



Secondary traumatic stress among emergency nurses: a cross-sectional study



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ABSTRACT

Emergency department nurses are required to deal with emotional trauma issues on a daily basis, which may result in them experiencing symptoms of secondary traumatic stress, a consequence of stress experienced when helping or wanting to help a person traumatised or suffering. This study measured emergency department nurses' self-reported levels of secondary traumatic stress. Registered nurses ($n = 117$) working at three emergency departments in the Western geographical region of Ireland were invited to complete the secondary traumatic stress scale (STSS). A response rate of 90% ($n = 105$) was achieved. Most participants ($n = 67/64\%$) met the criteria for secondary traumatic stress. A statistically significant finding was that the highest proportion (82%) of secondary traumatic stress existed in the staff nurse group ($p = 0.042$). Moreover, for those nurses reporting secondary traumatic stress, statistical significance was found for the variables 'change of career considered' ($p = 0.017$) and 'finds alcohol helpful in alleviating work-related stress' ($p = 0.004$), when compared with nurses not reporting secondary traumatic stress. The findings suggest the need to examine current crisis management interventions and to introduce new systems to support nurses in Irish emergency departments. Moreover, because different types of traumatic events in the ED require different types of interventions, the prevention and management of STS among emergency department nurses must be tackled using a variety of approaches.

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1. Introduction

Emergency department nurses are at the frontline of a demanding healthcare system and are required to deal with emotional trauma issues on a daily basis, which may result in them experiencing symptoms of secondary traumatic stress (STS). STS is defined by Figley (1995, p. 7) as a natural consequence of stress experienced when 'helping or wanting to help a traumatized or suffering person'. Workplace stressors in the emergency department have been explored extensively. Reported stressors for emergency department nurses include violence against staff (Gillespie et al., 2013), death or sexual abuse of a child (Adriaenssens et al., 2012; Jonsson and Halabi, 2006), and interpersonal conflicts (Healy and Tyrrell, 2011; Laposa et al., 2003; Nielsen et al., 2013). Secondary traumatic stress among emergency department nurses can result in physical symptoms of stress (Jeon and Ha, 2012) and feelings of depression, sadness, fear and shock (Van der Wath et al., 2013).

2. Background

The effects of stress on emergency department nurses have been extensively reported. For instance, Gillespie and Melby's (2003) study reported that stress causing emotional exhaustion among emergency department nurses resulted in feelings of distress or anger, often leading to absenteeism. Work related stress can also result in individuals displaying short tempered behaviour and irritability (Edwards et al., 2007). One study reported that emergency department nurses are 3.5 times more likely to use illegal drugs such as cocaine or marijuana as a coping strategy when compared with nurses in any other speciality (Trinkoff and Storr, 1998). Moreover, a Greek study reported that female emergency department nurses had higher anxiety scores and exhaustion levels than any other nurses, with 25% exhibiting very severe depressive mood and sleep disorders (Stathopoulou et al., 2011). However, it should be noted that assistant nurses with only two years education were included in this Greek study. Moreover, as emphasised by Stathopoulou et al. (2011), nurses working in Greek emergency departments do not require additional specialised education. The findings therefore are not generalisable to emergency departments in the UK or Ireland. In addition, contrary to the findings reported by Stathopoulou

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et al. (2011), an exploratory cross sectional study in the USA of emergency department nurses from a level 2 trauma centre reported that all nurses are at the same risk of stress irrespective of their speciality (Hooper et al., 2010).

The psychological effects of direct exposure to traumatic events (e.g. abuse) have been well documented over the past 30 years. However, the traumatic events that affect persons indirectly, has not been researched as extensively.

Nurses' STS has been reported among hospice nurses (Abendroth and Flannery, 2006), nurses in children's intensive care (Meadors and Lamson, 2008), healthcare professionals at a children's hospital (Robins et al., 2009), sexual assault nurses (n = 110) (Townsend and Campbell, 2009), oncology nurses (n = 42) (Quinal et al., 2009) and emergency nurses (n = 67) (Dominguez-Gomez and Rutledge, 2009).

Dominguez-Gomez and Rutledge (2009) reported a high prevalence of STS among emergency department nurses in the US. And while levels of PTSD have recently been reported among emergency department nurses in Belgium (Adriaenssens et al., 2012), the study reported here is the only known European study to specifically measure STS among emergency department nurses.

3. Method

3.1. Design

For this cross sectional study, all registered nurses (n = 117) working in three emergency departments attached to public teaching hospitals in the Western region of Ireland were invited to complete the study's questionnaire in February 2013. These three emergency departments are the only centres for major trauma in this region and treat both children and adults. During 2013, the largest department (Emergency Department 1) reported 63,827 attendances. The other two emergency departments reported attendance figures of 23,833 (Emergency Department 2) and 34,194 (Emergency Department 3). Student nurses on placement to the three emergency departments were excluded from the study.

3.2. Data collection

The study questionnaire was the secondary traumatic stress scale (STSS) (Bride et al., 2004). This is the only scale that exclusively measures STS (Beck, 2011). Permission to use the STS was granted by Bride. The STSS consists of seventeen items which evaluate the frequency of symptoms among three subscales: intrusion (5 items); avoidance (7 items); and arousal (5 items). The three subscales and the seventeen items correspond with criteria B (re-experiencing), C (avoidance) and D (hyperarousal) in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) necessary for Post Traumatic Stress Disorder (PTSD) diagnosis (Dominguez-Gomez and Rutledge, 2009).

The STSS's psychometric properties were tested on a sample of 287 master's level social workers (Bride, 2007). Cronbach's alpha coefficient for the full STSS was ($\alpha = .93$) (Bride et al., 2004). Further published studies using the STSS have achieved high levels of internal consistency reliability (Badger et al., 2008; Dominguez-Gomez and Rutledge, 2009; Perron and Hiltz, 2006; Stamm, 2002). In addition, Bride et al. (2004) demonstrated evidence for the scale's convergent and discriminant validity.

Respondents rate on the scale how often they experienced each symptom in the last 7 days ranging from never (1), to very often (5). A cut-off score of 38 or more is the criterion used to determine the presence of STS (Bride et al., 2004). No reverse scoring is used in the STSS. The STSS measures current rather than cumulative exposure to traumatised patients (Bride et al., 2004).

At the end of the questionnaire (following the scale items on the STSS), respondents were asked a number of demographic questions and were also asked ten questions requesting responses (Y/N) to stress relieving strategies. These questions included 'find alcohol helpful in alleviating work-related stress' and 'sought help from a counsellor for work-related stress'.

3.3. Human subjects protection

The study was approved by the ethics committees of the three hospitals.

The study questionnaires were distributed to the three emergency departments. Each questionnaire requested the nurses to indicate their consent and willingness to complete the questionnaire by ticking a box. The data were collected anonymously.

While it was deemed unlikely that participants would become distressed during the questionnaire completion process, consideration was given to its possibility. Therefore, contact details were provided of the relevant employee assistance persons to seek further support and reassurance if needed.

3.4. Statistical analysis

Data were analysed using IBM SPSS Statistics 20. The total STS score was calculated by summing the response value for each item (the highest score possible being 85 and the lowest score being 17). The nurses' individual scores were compared with the normative scores proposed by Bride (2007). A cut-off score of 38 or above on the STSS is indicative of PTSD symptomatology (Bride, 2007). Pearson's Chi square was used to compare the difference in proportions between categorical variables. Parametric data were assessed using ANOVA and Pearson's correlation, and Binary Logistic Regression was used to predict STS. Statistical significance was established when the 95% confidence interval did not contain zero and (α) level was <0.05.

4. Results

One hundred and five questionnaires were returned (n = 105) (response rate of 90%); 95.2% (n = 100) were female and 4.8% (n = 5) were male. The majority were staff nurses (78/74.3%), followed by clinical nurse managers (CNMs) (21/20%). Only four (3.8%) were paediatric nurses, and two (1.9%) represented advanced nurse practitioners (ANPs). The mean (SD) number of years practicing in emergency nursing was $14 \pm (6.9)$, and the mean duration of nursing experience was $19 \pm (8.1)$. The average age of the nurses was $40 \pm (8.1)$. The youngest aged participant was 21 years old, and the oldest was 60 years. Most of the nurses were married and were educated to postgraduate diploma level (Table 1).

The nurses' scores were examined to determine the presence of diagnostic criteria for PTSD. The presence of PTSD symptoms is indicative of STS. As delineated in the DSM-IV-TR (American Psychiatric

Table 1
Nurses' characteristics.

	Frequency	%
Marital status		
Married	67	63.8%
Single	30	28.6%
Cohabiting	4	3.8%
Separated/divorced	4	3.8%
Highest educational level		
Postgraduate diploma	58	55.2%
Diploma	21	20%
Bachelors degree	10	9.5%
Masters degree	16	15.2%

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