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## ICU Volume 7 - Issue 1 - Spring 2007 - Cover Story: Burnout in Care

### Staff Burnout in the Intensive Care Unit During Major Catastrophes:

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Carol S. North, MD, MPE<sup>2,4,5</sup>

Barry A. Hong, PHD<sup>6</sup> Paul E. Pepe, MD, MPH<sup>1,3,4</sup>

The School of Public of Health

(1) and the Departments of Psychiatry

(2), Medicine(3), and Surgery-/Division of Emergency Medicine

(4) at the University of Texas Southwestern Medical Center; the North

Texas Veterans Administration Health Care System(

5), Dallas, TX; and the Washington University School of Medicine Departments of Psychiatry and Internal Medicine

(6) [Paul.Pepe@UTSouthwestern.edu](mailto:Paul.Pepe@UTSouthwestern.edu)

#### Introduction

Catastrophic events can extract extraordinary physical and mental energy from care providers, not only at the actual disaster sites, but also in medical critical care settings. Extraordinary intensive care workloads can span hours, days, even weeks. Working around the clock and caring for countless critically ill persons, even the most veteran and tested professionals can be drained of their physical and mental reserves. Amplified by grotesque injuries, intense suffering and imminent deaths, disaster settings provide the essential ingredients for true, acute burnout.

Post-traumatic stress disorder (PTSD) is an anxiety disorder that develops in response to surviving or directly witnessing an event that threatens life or limb (American Psychiatric Association 2000), and considerable research has been conducted on PTSD among disaster survivors and disaster workers alike (Norris et al. 2002). But disaster burnout, which concerns the aftermath of prolonged stress and exhaustion after a catastrophic event, has received less attention. Most research into burnout has been conducted in relation to chronic work stress on firefighters, paramedics and critical care personnel in non-disaster settings. In these settings, burnout has been associated with factors such as duration of disaster work (Flannelly et al. 2005; Kinzl et al. 2006), patient care burden (Aiken et al. 2002; Poncet et al. 2006), lack of social support (Beaton et al. 1997; Embraco et al. 2007; Mitani et al. 2006; Poncet et al. 2006), conflicts with colleagues (Beaton et al. 1997; Embraco et al. 2007; Mitani et al. 2006), increasing age (Boscarino et al. 2004; Flannelly et al. 2005; Poncet et al. 2006), non-supportive work environment (Beaton et al. 2001; Boscarino et al. 2004; Kinzl et al. 2006), and ineffective leadership (Beaton et al. 2001). Little information is available on short-term burnout in intensive care units (ICUs) following mass-casualty situations, but, anecdotally, it does occur with frequency. Lacking sufficient data, experts currently must adapt suggestions for prevention and management of disaster burnout from the available literature on chronic burnout in ICU settings (Poncet et al. 2006; Embraco et al. 2007). Nevertheless, developing strategies sensitive to the unique demands of specific disaster phases in the ICU may provide pathways to help manage or even prevent acute burnout.

A suggested tool for preventing and managing disaster burnout may be found in P-FLASH II ©, an empirically-based disaster mental health training program. The medical center-oriented component of P-FLASH II© (entitled, "MC-FLASH") summarizes disaster mental health issues likely to occur in hospital critical care settings and provides interventional strategies relevant to the specific phases of post-disaster situations. While, for the sake of brevity, only the leadership and managerial aspects of mental health from this program will be reviewed in this discussion, those interested in this topic should pursue the full MC-FLASH materials.

#### The Disaster "Cascade"

Consideration and evaluation of the specific demands and interventions appropriate to various specific post-disaster phases are essential for effective disaster preparedness in medical facilities. Although specific reactions to disaster vary, MC-FLASH describes five general, discernable phases of response, including: 1) the "Crisis" phase; 2) a "Later" phase; 3) an "Even Later" phase; 4) a "Long-Term" phase; and, 5) a "Preparation" phase. Although these names provide a conceptual template for five stages, it should be emphasized that these phases are not always distinct, consistent and universally applicable, nor are they invariably predictable or even sequential in every circumstance. The "disaster cascade" is a metaphor that likens the phases to travel over a waterfall and through its downstream runoff. The "Crisis" phase is a relatively brief period of minutes to hours when casualties mount and survival is of primary concern (the "waterfall"). The "Later" phase, typically lasting days, is like the initial whitewater rapids below the falls, where those involved try to stabilize after the chaos and attempt to inventory their losses. The "Even Later" phase, lasting weeks to months, finds much smoother currents for the initiation of healing processes. Then, in the "Long-Term" phase, continuing for months or years, there is emergence into calmer waters, enabling people to come to terms with the residual effects of the disaster. Coming full circle, the "Preparation" phase, which is symbolized by a lake behind a dam, reflects how we anticipate and prepare for the

next (inevitable) event.

#### **“Crisis” Phase**

During the free-fall of the immediate crisis, the first disaster-related mental health task is to provide relevant information that will keep the ICU staff safe and informed about the safety of their loved ones. This task requires accurate, yet reassuring, risk communication. Leaders must skillfully defuse anxiety/fear-producing rumors with valid information. An attempt to triage the burdens of care is also needed when ICU personnel, already burdened with many critically ill patients, must suddenly take on the increased demands of many new injured/ill patients, and, at the same, worry about their personal safety and that of their loved ones. This may mean creation of a “safehouse” or protected, temporary nearby shelters. It may simply involve routine visitation mechanisms for loved ones where frequent visits can occur, especially to reassure staff.

#### **“Later” Phase**

The main problems in this early, tumultuous phase are productivity issues, interpersonal interactions, personnel problems and sheer exhaustion. To prevent burnout, sufficient staffing is needed, not only to meet the increased clinical demand in the postdisaster setting, but also to increase opportunities for periods of downtime to improve effectiveness and provide emotional support. For those who feel compelled to serve above and beyond in a time of crisis, “assigned” downtime can be incorporated as an integral part of their “duties.” At the same, managers need to treat and provide “care” for staff with the same compassion that they would “normally” provide for patients. Kind words, compassionate gestures, personal attention, food, even monetary compensation and time off are among the most powerful positive social reinforcement tools in the post-disaster workplace - as are access to mental health service and simple listening.

Some staff, particularly those with vulnerable family members, may feel pressure to leave (or not even arrive) for work, thus compounding the staffing needs. Others who decide to stay may need help balancing personal worries and selfcare with their duties. Clearly stressed, some will want to vent to supervisors, even without expectations that the problems will be solved. Listening empathetically to individuals and groups at some length is a powerful tool, but such venting should not go on indefinitely in the face of high clinical demand and increased need for personal downtime. After listening, managers must gently attempt to inspire and direct people to develop positive solutions. In addition, information about the emotional healing process and normal reactions to disasters can facilitate emotional adjustment and guide people to seek appropriate treatment when needed. In addition, the turbulence of interpersonal issues can be infectious, and managers must approach interpersonal issues proactively, using their persuasive skills or their authoritative strength to mediate conflicts and enforce overall decorum and order.

#### **“Even Later” Phase**

The issues in this downstream phase, spanning weeks to months, require a balance between postdisaster demands and the re-establishment of individual priorities. After a disaster, the re-stabilization of resources may have been too little and too slow. ICU leaders must be creative and flexible in re-prioritizing available resources and stress that interim interventions are expected only to be temporary solutions – such as reducing individual workloads to fit current priorities by adjusting their roles and responsibilities, understanding that many typical duties and needs may go unmet. Although the currents are relatively steadier, leaders will still need to serve as lightning rods for continued anger, blame and entitlement, which must be recognized as normal, universal coping behaviors. Leaders should appreciate that their task is to listen to problems without feeling defensive and that they are expected to solve problems (which are often clearly unsolvable). Nevertheless, setting gentle and compassionate limits on these venting behaviours may be appropriate and healthy.

#### **“Long-Term” and “Preparation” Phases**

In the “Long-Term” phase, ICU staff members adjust and stabilize, though life and work may no longer be the same. Emotional healing continues into this more tranquil phase, and behavioral problems are more likely to represent longstanding, difficult, unresolved problems. People may want to blame everything that is wrong in their lives on the disaster, becoming embittered and negative about the event and not their own inherent issues. The main behavioral tasks in this phase are to move forward by removing barriers to progress, re-establishing support patterns, implementing active future planning and aspiring to make things even better than they were before the disaster.

Over the long term, authorities must combat collective attitudes of blame, entitlement and negative thinking through effective communication. Maintaining a problem-focused and positive, futureoriented approach is essential. For managers, fiscal planning contingencies for such “rainy day” events (staffing, shelters, downtime, support) must be anticipated and become line items in annual budgets.

#### **Conclusion**

To prepare and appropriately counteract burnout in the ICU, knowledge about the various psychological phases of post-disaster situations and their potential effects on care providers and institutions is required. Having available strategies for managing them may lessen the threat of ICU burnout in the post-disaster phase.

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