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Symptoms of Posttraumatic Stress Disorder Among Pediatric Acute Care Nurses[1]

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In their work, pediatric acute care nurses may encounter traumatic events and be at risk for posttraumatic stress disorder (PTSD). This survey-based study examines the potential diagnosis of PTSD among nurses at a tertiary children's hospital with a Level 1 trauma center. Twenty-one percent of respondents had strong PTSD symptoms without significant difference between units. Nurses with potential PTSD had more comorbid symptoms of anxiety, depression, and burnout and were more often considering a career change. Furthermore, symptoms affected not only their work but also their personal lives. Future research should focus upon identifying pediatric nurses with PTSD to provide therapeutic interventions and reducing high-risk events and their potential impact.
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Background

NURSING IS WELL recognized as a high-stress job with potential for negative psychological impact such as anxiety, depression, and burnout syndrome (BOS). Acute care nurses, however, may be at particular risk for posttraumatic stress disorder (PTSD) given their exposure to life-threatening situations such as mass casualties or dying patients. The diagnosis of PTSD, defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*), requires either directly experiencing threat to oneself or witnessing a threat to others with feelings of intense fear, helplessness, and horror (APA, 1994). Although originally described in combat victims, PTSD may result from a wider range of exposures than in its original conception.

Mealer et al. found 20%–30% of adult critical care nurses surveyed had PTSD symptoms related to their work, a rate significantly higher than the estimated prevalence among the general U.S. adult population of 3.5% and lifetime prevalence of 6.8% (Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009; Mealer, Shelton, Berg, Rothbaum, & Moss, 2007). As situations involving children are often seen as having greater psychological impact, pediatric nurses may be at particular risk for PTSD (Figley, 1995; O'Connor & Jeavons, 2003). Prior research has demonstrated that nurses may be at risk of secondary traumatic stress (STS) related to their work (Badger, 2001; Beck, 2011; Maytum, Heiman, & Garwick, 2004; Meadors & Lamson, 2008; PTSD in nurses': the March viewpoint strikes a chord, 2005; Robins, Meltzer, & Zelikovsky, 2009). STS has been defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other…resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995). Individuals with evidence of STS may have PTSD-like symptoms. However, unlike PTSD, the chronicity and degree of functional impairment with STS have not been clearly defined (Elwood, Mott, Lohr, & Galovski, 2010). The Secondary Traumatic

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Stress Scale, the only scale to specifically focus on STS, only asks about symptoms within the past 7 days without a focus on functional impairment (Bride, Robinson, Yegidis, & Figley, 2004). In fact, among a sample of interviewed trauma workers, most did not have any interference with their work due to secondary traumatic symptoms (Ortlepp & Friedman, 2002). Despite these differences, much of the literature has focused upon STS rather than PTSD among pediatric nurses. Yet, PTSD could have a significant impact on the individual nurse's well-being, nursing retention, and potentially the care of patients.

Thus, we conducted this study to better understand the prevalence of potential PTSD among pediatric nurses, work-related risk factors, and impact on perceived job satisfaction. Because burnout has clearly been demonstrated among the nursing workforce and is a large component of compassion fatigue (which includes both STS and burnout symptoms), we also sought to measure the presence of BOS within this cohort and the impact of having potential PTSD with and without BOS (Acker, 1993; Devilly, Wright, & Varker, 2009; Firth, McIntee, McKeown, & Britton, 1985; Kanste, Miettunen, & Kyngas, 2006; Kennedy & Barloon, 1997; Maytum et al., 2004; Oehler & Davidson, 1992; Ostacoli et al., 2010; Poghosyan, Aiken, & Sloane, 2009; Poncet et al., 2007). We would expect that the rate of BOS, with feelings of emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA), to be significant but separate from PTSD symptoms (Maslach, Jackson, & Leiter, 1996; Maslach, Schaufeli, & Leiter, 2001). Furthermore, because other anxiety disorders and depression are risk factors for PTSD, we screened for the presence or absence of these coexisting symptoms. Our hypothesis was that BOS would be significant among all units surveyed but that nurses working in high-intensity areas such as oncology, intensive care unit (ICU), and emergency room (ER) would have significantly higher rates of potential PTSD.

Methods

This study was approved, with the need for informed consent waived, by the Colorado Multiple Institutional Review Board at the University of Colorado, Denver.

Participants and Design

Participants were nurses employed at a tertiary-care children's hospital with a wide referral base and Level 1 trauma services. Nurse managers for general medical, surgical, and oncology wards and pediatric intensive care unit and ER were contacted regarding potential participation. A member of the research team met personally with each interested nurse manager and explained the purpose of the study, with a focus on PTSD. However, they were encouraged not to inform the study participants of the specific aims as to reduce bias. After agreeing to participate, each nurse manager was given an appropriate number of surveys to be placed into each nurse's mailbox during the study period, December 2008 to March 2009.

Each survey contained a cover letter stating that the purpose of the study was to determine how individual nurses were affected by working in a stressful environment and the voluntary nature of participation. The specific focus of PTSD, anxiety, depression, and BOS were not mentioned to reduce response bias. Surveys were anonymously completed, sealed in a blank envelope, and returned to the designated unit location for collection by a research team member. The survey contained questions regarding demographic information (age, gender, race, general health, marital status, and family) and education and work experience. In addition, questions focused on the work environment, and perceptions of team members/team work were included. Nurses were asked about potential stressors associated with their pediatric work and the presence of nightmares, severe anxiety or panic, severe pain, or shortness of breath in relation to these stressors. Finally, the survey included three validated instruments to identify PTSD symptoms, screen for symptoms of anxiety and depression, and identify BOS (further described below). Nurses were grouped according to unit type defined as "high intensity" (ICU, ER, and oncology) or "low intensity" (general medical or surgical ward). For comparative analyses, nurses were then grouped by the presence and/or absence of PTSD symptoms and/or BOS.

Definition of Measured Conditions

The study survey evaluated four psychiatric/psychological conditions: PTSD, anxiety, depression, and BOS.

Posttraumatic Stress Disorder

PTSD is an anxiety disorder with specific diagnostic criteria as defined by the *DSM-IV*. These criteria include one or more reexperiencing symptoms (having upsetting thoughts or images about the traumatic event, bad dreams or nightmares, reliving the traumatic event, feeling emotionally upset when reminded of the traumatic event), three or more avoidance symptoms (avoiding activities, people, or places that remind them of the traumatic event; not being able to remember an important part of the event; feeling emotionally numb; feeling as if your plans or hopes will not come true), and two or more arousal symptoms (having trouble falling or staying asleep, feeling irritable or having fits of anger, having trouble concentrating, being overly alert, being jumpy or easily startled). These exhibited symptoms must be related to the individual's *direct* experience with a traumatic event or indirect exposure to a threat to others and feelings of intense fear, helplessness, or horror. Finally, these symptoms must have

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