COMMENTARY

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Burnout, Posttraumatic Stress Disorder, or Both — Listen Carefully!

Health care workers have described the hospital environment due to the Coronavirus disease 2019 (COVID-19) pandemic as "a war zone." They describe a chaotic, traumatizing environment surrounded by death of individuals unable to say their good-byes with family, and family members unable to grieve in their culturally acceptable manner. The medical literature and the lay press describe "burnout" among staff. A few articles mention posttraumatic stress disorder, but do not describe the differences.

The pandemic has brought a slew of articles on burnout. It seems that everyone has burnout: undergraduates because they are restricted socially; medical students who are over zoomed; residents who are now called upon to cover extra shifts or work in areas of the hospital in which they are uncomfortable; and attending physicians unprepared to handle the human devastation. Hospital administrators are burned out trying to procure personal protective equipment and maintain staffing as staff become ill or must restrict their hours with schools closed and their children learning on-line at home. As concerned as I am about increased 'burnout' among medical personnel, what I learned while a resident, residency program director, and a chair of a department of medicine, is that burnout is more likely to be observed with an array of interventions that can have significant positive effects, while posttraumatic stress disorder is more likely to be missed, with a greater chance of significant problems, including suicide. So, reflecting on my past and reading about the present, I have become very concerned for my colleagues, young and those more senior, that we may be missing the posttraumatic stress disorder due to COVID.

Burnout is not considered a "disease state." Instead, it is listed in the International Classification of Diseases and Related Health Problems, 11th edition as a syndrome resulting from chronic workplace stress that has not been successfully managed. Burnout is characterized in 3 dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job or feelings of negativism or cynicism related to one's job; and a sense of ineffectiveness and lack of accomplishment.[1] These 3 dimensions can be formally evaluated and followed using the Maslach Burnout Inventory.

During this time of the COVID pandemic, it is quite understandable that a large percentage of the public, let alone our health care workers, are exhausted, without having the opportunities to continue the activities that bring balance to their week: exercise, dinner with family, quiet time to read, a night out with friends, etc. Nurses and physicians often equate patient death with personal failure, and lack of needed resources for safe and effective patient care easily leads to workplace cynicism.

The burnout triad is easily recognized. Health care workers saddled with increased responsibility, often lacking self-confidence, who are working long hours and feeling unaccomplished can become very cynical. I kept a letter from my Chief Resident written to me mid-way through my second year of residency, recognizing my increasing burnout and urging me to care for myself and to spend more time with my husband and friends.

The intervention to reverse burnout must be directed to developing personal methods to achieve some control in one's work environment and investing in some activity such as singing in the church choir, a movie night with friends, or routine exercise that brings relief from the heavy burden of caring for others. As the burnout deepens, first signs of reactive depression may appear—change in sleep habits, irritability, and somatic complaints. When early intervention is not successful and continued burnout brings on a depressed state, referral to a counselor with the positive endorsement and support from the boss to include protected time to participate in individual therapy or support groups remains essential. The health care worker should not perceive burnout as a personal failure.

During my time as a Chair of Medicine, an internal medicine faculty member, who was active military and deployed to Iraq, returned 6 months later with nightmares, difficulty focusing, and a change in affect. It was clear that

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this "clinical presentation" was not burnout. After a few directive questions, the working diagnosis was posttraumatic stress disorder. The triggering witnessed traumatic event was the overwhelming disabling injuries, including loss of limbs in young adults, in addition to death. Most civilian health care workers, physicians, nurses, emergency medical technicians, etc. have been protected from the continuous trauma present in a war environment. Fortunately, this faculty member had a supportive family, caring colleagues, and a faith community. With professional help and time, the faculty member fully recovered and returned to his previous position. Reflecting on my residency, I ultimately understood the wisdom of assigning a psychiatrist to join work rounds in the intensive care unit once a week. The psychiatrist was positioned to help the residents and nursing staff handle the trauma of repetitive death.

Unlike burnout, posttraumatic stress disorder is recognized in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition.[2] The trigger to posttraumatic stress disorder is exposure to actual or threatened death, serious injury, or sexual violation. The exposure must result from one or more scenarios: the person must directly experience the traumatic event; personally witness the traumatic event; learn that the traumatic event occurred to a close family member or close friend; or experience first-hand repeated or extreme exposure to aversive details of the trauma. Behavioral symptoms are important to the diagnosis and include re-experiencing the traumatic event, such as recurrent dreams or flashbacks; avoidance described as distressing memories, thoughts, or reminders of the event; negative moods or cognitions; and arousal that include aggressive, reckless, or self-destructive behavior, sleep disorders, and hypervigilance.[2] The primary intervention for a person with posttraumatic stress disorder is psychotherapy, including cognitive therapy, exposure therapy, and eye movement desensitization, and reprocessing with or without medications.

When people with burnout or posttraumatic stress disorder are tested, the outcomes on the Maslach Scales may overlap.[3] Suicide is a concern in both groups. Burnout is felt not to be a direct cause of suicide, but significant chronic burnout may lead to clinical depression, which increases the risk of suicide. Studies suggest that depression is highly comorbid with posttraumatic stress disorder and a risk factor for death from suicide. Thus, depression may be a "confounder, mediator, or modifier of the association." Studies of veterans and active duty military have led to conflicting outcomes of the relationship of posttraumatic stress disorder, with increase in suicides.[4]

Acknowledgement of the difficult environment due to the COVID pandemic by leaders in health care is the first step in approaching the mental health challenges. Every intervention is helpful, from shortening shift lengths and rotating weekends off, to support groups and Schwartz rounds. Access to mental health providers is essential, but self-referral remains difficult for those in medicine. Colleagues suffering from stress need support to understand that they are not responsible for work-induced burnout. However, each of us has the ability to moderate our individual environment through the development of personal coping strategies in addition to working together to advocate for workplace change. Neither of these strategies are easy during a pandemic. Health care workers did not anticipate that the disruption and devastation of the COVID pandemic could trigger the posttraumatic stress disorder, nor has the medical literature directly discussed why the interventions for burnout were unlikely to reverse effects of the resulting trauma. Thus, it is important to differentiate the 2.

The COVID pandemic is likely to continue for many months. It is therefore imperative that every health care professional be mindful of their colleagues and feel a responsibility to intervene to support those with suspected or identified burnout or posttraumatic stress disorder. Colleagues should not avoid asking their colleagues the questions that identify symptoms consistent with significant mental health issues, nor avoid confidential reporting of their concerns. Leadership should follow Abraham Lincoln's strategy to "Get out of the office and circulate among the troops,"[5] both for support and to assess their staff. Health care workers are the last to admit their need for help. Let us pledge to extend to our colleagues the quality care we would want for ourselves to save the lives of our colleagues and our patients.

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