

# **SECONDARY TRAUMATIC STRESS AMONG MENTAL HEALTH PRACTITIONERS IN BUTABIKA AND MULAGO REFERRAL HOSPITALS IN UGANDA**

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**Abstract**

*Secondary Traumatic Stress (STS) leaves the care-givers feeling anxious, confused, depressed and depleted. This research aimed at establishing the prevalence of secondary traumatic stress among Mental Health Practitioners (MHPs) in Butabika and Mulago referral hospitals in Uganda. Simple random sampling was used to select a sample of 123 respondents, 61 from Butabika and 62 Mulago hospitals. The study used a retrospective cohort study design. Categorical variables were summarized as frequencies and corresponding percentages while continuous variables were summarized as frequencies, means and standard deviations. Chi-square tests were used to check association between variables in the two cohorts ( $P$ -value =0.05). The study revealed that 27.9 % of the MHPs from Butabika hospital and 32.3% from Mulago hospital had STS. The study showed that some MHPs in both hospitals were fatigued and recommended psychological care services for them.*

**Keywords:** Secondary traumatic stress, compassion fatigue,

**1.1 Introduction**

Traumatic experiences have overwhelmed mankind since time immemorial and still show no sign of letting up. From natural disasters like hurricanes, floods and mudslides, to man-made calamities such as automobile accidents, terrorist acts of violence, sexual abuse and torture have resulted in serious and chronic emotional and behavioral problems that are difficult to treat. Those who experience and perceive traumatic events are at risk of psychological disorders, including Post Traumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), major depression, anxiety, and drug abuse (Gold, 2008; Ozer, Best, Lipsey, & Weiss, 2003).

According to Norris and Slone (2013), by the start of adulthood, at least 25% of the population will have experienced a traumatic event, and by the age of 45, most of the population will have experienced one or more traumatic events. To nurture the primary victims who have experienced painful agony and subsequent psychological disturbances, treatment often includes mental health services (Elhai, Patrick, & Anderson, 2006; Gavrilovic, Schutzwohl, & Fazel, 2005; Williams, Helm, & Clemens, 2012). This creates an overload on MHPs and may take a toll on their emotional, psychosocial and physical well being. They are exposed to emotionally shocking stories, images of horror, pain and suffering which require them to be supportive and empathetic on a regular basis. In the process, they become victims of compassion fatigue or Secondary Traumatic Stress (Coetzee & Klopper, 2010; Choi, 2011; MacRitchie & Leibowitz, 2010; Newell & MacNeil, 2010; Ringel & Brandell, 2012).

Lombardo and Eyre (2011) defined STS as a combination of physical, emotional, and spiritual depletion related to caring for clients in major emotional agony and physical anguish. It is a stress response resulting from witnessing or knowing about the pain experienced by significant others (Bride, Robinson, Yegidis & Figley, 2004; Huggard, 2003). It leads to reduced capacity to provide empathy when caregivers focus on clients without practicing self-care (Deighton, Gurriss & Traue, 2007; Sabo, 2006).

STS affects all those involved in a care-giving relationship including psychiatrists, family practitioners, journalists, teachers, librarians, firefighters, Red Cross volunteers, physicians, psychiatrists, physical healthcare professionals, police, legal counsel and clergy among others. It can even affect others like community workers, family, friends and co-workers (Rank, Zaparanick & Gentry, 2009; Coetzee & Klopper, 2010; Mathieu, 2012).

The adverse emotional, physical and psychological impact of working directly with people experiencing pain has been documented (Bride, Hatcher & Humble, 2009; DuBois, 2010). It may result in anxiety, hyper arousal, memory problems, poor concentration, poor judgment, restlessness, mood swings, intrusive thoughts, gastrointestinal problems, muscle tension, headache, cardiac symptoms, sleep disturbances,

apathy, irritability, avoidance, depression, substance abuse, inefficiency and uncertainty about personal safety, poor service quality and absenteeism, eventually quitting the profession (Fetter, 2012; Galek, Flannelly, Greene, & Kudler, 2011; Gorman & Brooks, 2009; Wentzel & Brysiewicz, 2014). In short the affected are at risk of causing harm to their clients and are therefore not fit to practice (American Counseling Association, 2005; American Psychological Association, 1992; Boyle, 2011). Ager et al., (2012) studied the mental health of 376 Ugandan social workers at 21 humanitarian aid agencies and found out that a significant number of the respondents experienced symptoms of STS. That is, 68% had depression, 53% had anxiety disorders and 26% had PTSD. This indicates an alarmingly high number of those at risk of STS.

### **1.2 Rationale for this study**

Butabika is the only National psychiatric referral hospital while Mulago is the only National general hospital in Kampala, Uganda. The researchers worked on the assumption that there existed a significant difference between the STS levels of the MHPs in the two hospitals which serve an estimated population of 3.1 million people. Thus MHPs in these hospitals have heavy mental client's caseloads to deal with. For example in the financial year 2009/2010, Butabika alone provided inpatient mental health care to 4,394 first time admissions and 1,752 readmissions. This suggests that there were at least 6,146 admissions for mental disorders at the tertiary level in one year (Ndyanabangi et. al, 2012). Such overwhelming figures make MHPs in the two hospitals vulnerable to secondary traumatic stress. Given the impact of STS, Figley (2002) observed "it is, therefore up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise, we will lose clients and compassionate mental health psychotherapists" (p. 1440). Although the psychological, physical and emotional consequences of providing social support and care to traumatized clients have been documented in many countries, there seems to be no studies on MHPs working in Butabika and Mulago Hospitals. The purpose of the present study was to investigate the prevalence of secondary traumatic stress in a sample of MHPs in Butabika and Mulago National Referral Hospitals.

### **1.3 Objectives**

The study was guided by the following objectives:

- i. To compare the levels of secondary traumatic stress of MHPs in Butabika and Mulago national referral hospitals in Uganda.
- ii. To determine the demographic factors associated with secondary traumatic stress among MHPs in both Butabika and Mulago national referral hospitals in Uganda

### **2.0 Research Method**

The sample size consisted of 123 MHPs, 61 from Butabika and 62 from Mulago using a retrospective cohort study design. Data was collected using the Professional Quality of Life Questionnaire and analyzed using STATA version 18.0 Special Edition. Categorical variables were summarized as frequencies and corresponding percentages while continuous variables were summarized as frequencies, means and standard deviations. Non-parametric tests were used to check association between variables in the two cohorts. (P-value =0.05).

### **3.0 Results**

The first objective was to compare the levels of secondary traumatic stress of MHPs in Butabika and Mulago national referral hospitals in Uganda. The findings are tabulated in table 1

**Table 1:** Secondary Traumatic Stress levels in Butabika and Mulago Hospitals

MHPs cohorts	ProQAL scale scores (STS Sub-scale)		
	Stressed N (%)	Not Stressed N (%)	Total (%)
Butabika	27.9	72.1	100
Mulago	32.3	67.7	100

MHPs from the cohorts above experienced STS. More than a quarter (27.9%) working in Butabika hospital had developed STS compared to 32.3% of MPHs working in Mulago hospital. 72.1% and 67.7% were not stressed in the cohorts of MHPs working in Butabika and Mulago hospitals respectively.

The second objective was to determine the demographic factors associated with secondary traumatic stress among MHPs in both Butabika and Mulago national referral hospitals in Uganda. Table 2 outlines the findings

**Table 2** Demographic factors associated with secondary traumatic stress

MHPs characteristics		Butabika		Mulago	
Age		Fatigued	Not fatigued	Fatigued	Not fatigued
	20-24 years	1	1	1	2
	25-29 years	6	19	8	17
	30-34 years	3	11	6	8
	>35 years	7	13	5	15
		Chi square= 1.4683 p-value 0.6896		Chi square= 1.2042, p-value 0.751992	
Profession	Psychiatrists	17	20	20	24
	Counsellors	0	12	0	1
	Social workers	0	12	0	17
		Chi square= 15.2875, p-value 0.000479		Chi square=12.0779 p-value 0.002384	
Work experience	<5Years	7	23	11	33
	5-10 Years	5	18	6	4
	>10 Years	5	3	3	5
		Chi square= 5.5098, p-value 0.063616		Chi square= 5.5098, p-value 0.063616	
Gender	Gender	3	8	4	8
	Gender	14	36	16	34
		Chi square= 0.0024, p-value 0.961153		Chi square=0.0079 p-value 0.929296	

Results show no significant association between age and STS; gender and STS and working experience and STS in both cohorts. However, there was a significant association between profession and STS, especially for psychiatrists.

#### 4.0 Discussion

The first objective was to compare the levels of secondary traumatic stress of MHPs in Butabika and Mulago national referral mental hospitals in Uganda. The study revealed that 27.9 % of the MHPs in Butabika hospital and 32.3% of the MHPs in Mulago hospital had STS. These results suggest a uniformity of scores of MHPs and reveal no significant difference between the MHPs in the two facilities. However more than a quarter of MHPs in the two hospitals need to consider the impact their work is having on them and take preventive care to address the current indicators of STS. This is so with the psychiatrists.

The second objective was to determine the demographic factors associated with secondary traumatic stress among MHPs in both Butabika and Mulago hospitals in Uganda. The results showed that there was no association between demographics and STS in both cohorts of MHPs except for the different professions. Some of the findings agree with studies done by Nyenga et al., (2004) following the bombing of US embassy in Nairobi-Kenya and Simpson (2005). The study concluded that age, race, gender and years of experience have no significant predictive relationship with the potential for development of STS symptoms. There were significant differences between professions and STS. It should be noted that most studies of STS do not examine the differences in Scores and levels of STS in different professions involved in care-giving. However, Steed and Bicknell (2001) found that psychologists scored significantly lower on STS than social workers.

#### 5.0 Recommendations

MHPs in the two hospitals need to consider the impact their work is having on them and take preventive care to address the current indicators of STS. Otherwise they will become wounded healers. There is therefore need to support all MHPs with psychological and social services whether they have signs of STS or not.

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