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Research paper

Burnout and posttraumatic stress in paediatric critical care personnel: Prediction from resilience and coping styles

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ABSTRACT

Introduction: Our aims were (1) to explore the prevalence of burnout syndrome (BOS) and posttraumatic stress disorder (PTSD) in a sample of Spanish staff working in the paediatric intensive care unit (PICU) and compare these rates with a sample of general paediatric staff and (2) to explore how resilience, coping strategies, and professional and demographic variables influence BOS and PTSD.

Materials and Methods: This is a multicentre, cross-sectional study. Data were collected in the PICU and in other paediatric wards of nine hospitals. Participants consisted of 298 PICU staff members (57 physicians, 177 nurses, and 64 nursing assistants) and 189 professionals working in non-critical paediatric units (53 physicians, 104 nurses, and 32 nursing assistants). They completed the Brief Resilience Scale, the Coping Strategies Questionnaire for healthcare providers, the Maslach Burnout Inventory, and the Trauma Screening Questionnaire.

Results: Fifty-six percent of PICU working staff reported burnout in at least one dimension (36.20% scored over the cut-off for emotional exhaustion, 27.20% for depersonalisation, and 20.10% for low personal

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accomplishment), and 20.1% reported PTSD. There were no differences in burnout and PTSD scores between PICU and non-PICU staff members, either among physicians, nurses, or nursing assistants. Higher burnout and PTSD rates emerged after the death of a child and/or conflicts with patients/families or colleagues. Around 30% of the variance in BOS and PTSD is predicted by a frequent usage of the emotion-focused coping style and an infrequent usage of the problem-focused coping style.

Discussion and Conclusions: Interventions to prevent and treat distress among paediatric staff members are needed and should be focused on: (i) promoting active emotional processing of traumatic events and encouraging positive thinking; (ii) developing a sense of detached concern; (iii) improving the ability to solve interpersonal conflicts, and (iv) providing adequate training in end-of-life care.

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1. Introduction

Paediatric intensive care staff experience a very demanding environment day to day in which they are continuously exposed to traumatic events, changing and stressful situations, and children and families suffering. Research aiming at studying mental health among intensive care staff is scarce; however, studies published to date agree that they show rates of work-related stress so high that they have reached epidemic levels.¹

The most explored outcome in healthcare providers has been burnout syndrome (BOS). It was initially defined in the 1970s as a state of fatigue or frustration that resulted from professional relationships that failed to produce the expected rewards.² Maslach et al later defined BOS as an inappropriate response to chronic work stress (especially interpersonal) that involved three dimensions: emotional exhaustion (EE; the feeling of being over-extended and depleted of resources, representing the basic individual stress dimension of burnout), depersonalisation (DP; a cynical and distant attitude towards one's work and the people one works with), and a diminished sense of personal accomplishment (the tendency to evaluate one's achievements at work negatively).^{3–5} The three-dimensional structure of BOS has been confirmed in different studies.^{6,7} Clinical burnout symptoms are non-specific and include tiredness, headaches, eating problems, insomnia, irritability, emotional instability, and rigidity in relationships with other people.⁸ BOS occurs among various professionals who work with other people in challenging situations, especially in helping professions (e.g., physicians, nurses, teachers, and police officers). It has mostly been studied among healthcare providers, such as nurses and physicians.³

Considering that critical care healthcare workers deal with an especially high-risk context (they must encounter patients who are critically ill, care for unstable patients, carry out procedures accurately, react to extremely urgent matters, support the families when the patient dies,⁹ etc.), it is not surprising that studies consistently find high levels of BOS in this population.¹ Two studies conducted in adult intensive care units (ICUs) in France have found that around 50% of physicians¹⁰ and 30% of nursing staff reported BOS.¹¹ A study conducted in Spain showed lower rates, with 16% of nurses, 14% of resident doctors, 13% of physicians, and 10% of nursing assistants reporting BOS.¹² In the context of paediatric intensive care units (PICUs), findings have been similar. A study conducted in a PICU in the UK found that 61% of physicians and nurses showed high rates of burnout in at least one of its three dimensions,¹³ and a more recent study found a prevalence of 37%.¹⁴ In a study conducted in Argentina, the BOS rate in PICU physicians was 41%,¹⁶ and in the United States, it was nearly 50%.¹⁶ The overall view emerging from these studies is that in different countries the rates of psychological impairment in intensive care clinicians is alarmingly high. This can have many negative consequences, as burnout is associated with diminished work effectiveness,⁴

decreased quality of care,^{17,18} poor communication with the families,^{17,19} and costs related to absenteeism, all of which have particularly devastating consequences in the PICU.

A less studied psychological consequence in ICU and PICU staff is posttraumatic stress disorder (PTSD) even though it is the most commonly explored outcome in people who have faced traumatic situations. PTSD occurs as a consequence of the exposure to an event which is a threat to an individual's life or to the life of a close family member or friend. Furthermore, it may result from specific circumstances under which the individuals are repeatedly exposed to intense adverse situations,²⁰ such as professionals exposed to people who have suffered traumatic events (e.g., emergency personnel). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,²¹ a PTSD diagnosis requires symptoms of at least 1 month's duration that have a significant impact on social and occupational functioning and that are not the result of either another medical condition or the effect of substances. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, identifies four symptom clusters that characterise PTSD: intrusive symptoms, avoidance, disturbed emotional states, and alterations of arousal and reactivity.²¹ A meta-analytic review found that 14.8% of physicians reported PTSD, this prevalence being greater than in the general population.²² A study conducted in an ICU in the United States found that 24% of nursing staff reported PTSD, and that this rate is higher than in staff members from other units.²³ A study conducted in Singapore found that 33% of ICU staff suffered from significant PTSD symptoms.²⁴ Focusing on the PICU, Colville et al.¹³ found that 18% of staff members showed clinically significant symptoms of PTSD.

Considering the high occurrence of BOS and PTSD among PICU working staff, it is crucial to study which factors contribute to or can prevent the development of burnout and PTSD. Resilience, defined as the process of positive adaptation despite experiences of significant adversity,²⁵ has emerged as a protective factor for psychological disorders among intensive care staff members.^{13,14,26,27,28} Additionally, certain coping strategies have been associated with lower risk for burnout and PTSD. Individuals who chose to "keep busy" reported higher rates of burnout and those who regularly chose to "ignore stress" at work showed higher PTSD. In contrast, those who try to find benefits and learning in their work reported the lowest rates of psychological impairment.^{13,14} A study that aimed at exploring the mechanism by which resilience acts as a protective factor found high-resilient intensive care nurses use different coping strategies (more cognitive flexibility, optimism and higher social support) than those who report PTSD,²⁵ which suggests a relationship between resilience and coping strategies.

Additionally, some demographic variables are related to distress. Some studies have found no association of sociodemographic variables with mental health,⁶ while others found that women,¹⁰ younger professionals,^{11,15,29} and divorced/separated

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