

ORIGINAL PAPER

**EXPLORING THE COMPLEX INTERPLAY BETWEEN ACUTE STRESS,  
ANXIETY, AND DEPRESSION: A CROSS-SECTIONAL ANALYSIS AMONG  
EMERGENCY DEPARTMENT PATIENTS**

**Bircan Yavuz<sup>1(A,B,C,D,E,F,G)</sup>, Ece Alagöz<sup>2(A,D,E,F)</sup>**

<sup>1</sup>Department of Nursing, Graduate School, Istanbul Okan University, Istanbul, Türkiye

<sup>2</sup>School of Nursing, Maltepe University, Istanbul, Türkiye

Yavuz B, Alagöz E, Exploring the complex interplay between acute stress, anxiety, and depression: a cross-sectional analysis among emergency department patients. Health Prob Civil.  
<https://doi.org/10.5114/hpc.2025.149194>

Tables: 3

Figures: 0

References: 21

Submitted: 2024 Nov 23

Accepted: 2025 March 31

**Address for correspondence:** Ece Alagöz, School of Nursing, Maltepe University, Marmara Eğitim Köyü, Büyükbakkalköy Mah. Büyükbakkalköy Yolu Sk. Nr:39, 34857 Maltepe/Istanbul, Türkiye, e-mail: [ecealagoz@maltepe.edu.tr](mailto:ecealagoz@maltepe.edu.tr), phone: +905414494567

ORCID: Bircan Yavuz <https://orcid.org/0000-0002-7881-6267>, Ece Alagöz <https://orcid.org/0000-0002-4913-0944>,

Copyright: © John Paul II University in Biała Podlaska, Bircan Yavuz, Ece Alagöz. This is an Open Access journal, all articles are distributed under the terms of the Creative Commons AttributionNonCommercial-ShareAlike 4.0 International (CC BY-NC-SA 4.0) License (<https://creativecommons.org/licenses/by-nc-sa/4.0>), allowing third parties to copy and redistribute the material in any medium or format and to remix, transform, and build upon the material, provided the original work is properly cited and states its license.

## Summary

**Background.** This study evaluated acute stress symptom severity, anxiety, and depression levels in emergency department patients and examined their interrelationships.

**Material and methods.** A cross-sectional design was employed. The Acute Stress Symptom Severity Scale (ASSSS) assessed stress severity, while the Hospital Anxiety and Depression Scale (HADS) evaluated anxiety and depression. Descriptive statistics and correlation analyses were conducted.

**Results.** The mean ASSSS score was  $8.77 \pm 3.43$ , indicating moderate acute stress, with scores ranging from 2.0 to 20.0 and a median of 9.0. The mean HADS-Anxiety score was  $9.14 \pm 3.33$ , with a median of 10.0, reflecting moderate anxiety (range: 2.0-19.0). The mean HADS-Depression score was  $11.07 \pm 4.41$ , with a median of 10.0, indicating moderate depression with more variability (range: 1.0-21.0). Correlation analyses showed a weak positive relationship between the ASSSS and HADS-Anxiety scores ( $r=0.290, p<0.001$ ), suggesting higher acute stress is linked to increased anxiety. A weak negative correlation between the ASSSS and HADS-Depression scores ( $r=-0.364, p<0.001$ ) indicated higher stress is associated with lower depression levels.

**Conclusions.** Acute stress is moderately prevalent in emergency patients and positively correlates with anxiety while negatively correlating with depression. Integrated approaches are essential for managing these interconnected conditions in emergency care.

**Keywords:** acute stress, anxiety, depression, emergency, nursing

## Introduction

Acute stress, anxiety, and depression are common psychological responses observed in patients visiting emergency departments (EDs), often exacerbated by the critical nature of the situations that bring them to these settings [1]. These psychological symptoms affect not only mental health but also overall recovery. Understanding the interplay between acute stress, anxiety, and depression is crucial, especially for healthcare providers in emergency settings to offer comprehensive care that addresses both physical and psychological needs. Many studies have shown that anxiety, stress, and depression are prevalent among ED patients, complicating their clinical care [2,3]. For instance, anxiety and depression rates in ED patients are significantly higher compared to the general population, and these conditions often go unaddressed due to competing priorities in the ED [2,4]. Marchesi et al. [5] found that anxiety disorders are more common in ED patients, while depression is more frequent in medical units, emphasizing the need to address both in clinical management. Additionally, the ED environment can exacerbate stress and anxiety, negatively impacting the patient's experience [3]. Koyuncu and Karcioğlu [6] noted that patients with systemic diseases or acute exacerbations of chronic conditions tend to have higher anxiety levels, further complicating care [6]. Moreover, studies have shown that the use of complementary therapies, such as animal-assisted or music therapy, can significantly reduce stress and anxiety in ED patients, improving their overall experience [7,8].

Clinicians in the ED are often primarily focused on the immediate physical health of the patient. However, unaddressed psychological conditions like stress, anxiety, and depression can impede recovery and complicate the management of acute physical illnesses. Studies have shown that timely psychological intervention can reduce hospital stays, lower re-admission rates, and improve overall patient outcomes [6,7].

Recent studies have highlighted significant correlations between acute stress and both anxiety and depression in emergency settings. For example, research shows that increased acute stress is positively associated with increased levels of anxiety among patients, which can further complicate their clinical management [8,9]. Conversely, there is evidence suggesting that acute stress might have a complex relationship with depression, where it can sometimes be inversely correlated. Recent literature presents conflicting findings regarding the association between anxiety, stress, and depression in ED patients. While some studies suggest that acute stress exacerbates both anxiety and depression, others indicate that these relationships may differ based on the context or the severity of symptoms. Understanding these nuances is crucial for ED clinicians, as the psychological state of a patient can significantly influence both immediate care strategies and long-term outcomes. For example, effective management of stress and anxiety in the ED has been shown to reduce hospital stays and improve recovery rates [10,11].

Although prior studies have examined the relationship between stress, anxiety, and depression in general medical settings, there is a lack of focused research exploring how these psychological states interact specifically in ED patients. This study aims to fill this gap by investigating these relationships in a high-pressure, acute care setting.

Conflicting findings in literature indicate that the interaction between stress, anxiety, and depression may vary under different clinical circumstances. Recognizing and addressing these psychological factors is crucial, as mental health can significantly influence both short-term treatment and long-term recovery. Effective stress and anxiety management in the ED

patients has been shown to reduce hospital stays and improve recovery rates [12-14]. While previous studies have explored these relationships in general healthcare settings, there is a lack of focused research examining how these psychological states interact specifically within EDs. This study aims to fill this gap by investigating the interplay between acute stress, anxiety, and depression in a high-pressure ED setting.

Research Question: What is the relationship between acute stress, anxiety, and depression in patients presenting to the ED, and how do these psychological conditions impact their clinical management?

### **Aim of the work**

The aim of this study is to determine acute stress symptom severity, anxiety, and depression levels in ED patients and to examine the relationships between them.

### **Material and methods**

#### ***Study design and setting***

This descriptive and exploratory study was conducted in the ED of the Training and Research Hospital in Istanbul. Data collection began following the acquisition of ethical approval and institutional permissions between March and May 2023.

The inclusion criteria consisted of patients aged 18 and above who presented to the ED with acute conditions and voluntarily agreed to participate in the study.

The exclusion criteria in this study consisted of emergency cases from the yellow and red zones. The yellow and red zones are triage categories indicating the severity of a patient's

condition, with red representing critical, life-threatening cases and yellow representing serious but non-critical conditions.

### ***Study population and sampling***

A sample size of 220 participants was determined based on a power analysis. A minimum of 200 participants was necessary to achieve a power of 0.80, assuming a moderate effect size ( $r=0.30$ ) for the correlations between stress, anxiety, and depression. This ensures that the study has sufficient statistical power to detect significant relationships between these variables [15].

### ***Data collection***

At the onset of the study, ethical approval and institutional permission were obtained. The data was collected face-to-face by the nurse researcher working in the ED during the triage stage, prior to treatment.

### ***Data collection instruments***

#### ***Sociodemographic Data Form***

The Sociodemographic Data Form includes five questions covering the patient's age, gender, marital status, educational level, and income level. These variables define the independent variables of the study.

*Hospital Anxiety and Depression Scale (HADS)*

The HADS is a self-reported scale developed by Zigmond and Snaith [16] to assess the risk and severity of anxiety and depression in individuals with physical illnesses or those seeking primary healthcare services. The validity and reliability of the scale in Turkey were evaluated by Aydemir et al. [17]. The scale's usage permission was obtained from Ömer Aydemir. The scale consists of 14 questions: odd-numbered items (1, 3, 5, 7, 9, 11, and 13) measure anxiety, and even-numbered items (2, 4, 6, 8, 10, 12, and 14) measure depression. The responses are rated on a four-point Likert scale, with scores ranging from 0 to 3. In this study, the Cronbach's alpha value for the HADS was calculated as 0.735. The original version of the scale reported a Cronbach's alpha of approximately 0.80, indicating good internal consistency [16].

*Acute Stress Symptom Severity Scale (ASSSS)*

The ASSSS, originally designed by Lindeman in 1944, was validated and standardized in Turkish by Aşçıbaşı et al. [18]. This scale consists of seven items and is used to measure acute stress disorder symptoms in individuals aged 18 years and older following a highly stressful event. Each item assesses the severity of ongoing acute stress disorder symptoms over the past seven days on a scale of 0 (none) to 4 (extreme), with a total score ranging from 0 – 28. In this study, the Cronbach's alpha value for ASSSS was calculated as 0.767. In the Turkish validation study conducted by Aşçıbaşı et al. [18] the scale demonstrated a Cronbach's alpha coefficient of 0.83.

### ***Data analysis***

Statistical analyses were performed using the SPSS software package (IBM SPSS Statistics 27). Frequency tables and descriptive statistics played crucial roles in evaluating the findings. To determine the normal distribution of the data, separate tests were applied for each variable considering sample sizes. The Kolmogorov-Smirnov and Shapiro-Wilk tests were utilized on the basis of the sample size.

The relationships between non-normally distributed measurement values were examined via the "Spearman" correlation coefficient. For variables where significant differences were identified among three or more groups, pairwise comparisons were indicated via expressions such as "[1-2, 3]" denoting a significant difference between groups 1 and 2 and between groups 1 and 3.

### **Results**

Data obtained from sociodemographic data form, the ASSSS, and the HADS, which were administered to 220 patients who presented to the ED of the Training and Research Hospital, were analyzed to examine the relationships between acute stress levels and anxiety-depression symptoms (Tables 1 and 2).

**Table 1.** Distribution of patients according to their sociodemographic characteristics

Variable (n = 220)	n	%
<b>Age groups [Mean±SD → 51.54±16.94 (years)]</b>		
<b>&lt;40</b>	53	24.1
<b>40-49</b>	48	21.8
<b>50-59</b>	42	19.1
<b>≥60</b>	77	35.0

<b>Gender</b>		
<b>Female</b>	91	41.4
<b>Male</b>	129	58.6
<b>Marital status</b>		
<b>Single</b>	56	25.5
<b>Married</b>	144	65.4
<b>Divorced</b>	20	9.1
<b>Educational level</b>		
<b>Literate</b>	40	18.2
<b>Primary education</b>	94	42.7
<b>High school</b>	51	23.2
<b>University</b>	35	15.9
<b>Income level</b>		
<b>Income less than expenses</b>	22	10.0
<b>Income equal to expenses</b>	117	53.2
<b>Income more than expenses</b>	81	36.8
<b>Reasons for hospitalization</b>		
<b>Cardiovascular system</b>	19	8.6
<b>Respiratory system</b>	98	44.5
<b>Gastrointestinal system</b>	72	32.7
<b>Trauma</b>	4	1.8
<b>Neurology</b>	18	8.2

**Table 2.** Distribution of classifications according to the HADS

<b>Variable (n=220)</b>	<b>n</b>	<b>%</b>
<b>HADS-Anxiety categories</b>		
<b>0-7 points: Normal</b>	62	28.2
<b>8-10 points: Borderline</b>	81	36.8
<b>11 points and above: Abnormal</b>	77	35.0
<b>HADS-Depression categories</b>		
<b>0-7 points: Normal</b>	37	16.8
<b>8-10 points: Borderline</b>	75	34.1
<b>11 points and above: Abnormal</b>	108	49.1

A total of 36.8% (n=81) of the patients in the study were in the borderline category of HADS-Anxiety, and 49.1% (n=108) were in the abnormal category of HADS-Depression (Table 3).

**Table 3.** Comparison of patients' scores on the HADS and ASSSS

ASSSS (n=220)	
<b>HADS-Anxiety</b>	r=0.290
	p<0.001
<b>HADS-Depression</b>	r=-0.364
	p<0.001

A significant difference was observed between the ASSSS score and HADS-Anxiety score, with a weak positive correlation ( $r=0.290$ ;  $p<0.001$ ). As the scores on the ASSSS increase, the HADS-Anxiety scores also increase. Stress and depression were weakly but significantly negatively correlated ( $r=-0.364$ ,  $p<0.001$ ). Higher stress was associated with lower depression scores. As the ASSSS score increases, the HADS-Depression score decreases.

## Discussion

This study provides valuable insights into the complex relationships between acute stress, anxiety, and depression among patients in ED settings. The discovery that 36.8% of patients fell within the borderline category for HADS-Anxiety and 49.1% in the abnormal category for HADS-Depression underscores the high prevalence of psychological distress in acute care environments. The findings confirm that acute stress is more closely aligned with anxiety symptoms, while its relationship with depression may be more complex. These findings contribute to a deeper understanding of how acute stress affects mental health in ED patients. The positive correlation between acute stress and anxiety is well-supported by existing literature. Acute stress often exacerbates anxiety, particularly in high-stress environments like the ED, where patients face uncertainty and fear regarding their health. Abar et al. [3] found that anxiety rates are significantly higher in ED patients than in the general population, driven largely by the acute stress experienced in these settings. Similarly, Koyuncu, and Karcioğlu [6]

demonstrated that acute exacerbations of chronic illnesses and the presence of systemic diseases significantly elevate anxiety levels in ED patients, reinforcing the need for early interventions in this context. Interestingly, the negative correlation between acute stress and depression observed in this study deviates from traditional models, which generally predict a positive relationship between stress and depressive symptoms. For instance, Marchesi et al. [5] and Kim et al. [11] found that higher levels of acute stress were associated with increased depressive symptoms in emergency and cardiac care patients. Similarly, Konstantopoulou et al. [13] reported that both clinical and subclinical stress were positively correlated with depression and anxiety levels, suggesting that stress typically exacerbates both conditions. However, Schultebraucks et al. [19] proposed that acute stress responses may initially suppress depressive symptoms due to heightened arousal and hypervigilance – especially in the early stages of crisis – potentially leading to a temporary inverse relationship. These contradictory findings underline the complexity of stress-related psychological responses and highlight the need to consider factors such as the timing of symptom assessment, clinical context, cultural influences, and individual coping mechanisms. Our findings may reflect an early-phase psychological profile in which anxiety dominates, while depressive symptoms are less pronounced or emerge later. Marchesi et al. [5] found that stress typically correlates with increased depressive symptoms in medical patients. One potential explanation for the negative correlation in this study is that acute stress triggers immediate, high-arousal responses such as hypervigilance, which overshadow depressive symptoms like low energy or anhedonia. Recent studies suggest that acute stress responses, which activate survival mechanisms, may temporarily suppress depressive tendencies during high-arousal phases [19].

Another plausible explanation is the temporal dynamics of stress and mood disorders. Acute stress may initially trigger anxiety, but as stress persists, depressive symptoms may emerge as psychological and physiological resources are depleted. This progression from

anxiety to depression has been documented in longitudinal studies, such as those by Schultebraucks et al. [19], who demonstrated that prolonged stress exposure often leads to a shift from anxiety to depression. In the context of emergency care, patients may be in the early stages of this transition, where anxiety dominates the psychological profile while depressive symptoms remain less evident. This finding suggests the importance of early intervention in managing anxiety to prevent the progression to more severe psychological conditions such as depression or post-traumatic stress disorder (PTSD). Several other studies have highlighted the importance of addressing psychological distress in ED patients to improve both short-term outcomes and long-term healthcare efficiency. For instance, Bentley et al. [20] found that patients with untreated anxiety or depression experienced longer hospital stays and higher rates of readmission.. Timely psychological interventions, such as counseling, pharmacological support, or complementary therapies, can help mitigate these issues. Au and Assavarittirong [7] also found that complementary therapies, including music and art therapy, were effective in reducing anxiety and improving patient outcomes in hospital settings, suggesting that such therapies could be beneficial in managing acute stress in ED patients.

According to recent reviews, ED patients with unaddressed anxiety and depression are more likely to experience prolonged hospital stays and adverse outcomes [21]. This study did not perform subgroup analyses based on patients' specific medical diagnoses (e.g. respiratory, cardiovascular, gastrointestinal). Yet, it is plausible that different diagnostic categories may present with distinct psychological profiles. Given these findings, it is clear that integrating mental health management into routine ED care could significantly enhance patient recovery and reduce the burden on healthcare systems.

*Clinical implications*

In terms of clinical implications, these findings highlight the importance of integrating psychological assessments and interventions into the standard care protocols in emergency settings. The incorporation of brief, validated screening tools for anxiety and depression, such as the Generalized Anxiety Disorder (GAD-7) or Hospital Anxiety and Depression Scale (HADS), could facilitate early identification of patients at risk. Timely interventions – whether through psychological support, pharmacological measures, or complementary therapies – could reduce the psychological burden on patients, improve recovery trajectories, and even reduce healthcare costs by minimizing the need for extended care or recurrent visits [18]. Future studies may also consider evaluating the impact of specific interventions – such as brief counseling, stress management education, or complementary therapies – on patient outcomes in emergency settings. Integrating such interventions into routine ED care may help mitigate psychological distress and improve both short- and long-term recovery.

*Limitations*

This study has several limitations that should be considered when interpreting the results. First, the study was conducted at a single hospital, which limits the generalizability of the findings to other settings. The results may not fully represent the experiences of patients in different geographical regions or healthcare systems. Second, the sample consisted only of patients who voluntarily participated in the study, which could introduce selection bias. Patients with more severe psychological conditions or those who were unwilling to participate may have been underrepresented.

One of the limitations of this study is that it was conducted in a single hospital. Therefore, the results are limited to the responses of patients who presented to that hospital during the data collection period and who voluntarily participated in the study. Cultural and environmental factors play a crucial role in shaping how individuals perceive and react to stress. In some cultures, the expression of psychological symptoms such as anxiety and depression may be minimized or somatized, while in others, emotional distress is more openly expressed and acknowledged. Additionally, environmental stressors such as healthcare accessibility, overcrowding in EDs, and social support systems may influence psychological responses and coping mechanisms. As this study was conducted in a single hospital in Türkiye, the findings may reflect cultural norms specific to this population, and generalization to other cultural contexts should be made with caution. Another limitation is that participation was voluntary, which may introduce selection bias. In addition, the lack of information regarding participants' prior psychiatric diagnoses may have influenced anxiety and depression scores.

## Conclusions

This study highlights the complex relationships among acute stress, anxiety, and depression in emergency care patients. The weak positive correlation between acute stress and anxiety aligns with literature, whereas the negative correlation with depression introduces new perspectives on the temporal dynamics of stress-related disorders. Further studies should clarify the mechanisms behind these findings and help in the design of effective interventions for psychological distress in emergency care. While this study provides a snapshot of the psychological status of ED patients, the temporal nature of stress-related disorders cannot be fully understood through cross-sectional data. Longitudinal research is essential to trace the progression of symptoms over time, determine causality, and understand how acute stress may

evolve into anxiety, depression, or even PTSD. It is believed that the time patients spend in the ED (e.g. waiting in triage, pre-treatment, and post-treatment periods) may affect their psychological state. However, this study did not differentiate between these time intervals. Future studies are recommended to assess these differences.

### **Disclosures and acknowledgements**

This study was conducted as part of a master's thesis at the Institute of Health Sciences, Istanbul Okan University.

The authors declare no conflicts of interest with respect to the research, authorship, and/or publication of this article.

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Before initiating the study, necessary permission was obtained by contacting the owners of the scales via email. Prior to data collection, ethical approval was obtained from the Istanbul Okan University Non-Interventional Clinical Research Ethics Committee. Institutional permission was obtained from Koşuyolu High Specialization Training and Research Hospital and the Provincial Health Directorate. Patients were informed about the purpose of the study, and their verbal and/or written consent was obtained.

Artificial intelligence (AI) was not used in the creation of the manuscript.

The data presented in the study can be accessed via contact with the corresponding author.

**References:**

1. Alshammari F, Alharbi R, Alenezi M, Alenzi M, Alanazi A. Prevalence of anxiety and depression in emergency department patients: a cross-sectional study. *Int J Environ Res Public Health.* 2022; 19(15): 9320.
2. de Witte L, Declercq F, Hermans L, Van Heeringen C. Prevalence of psychological symptoms among emergency department patients: a systematic review. *J Psychosom Res.* 2020; 130: 110231. <https://doi.org/10.1016/j.jpsychores.2020.110231>
3. Abar B, Holub A, Lee J, DeRienzo V, Nobay F. Depression and anxiety among emergency department patients: Utilization and barriers to care. *Acad Emerg Med.* 2017; 24(11): 1286-12689. <https://doi.org/10.1111/acem.13261>
4. Laloo R, O'Connor M, Harnett P, McGuire P. Mental health conditions in emergency departments: a scoping review. *BMC Emerg Med.* 2021; 21(1): 96.
5. Marchesi C, Brusamonti E, Borghi C, Giannini A, Di Ruvo R, Minneo F, et al. Anxiety and depressive disorders in an emergency department ward of a general hospital: a control study. *Emerg Med J.* 2004; 21(2): 175-179. <https://doi.org/10.1136/emj.2003.006957>
6. Koyuncu N, Karcioğlu O. Emergency department patients' clinical and demographic characteristics regarding Hospital Anxiety subscale. *Turk J Emerg Med.* 2018; 18(4): 162-166. <https://doi.org/10.1016/j.tjem.2018.01.001>
7. Au TY, Assavarittirong C. The overview of utilizing complementary therapy to relieve stress or anxiety in emergency department patients: animal-assisted therapy, art therapy, and music therapy. *Ment Health Glob Challenges J.* 2021; 4(2). <https://doi.org/10.32437/mhgcj.v4i2.125>

8. Möhler R, Renom A, Renom H, Meyer G. Complementary therapies to reduce stress in emergency departments: A rapid review. *Complement Ther Clin Pract.* 2023; 51: 101748. <https://doi.org/10.1002/14651858.CD009812.pub3>
9. Homma K, Chang B, Shaffer J, Toledo B, Hefele B, Dalrymple N, et al. Association of social support during emergency department evaluation for acute coronary syndrome with subsequent posttraumatic stress symptoms. *J Behav Med.* 2016; 39(5): 823-831. <https://doi.org/10.1007/s10865-016-9748-4>
10. Bailey B, Jenewein J, Priebe S, Gäbler S. Traumatic stress in emergency settings: Correlation with Anxiety. *J Emerg Med.* 2011; 41(2): 175-82.
11. Kim Y, Soffler M, Paradise S, Jelani Q, Dziura J, Sinha R, et al. Depression is associated with recurrent chest pain with or without coronary artery disease: a prospective cohort study in the emergency department. *Am Heart J.* 2017; 191: 47-54. <https://doi.org/10.1016/j.ahj.2017.06.003>
12. Gecaite J, Burkauskas J, Brožaitienė J, Mickuvienė N. Cardiovascular reactivity to acute mental stress. *J Cardiopulm Rehabil Prev.* 2019; 39(1): 54-60. <https://doi.org/10.1097/HCR.0000000000000457>
13. Konstantopoulou G, Iliou T, Karaivazoglou K, Iconomou G, Assimakopoulos K, Alexopoulos P. Associations between (sub)clinical stress- and anxiety symptoms in mentally healthy individuals and in major depression: a cross-sectional clinical study. *BMC Psychiatry.* 2020; 20(1): 52. <https://doi.org/10.1186/s12888-020-02836-1>
14. Figura A, Kuhlmann SL, Rose M, Slagman A, Schenk L, Möckel M. Mental health conditions in older multimorbid patients presenting to the emergency department for acute cardiac symptoms: cross-sectional findings from the EMASPORT study. *Acad Emerg Med.* 2021; 28(11): 1262-1276. <https://doi.org/10.1111/acem.14349>

15. Cohen J, Cohen P, West SG, Aiken LS. Statistical power analysis for behavioral sciences. 2<sup>nd</sup> ed. New York: Routledge; 1988.
16. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatr Scand.* 1983; 67(6): 361-370. <https://doi.org/10.1111/j.1600-0447.1983.tb09716.x>
17. Aydemir Ö, Güvenir T, Küey L, Kültür S. Validity and reliability of the Turkish version of the Hospital Anxiety and Depression Scale (HADS). *Turk J Psychiatry.* 1997; 8(4): 280-287.
18. Aşçıbaşı S, Öztürk B, Karaca S. Acute Stress Symptom Severity Scale (ASSSS) Turkish Validation Study. *Alpha Psychiatry.* 2017; 18(2): 38-44. <https://doi.org/10.5455/apd.237985>
19. Schultebraucks K, Shalev AY, Michopoulos V, Grudzen CR, Shin S-M, Stevens JS, et al. A validated predictive algorithm of post-traumatic stress course following emergency department admission after a traumatic stressor. *Nature Medicine.* 2020; 26(7): 1084-1088. <https://doi.org/10.1038/s41591-020-0951-z>
20. Bentley MA, Crawford J, Wilkins JR, Fernandez AR, Studnek J. An assessment of depression, anxiety, and stress among nationally certified EMS professionals. *Prehosp Emerg Care.* 2013; 17(3): 330-338. <https://doi.org/10.3109/10903127.2012.761307>
21. Laloo R, O'Connor M, Harnett P, Ski D, Ross B, Thompson J, et al. Mental health conditions in emergency departments: a scoping review. *BMC Emergency Medicine.* 2021; 21: 96. <https://doi.org/10.1186/s12873-021-00484-3>