



International Journal of Research Publication and Reviews

Journal Homepage: www.ijrpr.com ISSN 2582-7421

Secondary Traumatic Stress and Psycho-Spiritual Wellbeing of Emergency Physicians in Abuja, Nigeria

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ABSTRACT:

Burnout among emergency physicians is a global concern, yet the spiritual and existential dimensions of distress captured by constructs such as secondary traumatization remain underexplored in Nigeria. This study investigated secondary traumatic stress (STS) and psycho-spiritual wellbeing among doctors in the Accident and Emergency (A&E) Unit of Abuja University Teaching Hospital (AUTH), Gwagwalada. Employing a mixed-method embedded design, data were collected from 80 doctors through total population sampling, with 74 valid responses (92.5%). Quantitative measures included the Professional Quality of Life Scale (ProQOL v5) and the Psycho-Spiritual Wellbeing Scale (P-SWBS), analysed using descriptive statistics, Pearson correlation, and multiple regression. A qualitative strand comprised semi-structured interviews with five purposively selected doctors, thematically analysed. Results indicated high STS (45.9%), burnout (45.9%), and overall secondary trauma (43.2%). Despite these challenges, 56.8% reported high psycho-spiritual wellbeing, with compassion the strongest domain ($M = 4.02$) and self-transcendence the weakest ($M = 3.47$). Secondary trauma correlated negatively with psycho-spiritual wellbeing ($r = -0.624$, $p < .05$), while STS and burnout jointly explained 47.7% of its variance ($R^2 = .477$), with STS the stronger predictor ($\beta = -0.417$). Coping strategies centred on prayer, meaning-making, and peer support, whereas professional counselling was least utilised. Findings suggest that burnout and psycho-spiritual distress are related but distinct phenomena. Addressing workload alone leaves the erosion of meaning, purpose, and spiritual vitality unaddressed. Integrating psycho-spiritual care, structured debriefing, and accessible counselling into Nigeria's health systems is essential to safeguard the wellbeing of emergency physicians.

Key Word: Burnout; Psycho-spiritual wellbeing; Secondary traumatic stress; Emergency physicians; Nigeria; Spiritual coping; Healthcare policy.

1. Introduction

The Accident and Emergency (A&E) unit of a modern hospital operates as a crucible of urgency, crisis, and unrelenting confrontation with human suffering. Doctors deployed to this frontline are trained to manage the primary trauma of their patients, yet they remain acutely vulnerable to a quieter injury: secondary traumatic stress (STS), a psychological change that arises from empathic engagement with the trauma of others¹. Unlike burnout, which develops gradually from chronic workplace stressors such as long hours and heavy caseloads, STS mirrors post-traumatic stress disorder in its intrusive thoughts, avoidance, and hyper-arousal, and is acquired indirectly, through bearing witness^{2,3}.

Burnout has, in the last decade, become the dominant lens through which the medical profession understands physician distress. Yet burnout, built around exhaustion, depersonalisation, and reduced accomplishment, was never designed to capture what happens to a healer's sense of meaning, purpose, and connection to the sacred when that healer works, week after week, inside rooms where death is, in the words of one respondent in this study, "almost a daily experience." This is the terrain of psycho-spiritual distress: the erosion, not merely of energy, but of the deeper architecture of belief, calling, and hope that first drew many doctors into medicine.

This article draws on an empirical dissertation study conducted among 74 medical doctors in the A&E Unit of the Abuja University Teaching Hospital (AUTH), Gwagwalada, Nigeria, which examined the influence of secondary traumatic stress on psycho-spiritual wellbeing using an integrated theoretical framework: the Psycho-Spiritual Wellbeing (PSWB) Theory⁴, Vicarious Traumatization Theory⁵, and Secondary Traumatic Stress Theory^{2,3}. Building on that study's findings, this article argues that mental-health support for Nigerian emergency physicians must move beyond burnout to explicitly integrate psycho-spiritual care such as counselling, spiritual accompaniment, resilience training, and institutional reform into a single, coherent architecture of support.

The inquiry was given contemporary urgency by the death of Ifunanya Nwangene, a 26-year-old Abuja-based singer, on 31 January 2026, following a venomous snake bite and a desperate search across facilities for anti-venom⁶. Cases such as hers, where outcomes are tragic despite clinicians' best efforts and where public scrutiny intensifies the emotional burden, illustrate the raw material of secondary trauma that Nigerian emergency doctors absorb as a routine feature of their vocation.

Three gaps motivated the study: the unknown prevalence of psycho-spiritual injury among Nigerian emergency doctors; the unclear role of faith as either a coping resource or a vulnerability; and the absence, in the local literature, of a framework linking secondary trauma to spiritual distress rather than treating each in isolation⁷. This article addresses these gaps by synthesising the study's quantitative and qualitative findings around four focus areas: the distinction between burnout and psycho-spiritual distress; the role of faith and meaning in resilience; practical strategies hospitals can adopt; and the implications for healthcare policy in Nigeria.

2. Material and Methods

This study adopted a mixed-method embedded design, in which a quantitative cross-sectional survey formed the primary strand and a qualitative interview component was embedded to explain and enrich the statistical findings. The study population comprised all eighty (80) medical doctors working in the A&E Unit of the Abuja University Teaching Hospital, Gwagwalada, cutting across House Officers, Medical Officers, Junior and Senior Registrars, Consultants, and Emergency Medicine Physicians. Given the relatively small and accessible size of this population, a total population (census) sampling technique was adopted. Eighty structured, self-administered questionnaires were distributed; 74 were returned properly completed, yielding a response rate of 92.5%.

Secondary traumatic stress and burnout were measured using the Professional Quality of Life Scale (ProQOL Version 5), developed by Beth Hudnall Stamm, which has reported Cronbach's alpha coefficients ranging from .75 to .88 across subscales. Psycho-spiritual wellbeing was measured using the Psycho-Spiritual Wellbeing Scale (P-SWBS), developed by Egunjobi and colleagues, which assesses five domains: self-awareness, connectedness, meaningfulness, compassion, and self-transcendence. Descriptive statistics summarized the prevalence of STS, burnout, and psycho-spiritual wellbeing; the Pearson Product-Moment Correlation Coefficient determined the strength and direction of the relationship between secondary trauma and psycho-spiritual wellbeing; and Multiple Regression Analysis determined the predictive contribution of STS and burnout to variance in psycho-spiritual wellbeing.

Due to the demanding schedules of emergency practice, the embedded qualitative strand employed semi-structured telephone interviews with five purposively selected doctors (coded P1–P5), lasting ten to twenty minutes each. Interviews were audio-recorded with consent, transcribed verbatim, and analysed thematically around four guiding questions concerning doctors' experience of secondary traumatic stress, their psycho-spiritual wellbeing, the effect of trauma exposure on their emotional and spiritual functioning, and the strategies they use to cope. Ethical approval followed informed consent, guaranteed anonymity, and a referral pathway to counselling for any participant who experienced distress during the study.

3. Result

Table 1: Demographic and Occupational Characteristics of Respondents (N = 74)

Variable	Frequency (f)	Percentage (%)
Sex		
Male	46	62.2
Female	26	35.1
Prefer not to say	2	2.7
Age Group		
27–29 years	18	24.3
30–39 years	34	45.9
40–49 years	16	21.6
50 years and above	6	8.1
Marital Status		
Single	28	37.8
Married	42	56.8
Divorced	3	4.1
Widowed	1	1.4
Professional Rank		
House Officer	10	13.5

Variable	Frequency (f)	Percentage (%)
Medical Officer	18	24.3
Registrar	22	29.7
Senior Registrar	14	18.9
Consultant	10	13.5
Years of Practice as a Medical Doctor		
Less than 5 years	24	32.4
5–10 years	28	37.8
11–15 years	14	18.9
16 years and above	8	10.8
Length of Service in the A&E Unit		
Less than 1 year	16	21.6
1–3 years	30	40.5
4–6 years	18	24.3
More than 6 years	10	13.5
Average Hours Worked per Week		
Less than 40 hours	4	5.4
40–59 hours	20	27.0
60–70 hours	34	45.9
80 hours and above	16	21.6

The sample was predominantly male (62.2%) and married (56.8%), with most respondents aged 30–39 years (45.9%) and holding the rank of Registrar (29.7%). Workload was heavy: 45.9% of doctors worked between 60 and 70 hours per week, and a further 21.6% worked 80 hours or more.

Table 2: Levels of Secondary Traumatic Stress, Burnout, and Overall Secondary Trauma

Construct	Low (%)	Moderate (%)	High (%)
Secondary Traumatic Stress (STS)	16.2	37.8	45.9
Burnout	13.5	40.5	45.9
Overall Secondary Trauma	14.9	41.9	43.2

Nearly half of the sample (45.9%) reported high levels of both STS and burnout, and 43.2% reported high overall secondary trauma. These findings align with global evidence that emergency healthcare workers are highly vulnerable to trauma exposure through continuous contact with critically ill and dying patients (DeLucia et al., 2019).

Table 3: Psycho-Spiritual Wellbeing Domains (Mean Scores)

Domain	Mean	SD	Interpretation
Self-Awareness	3.88	0.71	High
Connectedness	3.74	0.69	High
Meaningfulness	3.61	0.75	High
Compassion	4.02	0.64	High

Domain	Mean	SD	Interpretation
Self-Transcendence	3.47	0.73	High
Overall Mean	3.74	0.70	High

Compassion recorded the highest mean score ($M = 4.02$), followed by self-awareness ($M = 3.88$) and connectedness ($M = 3.74$), while self-transcendence recorded the lowest mean score ($M = 3.47$).

Table 4: Levels of Overall Psycho-Spiritual Wellbeing

Level	Frequency (f)	Percentage (%)
Low	8	10.8
Moderate	24	32.4
High	42	56.8
Total	74	100.0

Overall, 56.8% of respondents reported high psycho-spiritual wellbeing, 32.4% reported moderate levels, and only 10.8% reported low levels.

Table 5: Relationship between Secondary Trauma and Psycho-Spiritual Wellbeing

Variables	Mean	SD	r-value	p-value	Decision
Secondary Trauma	3.81	0.68	-0.624	0.000	Significant
Psycho-Spiritual Wellbeing	3.74	0.70	—	—	—

A significant negative relationship was found between secondary trauma and psycho-spiritual wellbeing ($r = -0.624$, $p < .05$): as secondary trauma increased, psycho-spiritual wellbeing decreased.

Table 6: Multiple Regression Analysis Showing the Predictive Effect of STS and Burnout on Psycho-Spiritual Wellbeing

Variables	B	Beta (β)	t-value	p-value
Constant	4.892	—	8.214	0.000
Secondary Traumatic Stress	-0.381	-0.417	-4.866	0.000
Burnout	-0.296	-0.352	-4.012	0.001

Model Summary: $R = .691$, $R^2 = .477$, Adjusted $R^2 = .462$, $F = 32.411$, $p < .001$. STS and burnout jointly explained 47.7% of the variance in psycho-spiritual wellbeing. Secondary traumatic stress exerted the stronger negative effect ($\beta = -0.417$), followed by burnout ($\beta = -0.352$).

Table 7: Strategies Used to Improve Psycho-Spiritual Wellbeing

Strategy	Mean	SD	Interpretation
Personal prayer, meditation, or reflection	4.31	0.66	Very Often
Reflecting on meaning and purpose of work	4.12	0.68	Often
Participation in religious/spiritual activities	4.08	0.71	Often
Emotional support from colleagues	3.92	0.73	Often
Peer debriefing after traumatic cases	3.88	0.70	Often
Seeking spiritual guidance	3.81	0.80	Often
Taking regular rest and time off work	3.74	0.78	Often

Strategy	Mean	SD	Interpretation
Physical exercise or relaxation techniques	3.69	0.76	Often
Professional counselling or psychotherapy	3.26	0.92	Sometimes
Grand Mean	3.87	0.75	Often

Personal prayer, meditation, and reflection were the most frequently used coping strategy ($M = 4.31$), while professional counselling and psychotherapy were the least utilised ($M = 3.26$).

Table 8: Profile of Qualitative Interview Participants

Participant	Rank	Years in A&E	STS Level
P1	Registrar	4	High
P2	Medical Officer	2	High
P3	Medical Officer	6	High
P4	Senior Registrar	6	Moderate
P5	House Officer	1	Low

The qualitative interviews illuminated the quantitative figures. Participants described the cumulative weight of loss: “In emergency medicine, death is almost a daily experience. Some cases remain in my mind long after I leave the hospital” (P1); “Many times, we do everything possible, yet we still lose patients. Those experiences stay with you for so long that you just feel like quitting the profession” (P2). Yet alongside this strain, participants described a resilient core of meaning: “Even with the stress, I still find meaning in helping patients and saving lives” (P4); “My work reminds me that life is sacred, and that keeps me grounded” (P5). Others described the specifically spiritual cost of the work: “The burden is not only physical. It affects your mind, emotions, and even your relationship with God” (P4).

On coping, prayer emerged repeatedly: “Prayer is my greatest source of strength. It helps me continue despite difficult experiences” (P2); “When I remember that I am helping people, it gives meaning to the sacrifices” (P3). Peer relationships also mattered: “Talking to colleagues after difficult cases helps reduce the emotional burden” (P1). At the same time, participants were candid about the limited uptake of formal psychological support: “Many doctors rarely seek counselling even when they need it” (P2); “There is still some stigma attached to seeking psychological support” (P4).

4. Discussion

4.1 Burnout versus Psycho-Spiritual Distress

The findings support a conceptual distinction that Nigerian healthcare policy has yet to make explicit. Burnout, as conventionally defined, centres on exhaustion, depersonalisation, and reduced sense of accomplishment arising from chronic occupational stressors such as long hours and heavy caseloads, and indeed, 45.9% of doctors in this study reported high burnout under conditions of gruelling workload, with nearly half working 60 hours or more per week. But Vicarious Traumatization Theory⁵ points to a different, deeper injury: an enduring, structural change in a helper’s worldview, trust, and most relevant here, their spirituality and sense of meaning. The study’s data give this distinction empirical weight. While compassion, the most interpersonally expressed domain of psycho-spiritual wellbeing, remained the strongest ($M = 4.02$), self-transcendence — the domain most concerned with existential integration and connection to the sacred — was consistently the weakest ($M = 3.47$). Doctors, in other words, may continue to function, to care, and to show up, even as the deepest layer of their spiritual and existential stability quietly erodes.

This distinction is reinforced by the regression findings: STS and burnout jointly explained 47.7% of the variance in psycho-spiritual wellbeing, with STS — the trauma-exposure variable, not the workload-exhaustion variable — carrying the stronger predictive weight ($\beta = -0.417$ versus $\beta = -0.352$ for burnout). This suggests that what is corroding doctors’ psycho-spiritual wellbeing is not simply how many hours they work, but what they are repeatedly exposed to. As one doctor put it starkly, “The burden is not only physical. It affects your mind, emotions, and even your relationship with God” (P4). A hospital wellness programme built solely around rest, leave, and workload reduction — the standard institutional response to burnout — will therefore leave this deeper, spiritual wound largely untouched.

4.2 The Role of Faith and Meaning in Resilience

Despite substantial trauma exposure, 56.8% of respondents reported high psycho-spiritual wellbeing, and personal prayer, meditation, and reflection were, by a clear margin, the most frequently used coping resource ($M = 4.31$). This finding resonates with Viktor Frankl’s⁹ observation that “those who

have a 'why' to live can bear with almost any 'how,'" and with Pargament's¹⁰ view of spirituality as an active, functional system through which people find meaning and cope with adversity, rather than a passive identity marker. It also echoes Ehusani's¹¹ reflection that lasting happiness and fulfilment flow not from pleasure, power, or possession, but from selfless service and sacrifice for others; a conviction that closely mirrors doctors' own accounts of finding meaning through care for patients despite personal cost. It is also consistent with regional evidence: Pienaar and colleagues¹² found that positive religious coping was associated with lower burnout among South African healthcare workers, while Akinwale and George¹³ found that strong existential attitudes correlated with better wellbeing among Nigerian nurses.

The qualitative data give this pattern a human voice. One doctor located meaning directly in the vocation itself: "When I remember that I am helping people, it gives meaning to the sacrifices" (P3). Another described how the encounter with mortality paradoxically deepened a sense of the sacred: "My work reminds me that life is sacred, and that keeps me grounded" (P5). A third named prayer explicitly as protective: "Prayer is my greatest source of strength. It helps me continue despite difficult experiences" (P2). Peer relationships functioned as a parallel, horizontal form of support, with doctors describing how "talking to colleagues after difficult cases helps reduce the emotional burden" (P1). Together, these resources which consist of vertical (faith, prayer, meaning) and horizontal (peer support, collegial debriefing), appear to be doing much of the resilience-building work that, in better-resourced systems, might be shared with formal psychological services.

That informal sharing of the load, however, is also a caution. Personal faith and peer support are protective, but they are not a substitute for professional care, and the data suggest they are currently being asked to carry more of that weight than they should.

4.3 Practical Strategies for Hospitals

The most striking imbalance in the findings is between the strength of informal, spiritually-oriented coping and the near-absence of formal psychological support: professional counselling and psychotherapy were the least utilised coping strategy ($M = 3.26$), and participants openly acknowledged that "many doctors rarely seek counselling even when they need it" (P2) because "there is still some stigma attached to seeking psychological support" (P4). Closing this gap, rather than choosing between spiritual and psychological care, is the central practical task facing hospital administrators.

Four strategies follow directly from the findings. First, hospitals should establish structured, confidential psychological support services within the A&E unit itself including trauma-informed counselling and regular psychological assessment, so that seeking help requires no special referral or public disclosure. Second, regular, structured peer debriefing after traumatic clinical incidents should be institutionalised rather than left to informal, ad hoc conversations between colleagues; the data show that doctors already value this kind of support ($M = 3.88$) and that formalising it would extend its reach. Third, hospitals should design dedicated psycho-spiritual wellness programmes such as chaplaincy or spiritual-care support, reflective sessions, mindfulness and resilience-building workshops, and meaning-centred therapeutic approaches that work alongside, rather than instead of, clinical mental-health services, since prayer and meaning-making are already doctors' most-used coping resources. Fourth, institutions should run deliberate anti-stigma campaigns normalising the use of counselling among medical staff, since stigma, not unavailability alone, appears to be suppressing uptake.

4.4 Implications for Healthcare Policy

The findings also carry implications beyond the level of any single hospital. Nearly half of the doctors in this study worked 60–70 hours weekly, with a further fifth working 80 hours or more, a workload pattern that both drives burnout directly and compounds the trauma-exposure pathway to psycho-spiritual erosion. This points to a structural, not merely individual, problem: doctors cannot pray, debrief, or counsel their way out of chronic understaffing. The Federal Ministry of Health and hospital administrators should therefore treat workload regulation which consist of adequate staffing ratios, shift limits, and improved workforce distribution across emergency units as a wellbeing intervention in its own right, alongside investment in the equipment, staffing, and emergency-response infrastructure that reduces the frequency of preventable, ethically distressing outcomes of the kind that generate moral injury^{14,7}.

At a broader level, this study suggests that Nigerian occupational health policy for healthcare workers has, to date, been framed almost entirely around psychological constructs such as stress, burnout, and depression, with little explicit recognition of the psycho-spiritual dimension of physician wellbeing. Given that spirituality is already doctors' primary coping resource in practice, policy that is silent on it is policy that is working against the grain of how doctors actually cope. Medical training curricula and residency programmes should incorporate education on secondary traumatic stress, moral injury, and psycho-spiritual self-care before doctors enter trauma-intensive units, so that resilience is built proactively rather than left to develop, unevenly, under fire.

5. Conclusion

This study found that medical doctors in the Accident and Emergency Unit of the Abuja University Teaching Hospital carry a substantial burden of secondary traumatic stress and burnout, and that this burden is significantly and negatively associated with their psycho-spiritual wellbeing ($r = -0.624$, $p < .05$), with secondary traumatic stress the stronger of the two predictors. At the same time, most doctors retain relatively high psycho-spiritual wellbeing, sustained chiefly through prayer, meaning-making, and peer support resources that are protective but that are currently being asked to substitute for, rather than complement, formal psychological care. Because the data are correlational, the study cannot claim that secondary trauma causes poor psycho-spiritual wellbeing, only that it is strongly and consistently associated with it.

Burnout and psycho-spiritual distress are related but distinct phenomena, and Nigerian mental-health support for emergency physicians has, thus far, been built almost entirely around the former. Moving beyond burnout means treating the erosion of meaning, purpose, and spiritual vitality as a legitimate and measurable occupational hazard in its own right; one requiring hospitals to integrate counselling, structured debriefing, and psycho-spiritual care into a single system of support, and requiring policymakers to address the workload and infrastructural conditions that generate the trauma in the first place. Only an integrated response of this kind is likely to protect the doctors who, shift after shift, absorb the suffering that the rest of the health system is built to relieve.

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