21	7.30	-.08	-.12	-.10	-.01	-.05	.07		
8	STS	37.88	10.05	-.02	-.02	.10	-.08	-.05	-.08	.34**	-

Note. Gender was coded as 0 = Male, 1 = Female. Marital Status and Professional Cadre were treated as categorical variables. *p < .05. **p < .01.

As shown in Table 3, several significant correlations were observed among the study variables and demographic characteristics. Age was positively and significantly correlated with gender (r = .26, p < .01), marital status (r = .23, p < .01), and years of experience (r = .93, p < .01), but negatively correlated with professional cadre (r = −.22, p < .01). Gender was also negatively and significantly correlated with professional cadre (r = −.28, p < .01), while marital status was positively correlated with years of experience (r = .23, p < .01). Regarding the substantive study variables, affective empathy was positively and significantly correlated with secondary traumatic stress (r = .34, p < .01), whereas cognitive empathy was not significantly correlated with secondary traumatic stress (r = −.08, p > .05). Cognitive empathy and affective empathy were also not significantly correlated with each other (r = .07, p > .05). None of the demographic variables showed a significant correlation with secondary traumatic stress (all ps > .05).

Hierarchical Multiple Regression Predicting Secondary Traumatic Stress

It was hypothesised that empathy (cognitive and affective) would significantly predict secondary traumatic stress among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State. A two-step hierarchical multiple regression was conducted, with demographic variables (age, gender, marital status, professional cadre, years of experience) entered in Step 1 and the two empathy dimensions entered simultaneously in Step 2. Results are presented in Table 2.

Table 4

Hierarchical Multiple Regression Predicting Secondary Traumatic Stress (N = 150)

Predictor	*B*	*β*	*t*	*p*	*R*	*R²*	*ΔR²*	*FΔ*
Step 1: Demographics					**.15**	**.02**	**.02**	**0.68**
Age	.04	.04	0.14	.889				
Gender	-1.09	-.05	-0.54	.594				
Marital Status	1.15	.12	1.39	.166				

Predictor	*B*	*β*	*t*	*p*	*R*	R^2	ΔR^2	$F\Delta$
Professional Cadre	-.79	-.08	-0.75	.457				
Years of Experience	-.68	-.10	-0.37	.712				
Step 2: Empathy					**.39**	**.15**	**.13*** **	**10.93*** **
Cognitive Empathy	-.11	-.09	-1.14	.255				
Affective Empathy	.50	.36	4.61	<.001				

Note. Dependent variable = Secondary Traumatic Stress (STS). ***p < .001.

Demographic variables entered in Step 1 did not significantly predict secondary traumatic stress, $R^2 = .02$, F (5, 144) = 0.68, $p = .640$. In Step 2, the addition of cognitive and affective empathy significantly improved the prediction of secondary traumatic stress, accounting for an additional 13.0% of the variance, $\Delta R^2 = .130$, F (2, 142) = 10.93, $p < .001$. Together with the demographic controls, the full model explained 15.3% of the total variance in secondary traumatic stress, $R^2 = .153$.

Examination of the individual predictors revealed that affective empathy significantly predicted secondary traumatic stress ($B = 0.50$, $\beta = .36$, $t = 4.61$, $p < .001$). For every one-point increase in affective empathy, secondary traumatic stress increased by approximately 0.50 points, holding all other variables constant. Cognitive empathy did not significantly predict secondary traumatic stress ($B = -0.11$, $\beta = -.09$, $t = -1.14$, $p = .255$). The hypothesis was therefore partially supported: together the empathy domains significantly contributed to the prediction of secondary traumatic stress, but only the affective component emerged as a significant independent predictor, while cognitive empathy was not a significant predictor.

Discussion

This study examined cognitive and affective empathy as predictors of secondary traumatic stress (STS) among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria. Before turning to the empathy findings, it is worth noting that none of the Step 1 demographic variables significantly predicted STS. This null pattern is consistent with recent cross-cultural evidence that demographic predictors of STS are highly context-dependent rather than universal: marital status, for instance, has been found to protect against STS among mental health professionals in some settings but shows no significant association in others (Butt et al., 2025). Similarly, gender has been shown to moderate STS-related associations only inconsistently across mental health worker samples, sometimes significant and sometimes not depending on the outcome and cultural setting examined (Özbay & Bülbül, 2025), lending further support to interpreting the present study's non-significant demographic effects as setting-specific.

The hypothesis that empathy would significantly predict STS was partially supported. After controlling for demographic variables, the two empathy dimensions collectively accounted for an additional 13% of the variance in STS scores ($\Delta R^2 = .130$, F (2, 142) = 10.93, $p < .001$), bringing the total explained variance to 15.3%. Examination of the individual predictors revealed a clear differentiation between the two empathy components: affective empathy emerged as a significant positive predictor of STS ($B = 0.50$, $\beta = .36$, $p < .001$), indicating that professionals who reported higher levels of emotional resonance with

their patients experienced greater severity of STS symptoms, while cognitive empathy did not significantly predict STS (B = -0.11, β = -.09, p = .255), despite a modest negative trend.

These findings are consistent with theoretical models and international empirical literature on STS. The Compassion Fatigue Resilience Model (Ludick & Figley, 2017) identifies emotional contagion and vicarious arousal as the primary mechanisms through which secondary traumatic stress develops; when a clinician affectively absorbs a patient's distress, the same internal stress responses that characterise primary trauma exposure are activated (Ludick & Figley, 2017). The present finding also replicates the differentiated empathy–STS pattern observed across diverse occupational and national contexts: among Polish therapists, personal distress (an affective component) was the strongest predictor of STS, while perspective-taking showed no significant effect (Juczyński et al., 2022); among Polish police officers, personal distress again emerged as the strongest correlate of STS, with cognitive components showing weak or non-significant relationships (Ogińska-Bulik & Bak, 2025); and in a structural model with medical professionals, affective empathy exerted a significant indirect effect on burnout through elevated STS, while cognitive empathy instead operated protectively (Dawkins & Seo, 2025; Maximiano-Barreto et al., 2026). That this same differentiation holds among mental health professionals in a Nigerian federal psychiatric hospital, a setting with a markedly different resource profile and trauma burden than those in which the pattern was first documented, suggests it reflects a consistent functional difference in how the two empathy dimensions operate, rather than a context-specific artefact.

This distinction is also theoretically coherent. Cognitive empathy centres on perspective-taking and understanding without emotional sharing (Davis, 1983), which may allow clinicians to engage therapeutically while maintaining sufficient emotional distance from the material they encounter. The near-zero coefficient observed for cognitive empathy in the present study therefore signals something substantive rather than a simple absence of effect: the capacity to cognitively understand a patient's traumatic experience does not appear to transmit psychological harm in the way that emotionally absorbing that experience does. Understanding, in this sense, appears comparatively safe; absorption does not.

Situating this finding within the study setting strengthens its relevance. Clinicians at FNPH Barnawa routinely engage with accounts of insurgency-related violence, sexual abuse, and severe mental illness amid the resource constraints common to Nigerian federal psychiatric institutions (Abdulmalik et al., 2019). Professionals in this environment cannot avoid exposure to traumatic material; what appears to vary, based on the present findings, is how deeply they emotionally absorb it. By showing that affective rather than cognitive empathy drives STS in this setting, the present findings extend the international evidence base to a high-trauma, low-resource context and suggest that the mechanism linking empathy to psychological harm in mental health work operates similarly across markedly different healthcare systems.

Implications of the Findings

These findings carry implications both for how secondary traumatic stress is theorised and for how it is addressed in clinical practice. Theoretically, the differential pattern observed here — affective empathy predicting STS while cognitive empathy did not — reinforces the value of treating empathy as a multidimensional construct in trauma-exposure research rather than measuring it as a single global trait. Studies that do not distinguish between empathy components risk obscuring meaningful relationships within their data, and the consistency of this differentiation across culturally and institutionally distinct settings, from Polish therapists and police officers (Juczyński et al., 2022; Ogińska-Bulik & Bak, 2025) to medical professionals elsewhere (Dawkins & Seo, 2025) to mental health professionals in a Nigerian federal psychiatric hospital, suggests that the mechanism linking emotional absorption to psychological harm operates similarly across markedly different healthcare systems and cultural contexts.

Clinically, the finding that affective empathy, not cognitive empathy, predicts STS suggests that the

emotional quality that makes a clinician effective in the consulting room is also what places them at psychological risk outside of it. A psychiatric nurse who bears empathic witness to a survivor of violence and genuinely feels the weight of that experience is not doing anything clinically inappropriate; they are engaging with the therapeutic presence their role demands. Yet without deliberate strategies for processing and containing that emotional weight, the accumulation of such encounters is associated with real psychological harm. The practical implication is that empathy should not simply be encouraged in clinical training and supervision; it should be taught alongside skills for managing its psychological cost, such as structured emotional processing, reflective supervision, and boundary-setting practices that allow clinicians to remain affectively engaged with patients without absorbing their distress unchecked.

Limitations

This study has some limitations. First, the cross-sectional design precludes establishing causal direction between empathy and STS; it is equally plausible that professionals already experiencing elevated STS report greater affective empathy. Future research should adopt longitudinal designs to clarify whether affective empathy precedes STS development or whether existing STS heightens emotional reactivity over time.

Second, all variables were assessed through self-report, introducing the possibility of response bias, particularly given the stigma associated with admitting psychological distress in clinical settings. Future studies could incorporate informant ratings or behavioural/physiological indices of STS alongside self-report measures.

Third, the study was conducted at a single institution and adopted a non-probability proportionate quota sampling technique, limiting generalisability of the study findings to other Nigerian psychiatric facilities that may differ in trauma exposure profiles and institutional culture. Future research should recruit larger samples spanning multiple federal and state psychiatric facilities across different geopolitical zones of Nigeria.

Finally, the sample was heavily skewed toward psychiatric nurses (65.3%), limiting subgroup analysis by professional cadre. Future studies should employ targeted recruitment strategies to achieve more balanced representation across psychiatrists, clinical psychologists, occupational therapists, and medical social workers, allowing cadre-specific risk patterns to be examined.

Conclusion

This study examined cognitive and affective empathy as predictors of secondary traumatic stress among mental health professionals at a Nigerian federal psychiatric hospital. The findings show that empathy does not affect all professionals equally: it is specifically the affective dimension, the tendency to emotionally absorb a patient's pain, that drives secondary traumatic stress, while cognitive empathy, the ability to understand a patient's experience without feeling it as one's own, showed no significant relationship with STS. It was therefore concluded that the risk embedded in empathy lies not in understanding, but in emotional absorption, and that this risk is borne disproportionately by professionals who feel most deeply alongside their patients.

This pattern, well documented internationally, replicates clearly in a high-trauma, low-resource Nigerian psychiatric hospital setting, suggesting that the psychological mechanisms linking empathy to secondary traumatic stress operate consistently across markedly different healthcare systems and cultural contexts. In an environment like FNPH Barnawa, where clinicians routinely encounter trauma from insurgency, sexual violence, and severe abuse, this finding carries direct implications for staff wellbeing and the sustainability of the care they provide.

Conflict of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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