# A Qualitative Study on the Psychological Impacts of Patient and Workplace Trauma on Emergency Nurses

Kelly-Anne Kriel

17601942

Research RESE8419

Schooool of Psychology and Communication

Bachechelor of Arts Honours in Psychology

Final Research Project


Supervisor: Dr. Sarah Heany

Word count: Abstract:204

Body: 12 540

DECLARATION

*I, Kelly-Anne Kriel, hereby declare that the Research Report submitted for the Bachelor of Arts Honours degree in Psychology to the Independent Institute of Education is my own work and has not previously been submitted to another University or Higher Education Institution for degree purposes.*

*Signed: K.Kriel.*

## ABSTRACT

Emergency nurses are subjected to numerous traumatic patient cases on the daily. Literature shows that the experiences of traumatic patient phenomena can have a significant impact on the psychological and emotional well-being of these nurses. Post-traumatic stress disorder and secondary-traumatic stress are becoming commonly recognized issues that emergency nurses are facing. In order to increase our basis of knowledge on this phenomenon, this research study attempts to explore the prevalent psychological impacts that distressing patient and workplace trauma can have on emergency nurses. Using a qualitative and interpretative design, this research study explores subjective discourses of emergency nurses' experiences with traumatic patient phenomena in seeking to paint a clearer picture of the psychological implications that occur thereof. Six South African emergency nurses with 30+ years of experience working at Tygerberg Hospital were interviewed through structured, open-ended questionnaires on their experiences and were recruited using purposive sampling. Phenomenological analysis revealed findings that show that emergency nurses who experience distressing patient phenomena such as patient calamity and violent-gang cases experience levels of psychological distress such as symptoms of post-traumatic stress disorder, secondary-traumatic stress, compassion fatigue, and vicarious trauma. In addition this emotional and psychological distress experienced stem mainly from a) constant exposure to patient tragedy b) traumatic paediatric cases c) emotional exhaustion and overwhelm and d)gang-related cases.

## TABLE OF CONTENT


1. Introduction……..5
2. Rationale for current research……6
3. Problem statement……..7
4. Research goal, aim & question ……...8
5. Research objective & hypotheses……...8
6. Theoretical foundation……9
   - 6.1. Classical conditioning when dealing with traumatic events ……..9
   - 6.2. Information processing theory ……..10
7. Literature review ……...11
8. Conceptualization of concepts ……..17
9. Design & Methodology ……20
   - 9.1. Research paradigm……20
   - 9.2. Research design……21
   - 9.3. Population……21
   - 9.4. Sampling……..22
   - 9.5. Data-collection method……23
   - 9.6. Data analysis method……26
   - 9.7. Validity, reliability & trustworthiness……..28
10. Findings……29
11. Discussion……34
12. Research question, objectives & hypotheses addressed…….. 38
13. Ethical considerations……40
14. Limitations of study……41
15. Heuristic value and implications for future research……..41
16. Conclusion……42
17. Annexures……51
18. Final summary document ……...67

## 1. INTRODUCTION

Emergency nurses are often described as being the “angels” of the emergency department. Treating, caring for, and providing a safe haven for patients going through the direst of states are some of their strongest abilities as healthcare workers. Going above and beyond their clinical duties, emergency nurses power through physically and emotionally draining times while providing the utmost care for their patients. Their immense endurance, however, comes at a cost. Constant subjection to traumatic and distressing events in the emergency department can be taxing on their mental health. In recent years, literature has shed some light on an increasingly prevalent issue that is expanding amongst their working field (Wright, 2018). It is believed that constant exposure to traumatic patient and workplace phenomena increases nurses’ risk for developing psychological issues such as post-traumatic stress disorder, secondary traumatic stress, compassion fatigue and vicarious trauma (Andrianssens, de Gucht, & Maes, 2012).The abundance of harrowing and emotionally laden events experienced in the emergency department has serious and predominantly unrecognized psychological implications.

Consequently, it is important and relevant to investigate how distressing patient and workplace trauma can emotionally and psychological affect emergency nurses. A review of the literature shows a significant gap of universal knowledge, with majority of the studies being Western or European based. As such, the context in which these emergency nurses work should not be neglected in our understanding of distressing experiences as gang-violence and aggression is on epidemic levels in Western Cape hospitals (Kennedy & Julie, 2013).Gaining a South African perspective on some of the issues that overwhelm emergency nurses in a Western Cape hospital allows us to examine if Northern literature holds true to a different context, as well as delving into context-specific aspects such as how gang-related violence in the hospital affects them.

This research study therefore sought out to investigate the various psychological impacts that occur as a result, with the aim to answer the question: in what ways do the experiences of patient and workplace trauma affect emergency

nurses emotionally and psychologically? Analyses of the subjective experiences of emergency nurses broaden our knowledge on an underrepresented topic and encourage us to enhance local understanding of such an important phenomenon that is affecting some of our most essential healthcare workers.

## 2. RATIONALE FOR CURRENT RESEARCH

Concerns about the unspoken mental health of the nursing population have increased in recent years, especially following a recent United States study that reported nurses to be at a higher risk of suicide than the general population (Davidson, Proudfod, Lee & Terterian, 2020). The study found that suicide phenomena in male and female nurses can be linked to unaddressed mental health issues that continue to prevail. The prevalence of mental health issues in nursing staff is obvious yet highly under-represented. Needless to say, few published research studies have sufficiently focused on the topic deeply enough to provide an adequate understanding of such a multifaceted phenomenon with many aspects to be investigated.

There are however some seminal authors who have bought this phenomenon to light. An imperative study conducted by Adrianessens, de Gucht and Maes (2012) discovered that nurses were frequently confronted with traumatic events, such as failed resuscitation of a patient, death of a minor, and acute patient accidents, leading to sub-clinical levels of anxiety, depression and somatic complaints. Furthermore, 8.5% of the nurses presented with clinical levels of Post Traumatic Stress Disorder. Another prevalent research study conducted by Dominquez-Gomez (2009) furthers on the concept that nurses experience symptoms of secondary traumatic stress, compassion fatigue and vicarious trauma. They reported that 85% of nurses experienced symptoms of irritability, patient avoidance and intrusive thoughts about patients. The evidence is, however, lacking in the fact that majority of relevant studies are quantitative in design. This leaves little room for exploratory and descriptive notions to be made. Enhancement upon this topic using qualitative and exploratory measures was therefore necessary.

Additionally, issues surrounding race, gender, violence and crime are still greatly active within South African society. Rispel (1995) deposits that nurses within the new healthcare system are still largely affected by the hefty number of violence and crime rates, evidently raising the stakes of their jobs. They note that discrimination, poor working conditions, and violent gang cases are some of the aspects that affect nurses within South Africa. Such social contexts are not well represented in research that is predominantly Western and European based. Local knowledge of the psychological implications that South African emergency nurses face therefore generated new understandings of the topic that can be better applied into contexts similar to South Africa's.

## 3. PROBLEM STATEMENT

The problem statement reflects upon the concern that the experiences of traumatic patient and workplace phenomena will have a negative psychological impact on emergency nurses. They experience an abundance of distressing patient calamity at alarming rates, and these firsthand experiences in succession can hold a significant influence over their well-being, work-focus and decision making. Wright (2018) explicates that 85% of emergency nurses experience symptoms of secondary traumatic stress disorder, otherwise known as compassion fatigue, and in turn experience diminished well-being and difficulty conducting thorough patient care.

Another problem is that of turnover rates. Flinkman, Isophakala-Bouret and Salantera (2013); Haddad, Annamaraju, and Tony-Butler (2020) state that there is an alarming global nursing shortage. 49% of nurses within the United States have considered leaving their profession due to burnout, mental health problems, staff harassment, and violence within the workplace. Since 2013, South African nursing staff has shockingly declined by 40%, meaning that an estimated 9000 registered nurses have either failed to join or left the work force (Brits, 2019). What's more is that the Democratic Nursing Organisation of South Africa note that emergency and trauma nurses in South Africa attend to catastrophic cases daily with little to no support structures or trauma debriefing resources to help mitigate the distress it causes (Matshili, 2019). This posed a problem to be researched as emergency

nurses are suffering the harrowing effects of workplace and patient trauma to the extent of either leaving the profession or not joining.

## 4. RESEARCH GOAL, AIMS & QUESTION

Working with emergency patients who have been in car accidents, shootings, or need resuscitation, for example, are situations in which nurses can feel inundated with emotion, stress, and anxiety when working under such haste circumstances. Findings in the literature suggest that these dire circumstances can have a significant effect on their mental states and behaviour.

The primary aim of this study was therefore to identify and describe the psychological impact(s) that distressing patient phenomena can cause in emergency nurses. A secondary aim was to investigate symptoms of post-traumatic stress disorder, secondary-traumatic stress, compassion fatigue, and vicarious trauma as a response to distressing patient experiences. The final aim was to explore how distressing patient experiences such as on-the-job violence affect their psychological well-being and job performance.

Primary research question: In what ways do the experiences of patient and workplace trauma affect emergency nurses emotionally and psychologically?

## 5. RESEARCH OBJECTIVE & HYPOTHESES

The research objective was to examine and decipher the psychological impacts that traumatic patient phenomena has on emergency nurses' psychological well-being as well as job performance

*Sub question:* Do the experiences of workplace trauma play a role in how nurses function within their working life?

*The hypothesis for the study stood as:* Emergency nurses who are faced with severe patient and workplace traumatic phenomena will experience degrees of psychological distress such as symptoms of post-traumatic stress disorder, secondary traumatisation, compassion fatigue, and vicarious trauma.

*The second hypothesis stood as:* Distressing patient and workplace events such as on-the-job violence will play a role in how emergency nurses function within their working life, such as a decreased sense of psychological well-being and job performance.

## 6. THEORETICAL FOUNDATION

### *6.1. Classical conditioning when dealing with traumatic events*

The theory of classical conditioning was coined by renowned physiologist Ivan Pavlov in the 1890's. The basis of traditional classical conditioning lies in the idea that when a stimulus that is capable of evoking a response (the unconditioned stimulus) recurrently precedes another neutral stimulus, the one that occurs first can become a signal of sorts for the second conditioned stimulus (Branscombe & Baron, 2017; Pavlov, 1928). Further, as described by Sigelman and Rider (2018), the theory of classical conditioning is a simple form of learning. Essentially, a stimulus that has had no effect on an individual prior brings forth a behavioural and/or cognitive response through the process of repeated learning and generalization (Sigelman & Rider, 2018).

This behavioural learning theory is therefore relevant to my study as cued responses to trauma can be attained through learning. Brewin and Holmes (2003) therefore sought out to apply conditioning theories towards anxiety and trauma. The main concepts from their theorization bring forth that an initial phase of fear acquisition through classical conditioning results in the stimuli during a traumatic event eliciting fear-inducing properties. Simply put, the stimuli that are present during trauma will eventually obtain fear, anxiety and stress inducing cues – therefore associating these distressing cues with trauma. (Brewin & Holmes, 2003). When dealt with trauma, the response to stimuli therefore becomes an adaptive method for self-protection.

Whereas the conditioning theory does not clearly distinguish learned cues towards the experiences of trauma, it does provide a prominent explanation for psychological and physiological arousal as well as conjecturing behaviour, such as

avoidance and panic, when dealing with emotional arousal. This theory therefore created a roadmap for why emergency nurses respond to trauma in learned ways, for example feeling panic when new cases come in, avoidance of patients, and heightened reactivity when faced with patient and workplace trauma.

### 6.2. *Information Processing Theory*

Classical conditioning however generates a theoretical gap when looking at conscious mental processes. The Pavlovian perspective holds a strong focus on behaviour and learning, and henceforth disregards conscious cognitive processing. Atkinson and Shiffrin (1968) deposit that the human mind, much like a computer, processes the information from experiences, rather than just merely responding to stimuli. The information processing theory therefore allows us to look at behaviour as a cycle of how one processes information, and how they respond due to the ways in which it was processed. McClelland and Gilyard (2019) explain that when an individual experiences a traumatic event, adrenaline rushes through the body in response to sensory information (i.e. the traumatic event). One's fight-or-flight response will be initiated: increased heart rate, increased blood flow to muscles as well as pupil dilation. The person's stress response is therefore imprinted into the amygdala. This causes the brain to be easily triggered by misinterpreted sensory information that has been newly processed. Utilizing the information processing theory to explain trauma, Brewin and Holmes (2003) explicate that the central idea of the information processing theory is that there is uniqueness in the way that a traumatic experience is processed and represented within one's memory. If a distressing experience is not processed in an appropriate way, then psychopathology (stress, anxiety and/or PTSD) will result (Brewin & Holmes, 2003).

Improving how one can process information from a traumatic event is through talk therapy and reasoning (McClelland & Gilyard, 2019).The information processing theory therefore stands as relevant to my study as Walsh & Buchanan (2011) assert that distressed nurses use maladaptive coping mechanisms, such as emotional distancing and avoidance of patients, as a way of attempting to cope with their experience of patient trauma, rather than talking through the experience. These

maladaptive coping strategies will henceforth lead to information being processed in dysfunctional ways.

## 7. LITERATURE REVIEW

### Traumatic Patient Cases

An important theme in the study of emergency healthcare workers is that of related stress, anxiety and trauma that is experienced in response to the traumatic events that they encounter with their patients. A review conducted by Cocker and Joss (2016) describes compassion fatigue, a key aspect of secondary traumatisation, in the context of emergency healthcare providers, such as nurses, social workers and disability workers, who are frequently exposed to second-hand trauma. They note that emergency healthcare providers suffer great amounts of mental exhaustion – compassion fatigue, secondary traumatic stress and cumulative burnout. Regular exposure towards these experiences of traumatic patient events heightens their chances of developing said psychological modes of exhaustion. Their findings revealed that the majority of research was conducted on nurses within the United States, and that interventions pertaining to compassion fatigue showed evidence of well-being enhancement. The authors' final results provide evidence of the effectiveness of compassion fatigue and burnout interventions, and therefore recommend them as a means of ensuing better physical and mental health outcomes for health care providers. This literature however does not delve deep enough into the many-sided experiences of specialized emergency nurses.

Seminal work in this field has been published by Adriaenssens, de Gucht and Maes (2012). The authors investigated the impact of traumatic events on emergency room nurses. They state that emergency nurses are confronted with work related traumatic events and intense working conditions on a regular basis. The main objectives of the study were to 1) examine the frequency of exposure to and the nature of traumatic events in emergency nurses, 2) examine the percentage of nurses that report symptoms of PTSD, anxiety, depression, somatic complaints and fatigue, and 3) examine the contribution of traumatic events, coping strategies and social support of PTSD symptoms, somatic complaints, fatigue, sleep disturbances

and psychological distress. The authors studied 248 emergency nurses in Belgium and showed that emergency nurses were found to be frequently (not stated how frequently) confronted with work related traumatic events. Additionally, the study found that instances of death and serious injury of a child/adolescent were the most traumatic events across the sample. Furthermore, they found that 33.3 % of nurses met sub-clinical levels of somatic complaints anxiety, depression, and that 8.5% of the sample met clinical levels of PTSD. Fatigue was a present factor within the data, however, there was found to be no significant correlation between fatigue and frequent traumatic exposure. This pivotal study therefore supports the proposal that emergency nurses experience a psychological impact when exposed to patient and work trauma.

A similar study by Berg et al. (2006) investigated intensive care unit (ICU) nurses and their repeated exposure to traumatic cases and stressful events. The study aimed to determine whether there is an increased prevalence of psychological symptoms in ICU nurses in comparison to regular nurses. The researchers surveyed 491 ICU and general nurses and the data concluded that 24% of the ICU nurse sample experienced symptoms of PTSD relating to their work environment, whereas only 14% of general nurses experienced symptoms of PTSD. There were, however, no differences in depression and anxiety levels between the two samples. Their research, however, does not delve deeper into other outcomes of constant exposure to traumatic cases, such as secondary traumatic stress or compassion fatigue.

**Psychological implications of patient trauma – post-traumatic stress disorder, secondary traumatic stress, and compassion fatigue.**

A review of on-the-job trauma was conducted by Schwarz (2005). The author compiled a viewpoint on post-traumatic stress disorder in nurses and how it might be driving nurses out of the profession. Schwarz asserts that the mass shortage of nurses in the United States is due to burnout, symptoms of PTSD (ragged emotions, avoidance, and heightened reactivity) and secondary traumatisation (emotional exhaustion, emotional numbness, and detachment). They further explain that while some nurses are quick to become overwhelmed by the distressing experiences and quit, others remain emotionally undaunted – burnt out but functional. The author

believes that nurses are either undiagnosed, unaware of, or deny the causes of their negative affect, fatigue, addiction and irritability. Further elaboration is made on the idea that nurses need help in identifying these psychological impacts as a way of coping with the burdens of distressing work. Despite the focus on burnout and PTSD, the review does not sufficiently address the other aspects of secondary traumatic stress - compassion fatigue or vicarious trauma.

Walsh and Buchanan (2011) examined the experience of witnessing patients' trauma and suffering among acute care nurses. The authors assert that witnessing patients' trauma and suffering is multifaceted and complex. Through phenomenological analysis, this qualitative research focused on the lived experiences of five acute care nurses and their work stress. Symptoms of PTSD, secondary traumatic stress, compassion fatigue and burnout were found to be prevalent. Moreover, they established five emergent themes within their data; a) shock and prolonged witnessing of suffering, b) long-term effects, c) distancing as a coping strategy, d) feelings of guilt and helplessness, and e) dissonance in core beliefs about self. These were therefore labelled as the impacts that affected nurses when experiencing patients' suffering. This research study provides valuable empirical evidence, including written accounts from each nurse explaining their harrowing experiences and just how detrimental these experiences have been on their mental health. This research study provides newfound leverage into the study of nursing and trauma as it details a relation between witnessed trauma and psychological suffering. This complements Berg et al.'s (2006) findings of increased PTSD symptoms in trauma nurses and enhances our exploration of psychological impacts on the nursing population.

The application of secondary-traumatic stress to the study of nursing professionals is a recent development. Dominques-Gomez and Rutledge (2009) examined the prevalence of STS among experienced emergency nurses. They conducted research on a sample of 67 emergency nurses from three general hospitals in California, United States and ultimately found that nurses were most likely to experience symptoms of psychological arousal: 54% reported irritability, 52% reported avoidance of patience, and 46% reported intrusive thoughts about patients. Strikingly, 85% of the sample reported to have at least experienced one of

these symptoms in the last week. The authors conclude that the high prevalence of STS in their sample indicates that potentially large numbers of emergency nurses universally may be experiencing negative effects of secondary traumatic stress. PTSD and secondary traumatisation were therefore recurrent psychological impacts in the literature.

**Job performance and workplace violence**

Relating to my second hypothesis on work performance, the correlation of work stress and post-traumatic stress disorder was studied in emergency department nurses by Laposa, Alden, and Fullerton (2003). They sought to investigate the link between work-related stress and the development of anxiety disorders, such as post-traumatic stress disorder. A sample of 51 experienced (13 + years) emergency department nurses from Canada completed questionnaires that measured PTSD and sources of work stress. They answered questions relating to work-related responses to stress or trauma. Their results detailed that interpersonal conflict is significantly associated with PTSD symptoms. 67% of the participants believed to have not received adequate support from the hospital following a traumatic incident, and 20% considered leaving their job as a result of trauma. Only 18% attended critical incident debriefing and none sought outside help for their psychological distress. The authors further reinstates that there is a desperate need for hospitals to provide their staff with resources to mitigate the development of psychological distress and PTSD symptoms.

A study by Dyrbye et al. (2019) investigated the high prevalence of burnout among nurses and how that might affect absenteeism and work performance. A national sample of nurses from the United Sates was sent a cross-sectional survey that addressed topics such as burnout, absenteeism and poor work performance. There were 812 participants of which 94% were female, and 61% were married. The participants had a mean of 26 years of experience working as a nurse with 38.2% having a Master of Science degree. The results elicited that 35.3% had symptoms of burnout, 30.7% had symptoms of depression, 8.3% had been absent for one of more days during the month of data collection, and 43.8% had poor work performance in the month of data collection. They conclude that nurses who have symptoms of

burnout and fatigue are more likely to have been absent and have poor work performance.

A study by Kennedy and Julie (2013) investigated nurses' experiences and understating of workplace violence in a trauma and emergency department in South Africa. The authors state that violence within the hospitals perpetrated by patients is on epidemic levels. The researchers conducted eight semi-structured interviews with eight registered nurses (2 men and 6 women) who work the emergency and trauma department on a rotational basis. The participants revealed that verbal abuse, physical abuse, psychological violence and imminent violence were things that they had to go through on a daily basis. The effects on work performance in face of the violence they received varied. The male participants found that the violence did not affect their work performance as they were accustomed to workplace violence, whereas the female nurses felt they had poor work performance such as, being upset and avoiding the patient, after being abused. Generally, all participants felt as if how well they did their work wasn't affected, but rather their attitude about the patient and their job.

Finally, Rispel (1995) conducted a review on the challenges that face nurses in South Africa. The main tenets of the review highlighted issues relating to the apartheid regime, poor working conditions, inadequate pay, and discrimination in the workplace are aspects that affect nurses in South Africa. Furthermore, the author states that South African nurses are still largely affected by the ever-increasing number of violence and crime rates that take place in many regional hospitals. Nurses experience prisoners and hostile patients coming in from gang-stricken areas, and are therefore put in direct danger when working. Rispel (1995) additionally notes that these factors evidently raise the stakes of the jobs. This review however is outdated and would benefit from more modern insights.

**Resiliency in nursing**

Research on nursing resiliency is on the rise. A study on resilience and struggling within the nursing profession asserts that situations of distress in the

workplace can play a crucial role in physical and mental problems in nurses (Yilmaz, 2017). Stressors such as work overload, lack of self-care, inadequate emotional preparation, conflict with doctors, and patient death are some situations that affect nurses on a regular basis. In response to these stressors, Yilmaz elicits that physical and mental dysfunctioning occurs, including: fatigue, irritability, lack of concentration, unhappiness, depressive affect, depersonalization, and emotional exhaustion. As for resilience, Yilmaz asserts that despite the challenges, building resilience through training can enable nurses to cope with distressing work environments and maintain healthy and stable psychological functioning.

Coping strategies and resiliency was addressed in Ramalisa, du Plessis, and Koen's (2018) study on general nurses. The aim of their study was to investigate how general nurses use strategies to overcome the many challenges brought about by patients who are involuntarily admitted for mental health issues. Their findings revealed a significant theme - that coping strategies and resiliency towards difficult circumstances such as aggression, refusal, and communication barriers came from the skills and experience nurses had developed over many years. Meaning that the more experience the nurse had with such difficulties, the easier it became for them to cope and overcome it.

We can see a convincingly recurrent correlation between the experiences of distressing patient phenomena and post-traumatic stress disorder, secondary traumatisation, compassion fatigue and vicarious trauma. Given the consistencies in the findings of Western and European research on this topic, I was able to ground my hypotheses on established and insightful research.

## 8. CONCEPTUALIZATION OF CONCEPTS

*Emergency nurse*

Emergency nurses treat patients who are suffering from trauma, acute injury, or severe medical conditions that require urgent treatment (Brooks, 2018). They work in demanding crisis situations which require haste decision making abilities in order to treat the patient. Conditions they encounter include gunshot wounds, stabbings, accident related injuries, car fatalities, and resuscitation patients. It is important to differentiate between emergency and trauma department nurses within South Africa. According to Stanton (2019) emergency department nurses in South Africa handle cases of accident and emergencies, whereas the trauma department handle shooting and stab wound cases. The concept of emergency and trauma nurses was amalgamated throughout this research study as they both experience cases of parallel traumatic severity.

*Patient trauma*

Patient trauma in this research study refers to a patient who has suffered a serious, potentially life-threatening physical injury that requires immediate care (American Trauma Society, 2020). Trauma patients are treated at major hospitals with emergency or trauma departments that specialize in certain traumatic injury (ATS, 2020). This research study mentions both patient trauma and emotional trauma. It is important to differentiate that patient trauma is referring to the traumatic patient phenomenon, and emotional trauma concerns the psychological distress of the emergency nurse.

*Emotional trauma*

The American Psychological Association (2020) defines trauma as an emotional experience in response to a distressing event such as an accident, natural disaster, or rape. Emergency nurses are met with various types of patient trauma on a daily basis (Walsh & Buchanan, 2011) and are said to often encounter psychological trauma from witnessing a patient in extreme medical need, sever pain and suffering, as well as the personal risks of injury and violence that ensues under such haste conditions.

*Psychological distress*

According to Robinson, Smith, and Segal (2020) emotional and psychological trauma is the result of an extraordinarily stressful event that ultimately shatters one's sense of security, making one feel helpless in a dangerous world. Not only do they highlight these experiences as a threat to one's life and safety, they also include that situations where one feels overwhelmed, distressed and isolated can result in emotional trauma, and that it is not the event alone, but rather the way in which we perceive and respond to the emotional experience that fuels our emotions. This idea is therefore relevant to my research as it is a common concept bought up in nursing research, as well as common throughout the average day of an emergency nurse. Walsh and Buchanan (2011) describe that prolonged witnessing of patient injury and suffering has adverse effects on nurses' mental and physical well-being.

*Psychological impact/effect*

The dictionary defines this phenomenon as pertaining to, dealing with, or affecting the mind, especially as function of awareness, feeling or motivation. With regards to nursing, Dominques-Gomez and Rutledge (2009) introduce some of the psychological impacts faced by nurses that accompany emotional trauma; irritability, avoidance, intrusive thoughts, anxiety, depression, secondary traumatic stress and compassion fatigue. This concept therefore stood as relevant to my study as these were some of the critical components and symptoms investigated.

*High work stress environment*

The American Psychological Association (2019) defines a high work stress environment as a chronically stressful and overwhelming workplace environment that can be harmful to both physical and emotional health. A stressful working environment has many opposing effects on the human body and mind, such as; headaches, stomach aches, sleep disturbances, insomnia, high blood pressure and a weakened immune system (APA, 2019). For this reason, it was important that this research study investigated emergency nurses' high work stress environment, in this case traumatic patient phenomena and on-the-job violence, and examine the psychological implications thereof.

*Post-traumatic stress disorder (PTSD)*

PTSD is characterized as an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which serious physical harm occurred or was threatened (Kail, Cavanaugh & Muller, 2019). However, in the case of emergency nursing, Danella, Hamilton, and Heinrich (2017) describe that PTSD develops after a direct, as well as indirect, exposure to an extreme emotionally or physically traumatic stressor. The indirect aspect of PTSD was critical to my study as Danella et al. state that the stressor can range from actual or threatened death, assault, witnessing the death or injury of another individual, and in most cases, exposure to details of a traumatic event. Relevance of PTSD to my study lied in the fact that nurses are repeatedly exposed to traumatic stressors within the emergency department which ultimately creates an environmental predisposition to the development of psychological disorders (Danella et al., 2017).

*Secondary-traumatic stress (STS)*

Secondary-traumatic stress (STS) or secondary traumatisation, compassion fatigue and vicarious trauma are all conceptualized within a parallel framework – developing from consistent working with trauma. STS, although not very well acknowledged prior to recent research, is a disruptive by-product of working with traumatized individuals, and can be considered a set of observable reactions to working with people who are experiencing states of physical or emotional trauma (Lederman, Osofsky, & Putnam, 2008).

*Compassion fatigue (CF)*

CF lies in the idea that empathetic ability is primary in the care of others, but also puts healthcare workers at risk for suffering negative effects (Figley, 2002). Symptoms of CF can range from a state of emotional and physical depletion, aversion to work, avoidance, recollection of a traumatic event, detachment from others, as well as efforts to avoid any cues that repeat the event (Walsh & Buchanan, 2011).

*Vicarious trauma (VT)*

VT is the emotional residue of exposure that healthcare providers have from hearing stories from trauma victims and becoming witness to the pain, fear and terror that people have endured (Bleuer & Walz, 2016). It is a state of constant tension and preoccupation of the trauma that leads to a persistent arousal state as well as a feeling of numbness (Bleuer & Walz, 2016). STS, CF, and VT are often referred to as one through the word secondary traumatisation.

## 9. DESIGN AND METHODOLOGY

### 9.1. Research Paradigm

As a qualitative study, the paradigm that best fit this research study was interpretivism. The interpretivist paradigm, in brief, is ultimately rooted in understanding the world from the subjective, one-sided perceptions and experiences of individuals. As such, researchers using qualitative measures can therefore gather comprehensive perceptions and worldviews from their participants, as well as utilizing the meaning of subjective experiences to explain specific phenomena (du Plooy-Cilliers, Davis & Bezuidenhout, 2018).

Using interpretivism allowed for greater understanding into how experiencing harrowing patient phenomena affected these nurses. To elaborate, interpretivism facilitates the detection and exploration of each individual's own level of resilience and susceptibility. Wright (2018) explains that response to trauma is highly individual. Certain occurrences in the hospital which may distress or traumatise one nurse, on the other hand, may not affect another, and is all up to individual human experience and their unique levels of psychological resilience. By using this paradigm, I was able to take a deeper look into each participant's unique experiences within the hospital – what types of distressing patient phenomena they experience, how it affects their psychological well-being and ability to work, and how they chose to deal with it, or often times, not dealt with it. By doing this at an individual level, I was able to see the phenomenological meanings and themes that were recurrent between each participant, as well seeing what differs distinctively between nurse to nurse.

Walsh and Buchanan's (2011) study utilized the interpretivist viewpoint within their data collection and analysis approach. To explore the lived experiences of acute care nurses, they were able to gain extensive insight into each participant's unique experience by using this in-depth approach. Interpretivism allowed them to attain thorough, open-ended data from each participant, with detailed explanations of their experiences as acute care nurses. However, I found this study to be the only one to employ this approach on the topic. There is therefore a gap in viewpoint. This paradigm was chosen not only because of the shortage of interpretivist viewpoint, but also as a means of expanding the field of research with a richer, exploratory understanding into emergency nurses' individual experience.

## 9.2. Research Design

This is an exploratory-descriptive phenomenological research study which utilized qualitative methods. Because of the paucity in literature and empirical knowledge of emergency nurses' subjective experience with psychological distress and emotional trauma as a response to distressing patient phenomena, an exploratory and descriptive design was essential in broadening our knowledge and clearly defining the topic of emergency nurses' subjective experiences in varying depth so that more conclusive research can be conducted. Since the phenomenon being studied is relatively in its infancy, this design was chosen to create a better understanding of how these traumatic events are affecting emergency nurses and creating an interpretation of why such a phenomenon is occurring. This exploratory-descriptive phenomenological design was therefore used as a medium to identify the issues experienced by emergency nurses so that they can be a focus for future research.

## 9.3. Population

The target population included registered nurses and registered nursing assistants who either work in, or had at least 25 years experience working in, hospital emergency settings. Inclusion criteria for the target population included having experienced some form of psychological or emotional distress pertaining to

their work in emergency settings. This inclusion criterion was established so that the final sample could be representative of the target population.

The portion of the target population that this study had access to was limited to the region of Cape Town, South Africa. The accessible population consisted of emergency and trauma nurses employed by Tygerberg Hospital in Parow, Cape Town. This provincial government hospital was chosen based on their annual report which records an average of 17 000 patient trauma and emergency cases per annum (Western Cape Government, 2016). Many of these cases are bought in from the surrounding townships concerning gang-related knife crime, shootings and alcohol-fuelled violence (Stanton, 2019).

### 9.4. Sampling

The sample was selected through non-probability purposive sampling, which allowed me to select a sample representative of the elements required for the study based on my judgement (Foley, 2018). Recruitment of the sample entailed approaching the emergency departmental head of Tygerberg Hospital via telephone who permitted the participation of 10 emergency nurses. Prospective participants were addressed through call and email, and six final participants were selected based on their extensive experience working in the emergency departments, and having either traumatic or distressing experiences relating to patient trauma such as, caring for patients with severe traumatic injury, the traumatic death of a patient, or gang-related injury. I therefore included only participants who a) had at least 30 years of experience with emergency and trauma cases; b) were experiencing some form of psychological distress in response to one or more traumatic patient cases; and c) encountered forms of on-the-job violence or aggression from patients. Conducting research on sensitive topics, such as personal trauma, raises a number of ethical issues for the researcher (Draucker, Martsolf, & Poole, 2009). For the purpose of ethical concerns and to serve the well-being of the participants, it was best suited to only include participants with extensive nursing experience in order to mitigate potential emotional distress during the data collection process.

Both emergency and trauma nurses have been included for this study as both departments see equally distressing cases of traumatic incidents. Since the study is qualitative in nature, the final sample size included six emergency and trauma nurses in order to thoroughly focus on the subjective experience of each nurse. Components such as race, age, socio-economic status, and marital status did not play a major role in the selection of the participants. Ideally, the sample would have a heterogeneous assortment of male and female nurses, each from varying ethnic backgrounds in order to assure utmost reliability and generalizability of the results. However, due to the limitations of the Covid-19 pandemic, the final sample was a homogenous sample comprised of six extremely experienced registered female emergency and trauma nurses, and one female trauma nursing assistant. The sample was comprised of 3 'white' and 3 'coloured' nurses ranging of the ages from 47 to 62. Each nurse had 30+ years of experience working with patient trauma in the emergency, trauma, triage, and resuscitation departments on a rotational shift basis. Each participant was fluent in both English and Afrikaans, resided in the surrounding urban and semi-rural residential areas of Cape Town, and had equivalent levels of tertiary education and nursing training.

### 9.5. Data-collection Method

Because of the paucity of qualitative literature on the topic, it was important that this study followed an interpretative phenomenological approach. This method was chosen as it allows researchers to focus on the commonality of a lived experience within a specific group being researched (Maxwell, 2013). A prominent study on the lived experiences of acute care nurses, conducted by Walsh and Buchanan (2011), utilized an interpretivist data collection approach in order to collect thorough, open-ended data with detailed explanations of each nurse's experiences with acute patient care. My research study was largely inspired by their selected methodological techniques as this in-depth approach facilitates the collection of extensive and insightful data into each participant's unique lived experience. Given that the theory of knowledge for the topic being studied is at a shortfall, replication is vital for seeing if the results found on acute care nurses, who work in similar emotionally distressing environments, hold true to emergency nurses. Moreover, if

the results are similar, it will give greater validity to both findings, meaning that the results obtained are more likely to be generalized onto the larger nursing population (Cherry, 2020).

The ideal data collection methods for phenomenological research incorporate in-depth interviews, focus groups, or observations with the sample being investigated (du Plooy-Cilliers et al., 2018). However, due to the limitations of the Covid-19 pandemic and the restrictions inside Tygerberg Hospital, qualitative, in-depth questionnaires were implemented. This restructured method of collection was chosen to make the study both easily accessible to the sample with little to no transmission risk, as well as allowing them added time to take the questions home and better reflect on their experiences and answers.

The original semi-structured interview template was reconstructed into on-paper questions to form a qualitative, open-question, and structured questionnaire. This format best suited the research study as it consisted of a set of standardized questions with a fixed scheme in which the exact order of the questions is specified (Cheung, 2014). The open-question nature of the questionnaire encouraged open-ended answers, explored participant thought, feelings, and beliefs about their psychological distress, and delved deeper into personal and sometimes sensitive topics (DeJonckheere & Vaughn, 2018). It is common for qualitative and exploratory studies to employ open-ended questions in order to take a holistic and comprehensive look at the topic being researched, as well as collect open-ended data (Allen, 2017).Open-ended questions were therefore utilized rather than a predetermined set of closed-ended questions as it permitted participants autonomy to answer in ways they saw appropriate (Allen, 2017), thus the data collected had more depth and diversity than would be possible with closed-ended questions.

The original framework of themes for the semi-structured interview remained employed within the questionnaire. The themes addressed were as follows:

1. The experience of patient and workplace trauma.
2. If and how these experiences bought about symptoms of psychological distress, post-traumatic stress disorder, secondary traumatic stress, compassion fatigue, or vicarious trauma.

3. The effects on job-performance.
4. On-the-job violence.

Because of the open-ended nature of questionnaire, the participants were encouraged to introduce and discuss new themes which they felt needed to be addressed in relation to the topic, for example, how working with Covid-19 patients had affected their psychological well-being and work performance.

The final questionnaire consisted of 16 open-ended questions with enough line spacing for paragraphs of information, giving the participants the opportunity to express themselves freely and direct their responses in any way they wished. The participant folder (see addendum B) is what the participants received in order to answer within a two week period and return to the emergency departmental head. To ensure that the participants understood the topics being researched as well as the questions being posed, an information fact sheet was provided which detailed a description of post-traumatic stress disorder, secondary-traumatic stress disorder, compassion fatigue, vicarious trauma, and burnout as well as the symptomology that is indicative of each condition. For each question, the participants were asked to write a paragraph or two of freely-flowing thought detailing their exact experiences with the aforementioned conditions, as well as their unique experiences with regards to patient and workplace trauma.

The first set of questions posed as an introduction for each participant. The second set of questions addressed their experiences with traumatic patient cases and the adverse psychological implications that may have occurred in response to that. The third set of questions addressed job performance and on-the-job violence in relation to prisoner and gang-related cases. In order to address whether patient and workplace trauma impacted their psychological well-being, the participants were asked in question 3 to detail some of the traumatic experiences they have encountered with patient trauma in the emergency/trauma departments.

Majority of the questions required the participant to elaborate on the answers provided. Phrasing the questions in such an open manner encouraged participants to write as much as they can about their subjective experiences, thoughts, and emotions about the topics, as well as giving them the opportunity to elicit a

‘conversation’ between their answers. Question four, seven, and eight (see addendum B) were constructed so as to explore more of the deeper psychological reactions and symptoms they were experiencing in response to distressing patient and workplace trauma. The participants were then asked if they encountered any of the symptoms explained in the information fact sheet, and to detail their experiences with the symptoms if they did. This question was imperative in addressing the theme of how their traumatic patient experiences bought about symptoms of the psychological conditions under consideration. The remaining questions thereafter addressed their experience with gang-related patients, on-the-job violence and aggression, and how these experiences could have an effect on how they perform patient care.

### 9.6. Data Analysis Method

The data analysis approach applied was inductive in nature. This approach sought to explain the complexity of the phenomenon being studied by defining patterns and themes in the emergence of findings (Marshall & Rossman, 2006). The exploratory nature of the open-ended inquiry into my research question required that I actively participate in deciphering and explaining the meaning of the phenomenon being studied (Kawulich, 2004). This facilitated a richly detailed analysis that embodied understanding of emergency nurses’ experience with psychological distress in response to patient trauma.

Interpretative phenomenological analysis has proven valuable in the studies of pain, suffering, and trauma as it seeks to describe experiences that are often times individualized and emotionally charged (Smith & Osborn, 2015). This approach best aligned with the purpose and objectives of this research study, which was to explore the deeper unvoiced mental and emotional implications that sever patient trauma can have on emergency nurses. Provided that the objective of this study was to examine and decipher the ways in which personal trauma effects psychological well-being and job performance, this method further suits the ambiguousness that comes along with such personal experiences.

A replication of Walsh and Buchanan's 6-step process of interpretative phenomenological analysis as outlined by Smith and Osborn (2015) was conducted. The authors' parallel study on acute care nurses used phenomenological analysis to construct detailed analyses of their data, and accumulated an assortment of themes that constitute a general description of the phenomenon being studied. This exploratory approach was therefore chosen as I aimed to present comprehensive examinations of the individual lived experiences of emergency nurses, as well as decipher the various psychological impacts (symptoms of post-traumatic stress disorder, secondary-traumatic stress, compassion fatigue, and vicarious trauma) in response to patient and workplace trauma.

The 6-step process of phenomenological analysis was conducted as follows:

1. A transcript of each participant questionnaire was typed out in verbatim.

2. A thorough reading of each transcript was completed to acquire a better sense of each participant's background and experiences with emergency patients, job performance, on-the-job violence, and the emotional implications thereof.

3. Exemplary quotes and significant statements from each transcript that supported the themes and units of analysis under investigation were noted. Additional themes bought up which added to the investigation of the topic were also noted. Interpretative meanings of the statements were thereafter developed to construe each participant's reality and experiences of patient and workplace trauma and the psychological effects thereof.

4. The interpretive meanings were organized into clusters, which allowed themes to emerge among each transcript. An investigation of the differing themes and thematic structures were completed, making sure to substantiate each theme back to the research question, objective and hypotheses.

5. The themes were then integrated into a comprehensive description. A concise statement of the thematic descriptions was additionally completed in order to provide an overall essence of the experience.

6. A reduced summary of each transcript, the findings, and the thematic descriptions were completed and presented back to the participants via email in order to validate the conclusions. Any discrepancies bought up from the participants were noted and revised in order to mitigate any inconsistencies in the validity of the findings.

From their personal narratives and stories, comparisons of how each participant experienced the phenomenon either similarly or differently were therefore examined. The final stages of the analysis process required me to think deeply about the emerging thematic clusters and make sense of the experiences before developing the descriptive thematic units. It was expected that the units of analysis would elicit certain themes such as psychological resilience, distancing and avoidance, and burnout.

## 9.7. VALIDITY, RELIABILITY, & TRUSTWORTHINESS

Vigilance in selecting the inclusion criteria for the sample was crucial so that the participants fit the requirements of the study. Participants varied between urban and rural Cape Town as a means of making my research study applicable to the demographic individuality of the nursing population. Each participant was fully aware of the research studies criteria and purpose and any probes and queries that arose were answered in detail via email in order to mitigate any uncertainty about the questions. The abovementioned methodology was selected partly in an attempt to keep personal biases out of the data analysis stages so that no imposition of my personal experience or opinion on the phenomenon could taint the findings. Caution was taken in holding aside any information that may influence the data in any shape or form. Because the methodology adopted from Walsh and Buchanan (2011) has been peer reviewed, it increased the validity and reliability of how I conducted

collection and analysed the data. Making the analysis more replicable, phenomenological analysis was conducted twice to assure that the attained themes and units were analysed correctly and reliably. Additionally, my full methodology is available for replication.

## 10. FINDINGS

After a thorough review of each nurse's questionnaire transcript, five apparent themes were found.

### *Emotional detachment and numbing as a coping strategy*

Commonality between participants was acknowledged in their use of emotional detachment as a coping strategy. Each participant discussed in relation to Question 6 and 10 (see addendum B) the learned use of detaching their emotions and feelings that they experience during traumatic injury cases as it could potentially affect their work functionality. Participant 3 shared their experience of learning how to detach oneself emotionally from cases:

"I can feel every emotion possible during really stressful cases. I can be sad, happy, angry, depressed, but over the years I was forced to learn to dissociate my emotions and feelings from my work otherwise I end up psyching myself out and end up in a downward spiral." (Participant 3).

Participant 5 spoke similarly regarding emotional detachment:

"… Almost always it is the nurse who must deal with the grieving family. Sometimes I feel overwhelmed and really emotionally drained when doing this as I also feel saddened if a patient has just died. I have learnt to put up walls to prevent total emotional destruction. I try to detach myself from the situation if I feel overwhelmed and just focus on getting the job done." (Participant 5).

Three of the participants all expressed mechanisms that aided in their emotional detachment: 1) distracting themselves with other patients or nursing duties, 2) not getting emotionally invested with patients or in cases, and 3) never brining work home. Additionally, the idea of shutting one's emotions down after

stressful cases was bought up. Participant 1 felt as if "… turning off my emotions after witnessing a decapitation when I was just starting out was the only way I could get through the rest of my days work. I am not sure if it worked or not, as it still haunts me to this day." Similarly, participant 6 expressed feeling "emotionally fatigued and burnt out" if they allow themselves to get emotionally occupied in emergency cases. Moreover, a point of vulnerability was addressed by two of the participants, expressing how emotional attachment to patients, especially children, caused them to be overtly vulnerable when it came to grieving their loss.

***Secondary traumatisation and lax in compassion***

Secondary traumatisation was apparent in each nurse with them feeling emotionally overwhelmed and mentally exhausted in face witnessing the extreme pain and suffering of their patients. Similarly, the participants collectively commented on experiencing symptoms of compassion fatigue (an aspect of secondary-traumatic stress) as a result of repeated exposure to traumatized victims. This form of emotional exhaustion may seem similar to emotional detachment, but it differs in the fact that their secondary-traumatic stress and compassion fatigue was not a voluntary form of coping, but rather an after-effect of many years of emergency nursing.

Four of the nurses experienced a reduced ability to feel empathy for their patients, increased absenteeism, a reduced enjoyment of work, and irritability when working with patients, while the remaining two nurses experienced the more harrowing effects of secondary traumatisation and compassion fatigue –substance abuse as a way to cope with high work stress environments. Participant 2 describes her symptoms of secondary-traumatic stress, compassion fatigue and vicarious trauma:

> "I believe I suffer from compassion fatigue and vicarious trauma because I sometimes don't want to attend work due to me having to face the children's rape cases and traumatic amputations. I have also become angry and have aggressive feelings towards patients after all these years rather than being compassionate and understanding like when I was younger." (Participant 2)

Their negative attitudes and behaviours now as a nurse were all communally linked back to two ideas: constant exposure to patient trauma and feelings of mental and emotional exhaustion (secondary traumatisation). The majority of the participants had an overt understanding of how years of patient trauma affected them emotionally and psychologically, and were somewhat aware of their lack of compassion but not their secondary traumatisation.

### *Psychological resilience*

Psychological resilience as a nurse was frequently mentioned. Three of the participants spoke about a career-long process of learning how to cope and deal with traumatic cases in face of one's own reactions. They mentioned having to learn how to not let certain cases get to them emotionally and the process eventually became second nature to them despite its complexities.

> "My experiences helped me learn how to cope better in the long run. I learned how to not attach myself to patients and learned how to move on from cases and carry on. I believe it is a learning process that you get better at." (Participant 5).

The ways in which the participants were impacted were also mentioned as being dependant on the person. Three of the participants mentioned in response to Question 9 that they believe the emotional and psychological responses differ from person to person.

> "… There were colleagues who also experienced the emergency decapitation but they were not as troubled by it as I was. They were older and more experienced at that time while I was still young and learning how to wrap my head around the [cases] we see." (Participant 1).

The distress that these nurses went through can be related to an undeveloped sense of resilience as the participants mentioned the experiences gradually getting easier with the influx of patients as time goes by.

### *The psychological impact of paediatric cases*

Although each participant holds their own unique experiences with and reactions to traumatic cases that involve infants and children, the emotional and psychological implications of their experiences seem to hold parallel meaning for each. Each participant spoke about being particularly traumatised and distressed when faced with an emergency case involving a young child, infant, or adolescent.

> "I was particularly traumatised by an emergency theatre case that I scrubbed in for that involved a 4 year old girl. She was shot during a drive by shooting by gangsters in the Cape Flats. This innocent little girl died on the theatre table. This has never left me, I can still see her open chest with blood everywhere. I sometimes wish I never scrubbed in for that case." (Participant 5)

> "Accidents that involve children are particularly traumatising for me because I sometimes know the chances of their survival. No matter how much we nurses pray for them and the families and wish for miracles to happen, there is sometimes no chance. Then we sit suffering with the families." (Participant 2).

These experiences were noted as a common cause for their feelings of anxiety, depression, and stress while working in the emergency and trauma departments. Three participants mentioned being emotionally distraught as a reaction to having maternal instincts themselves as mothers. Participant 6 describes how she was negatively affected by paediatric cases as a maternal response:

> "… I have children myself, and each time I see a child or baby die I can't help but empathize with the mother. I always see my own children in those situations and it really gets to me. What if that was my child? It's painful to think about." (Participant 6)

In addition to the maternal implications of traumatic paediatric cases, the participants spoke of some more serious effects following their distressing experiences. Nightmares, flashbacks, and insomnia, all common symptoms of Post Traumatic Stress Disorder as outlined by Bisson, Cosgrove, Lewis, & Roberts (2015)

were commonly brought up when asked to elaborate on their experiences with the symptomotology in Question 7. Participant 4 describes her experiences and symptoms of PTSD after witnessing a baby without a skull being born:

> "… I cried for days after his birth and I cried for days after his death. I still have nightmares about it as it was something I have never seen before in all my years as a nurse. I could not go sleep at night without picturing [the baby] in my mind. Whenever I work obstetrics now, I always picture [the babies] coming out with no skull." (Participant 4)

It became apparent that most of the participants' experiences with personal psychological distress and symptoms of PTSD are closely associated with traumatic paediatric cases. Furthermore, the participants each described their unique struggle with remaining a nurse as a reaction to their traumatizing experiences. Three of the nurses explained how struggling with the after-effects (nightmares, insomnia, flashbacks, depression, irritation) of a traumatic experience resulted in their change in nursing specialization.

***Threat of gangsterism***

The immense threat of gansterism in Cape Town showed to be a common theme when asked about on-the-job violence and gang-related cases in Question 11. There was collective agreement that the phenomenon of gangster-related killings posed a great threat to them as nursing staff. Participant 4 explains the experience:

> "On night shift I fear the gang members returning to the hospital to finish killing the patient that they injured. They will do anything to finish the job, even hurt the staff if we get in the way." (Participant 4).

An additional perspective discussed by two of the participants was that they do not feel safe in a predominantly female work-force while doing night shift. The participants felt unsafe with the prospect of gangsters returning to the hospital and uncomfortable with the lack of security and protective resources provided from the hospital. The participants noted that this threat made them feel anxious, vulnerable, and contributed to their evasion of gang patients.

"… then one day we were told this particular gang leader was shot and being cared for in my department. Word was out that the opposite gang was coming to the hospital to finish him out. Imagine that, I was so afraid, stressing the entire day, praying I don't end up getting shot. I avoided that wing all day out of fear for my own life" (Participant 5).

## 11. DISCUSSION

### Emotional detachment as a coping strategy

Emotional detachment as a coping strategy can be attributed to the emotionally demanding environment in which emergency nurses work. It is logical to assume that emotions such as grief, frustration, and sadness are very much part of nurses' work experience and their learned detachment of emotion is something well documented. According to Dolan, Stodi, and Hamernik (2012) as nurses grow older and their experiences with emotionally laborious work increases, emotional distancing and detachment become useful tools in coping with distressing situations. It is suggested that emotional distancing can be instrumental in building resilience as a nurse (Dolan et al., 2012). However, my findings suggest that the emergency nurses are not predominantly distancing themselves in a healthy manner, but rather disengaging all emotionality, empathy, or regard towards certain patients as a means of moving forward and carrying on with the job. This could be understood as a survival reaction towards a previous incident that may have influenced them to shut off their emotion for patients, or as a way to avoid emotional vulnerability to emergency cases.

These findings aligned with the findings of Walsh and Buchanan's (2011) study. The authors' findings suggest that the population of acute care nurses distanced and detached themselves from their experiences of patient suffering to evade vulnerability. They describe acute care nurses as numbing their emotions as one of the only ways they could persist through the day. This idea lies parallel with my findings as the participants all recalled disengaging their feelings and emotions as a strategy for persevering. Looking at the theory, classical conditioning can be

used to explain this. Their distressing experiences with patient trauma in the past may have caused them to associate fear and anxiety towards new patient cases. This can make them feel as if each case is going to tear them down emotionally, so it is easier to rather detach and numb themselves emotionally than feel the distress once experienced. Emotional detachment can therefore be understood as an adaptive method of self-protection that occurs due to a learned response.

### Secondary traumatisation and lax in compassion

The findings suggest that emergency nurses are predisposed to developing secondary-traumatic stress and compassion fatigue as a result of constant subjection to the influx of patient pain and suffering witnessed on the daily. Deficits in emotional responses or reactivity are claimed to be a way of life for people to protect themselves from further emotional destruction (Lindberg, 2020). Repeated emotional stimuli can result in emotional overwhelm –a state of extreme emotion that is often too difficult to manage (Good Therapy, 2019). When we examine the context these nurses work in, they face a higher risk of developing symptoms of STS and CF due to the demanding environments in which they are subjected to. The high stress-action environment of the emergency and trauma departments of Tygerberg Hospital in correlation with constant exposure towards traumatic patient cases negatively impacted the emotional responses of the participants – resulting in their symptoms of secondary traumatisation and a lack of compassion and empathy for patients and other hospital staff.

A study conducted by Upton (2018) has similar findings regarding compassion fatigue in acute care nurses. The author found several emotional effects of compassion fatigue to be present in their participants such as emotional exhaustion, emotional numbness, frustration and irritability with patients and work, and a depleted sense of work ethic and motivation. Behaviourally, their findings revealed that most of the participants used emotional avoidance to evade patients. There is great comparability between the results found by Upton and this research study as the acute medical care nurses' experiences with the symptoms of compassion fatigue parallel with what my sample was experiencing.

### Psychological resilience

Psychological resilience as a theme arose due to the key need that nurses develop a strong sense of resilience towards the emotionally overbearing work that they are subjected to. The findings suggest that as time goes by and the nurses experience patient trauma on a regular basis, the stronger their psychological ability to overcome the emotional burden of distressing cases increases. The participants mentioned psychological resilience as becoming second nature and that they have learned the ways in which they best cope with traumatic cases. Yilmaz (2017) notes that resilience is an important strategy for dealing with the challenges related to the nursing profession such as stressors, work-overload, death, inadequate emotional preparation, and traumatic situations. Although some belief resilience to be an inherent ability, my findings suggest that resilience can be a learned strategy that nurses develop over the years as a way of coping with demanding work environments as well as maintaining healthy psychological functioning themselves rather than letting traumatic patient cases affect them long-term. Literature suggests that resiliency training interventions are on the rise for the nursing population. Factors such as education, experience, security, and support are found to be imperative measures for strengthening the resiliency of nurses (Ramalisa, du Plessis & Koen, 2018).

### Psychological impact of traumatic paediatric cases

It is apparent that the experiences of witnessing emergency cases that involve infants, children, and adolescents are complex and multifaceted. The subjective experience of being mothers themselves and employing a sense of innate maternal values seemed to play a major role in their experiences. The findings can be interpreted as the participants having a maternal instinct to protect, care, and nurture a young patient, and it can be easily understood why traumatic incidents involving youth can put the participants in great emotional distress. Additionally, witnessing the traumatic injury, accident, or a stillborn birth can be an understandably traumatic experience if the participant has children of their own. Their ability to empathize with the families and patients seems to be increased by this aspect of their life – being mothers. The upsetting nature of the cases along with their motherly instincts could be linked to their symptoms of PTSD – nightmares, flashbacks, insomnia – as they

all took place because of traumatic paediatric cases. The prominent emotional effects that child and infant death had on the participants corroborate with what Davies et al. (1996) found in their study on nurses' experiences with child death. Their findings suggest that nurses who faced the inevitable death of a child particularly struggled with grief distress and moral distress. The close nurse-patient relationship was seen to contribute to nurses' distress. A study by Lima, Goncalves, and Pinto (2018) researched the traumatic experience of sudden paediatric death on critical care nurses. The authors found that the sudden death of a child or adolescence elicited symptoms of secondary-traumatic stress in the nursing sample. Additionally, their findings suggest that the level and severity of the emotional impact critical nurses had been contingent on other factors such as motherhood. Nurses who are mothers are therefore believed to experience more distress than those who are not.

**Threat of gansterism**

A fear of gang-related violence is inseparable from the local socioeconomic contexts in which the nurses live and work. The high levels of gang warfare in Western Cape state hospitals leave hospital staff and nurses being exposed and vulnerable to theft, muggings, rape, and murder on a regular basis (Swingler, 2014). Socioeconomic factors also play a factor in the nurses' predisposed fear of potential gang occurrences, with three of the participants living in areas beset by gang-related activities. It is believed that their fear and anxiety can be linked to the social context that they and many nurses in the Western Cape are accustomed to. According to Medical Brief (2014) Tygerberg Hospital had been at the epicentre of gang-related incidents over the years. One participant mentioned that her fear of gang-related cases during shifts arose during her nursing training, where she experienced a personal encounter at a taxi rank. Her experience is descriptive of how these nurses' socioeconomic context plays a role in their fear, anxiety, and stress in the hospital. When we look at the theory, the nurses have learned to have a fear response of gangster related incidents. This learned fear-response that develops from the socio-economic environment they live in and constant hearing and experiencing gang-related incidents therefore results in their evasive and avoidant behaviour of gang-related cases in the hospital.

The noted psychological implications that the threat of gangsterism holds on the emergency nurses is consistent with the findings of Kennedy and Julie (2013). Their Cape Town study on emergency nurses' experience with workplace violence revealed that emergency nurses in Cape Town experience physical threats, verbal abuse, psychological abuse, and imminent violence by gangster and non-gangster patients on a regular basis. Their participants revealed that gangster patients display psychological abuse such as disrespect, swearing, rudeness, and demands. These findings are important as their findings also saw nurses using evasive learned behaviour in face of gang-related patients. Furthermore, Kansagra et al. (2008) reported that emergency nurses felt the least safe of all participants studied across 65 emergency departments in the United States. Additionally, Zuzelo, Curran, & Zeserman (2012) found that 92% of nurses expected to be violently assaulted by patients. This corresponds with my findings as majority of the nurses reported feeling unsafe and on edge during night shift due to the high risk of them being assaulted on the job.

## 12. RESEARCH QUESTION, OBJECTIVES & HYPOTHESES ADDRESSED

The primary research question was to examine the ways in which the experiences of patient and workplace trauma affect emergency nurses. The findings obtained have suitably addressed my research question. One way to understand the ways in which patient and workplace trauma affected the participants is to look at their experiences emotionally, cognitively and behaviourally. Emotionally, the nurses were affected through their lack in compassion for patients, their increased irritability and aggressiveness, their heightened sense of apprehensive fear and anxiety, as well as their overwhelming sense of sadness and grief in face of patient death. Cognitively, the nurses experienced intrusive thoughts about patients, nightmares, flashbacks, and anticipated harm in face of gangster-related cases. Behaviourally, the nurses detached themselves from patients, had a heightened sense of avoidance and experienced bouts of insomnia.

### *12.1. Research objective*

The research objective described what was expected of this research study: to examine and decipher the psychological impacts that patient injury trauma has on emergency nurses' psychological well being as well as job performance. The research objective was in part successfully addressed pertaining to psychological well-being, but less so when examining job performance, although aspects of patient interaction and how it is affected by nurses' emotional states have been discussed. For psychological well-being, it was established that in the wake of experiencing patient injury, accidents, near-death, and death, the nurses' own psychological well-being was overtly affected by the traumatic nature of the experience. The following deductions were made about the psychological impacts on their well-being:

- Witnessing acute patient and family suffering and distress resulted in the use of emotional detachment and numbing as a way to cope with the severe psychological effects the experience has on the emergency nurses.
- The emergency nurses were experiencing secondary-traumatic stress as a result of constant exposure to distressing patient trauma and emotional exhaustion which contributed to their lapse in compassion and empathy towards patients.
- The development of psychological resilience through exposure and experience of patient trauma contributed to a stronger ability to mentally and emotionally cope with traumatic cases as one grows older.
- Emergency nurses are particularly distressed and present with the most PTSD symptoms when facing traumatic cases that involve infants, children or adolescents. These cases seem to cause the most psychological implications for them – nightmares, insomnia, and flashbacks etc – due to them being mothers.
- The threat of gangsterism and danger that nurse's face in the emergency department can be directly linked to their feelings of fear, anxiety, stress, and avoidant behaviour of patients and hospital duties.

The research objective regarding whether these psychological responses play a role in how emergency nurses carry out their work was only partially addressed. I was unable to get objective insights on each nurses' experience of job performance

as their answers focused more on how they feel about certain aspects of their job rather than their performance.

### *12.2. Research Hypothesis*

My main hypothesis proposed that emergency nurses who are faced with severe patient and workplace trauma would experience levels of psychological distress such as secondary-traumatic stress, compassion fatigue, and vicarious trauma. My research findings support this hypothesis. The participants were found to have experienced many emotional, affective, and behavioural disturbances when faced with traumatic patient cases. Their psychological distress presented as symptoms of secondary traumatisation, which resulted in their symptoms of compassion fatigue and vicarious trauma (to the lesser extent). Symptoms of post-traumatic stress disorder such as nightmares, insomnia, avoidance, emotional impassiveness, and substance abuse were additionally found in the presence of traumatic paediatric cases.

The second hypothesis saw patient and workplace trauma and on-the-job violence as playing a role in how nurses function within their working life, such as decreased job performance. Due to the lack of data provided by the participants, and lack of interview discussion format needed to access adequate information on the subject, there were insufficient findings to address this particular hypothesis at this time. Work ethic and job performance were not strongly noted as being affected by the traumatic experiences these nurses had in the hospital. Half of the participants believed their experiences contributed to a stronger sense of work pride as a nurse, while the remaining half believed their experiences to be part of the process they have learnt to be devoted to. In response to Questions 13, 14 and 15 majority of the answers did not address a diminished sense of work performance but rather focused on omitting personal experiences from obstructing patient care. Due to the ambiguousness of the answers, the second hypothesis remains open for further research.

## 13. ETHICAL CONSIDERATIONS

Following the Code of Human Research Ethics (2014) as well as the World Medical Association's Declaration of Helsinki (1964), appropriate ethical guidelines were taken into consideration throughout the process of this research study. Participants were fully informed about the details and purpose of the study, as well as receiving a detailed informed consent form where all risks and benefits of the study were specified for them to sign. Participation was voluntary and participants had full autonomy to pull out of the study at any given time, as well as revoking use of their data. Participant names were kept confidential throughout the presentation of the findings. Regarding confidentiality, anonymity, and privacy in an online setting, all transcripts and data files are being securely stored and backed up in both electronic and paper form for a minimum of three years in order to avoid potential ethical risks that could breach participant confidentiality. Pertaining to the topic of the study, extreme caution was taken when considering and presenting the questions to the participants in order to avoid causing potential triggers. The participants were also briefed on what type of questions would be asked and if they were comfortable with answering them. Because trauma is such a complex and intense topic to divulge into, only participants with moderate to high nursing experience were recruited. This was done as to minimize the distress certain topics and questions could cause as younger nurses are noted to have a harder time coping with the traumatic phenomena witnessed in the hospital (Erickson & Grove, 2008).

## 14. LIMITATIONS OF THE STUDY

This restriction of experience however created a specific limitation regarding the type of data collected. This research study would have greatly benefitted from a sample with a varying age ratio as Erickson and Grove (2008) suggest that nurses with under 20 years experience tend to have a more emotionally laborious and stressful time with the demanding nature of patient care. Attaining data from younger, more inexperienced emergency nurses would have facilitated more expressively driven answers to certain topics, especially that of job performance, which could have increased the validity and reliability of the second hypothesis. As such, interpretations of the second hypothesis should be taken with caution due to the limited nature of the data given. Additional limitations concerned the Covid-19

pandemic which created a restriction omitting the use of in-depth interviews with the participants due to the time-constraints placed on Tygerberg Hospital nurses. In addition, the target population I could access was also restricted. The ideal sample would have consisted of three male and three female emergency nurses whose demographic profiling differed concerning ethnicity and culture. Aspects such as cultural background and socioeconomic status are therefore suggested for future research as they may pose a significant influence over nurses' experience and resiliency when facing traumatic phenomena.

## 15. HEURISTIC VALUE AND IMPLICATIONS FOR FUTURE RESEARCH

This research study is the first of its own in South Africa to examine the psychological effects of patient and workplace trauma on emergency nurses. The findings were consistent with the existing literature on the topic, while at the same time adding to the foundation of what is already known. The methodological design, despite its limitations, were successfully adapted in a way that significant findings were deducted that hold great value to psychological research. There, however, remains more to explore on the topic. Suggestions for further research include replication studies as the empirical foundation for this topic would greatly benefit from additional perspectives. Since the foundation of literature is predominantly Western and European based, research in similar demographic contexts as South Africa would broaden our knowledge on the influence of certain aspects such as socioeconomic and cultural influences. Replicated studies should consist of a more diversified sample in order to gain understanding on the multifaceted cultural, gender, and socioeconomic factors that may play a role in the experiences of personal trauma. Differentiating between years of experience, age, gender, and race would allow for a stronger generalizability of the results onto the larger population of emergency nurses.

Methodology and format changes are needed should anyone replicate this study. Altering of the data collection methods to accommodate personal in-depth interviews would aid in more substantial and reliable data and knowledge of what nurses are experiencing and the reasoning behind it. The question concerning job performance gave an underwhelming response from the nurses. Changing the question, or incorporating it into a more discussion-based matter, would elicit more

information on the topic. While the research questions have been addressed, questions still remain on the topic. The question of whether patient and workplace trauma affect job performance still stands as inconclusive. It is suggested that further research be conducted on how patient and workplace trauma affect nurses ability to do their job.

## 16. CONCLUSION

This research study provided evidence for the fact that emergency nurses face various psychological implications in face of traumatic patient and workplace experiences. As evidenced in the findings, the research objectives and hypotheses were substantiated in that the sample experienced majority of what the body of literature asserts – that emergency nurses experience post-traumatic stress disorder, secondary-traumatic stress, compassion fatigue, and vicarious trauma. Much of their distress and emotional trauma was attributed to 5 significant themes: 1) emotional detachment and numbing as a coping strategy, 2) secondary traumatisation and lax in compassion, 3) psychological resilience 4) traumatic paediatric cases, and 5) threat of gangsterism. Being the first of its kind in South Africa, this work is a significant step towards increasing universal and local understanding of the many psychological issues faced by the larger nursing population.

## REFERENCES


Adriaenssens, J. De Gucht, V. & Maes, S. (2012). The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. *International Journal of Nursing Studies*, *49*(11), 1411-1422. https://www.ncbi.nlm.nih.gov/pubmed/22871313

Allen, M. (2017). Survey: Open-ended questions. In *The SAGE encyclopedia of communication research methods.* https://dx.doi.org/10.4135/9781483381411.n608

American Psychological Association. (2020). Trauma and shock. https://www.apa.org/topics/trauma/

American Psychological Association. (2019). Coping with stress at work. https://www.apa.org/helpcenter/work-stress

American Trauma Society. (2020). Traumatic injuries: Diagnosis, treatment and complications. https://www.traumasurvivorsnetwork.org/traumapedias/traumatic-injuries-diagnosis-treatment-and-complications

Atkinson, R. & Shiffrin, R. (1968) *Human Memory: A Proposed System and its Control Processes*. California: Stanford University.

Berg, B., Mealer, M., Rothbaum, B. & Shelton, A. (2006). Increased prevalence of post-traumatic stress disorder symptoms in acute care nurses. *American Journal of Respiratory and Critical Care Medicine*, *175*(7), 606-735. https://www.atsjournals.org/doi/full/10.1164/rccm.200606-735OC

Bisson, J. I., Cosgrove, S., Lewis, C., & Roberts, N. P. (2015). Post traumatic stress disorder. *British Medical Journal, 351.* https://doi.org/10.1136/bmj.h6161

Bleuer, J., & Walz, G. (2016). Vicarious trauma and its influence on self-efficacy. https://www.counseling.org/docs/default-source/vistas/article_2721c024f16116603abcacff0000bee5e7.pdf?sfvrsn=6

Branscome, N. & Baron, R. (2017). *Social Psychology: Fourteenth Edition*. England: Pearson Education.

Brewin, C. & Holmes, E. (2003). Psychological theories of post-traumatic stress disorder. *Clinical Psychology Review*, *23(1)*, 339-376. http://www.gruberpeplab.com/teaching/psych3303_spring2019/documents/3.2_BrewinHolmes_2003.pdf

Brits, W. (2019). Health care nearing crisis due to shortage of nursing staff. https://solidariteit.co.za/en/health-care-nearing-crisis-due-to-shortage-of-nursing-staff/#:~:text=There%20has%20been%20a%20shortage,workforce%2C%E2%80%9D%20Welthagen%20pointed%20out.

British Psychological Society. (2014). Code of Human Research Ethics. Leicester: The British Psychological Society.

Brooks, A. (2018). Emergency nursing: Everything you need to know about being an ER nurse. https://www.rasmussen.edu/degrees/nursing/blog/emergency-nursing/

Cherry, K. (2020). Replication in psychology research. https://www.verywellmind.com/what-is-replication-2795802#:~:text=When%20studies%20are%20replicated%20and,generalized%20to%20the%20larger%20population.

Cheung, A. K. L. (2014). Structured questionnaires. In *Encyclopedia of quality of life and well-being research*. https://doi.org/10.1007/978-94-007-0753-5_2888.

Cocker, F. & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*(6), 618. https://pubmed.ncbi.nlm.nih.gov/27338436/

Danella, N., Hamilton, S., & Heinrich, C. (2017). Posttraumatic stress disorder in critical care nurses. *Nursing Critical Care*, *12*(3), 40-46. https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1097%2F01.CCN.0000515980.94246.40

Davidson, J. E., Proudfoot, J. A., Lee, K., & Terterian, G. (2020). A longitudinal analysis of nurse suicide in the United States (2005-2016) with recommendations for action: Longitudinal analysis of U.S. nurse suicide. *Worldviews on Evidence-Based Nursing, 17*(1), 6-15. https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1111%2Fwvn.12419

Davies, B., Clarke, D., Connaughty, S., Cook, K., MacKenzie, B., McCormick, J., … & Stutzer, C. (1996). Caring for dying children: Nurses' experiences. *Paediatric Nursing, 22*(6), 500-507. https://pubmed.ncbi.nlm.nih.gov/9087087/

DeJonckheere, M. & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, *7*(2), 1-8. https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1136%2Ffmch-2018-000057

Dolan, G., Strodl, E., &Hamernik, E. (2012). Why renal nurses cope so well with their workplace stressors. *Journal of Renal Care, 38*(4), 222-232. https://doi.org/10.1111/j.1755-6686.2012.00319.x

Dominiques-Gomez, E. & Rutledge, D. N. (2009). Prevalence of secondary traumatic stress among emergency nurses. *Journal of Emergency Nursing*, *35*(3), 199-204. https://www.ncbi.nlm.nih.gov/pubmed/19446123

Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing*, *23*(5), 343-350. https://www.svri.org/sites/default/files/attachments/2016-01-13/pdf_0.pdf

du Plooy-Cilliers, F., Davis, C. & Bezuidenhout, R. (2018). *Research Matters.* Cape Town: Juta & Company.

Dyrbye, N., Shanafelt, T. D., Johnson, P. O., Johnson, L., Satele, D. & West, C. P. (2019). A cross-sectional study exploring the relationship between burnout, absenteeism, and job performance among American nurses. *BMC Nursing, 18*(1), 57. https://doi.org/10.1186/s12912-019-0382-7

Erickson, R., & Grove, W. J. C. (2008). Why emotions matter: Age, agitation, and burnout among registered nurses. *Online Journal of Issues in Nursing, 13*(1). https://www.researchgate.net/publication/26571313_Why_Emotions_Matter_Age_Agitation_and_Burnout_Among_Registered_Nurses

Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York, NY: Brunner-Routledge.

Figley, C. R. (Ed.). (2002). Psychosocial stress series, no. 24.Treating compassion fatigue. Brunner-Routledge. https://psycnet.apa.org/record/2002-17425-000.

Flinkman, M., Isopahkala-Bouret, U., & Salantera, S. (2013). Young registered nurses' intention to leave the profession and professional turnover in early career: A qualitative case study. *International Scholarly Research Notices, 2013*(3), 1-12. https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1155%2F2013%2F916061

Foley, B. (2018). What is purposive sampling? https://www.surveygizmo.com/resources/blog/purposive-sampling-101/

Good Therapy. (2019). Emotional overwhelm. https://www.goodtherapy.org/learn-about-therapy/issues/emotional-overwhelm

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3(*1), 42-55. https://doi.org/10.1177%2F160940690400300104

Haddad, M., Annamaraju, P. & Toney-Butler, T. (2020). Nursing shortage. In *StatPearls.* https://pubmed.ncbi.nlm.nih.gov/29630227/.

Kail, R., Cavanaugh, J., & Muller, J. (2019). *Human Development: A Life-Span View*. Great Britain: Ashford Colour Press.

Kansagra, S. M., Rao, S.R., Sullivan, A. F., Gordon, J. A., Magid, D. J., Kaushal, R., … & Blumenthal, D. (2008). A survey of workplace violence across 65 U.S. emergency departments. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine, 15*(12), 1268-74. https://doi.org/10.1111/j.1553-2712.2008.00282.x

Kawulich, B. (2004). Qualitative data analysis techniques. https://www.researchgate.net/publication/258110388_Qualitative_Data_Analysis_Techniques

Kennedy, M. & Julie, H. (2013). Nurses' experience and understanding of workplace violence in a trauma and emergency department in South Africa. *Journal of Interdisciplinary Health Science, 18*(1) 663-672. https://hsag.co.za/index.php/hsag/article/view/663/878

Laposa, J., Alden, L. & Fullerton, L. (2003). Work stress and post-traumatic stress disorder in ED nurses/personnel. *Journal of Emergency Nursing, 29* (1), 23-28. https://pubmed.ncbi.nlm.nih.gov/12556825/

Lederman, C. Osofsky, J. & Putnam, F. (2008). How to maintain emotional health when working with trauma. *Juvenile and Family Court Journal*, *59*(4), 91-102. https://www.researchgate.net/publication/227968103_How_to_Maintain_Emotional_Health_When_Working_with_Trauma

Lima, L., Goncalves, S., & Pinto, C. (2018). Sudden death in paediatrics as a traumatic experience for critical care nurses. *Nursing in Critical Care, 23*(1), 42-47. https://doi.org/10.1111/nicc.12326

Lindberg, S. (2020). What is emotional numbing? https://www.verywellmind.com/emotional-numbing-symptoms-2797372

Marshall, C. & Rossman, G. B. (2006). *Designing Qualitative Research (4th ed.).* Thousand Oaks, CA: SAGE Publications, Inc.

Matshili, R. (2019). The deathly silence of depression and anxiety. https://www.iol.co.za/pretoria-news/the-deathly-silence-of-depression-anxiety-34893365

Maxwell, J.A. (2013). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: SAGE Publications, Inc.

McCelland, D. & Gilyard, C. (2019). Calming trauma: How understanding the brain can help. https://www.phoenix-society.org/resources/calming-trauma

Medical Brief. (2014). Cape Town's Tygerberg Hospital is a shopping centre for crooks. https://www.medicalbrief.co.za/archives/cape-towns-tygerberg-hospital-is-a-shopping-centre-for-crooks/

Pavlov, I.P. (1928). Conditioned reflexes: An investigation of the physiological activity of the cerebral cortex. *Nature*, *121*(3052), 662–664. https://www.nature.com/articles/121662a0

Ramalisa, R. J., du Plessis, E. & Koen, M. P. (2018). Increasing coping and strengthening resilience in nurses providing mental health care: Empirical qualitative research. *Health SA Gesondheid: Journal of Interdisciplinary Health Sciences, 23*(1), 1094, https://dx.doi.org/10.4102%2Fhsag.v23i0.1094

Rispel, L. (1995). Challenges facing nurses in the Republic of South Africa. *Journal of Nursing Scholarship*, *27*(3), 231-234. https://sigmapubs.onlinelibrary.wiley.com/doi/abs/10.1111/j.1547-5069.1995.tb00864.x

Robinson, L., Segal, J., & Smith, M. (2020). Coping with emotional and psychological trauma. https://www.helpguide.org/articles/ptsd-trauma/coping-with-emotional-and-psychological-trauma.htm

Schwarz, T. (2005). PTSD in Nurses: On-the-job trauma may be driving nurses from the profession. *The American Journal of Nursing*, *105*(3), 13. https://www.researchgate.net/publication/232127991_PTSD_in_Nurses_On-the-job_trauma_may_be_driving_nurses_from_the_profession

Sigelman, C. & Rider, E. (2018). *Life-Span Human Development: Ninth Edition*. Boston: Cengage Learning.

Smith, J. & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experiences of pain. *British Journal of Pain*, *9*(1), 41-42.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4616994/

Stanton, N. (2019). Trauma and emergency medicine departments, Tygerberg Hospital, South Africa. https://jewishmedicalassociationuk.org/trauma-and-emergency-medicine-departments-tygerberg-hospital-south-africa/

Swingler, S. (2014). Gang warfare in state hospitals. *Health 24*.https://www.health24.com/News/Public-Health/Gang-warfare-in-state-hospitals-20141006

Upton, K. V. (2018). An investigation into compassion fatigue and self-compassion in acute medical care hospital nurses: A mixed methods study. *Journal of Compassionate Health Care, 5*(7). https://doi.org/10.1186/s40639-018-0050-x

Walsh, M. & Buchanan, M. (2011). The experience of witnessing patients' trauma and Suffering among acute care nurses. *Canadian Journal of Counselling and Psychotherapy, 45*(4), 349-364. https://files.eric.ed.gov/fulltext/EJ956977.pdf

Western Cape Government. (2016). Tygerberg Hospital annual report 2016. https://www.westerncape.gov.za/your_gov/153/documents/annual_reports/2016

World Medical Association. (2018). WMA Declaration of Helsinki- ethical principles for medical research involving human subjects. https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/

Wright, D. (2018). I left nursing because of secondary traumatic stress. https://www.reflectionsonnursingleadership.org/features/more-features/i-left-nursing-because-of-secondary-traumatic-stress

Yilmaz, E.B. (2017). Resilience as a strategy for struggling against challenges related to the nursing profession. *Chinese Nursing Research*, *4*(1), 9-13. https://www.researchgate.net/publication/315728156_Resilience_as_a_strategy_for_struggling_against_challenges_related_to_the_nursing_profession

Zuzelo, P., Curran, S. S., & Zeserman, M. A. (2012). Registered nurses' and behaviour health associates' responses to violent inpatient interactions on behavioural health units. *Journal of the American Psychiatric Nurses Association, 18*(2), 112-26. https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1177%2F1078390312438553

## ANNEXURES

## ADDENDUM A: ETHICAL CLEARANCE


**30 June 2020**

**Student name:** Kelly-Anne Kriel
**Student number:** 17601942
**Campus:** Varsity College Cape Town

**Re: Approval of Honours in Psychology Proposal and Ethics Clearance**

**HONOURS ETHICAL CLEARANCE LETTER**

Your research proposal and the ethical implications of your proposed research topic were reviewed by your supervisor and the campus research panel, a subcommittee of The Independent Institute of Education's Research and Postgraduate Studies Committee.

Your research proposal posed no significant ethical concerns and your supporting documents and instruments are in order to proceed. We hereby provide you with permission to proceed with your research.

In the event of you deciding to change your research methodology in any way, kindly consult your supervisor to ensure all ethical considerations are adhered to and pose no risk to any participant or party involved. A revised ethical clearance letter will be issued.

We wish you all the best with your research!

**ADDENDUM B**


PSYCHOLOGY HONOURS RESEARCH

PARTICIPANT FOLDER

A QUALITATIVE STUDY ON THE PSYCHOLOGICAL IMPACTS OF PATIENT AND WORKPLACE TRAUMA ON EMERGENCY NURSES.

2020

THE INDEPENDENT INSTITUTE OF EDUCATION

## PARTICIPANT CONSENT FORM

**Explanatory information sheet and consent form for participants**

Dear participant,

My name is Kelly-Anne Kriel and I am a student at IIE's Varsity College. I am currently conducting research under the supervision of Dr. Sarah Heany about the psychological impact of patient and workplace trauma on emergency nurses. My research study will therefore investigate the concern that the experiences of traumatic workplace and patient trauma within the field will have a psychological impact on these nurses.

I hope that this research will enhance our understanding of how experiences of patient and workplace trauma can affect nurses' psychological well-being and job performance, as well as providing emergency nurses, as well as the nursing community with a deeper understanding of traumatic experiences relating to their work.

I would like to invite you to participate in my study. In order to explain to you what your participation in my study will involve, I have formulated questions that I will try to fully answer so that you can make an informed decision about whether or not to participate. If you have any additional questions that you feel are not addressed or explained in this information sheet, please do not hesitate to ask me for more information. Once you have read and understood all the information contained in this sheet and are willing to participate, please complete and sign the consent form below.

**What will I be doing if I participate in your study?**

I would like to invite you to participate in this research because your experience as an emergency and/or trauma nurse will provide my research study with insightful information into the topic I am researching. If you decide to participate in this research, I would like you to partake in a confidential questionnaire in which I will ask in-depth questions pertaining to your experiences as an emergency or trauma nurse.

You can decide whether or not to participate in this research. If you decide to participate, you can choose to withdraw at any time or to decide not to answer particular interview questions.

**Are there any risks/ or discomforts involved in participating in this study?**

Whether or not you decide to participate in this research, there will be no negative impacts on you. There are no direct risks or benefits to you if you participate in this study. You might, however, indirectly find that it is helpful to talk about your experiences of patient and workplace trauma, and how that may have caused you any psychological distress. If

you find at any stage that you are not comfortable with the line of questioning, you may withdraw or refrain from participating.

**Do I have to participate in the study?**

- Your inclusion in this study is completely voluntary;
- If you do not wish to participate in this study, you have every right not to do so;
- Even if you agree to participate in this study, you may withdraw at any time without having to provide an explanation for your decision.

**Will my identity be protected?**

I promise to protect your identity. I will not use your name in any research summaries to come out of this research and I will also make sure that any other details are disguised so that nobody will be able to identify you. I would like to ask your permission to store and analyse the questionnaire, but only my supervisor, I and possibly a professional transcriber (who will sign a confidentiality agreement) will have access to your data. Nobody else, including anybody at IIE's Varsity College, will have access to your questionnaire information. I would like to use quotes when I discuss the findings of the research, but I will not use any recognisable information in these quotes that can be linked to you.

**What will happen to the information that participants provide?**

Once I have finished collecting your data, I will write summaries to be included in my research report, which is a requirement to complete my Honours Degree in Psychology. You may ask me to send you a summary of the research if you are interested in the final outcome of the study.

**What happens if I have more questions about the study?**

Please feel free to contact me or my supervisor should you have any questions or concerns about this research, or if there is anything you need to know before you decide whether or not to participate.

You should not agree to participate unless you are completely comfortable with the procedures followed.

My contact details are as follows:
Kelly-Anne Kriel

The contact details of my supervisor are as follows:
Dr. Sarah Heany

PLEASE SIGN THE FOLLOWING

| **Consent form for participants** | |
|---|---|
| I, _____, agree to participate in the research conducted by Kelly-Anne Kriel about a qualitative study on the psychological impact of patient and workplace trauma on emergency nurses.<br>This research has been explained to me and I understand what participation in this research will involve. I understand that: | |
| • I agree to be interviewed for this research. | |
| • My confidentiality will be ensured. My name and personal details will be kept private. | |
| • My participation in this research is voluntary and I have the right to withdraw from the research at any time. There will be no repercussions should I choose to withdraw from the research. | |
| • I may choose not to answer any of the questions that are asked during the research interview. | |
| • I may be quoted directly when the research is published, but my identity will be protected. | |
| | |
| | |
| **Signature** | **Date** |

How can I contact you?

Email: _____

Telephone: _____

Cell: _____

**What is Post Traumatic Stress Disorder?**

Posttraumatic Stress Disorder is an enduring mental health condition that is triggered by a terrifying event – either experiencing it or witnessing it. PTSD is a common occurrence in nurses who are in a setting consumed by experiences of or witnessing acute trauma and death. Symptoms may include nightmares, sever anxiety, flashbacks, uncontrollable thoughts, substance abuse, as well as insomnia.

**What is Secondary Traumatic Stress Disorder?**

Secondary Traumatic Stress is trauma resulting from caring for, hearing about or witnessing the intense suffering of others. Over time, the cumulative effect can result in an internalization of trauma, leading to compassion fatigue or burnout. Symptoms include fatigue, apathy towards patients, mood swings, feeling numb or detached, engaging in self-destructive behaviour to forget about work.

**What is Compassion Fatigue?**

Compassion Fatigue is a condition linked to Secondary Traumatic Stress. It is characterized by emotional and physical exhaustion leading to a diminished ability to empathize or feel compassion for others. Symptoms include avoidance or dread of working with patients, reduced ability to feel empathy for patients, frequent use of sick days, decreased intimacy, and detachment.

**What is Vicarious Trauma?**

Vicarious trauma is the indirect trauma and emotional residue that health care workers experience when working with trauma or emergency patients. Hearing, witnessing and caring for patients' pain, fear, and terror often results in this phenomenon. Symptoms include avoiding talking about how patient trauma has effected them, difficulty talking about their feelings, startle effect/being jumpy, losing sleep over patients, feeling trapped by their work, as well as attempting to avoid working with trauma patients.

**What is Burnout?**

Burnout is a state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress. It occurs when one feels overwhelmed, emotionally drained, and unable to meet demands. For nurses, this widespread phenomenon is characterized by a reduction in nurses' energy that manifests in emotions exhaustion, lack of motivation, and reduced work efficacy. Further symptoms include work-related cynicism, inability to make decisions, sleep disorders, constant fatigue, and reduced performance.

Participant Questionnaire

- While answering the questions below, write a few sentences or a paragraph of freely flowing thought about your experiences.
- Longer answers will allow me to gather a stronger understanding of your unique experiences.
- If you are unsure of the terminology, kindly refer back to the information sheet provided.
- A reminder that all of your responses and data are entirely confidential prior to analysis.

NAME: _____ AGE: _____ DATE: _____

1. Please tell me a little bit about yourself and your profession.

2. How long have you been working/worked as a nurse in the trauma and/or emergency department?

3. Can you share some of the experiences that you've encountered with patient trauma while working in the emergency and/or trauma department? Would you label these specific experiences as traumatic for you?

4. Have you experienced any psychological distress or emotional trauma (e.g. upsetting emotions, anxiety, acute stress) when faced with the abovementioned experiences either during the incident or after? If so, please elaborate.

5. Working with patients who have just been in car accidents, shootings or are in need of being resuscitated, for example, are situations in which nurses can feel inundated with emotion, stress and anxiety. Do you believe that these situations in excess could cause emotional trauma for the nurse? If so, please explain why.

6. Do you believe that your own traumatic experiences of patient and workplace trauma play a role in how you function within your working life? Please explain your answer.

7. Have you encountered symptoms of irritability, depression, anxiety, hyperarousal, avoidance of patients, flashbacks and/or numbing of emotional responsiveness regarding specific events in the hospital? If so, please elaborate in detail your experience.

8. Referring to the brief attached, are there any symptoms of Posttraumatic Stress Disorder, Secondary Stress Disorder, Compassion Fatigue, and/or Vicarious Trauma you have experienced while working in the emergency or trauma department? If yes, please explain your exact experience with the mentioned disorders.

9. In your own opinion, why do you think that emergency/trauma nurses have such a strong emotional and psychological reaction to patient and workplace trauma?

10. Throughout your years of being a nurse, how has working with patient trauma affected you emotionally?

11. Workplace violence poses a risk to many nurses when caring for inmate patients and patients from gang-related areas, what are your experiences with violence in the hospital?

12. How has violence/aggression from patients affected you emotionally and psychologically?

13. Regarding job performance, when faced with your own trauma and distress, do you think that it has an impact on how you carry out your work? If so, please elaborate on how it affects your work-focus and decision making.

14. Have you ever experienced work burnout while working in these departments? If so, kindly elaborate on your experience with burnout and how you dealt with it.

15. Based on your own traumatic experiences in the workplace, where there ever times in which you did not want to show up to work in fear of re-experiencing such events? Additionally, have you ever considered leaving the nursing profession due to your unique experiencing in the trauma/emergency departments?

16. Lastly, have you been provided with or sought out psychological resources or services such as counselling, therapy and/ or trauma debriefing when faced with distressing experiences? Do you think that these resources would have been beneficial to you when dealing with trauma?

End of questionnaire.

THE INDEPENDENT INSTITUTE OF EDUCATION

Join us at a FREE Online

# Trauma, Anxiety & Post Traumatic Stress Disorder Support Group

When
Sunday, 30th of August 2020
(Launch)

Where
Contact Jamie-Lee for Zoom meeting details
Time
4pm

For more Info & to RSVP
Jamie-Lee: 079 778 5718

HEALTHCARE WORKERS
CARE NETWORK
Caring for the Carers by the Carers

## Join an Online Support Group For Healthcare Workers

If you are feeling lonely, isolated, overwhelmed, or just in need of a good chat with colleagues, we are running a small group for all healthcare workers who would like to share experiences about how they're finding life at work and at home right now.

Anna Schmidt-Ehmcke and Lauren Gower are psychologists and they will be facilitating the group which will meet on Saturdays weekly for approximately one hour at 1:30 pm.

The group will be hosted on Zoom, it is free, voluntary, and will be confidential.

If you're interested in joining the group, please Whatsapp Lauren on +27 826885957 or email hwcngroups@gmail.com

24 Hour Helpline 0800 21 21 21 SMS 43001

| | |
|---|---|
| SADAG Office | 011 234 4837 |
| Suicide Crisis Helpline | 0800 567 567 |
| Dr Reddy's Mental Health Helpline | 0800 21 22 23 |
| Pharma Dynamics Trauma Helpline | 0800 20 50 26 |
| Adcock Ingram Depression and Anxiety Helpline | 0800 70 80 90 |
| ADHD Helpline | 0800 55 44 33 |
| Destiny Helpline | 0800 41 42 43 |
| HDI "You Decide" Youth Helpline | 0800 33 33 77 |
| 24 Hour Substance Abuse Helpline | 0800 12 13 14 |

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

WEBSITE: www.sadag.org EMAIL: zane1@medport.co.za SMS: 31393

The South African Depression and Anxiety Group TheSADAG

**Final Research Report Summary Document**

**TITLE: A Qualitative Study on the Psychological Impacts of Patient and Workplace Trauma on Emergency Nurses.**

<table>
<tr><td>Research Purpose/Objective</td><td>Primary Research Question</td><td>Research Rationale</td><td>Seminal authors/ Sources</td><td>Literature Review- Conceptual framework</td><td>Paradigm</td><td>Approach</td><td>Data Collection Methods</td><td>Ethics</td><td>Key Findings</td><td>Recommen-dations</td></tr>
<tr><td rowspan="2">To examine and decipher the psychological impacts that traumatic patient phenomena has on emergency nurses' psychological well-being as well as job performance.</td><td rowspan="2">In what ways do the experiences of patient and workplace trauma affect emergency nurses emotionally and psychologically?</td><td rowspan="2">To improve upon the gap in literature using exploratory and descriptive measures. To provide insight into the topic in a S.A. context.</td><td rowspan="2">Walsh & Buchanan (2011)<br><br>Adriaenssens, de Gucht and Maes (2012)</td><td rowspan="3">Traumatic patient cases.<br><br>Psychological implications of patient trauma – PTSD, STS, CF.<br><br>Job performance and work violence.<br><br>Resiliency in nursing.</td><td rowspan="3">Interpretative design using exploratory and descriptive measures to identify and describe the subjective experiences of emergency nurses.</td><td>Qualitative</td><td rowspan="2">Interpretative phenomenological approach – revised structured questionnaire consisting of 16 open-ended questions.</td><td rowspan="2">This study omitted the participation of emergency nurses with under 25 years of experience in order to mitigate potential distress.</td><td rowspan="2">The nurses used emotional detachment as a coping strategy.<br>They experienced symptoms of secondary traumatisation and compassion fatigue.<br>Their experiences were found to be influential in developing a stronger sense of resilience.<br>They experienced the most emotional distress and symptoms of PTSD in face of traumatic paediatric cases due to their motherly instincts.<br>The threat of gangsterism in Cape Town made them fearful and evasive of gang-patients.</td><td rowspan="3">Replication studies in differing contexts for additional perspectives.<br><br>Methodology update in order to fit qualitative interviews.<br><br>Further insights into job performance.</td></tr>
<tr><td>Population<br><br>Emergency and trauma nurses.<br><br>Accessible: Emergency nurses at Tygerberg Hospital.</td></tr>
<tr><td>Research Problem</td><td>Secondary Questions/ Hypotheses/ Objectives</td><td>Key Concepts</td><td>Key Theories</td><td>Sampling</td><td>Data Analysis Methods</td><td>Limitations</td><td>Key Contribution</td></tr>
<tr><td>Abundance of traumatic cases are being found to negatively affect the psychological health of emergency nurses. There is a global nursing shortage which can be linked to the distressing nature of their</td><td>Sub question: do the experiences of workplace trauma play a role in how nurses function within their working life?</td><td>Emergency nurses<br>Patient trauma<br>Emotional trauma<br>Psychological distress<br>Psychological impact/effect<br>High work-stress environment<br>PTSD<br>STS/CF/VC</td><td>Classical conditioning theory (Pavlov, 1928)<br><br>Information processing theory (Atkinson & Shiffrin, 1968)</td><td></td><td></td><td>Purposive. 6 female emergency nurses currently working at Tygerberg Hospital with over 30 years of experience.</td><td>Adopted 6-step phenomenological analysis approach from Walsh and Buchanan (2011)</td><td>Covid-19 placed restrictions on the accessible population as well as restricted me from conducting in-depth interviews.</td><td>Significant in adding to the body of literature and filling in the local gap. Adds additional insight and confirmation of the various psychological</td><td></td></tr>
</table>

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **work.** | | | | | | | | | **impacts.** | |