



# The Relations between Violence Exposure, Posttraumatic Stress Symptoms, Secondary Traumatization, Vicarious Post Traumatic Growth and Illness Attribution among Psychiatric Nurses



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## ABSTRACT

This study examined posttraumatic stress disorder symptoms (PTSD), secondary traumatization (ST) and vicarious posttraumatic growth (VG) among Israeli psychiatric nurses (PN) who were compared to community nurses (CN). Furthermore, we examined the contribution of PN perceptions of the etiology of their patients' mental illness to their PTSD, ST and VG. Results show that PN reported higher levels of both PTSD and ST symptoms, but lower levels of VG, as compare to CN. While ST symptoms were positively related to VG among CN, PTSD and ST symptoms were negatively associated among PN. Finally, exposure to patients' violence, PTSD or ST symptoms, and illness attribution dimensions of 'powerful others', predicted nurses' VG. PN are an at-risk population for work-related stress residues.

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## POSTTRAUMATIC STRESS DISORDER AND SECONDARY TRAUMATIZATION SYMPTOMS

Psychiatric nurses working in hospitals and wards are exposed to high levels of work-stress. In their daily routines psychiatric nurses may directly experience high rates of physical and verbal violence, sexual harassment (Chen, Hwu, Kung, Chiu, & Wang, 2008; Moylan & Cullinan, 2011), and even encounter incidence of completed suicides (Takahashi et al., 2011). It is no surprise that the stress of exposure to assault and the fear of potential assault appear to impact nurses' emotional states in the form of posttraumatic stress disorder (PTSD). However, as compare to other nurses (e.g., oncology), there are only four studies that assessed PTSD symptoms among psychiatric nurses, mostly in the absence of a comparable group (Caldwell, 1992; Nachreiner et al., 2007; Richter & Berger, 2006). In his review, Jacobowitz (2013) concluded that most of these studies reported a 9–10% prevalence rate of PTSD in this population.

Not only are psychiatric nurses subjected directly to work-stress, but they can also be indirectly exposed to first-hand accounts of patients' extreme traumatic experiences that might affect their psychological states in the form of secondary traumatization (ST; Figley, 1995). The negative effects of ST may include fear, sleep difficulties, intrusive images, or avoiding reminders of the person's traumatic experiences. As

a result, ST entails physiological, cognitive and emotional symptoms resembling those of the victim's (Stamm, 2010). For example, research on ST among helping professionals indicated rates of 16–20% among social workers in a U.S. military hospital (Beder, Postiglione, & Strolin-Goltzman, 2012), and rates of 17–19% among physicians in hospitals across New-Zealand. Specifically, among nurse populations ST rates ranged from 25% to 38%, where oncology and hospice nurses' ST rates were the highest (Beck, 2011). To the best of our knowledge, there is no study that specifically examined ST among psychiatric nurses. This study aims to assess not only the pathogenic ramifications of trauma in the forms of PTSD and ST symptoms, but also its potentially positive consequences in the form of vicarious posttraumatic growth.

## VICARIOUS POSTTRAUMATIC GROWTH

The study of the salutogenic aspects of human experience in the face of adversity has been gaining momentum in the last decade (e.g. Almedom & Glandon, 2007). The current theoretical definition of post-traumatic growth (PTG) describes it as a positive outlook following trauma, manifested by one's relation to others, perception of new possibilities, enhanced personal strength, a spiritual change, and a higher appreciation for life. A person who has developed PTG needs to develop beyond his previous level of psychological functioning (Tedeschi & Calhoun, 2004). Studies have shown that various populations may experience PTG after exposure to a variety of traumas, such as sexual assault (Grubaugh & Resick, 2007), chronic diseases (Sawyer, Ayers, & Field, 2010), accidents and disasters (e.g., McMillen & Cook, 2003).

Only in the last decade have several studies been conducted to examine PTG in indirect victims of trauma. Arnold, Calhoun, Tedeschi,

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and Cann (2005) formulated the concept of *vicarious posttraumatic growth*, which relates to a process of growth experienced specifically by therapists treating trauma victims as a result of vicarious trauma, through similar meaning-making processes that follow direct trauma. Thus, helping professionals reported significant changes in their existing global beliefs that were reflected in their work-related benefits or rewards in domains such as appreciation for the resilience of people (Linley & Joseph, 2011). In this line of reasoning, updated research has found higher levels of VG among social workers (Ben-porat & Itzhaky, 2009), and mental health workers (Hyatt-Burkhart, 2014). A number of studies examined VG among nurses and found that they reported higher levels of VG as compare to other helping professionals such as social workers (Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2008), and physicians (Taubman-Ben-Ari & Weintroub, 2008). However, to date no study has directly examined VG among psychiatric nurses. As the phenomenon of VG may reduce nurses' burnout and increase their satisfaction from work (e.g., Xu & Wu, 2014), it is important to examine VG among this population and the possible psychological mechanisms that contribute to VG development, such as psychiatric nurses' attribution of their patients' mental illness to an internal or external locus of control.

## ILLNESS ATTRIBUTION

Attribution theory assumes that people strive to attain a causal understanding of the world and thus develop 'theories' that explain the causes of the occurrence of various events in their world (Weiner, 1992). In the same line of reasoning, Rotter (1966) conceptualized 'locus of control' as the way people react to environmental events as dependent on the meaning that they attribute to an event. People with internal locus of control attribute the responsibility of what happened to them to their own behaviors. People with external locus of control would interpret their experiences as the result of fate, luck or other people out of their control. Illness attribution refers to the way a person perceives the etiology of the disorder and the cause for its outbreak, whether an arbitrary lack of fate or, alternatively, a punishment or a result of human actions.

Most empirical studies documented the positive association between external attribution or external locus of control to higher probability for PTSD (e.g., Nickerson, Aderka, Bryant, & Hofmann, 2013). Furthermore, external locus of control was found to correlate with higher distress and more negative functioning among nursing staff in closed psychiatric wards (Yarovitsky & Tabak, 2009). As for PTG, it was found that people with an external locus of control also tend to develop less PTG because of the need for personal thought processes following trauma, and engaging in redefining the world of human perceptions that leads to growth (Cummings & Swickert, 2010). However, when it comes to psychiatric nurses' attribution of their patients' mental illness to internal or external locus of control, the issue becomes more complex.

Various studies have shown that people tend to attribute to mentally ill individuals control over their condition and the ability to recover from their diseases (Bennett, Thirlaway, & Murray, 2008). Attempts to explain mental illness as a result of a complex set of genetic, biological and environmental factors, which are beyond the sole control of the person, do not necessarily lead to reducing the stigma (Hinshaw & Stier, 2008). Even perceptions of mentally illness by mental health professionals were very similar to those of the general population (Nordt, Rössler, & Lauber, 2006). It still remains unclear what the role of these perceptions is in the stress-related condition of psychiatric nurses. In this study we suggest that nurses who attribute their patients' mental illness to factors beyond the individual's control ('nature attribution' or 'external locus of control'), will experience less PTSD and ST symptoms and higher levels of VG.

Based on the literature review, we hypothesize that: (1) psychiatric nurses will report more PTSD and ST symptoms and higher levels of

VG than community nurses; (2) among psychiatric nurses, there will be positive correlations between exposure to patients' violence and PTSD and ST symptoms and VG. Furthermore, illness attribution dimensions of 'chance', 'powerful others' or 'potential vulnerability' ('nature attribution') will be negatively associated with PTSD and ST symptoms and VG; (3) among psychiatric nurses, exposure to patients' violence, and illness attribution of 'chance', 'powerful others' or 'potential vulnerability' ('nature attribution') will independently predict PTSD and ST symptoms and VG.

## METHOD

### *Design and Sample*

A descriptive, comparative cross-sectional study was conducted in 2012–2013.

Participants were 196 Israeli nurses that consisted of two groups: (1) psychiatric nurses (research group); and (2) community clinic nurses (comparison group).

### *Psychiatric Nurses*

This group consisted of 90 participants of the nursing staff at two major government psychiatric hospitals. The psychiatric nurses work on various in-patients wards in these institutions. Those units are populated by acute and chronic, male and female, voluntary and involuntary patients. Eligible participants included all frontline certified psychiatric nurses providing direct patient care in in-patient acute care and chronic care departments.

### *Community Clinic Nurses*

This group consisted of 106 nurses. In the absence of normative rates of PTSD, ST and VG among general nurses in Israel, we chose this group of nurses to represent the general, low-risk Israeli nurses with which our data on psychiatric nurses can be compared. These nurses were affiliated with new-born, community and family health clinics in four regions: Tel-Aviv, Judea, the low hill country and the north. For the sake of simplicity, we considered all the non-psychiatric nurses that work in new-born, community and family health clinics as community nurses. As part of their responsibilities, these nurses meet patients for routine check-ups and run various medical tests. In addition, nurses are responsible for health education in the community. Eligible participants included all nurses that were qualified in nursing studies in the School of Nursing nationwide.

### *Measures*

PTSD Inventory (Solomon et al., 1993). Nurses' PTSD symptoms were assessed with the PTSD inventory that taps the 17 symptoms listed in the DSM-IV-TR (APA, 2000). Participants were asked to rate how often they suffered from each symptom in the previous month on a scale ranging from 0 (not at all) to 4 (almost always). The number of positively endorsed symptoms was calculated by counting the items in which the respondents answered '3' or '4'. Participants were asked about their reactions to their work place or the patients they are treating. (e.g., "I have recurrent dreams and nightmares about my work or the patients that I treat"). This symptom count was used to operationalize PTSD both as a continuous variable of number of post-traumatic symptoms and as a dichotomized DSM diagnosis. Using DSM-IV symptom criteria, participants were identified as having PTSD if they endorsed at least one intrusive symptom, three avoidant symptoms, and two hyper-arousal symptoms. DSM-IV-TR also specified the F criterion as clinically significant distress or impairment in the social area, occupational area, or other important areas of functioning. Disability was defined as impairment in the social area in the previous month. This inventory has proven psychometric properties in terms of high test-retest reliability, concurrent validity, and convergent validity

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