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Professional Cadre and Gender Differences in Secondary Traumatic Stress among Mental Health Professionals in a Nigerian Neuropsychiatric Hospital

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Abstract

Secondary traumatic stress (STS) is a significant occupational hazard among mental health professionals; however, evidence regarding whether vulnerability differs by professional cadre or gender remains inconsistent, particularly within low-resource mental health systems such as Nigeria's. This study examined professional cadre and gender differences in STS among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria. A comparative cross-sectional survey design was employed. Using proportionate quota sampling, 150 licensed mental health professionals (112 females and 38 males), aged 25–58 years (M = 40.49, SD = 9.14), were recruited. Data were collected using the Secondary Traumatic Stress Scale and analysed using descriptive statistics, one-way analysis of variance, and independent-samples t-test. The findings revealed no significant differences in STS across professional cadres, $F(4, 145) = 1.66$, $p = .17$, $\eta^2 = .04$, or between male and female professionals, $t(148) = 0.20$, $p = .84$, $d = 0.04$. These findings suggest that secondary traumatic stress may be experienced relatively uniformly across mental health professionals irrespective of professional role or gender within this setting. The study highlights the importance of institution-wide staff wellbeing initiatives, including regular psychological support, clinical supervision, and trauma-informed workplace interventions, rather than approaches targeted at specific professional groups.

Keywords: secondary traumatic stress, mental health

Introduction

Mental health professionals occupy a unique position in the landscape of trauma exposure. Unlike first responders or military personnel, they rarely encounter traumatic events directly; instead, they experience trauma indirectly through sustained, empathic engagement with individuals who have survived violence, abuse, armed conflict, severe mental illness, and other psychologically distressing events (Newell & MacNeil, 2010; Salston & Figley, 2003). Although empathic engagement is indispensable for establishing therapeutic alliances and promoting recovery, repeated

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exposure to clients' traumatic experiences may also have unintended psychological consequences for the clinician (Ludick & Figley, 2017).

Although the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) conceptualises traumatic exposure primarily as direct experience, witnessing traumatic events, or learning that such events occurred to a close family member or friend (American Psychiatric Association [APA], 2013), evidence accumulated over the past three decades demonstrates that repeated professional exposure to clients' traumatic narratives can also precipitate clinically significant trauma-related symptoms (Bride, 2007; Figley, 1995). Figley (1995) described this phenomenon as secondary traumatic stress (STS), referring to the natural emotional and behavioural responses that arise from helping or wanting to help individuals who have experienced traumatic events. Secondary traumatic stress is characterised by intrusive recollections, avoidance, hyperarousal, and persistent negative alterations in mood and cognition, producing a symptom profile that closely resembles post-traumatic stress disorder (APA, 2013; Bride, 2007; Figley, 1995). Importantly, repeated occupational exposure to clients' traumatic experiences may satisfy the DSM-5 Criterion A4 for trauma exposure when other diagnostic criteria are also met, underscoring the clinical significance of indirect trauma exposure among helping professionals (APA, 2013; Bride, 2007).

Mental health professionals are particularly susceptible to STS because empathic engagement is not incidental to their work but an essential component of effective clinical practice. Through repeated therapeutic encounters, clinicians continually absorb the emotional impact of clients' traumatic experiences, making indirect trauma exposure an inherent occupational hazard of mental healthcare (Ludick & Figley, 2017; Michelson & Kluger, 2021; Turgoose et al., 2017). Beyond its impact on individual wellbeing, STS has been associated with emotional exhaustion, impaired clinical judgement, reduced therapeutic effectiveness, absenteeism, and increased intentions to leave the profession, ultimately compromising the quality of care delivered to vulnerable populations (Branson, 2019; Cieslak et al., 2014; Hensel et al., 2015).

The relevance of STS is particularly pronounced within the Nigerian mental healthcare system. Mental health professionals working in federal neuropsychiatric hospitals routinely provide care for individuals affected by armed conflict, insurgency-related violence, kidnapping, ritual abuse, sexual violence, and other forms of severe psychological trauma (Akpotor, 2018; Amedu & Dwarika, 2025; Amusan & Ejoke, 2017). This work is undertaken within a mental health system characterised by limited human resources, inadequate funding, and persistent service demands, conditions that may further increase vulnerability to occupational stress (Abdulmalik

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et al., 2019; WHO, 2021). Existing Nigerian evidence suggests that the burden of STS may already be substantial. For example, Yabilsu-Guyuk et al. (2022) reported STS prevalence rates of 47% among humanitarian counsellors and 46% among nurses working with conflict-affected populations in north-eastern Nigeria. These studies indicate that STS represents a significant occupational concern within trauma-exposed helping professions in Nigeria and underscore the need to identify which groups of mental health professionals may be at greatest risk.

Theoretical explanations for professional cadre differences are primarily grounded in the Job Demands–Resources (JD-R) model (Demerouti et al., 2001), which proposes that occupational strain develops when job demands exceed the resources available to manage them. Within mental healthcare, demands such as high caseloads, prolonged client contact, emotional labour, and repeated exposure to traumatic material vary considerably across psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers. Likewise, access to protective resources—including supervision, professional autonomy, staffing, and trauma-specific training—also differs across these professional groups. Consequently, the JD-R model predicts that vulnerability to STS should vary across professional cadres, although it does not specify which cadre is likely to experience the greatest burden.

Empirical evidence generally supports the view that professional cadre influences STS, although findings remain inconsistent regarding the direction of these differences. Several studies have reported comparatively lower STS among psychologists, attributing this advantage to broader caseload diversity, stronger professional preparation, and greater engagement in self-care practices (Gürdil-Birinci & Erden, 2016; Manning-Jones et al., 2017; Pellegrini et al., 2022; Zara & İçöz, 2015). In contrast, Brugman et al. (2022) found that case managers experienced significantly higher STS than physicians and psychologists, whereas Shaheen and Sadiq (2024) reported higher STS among psychiatrists than clinical psychologists, attributing this difference largely to heavier patient workloads. Collectively, these findings suggest that professional cadre is an important source of variation in STS; however, the specific distribution of occupational demands and protective resources appears to differ across healthcare systems, making it inappropriate to generalise findings from one context directly to another.

Gender has also received considerable attention as a potential determinant of STS. Social role theory proposes that women are socialised into caregiving roles that encourage emotional responsiveness and interpersonal sensitivity, characteristics that may increase vulnerability to trauma-related distress in helping professions (Baum et al., 2014;

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Glomazić & Mikić, 2022). This proposition is reinforced by evidence indicating that women generally report higher levels of trait empathy than men (Harton & Lyons, 2003), while affective empathy has consistently been identified as one of the strongest predictors of STS (Ogińska-Bulik & Juczyński, 2020; Turgoose et al., 2017). Consequently, women would be expected to experience greater STS than their male counterparts.

Empirical findings, however, are far less consistent than this theoretical expectation suggests. Female psychotherapists have reported greater emotional exhaustion than male colleagues (Kounenou et al., 2023; Rupert & Morgan, 2005), and women have demonstrated higher STS in samples of social workers and emergency healthcare personnel (Carmassi et al., 2022). These findings align with broader epidemiological evidence indicating that women develop PTSD more frequently than men despite experiencing comparable rates of trauma exposure (Farhood et al., 2016; Kilpatrick et al., 2013; Silove et al., 2017). In contrast, other studies have reported no significant gender differences in STS (Glomazić & Vidović, 2024; Ogińska-Bulik et al., 2021), while Søegaard et al. (2021) found greater trauma-related symptoms among men on selected dimensions of complex trauma. One explanation for these inconsistencies is that gender differences in help-seeking and emotional disclosure may influence self-reported STS, such that observed differences reflect reporting behaviour as much as actual psychological vulnerability (Cui, 2022; Olff, 2017; Staiger et al., 2020). Nigerian findings are similarly inconsistent. Lawal et al. (2018) found no significant gender differences in post-traumatic stress reactions among victims of cattle rustling, whereas Ajagbe et al. (2026) reported significantly higher compassion fatigue among female teachers than their male counterparts. However, neither study examined mental health professionals, limiting the applicability of these findings to clinical populations routinely exposed to clients' traumatic experiences.

The literature establishes that STS is a significant occupational hazard among mental health professionals and that both professional cadre and gender are theoretically plausible sources of variation in STS. Nevertheless, empirical findings remain inconsistent across settings, and no published Nigerian study has examined whether these factors differentiate STS among mental health professionals working within a neuropsychiatric hospital. Consequently, hospital administrators lack evidence to identify staff groups most vulnerable to STS and to direct supervision, workload management, and trauma-informed support strategies where they are most needed. The present study addresses this gap by examining professional cadre and gender differences in secondary traumatic stress among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria. Guided by the Job

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Demands–Resources model and Social Role Theory, the study tested the following hypotheses:

H1: Secondary traumatic stress scores differ significantly across professional cadres (psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers).

H2: Secondary traumatic stress scores differ significantly between male and female mental health professionals.

Method

Research Design

This study employed a comparative cross-sectional survey design to examine differences in secondary traumatic stress across professional cadres and gender among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa. The design was appropriate because it permits the comparison of naturally occurring groups on a continuous outcome variable without manipulation of the independent variables.

Research Setting

The study was conducted at the Federal Neuro-Psychiatric Hospital (FNPH), Barnawa, Kaduna State, Nigeria, one of the country's federal specialist psychiatric hospitals. The hospital serves as a major referral centre for psychiatric and mental healthcare services in Kaduna State and neighbouring states in northwestern Nigeria. It provides comprehensive inpatient and outpatient mental health services through a multidisciplinary team comprising psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, medical social workers, and other allied mental health professionals. Owing to the nature of its clinical services, healthcare professionals at the hospital are routinely engaged in the assessment, treatment, and rehabilitation of individuals presenting with severe mental illness and trauma-related psychological conditions, making the facility an appropriate setting for investigating secondary traumatic stress among mental health professionals.

Sample Size/Sampling Technique

The target population comprised 228 licensed mental health professionals engaged in direct patient care at the Federal Neuro-Psychiatric Hospital, Barnawa. The required sample size was determined using Yamane's (1967) formula for finite populations. he calculation yielded a minimum sample size of 145 participants. To minimise the effect of potential non-response and incomplete questionnaires, the target sample size was increased to 150 participants.

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A proportionate quota sampling technique was employed to ensure that each professional cadre was represented according to its proportion within the study population. Quotas were allocated across psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers based on their respective workforce sizes. Within each cadre, eligible participants were recruited consecutively until the predetermined quota was attained. This approach ensured adequate representation of smaller professional groups while maintaining the population distribution of the mental health workforce.

Table 1.

Proportionate Quota Allocation By Professional Cadre

Profession	Population (N = 228)	Percentage	Target Quota (n = 150)
Psychiatrists	45	19.74%	30
Clinical Psychologists	7	3.07%	5
Psychiatric Nurses	150	65.79%	98
Medical Social Workers	14	6.14%	9
Occupational Therapists	12	5.26%	8
Total	**228**	**100.00%**	**150**

Participants

Eligible participants were psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers employed at the Federal Neuro-Psychiatric Hospital, Barnawa, who were actively engaged in direct patient care during the study period. Professionals on extended leave, non-clinical staff, interns, and National Youth Service Corps (NYSC) personnel with less than six months of clinical posting were excluded from the study.

A total of 150 mental health professionals participated in the study, all of whom returned complete questionnaires suitable for analysis. Participants ranged in age from 25 to 58 years (M = 40.49, SD = 9.14). The sample comprised 112 (74.7%) females and 38 (25.3%) males. Additional demographic characteristics, including marital status, professional cadre, and years of post-qualification experience, are presented in Table 2.

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Table 2.

Demographic Characteristics of the Sample

	Category	n	%
Gender	Female	112	74.7
	Male	38	25.3
Marital Status	Single	24	16.0
	Married	103	68.7
	Divorced	5	3.3
	Widowed	5	3.3
	Separated	13	8.7
Professional Cadre	Psychiatrist	30	20.0
	Clinical Psychologist	5	3.3
	Psychiatric Nurse	98	65.3
	Medical Social Worker	9	6.0
	Occupational Therapist	8	5.3
Years of Post-Qualification Experience	Less than 5 years	29	19.3
	5–10 years	23	15.3
	11–15 years	25	16.7
	16–20 years	30	20.0
	More than 20 years	43	28.7

Measures

Demographic Variables

Information on participants' gender, age, marital status, professional cadre, and years of post-qualification experience was obtained using a brief demographic questionnaire developed for the study.

Secondary Traumatic Stress Scale (STSS)

Secondary traumatic stress was assessed using the Secondary Traumatic Stress Scale (STSS) developed by Bride et al. (2004). The STSS is a 17-item self-report measure designed to assess trauma-related symptoms resulting from indirect exposure to clients' traumatic experiences. The scale measures three symptom clusters consistent with the diagnostic criteria for post-traumatic stress disorder: intrusion (5 items), avoidance (7 items),

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and arousal (5 items). Participants rated the frequency with which they experienced each symptom during the preceding seven days on a 5-point Likert scale ranging from 1 (*never*) to 5 (*very often*).

Total scores are obtained by summing responses across all 17 items, yielding scores ranging from 17 to 85, with higher scores indicating greater levels of secondary traumatic stress. The STSS has demonstrated excellent psychometric properties across diverse helping-professional populations, with reported internal consistency coefficients ranging from .93 to .95 (Bride et al., 2004). In the present study, the scale demonstrated excellent internal consistency (Cronbach's $\alpha = .94$).

Procedure

Following approval from the Research and Ethics Committee of the Federal Neuro-Psychiatric Hospital, Barnawa, institutional permission to conduct the study was obtained through the Office of the Medical Director. Eligible mental health professionals were approached at their respective clinical units and informed about the purpose and procedures of the study. Those who agreed to participate provided written informed consent before completing the study questionnaire in a quiet location within the hospital.

Participants completed a demographic questionnaire and the Secondary Traumatic Stress Scale (STSS), which required approximately 10–15 minutes to complete. Completed questionnaires were returned immediately in sealed envelopes to the researcher or a trained research assistant to ensure confidentiality. Participation was voluntary, no incentives were offered, and no participant declined or withdrew after providing consent.

Data Analysis

Data were analysed using IBM SPSS Statistics Version 23. Prior to hypothesis testing, the data were screened for completeness, outliers, and compliance with the assumptions of normality and homogeneity of variances. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were computed to summarise participants' demographic characteristics and secondary traumatic stress scores.

To test the study hypotheses, an independent-samples *t*-test was conducted to examine gender differences in secondary traumatic stress, while a one-way analysis of variance (ANOVA) was performed to compare secondary traumatic stress scores across the five professional cadres. Cohen's *d* and eta squared (η^2) were reported as measures of effect size for the independent-samples *t*-test and one-way ANOVA, respectively.

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Statistical significance was determined using a two-tailed alpha level of .05.

Ethical Considerations

Ethical approval for this study was obtained from the Research and Ethics Committee of the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria (Approval No. **FNPH/KD/40/I/461**) prior to data collection. Participation was voluntary, and written informed consent was obtained from all participants before questionnaire administration. Participants were assured of the anonymity and confidentiality of their responses and informed of their right to decline participation or withdraw from the study at any time without penalty. The study was conducted in accordance with the ethical principles outlined in the *American Psychological Association Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017).

Results

Preliminary Analyses

Prior to hypothesis testing, the assumptions of homogeneity of variance for the independent-samples *t*-test and one-way analysis of variance (ANOVA) were examined. Levene's test indicated that the assumption of homogeneity of variance was met for the comparison of secondary traumatic stress (STS) scores across professional cadres, $F(4, 145) = 0.62$, $p = .651$, and was also not violated for the comparison of STS scores between male and female participants, $F(1, 148) = 3.72$, $p = .056$. Accordingly, the standard (equal-variances) forms of the ANOVA and independent-samples *t*-test were used to test Hypotheses 1 and 2, respectively.

Hypothesis 1: Professional Cadre Differences in Secondary Traumatic Stress

Hypothesis 1 stated that STS scores would differ significantly across professional cadres. A one-way between-groups ANOVA was conducted to compare STS scores among psychiatrists, clinical psychologists, psychiatric nurses, medical social workers, and occupational therapists. Descriptive statistics for each cadre are presented in Table 3. Clinical psychologists recorded the highest mean STS score ($M = 46.20$, $SD = 7.40$), followed by psychiatrists ($M = 38.07$, $SD = 9.07$) and psychiatric

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nurses ($M = 38.02$, $SD = 10.20$), while medical social workers recorded the lowest mean score ($M = 32.33$, $SD = 9.71$).

Table 3

Means, Standard Deviations, and Sample Sizes for Secondary Traumatic Stress by Professional Cadre

Professional Cadre	n	*M*	*SD*
Psychiatrist	30	38.07	9.07
Clinical Psychologist	5	46.20	7.40
Psychiatric Nurse	98	38.02	10.20
Medical Social Worker	9	32.33	9.71
Occupational Therapist	8	36.63	11.76
Total	150	37.89	10.05

Note. STS = Secondary Traumatic Stress. Total scores could range from 17 to 85.

As shown in Table 4, the omnibus ANOVA was not statistically significant, $F(4, 145) = 1.61$, $p = .176$, $\eta^2 = .04$, indicating that professional cadre accounted for approximately 4% of the variance in STS scores, a small effect. Hypothesis 1 was therefore not supported: secondary traumatic stress scores did not differ significantly across professional cadres.

Table 4

Summary of One-Way ANOVA for Secondary Traumatic Stress by Professional Cadre

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	638.57	4	159.64	1.61	.176	.04
Within Groups	14414.50	145	99.41			
Total	15053.07	149				

Note. η^2 = eta squared.

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Hypothesis 2: Gender Differences in Secondary Traumatic Stress

Hypothesis 2 stated that STS scores would differ significantly between male and female mental health professionals. An independent-samples *t*-test was conducted to compare STS scores of female and male participants. Descriptive statistics are presented in Table 5. Female participants (M = 37.98, SD = 9.45, n = 112) reported a slightly higher mean STS score than male participants (M = 37.61, SD = 11.78, n = 38).

Table 5

Means and Standard Deviations for Secondary Traumatic Stress by Gender

Gender	n	*M*	*SD*
Female	112	37.98	9.45
Male	38	37.61	11.78

As shown in Table 6, this difference was not statistically significant, $t(148) = 0.20$, $p = .842$, 95% CI [-3.36, 4.12]. The effect size was negligible, Cohen's $d = 0.04$, indicating that gender accounted for virtually none of the variance in STS scores. Hypothesis 2 was therefore not supported: secondary traumatic stress scores did not differ significantly between male and female mental health professionals.

Table 6

Summary of Independent-Samples t-Test for Secondary Traumatic Stress by Gender

t	*df*	*p*	Mean Difference	95% CI	Cohen's d
0.20	148	.842	0.38	[-3.36, 4.12]	0.04

Note. CI = confidence interval for the mean difference.

Discussion of Findings

This study examined whether secondary traumatic stress (STS) among mental health professionals in a Nigerian federal neuropsychiatric hospital differed according to professional cadre and gender. Contrary to the study

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hypotheses, STS scores did not differ significantly across professional cadres or between male and female professionals. These findings suggest that, within the present setting, STS may represent a relatively uniform occupational hazard rather than one concentrated within particular professional groups or genders.

The first hypothesis, derived from the Job Demands–Resources (JD-R) model (Demerouti et al., 2001), proposed that STS would differ across professional cadres because variations in job demands and access to protective resources should produce corresponding differences in occupational strain. Contrary to this expectation, no significant differences in STS were observed among psychiatrists, clinical psychologists, psychiatric nurses, occupational therapists, and medical social workers. Although clinical psychologists recorded the highest mean STS score and medical social workers the lowest, these differences were small and did not reach statistical significance.

This finding contrasts with studies reporting significant cadre-based differences in STS. For example, Brugman et al. (2022) found that case managers experienced significantly higher STS than physicians and psychologists, whereas Shaheen and Sadiq (2024) reported greater STS among psychiatrists than clinical psychologists, attributing these differences to variations in workload and patient volume. Likewise, psychologists have often been reported to experience comparatively lower STS because of broader clinical training, more diverse caseloads, and greater engagement in self-care practices (Gürdil-Birinci & Erden, 2016; Manning-Jones et al., 2017; Pellegrini et al., 2022; Zara & İçöz, 2015). Interestingly, the present study observed the opposite descriptive pattern, with clinical psychologists reporting the highest mean STS score. However, given the absence of statistical significance and the very small number of psychologists in the sample, this apparent pattern should be interpreted with considerable caution.

Several contextual factors may explain the absence of significant cadre differences. First, all participants were employed within the same federal neuropsychiatric hospital and were therefore exposed to broadly similar clinical demands, including frequent contact with individuals experiencing severe mental illness and trauma-related conditions. Unlike studies comparing professionals across different healthcare settings, the shared institutional environment in the present study may have reduced variation in trauma exposure across professional roles. From the perspective of the JD-R model, when job demands are relatively comparable across occupational groups, differences in strain attributable to professional cadre are less likely to emerge.

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Second, the unequal distribution of participants across cadres may have reduced the statistical power to detect genuine differences. While the predominance of psychiatric nurses accurately reflected the hospital's workforce composition, the comparatively small numbers of clinical psychologists, occupational therapists, and medical social workers limited the precision of group estimates. Consequently, the higher mean STS observed among clinical psychologists should not be interpreted as evidence that this cadre is at greater risk, but rather as a finding requiring confirmation in studies with larger and more balanced samples.

Third, structural characteristics of the Nigerian mental healthcare system may have contributed to the observed pattern. Persistent shortages of mental health professionals, limited access to supervision, and chronic resource constraints are well-documented features of psychiatric care in Nigeria (Abdulmalik et al., 2019; WHO, 2021). These challenges affect professionals across disciplines and may reduce the availability of occupational resources that ordinarily distinguish one cadre from another. As a result, resource limitations may be experienced relatively uniformly across the multidisciplinary workforce, thereby weakening the cadre-specific differences predicted by the JD-R model.

The second hypothesis was informed by social role theory (Baum et al., 2014; Glomazić & Mikić, 2022), which proposes that women are socialised to adopt more nurturing and emotionally responsive roles. Coupled with evidence that women generally report higher levels of trait empathy (Harton & Lyons, 2003), this perspective suggested that female mental health professionals would experience higher levels of STS than their male counterparts. Contrary to this expectation, no significant gender difference was observed, and the effect size was negligible, indicating virtually no practical difference in STS between male and female professionals.

This finding is consistent with studies reporting no significant gender differences in STS among helping professionals (Glomazić & Vidović, 2024; Ogińska-Bulik et al., 2021) and with Lawal et al.'s (2018) finding that post-traumatic stress reactions did not differ significantly between male and female victims of cattle rustling in Nigeria. However, it differs from studies reporting greater STS or emotional exhaustion among women (Carmassi et al., 2022; Kounenou et al., 2023; Rupert & Morgan, 2005) and from Ajagbe et al.'s (2026) report of higher compassion fatigue among female teachers.

Several explanations may account for the present finding. First, the gender distribution of the sample reflected the predominance of women within psychiatric and nursing services, resulting in a substantially smaller male subgroup. Although this imbalance mirrors the demographic composition

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of the workforce, it may have reduced the study's ability to detect modest gender differences.

Second, the absence of a gender effect may indicate that men and women working within the same psychiatric institution experience similar occupational demands and are exposed to comparable trauma-related stressors. Under such conditions, shared workplace experiences may exert a stronger influence on STS than gender-based differences in emotional socialisation.

Third, previous research suggests that gender differences in self-reported trauma symptoms may partly reflect differences in emotional disclosure and help-seeking rather than genuine differences in psychological vulnerability (Cui, 2022; Olff, 2017; Staiger et al., 2020). If male and female mental health professionals in the present setting were similarly willing to acknowledge trauma-related symptoms, gender differences reported elsewhere may not be expected to emerge. In addition, professionals who remain in psychiatric practice within a resource-constrained healthcare system may share similar levels of occupational resilience and coping, thereby reducing the influence of gender on STS. This interpretation is also consistent with Søegaard et al.'s (2021) observation that gender differences in trauma-related symptoms vary across populations and contexts rather than representing a universal pattern.

Implications of the Findings

The findings suggest that secondary traumatic stress should be regarded as an occupational risk affecting mental health professionals irrespective of professional cadre or gender. Consequently, interventions aimed at preventing and managing STS should adopt an institution-wide rather than cadre- or gender-specific approach. Mental health facilities may benefit from implementing routine psychological wellbeing assessments, regular clinical supervision, peer support programmes, and trauma-informed staff wellness initiatives for all mental health professionals. Such strategies may help mitigate the psychological burden associated with repeated exposure to clients' traumatic experiences and promote a healthier, more resilient workforce.

Conclusion

This study investigated professional cadre and gender differences in secondary traumatic stress among mental health professionals at the Federal Neuro-Psychiatric Hospital, Barnawa, Kaduna State, Nigeria. The findings revealed no significant differences in secondary traumatic stress across professional cadres or between male and female professionals, suggesting that the psychological impact of indirect trauma exposure may

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be experienced relatively uniformly across the multidisciplinary mental health workforce in this setting. These findings highlight the importance of viewing secondary traumatic stress as a shared occupational challenge rather than one confined to particular professional groups or genders.

Recommendations

Based on the findings of this study, the following recommendations were made:

1. The management of the Federal Neuro-Psychiatric Hospital, Barnawa, should implement institution-wide staff wellbeing programmes, including routine screening for secondary traumatic stress, structured clinical supervision, and peer support initiatives for all mental health professionals, irrespective of professional cadre or gender.
2. The Federal Ministry of Health and Social Welfare, in collaboration with hospital administrators, should develop and implement policies that integrate trauma-informed staff wellness, psychological support services, and regular mental health monitoring into occupational health programmes for mental health professionals working in psychiatric facilities.

Limitations and Directions for Future Research

This study has some limitations that should be considered when interpreting the findings. First, the study was conducted in a single federal neuropsychiatric hospital, which may limit the generalisability of the findings to mental health professionals working in other psychiatric facilities or healthcare settings across Nigeria. Future studies should adopt multi-centre designs involving diverse clinical settings to establish the consistency of these findings across different organisational contexts.

Second, although the sample reflected the actual workforce composition of the hospital, the distribution across professional cadres was markedly unequal, with relatively few clinical psychologists, occupational therapists, and medical social workers. This imbalance may have reduced the statistical power to detect meaningful differences between professional groups. Future research should recruit larger and more balanced samples to permit more robust comparisons across professional cadres.

Finally, the cross-sectional design captured secondary traumatic stress at a single point in time and therefore does not permit conclusions about temporal changes or causal relationships. Longitudinal studies are recommended to examine how secondary traumatic stress develops over time and to identify organisational and individual factors that may influence its progression among mental health professionals.

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