Coping with Trauma Exposure at work in Forensic and Clinical Psychiatry

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The primary research questions are: 1. What is the extent of Adverse and Benevolent Childhood Experiences in frontline staff and treatment staff in general and forensic inpatient psychiatry in comparison to non-clinical staff? 2. To what extent is...

Ethical review	Approved WMO
Status	Recruiting
Health condition type	Other condition
Study type	Observational non invasive

Summary

ID

NL-OMON52666

Source
ToetsingOnline

Brief title
The CRITIC Study

Condition

- Other condition
- Psychiatric and behavioural symptoms NEC

Synonym
Childhood Adversity and Quality of Life

Health condition

Kwaliteit van Leven

Research involving
Human

Sponsors and support

Primary sponsor: Fivoor
Source(s) of monetary or material Support: door de werkgever van hoofdonderzoek A.F.T. Bloemendaal;betaald binnen zijn vaste aanstelling aldaar

Intervention

Keyword: Clinical Psychiatry, Frontline staff, Personal Life History, Trauma exposure

Outcome measures

Primary outcome

The main study parameters are:

1. Adverse and Benevolent Childhood Experiences

2. Professional Quality of Life (ProQol)

Secondary outcome

None

Study description

Background summary

Workplace trauma exposure in the psychiatric health care setting has a major impact on caregivers* functioning and health (Schablon, Wendeler et al. 2018). In the literature on current trauma exposure at the workplace several related concepts are being used including severe incidents, workplace violence, secondary or vicarious trauma, physical and psychological violence, occupational stressors and aggression towards staff (Baum 2016). This protocol will study all these forms of trauma exposure in forensic and clinical psychiatry using the term: workplace trauma exposure.
The prevalence of these forms of trauma exposure has been studied with increasing interest since the last years of the previous century. Poster (1996) provides us with an overview of studies done in the UK, Australian and United States presenting percentages of nurses working in acute and inpatient psychiatry experiencing an assault (lifetime and previous year) . In the UK more than 90% had experienced a physical assault during their career and 34%

more than 10 physical assaults, in Australia 85% of nurses experienced targeted aggression towards them and in the United States 76% of nurses were physically assaulted at least once in their career (Poster 1996). Two more recent studies describe similar results: Itzhaki, Bluvstein et al. (2018) reported that almost 89% of mental health nurses working in acute and inpatient psychiatry in Israel experienced verbal aggression in the last year and 56% physical violence. Niu, Kuo et al. (2019) reported rates that were very similar (82% verbal aggression and 56% physical aggression) in acute inpatient psychiatry in Taiwan in the previous year.
These aggressive incidents can have severe consequences. Schablon, Wendeler et al. (2018) found that between 27% and 44% of employees felt high levels of self-reported stress as a result of the incidents. This survey was conducted in Germany amongst nurses working in inpatient psychiatry, geriatric care, other residential facilities and day care centres (N=1984), of whom 94% had experienced verbal abuse and 70% physical abuse (Schablon, Wendeler et al. 2018). Additionally, in their systematic review, Lanctot (2014) found various categories of consequences of workplace violence for healthcare workers, including decreased physical, psychological and emotional functioning and various aspects of impaired worker performance (quality of care, financial, social and general impact).

Workplace trauma exposure in frontline and treatment staff versus non-clinical staff
The group with most exposure to workplace violence are nursing staff who work in inpatient units (Schablon, Wendeler et al. 2018). Magnavita and Heponiemi (2012) found that nurses in public health care, also called frontline staff, were more likely to encounter aggressive behaviour due to the increased amount of time spent caring for patients, compared to treatment staff who have less encounters with patients.
Frontline staff can be defined as the men and women working on the psychiatric wards in the direct and 24 hour care of admitted patients. They see patients many times during their shifts. There is much more interaction between frontline staff and patients than there is between treatment staff (comprising of physicians, social workers, psychiatrists and psychologists) and patients. Treatment staff may see the patients as little as once per two weeks, specialists sometimes even less. Finally, most non-clinically working staff have only minimal contact with patients, since usually they work in offices outside patient wards.

Childhood adversity and benevolent experiences as moderators for the association between workplace trauma exposure and professional quality of life
In recent years focus has shifted from psychiatric patients (who have relatively high levels of trauma and neglect in childhood), to professionals (psychologists, social workers, psychiatrists and direct support staff) working in mental health care, who also have higher incidence levels of childhood adversity than the general population (Esaki, 2013; Thomas, 2016; Keesler, 2018; Felitti, 1998; Anda, 2004; Herzog, 2018).

In his landmark study Felitti et al. (1998) first investigated to what extent the general population had experienced childhood adversity prior to the age of 12, and the impact of this adversity in later life. He defined these adversities, which he called an *Adverse Childhood Experience (ACE)*, as exposure to childhood emotional, physical or sexual abuse, and household dysfunction. The impact of ACE*s on many life domains, including mental and physical health, has been demonstrated in several studies that followed (for instance: Anda, 2004 and Herzog, 2018).
Interestingly, in professionals working in health care services, higher levels of ACE*s have been demonstrated as compared to professionals working in other areas. For example, in a study by Thomas (2016) it was found that Master of Social Work (MSW) students had experienced a relatively high number of ACEs as compared to the general population. Almost 80% experienced one or more ACEs and 42% four or more. The most frequently cited ACEs were physical abuse, emotional neglect and substance abuse (all > 40%) and about one-third reported mental illness and emotional abuse (Thomas, 2016).
Esaki (2013) reported that approximately 70% of child service providers reported at least one ACE, 54% two or more ACEs and 16% four or more ACEs, which is nearly twice as high as the general population.
Keesler (2018) investigated Direct Support Professionals (DSP) (N=386). DSPs provide support and care to people with intellectual and developmental disabilities. His online survey revealed 75% of the DSPs experienced one or more ACEs and 30% four or more ACEs. Female DSPs and persons who worked less than a year in this setting reported significantly higher ACE scores than males and more experienced staff (Keesler, 2018).

To date however, no research is known to the authors about the incidence of Adverse Childhood Experiences (ACEs) in frontline staff, treatment staff and non-clinical workers in general and forensic in- and outpatient psychiatry.
Also there might be a graded difference between frontline staff, and treatment staff and non-clinical staff in the incidence of childhood adversity.

Benevolent Childhood Experiences

In addition, there is increasing scientific interest into the counterpart of Adverse Childhood Experiences (ACEs): Benevolent Childhood Experiences (BCEs) (Narayan, Rivera et al. 2018). It is believed that higher BCEs are protective against the long term effects of ACE*s and that this is associated with resilience, less trauma related symptomatology and less stress exposure during pregnancy (Narayan, Rivera et al. (2018); Sheerin, Amstadter et al. (2019).
Very little is known about ACEs and BCEs in frontline staff, treatment staff and non-clinical workers, and how they interact in case of stressors at the workplace.

Professional Quality of Life and workers performance

Previous or ongoing stressors have been shown to be risk factors for a negative mental health outcome of current critical incidents (Brewin, Andrews et al. 2000). Remarkably, not much is known about the personal histories of frontline

staff, treatment staff and non-clinical staff, both negative and positive, and how this influences their professional quality of life and coping strategies with traumatic events.

In summary, the topics addressed above indicate the importance and relevance of gaining more knowledge about the associations between workplace trauma exposure and professional quality of life in frontline and treatment staff, compared to non-clinical staff, and how this association is moderated by ACE*s and BCE*s. This study has conceived the following aims to diminish this gap in our understanding.

Study objective

The primary research questions are:
1. What is the extent of Adverse and Benevolent Childhood Experiences in frontline staff and treatment staff in general and forensic inpatient psychiatry in comparison to non-clinical staff?

2. To what extent is the relation between workplace trauma exposure and professional quality of life moderated or mediated by childhood adversity and benevolence?

Study design

Cross-sectional design

Study burden and risks

The nature and extent of the burden and risks associated with participation are:
1. Answering questions about adverse childhood experiences and stressful experiences at work can be experienced as confronting and invoke negative emotions.
2. Completing the questionnaires will take 30-45 minutes. The questionnaires may be completed in parts to diminish the burden.

This study covers the very important subject of investigating new pathways to improving the professional quality of life in frontline staff. The burden of completing several questionnaires is acceptable within the scope of this study.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)

Inclusion criteria

• Work in clinical or forensic psychiatry in The Netherlands as frontline staff, other clinicians or administrative staff.
• Have enough mastery of the Dutch language to complete the measurements.
• Have given informed consent.
• Over the age of 18

Exclusion criteria

• Have not given informed consent

Study design

Design

Study type:	Observational non invasive
Intervention model:	Other
Allocation:	Non-randomized controlled trial
Masking:	Open (masking not used)

Primary purpose: Basic science

Recruitment

NL

Recruitment status:	Recruiting
Start date (anticipated):	15-03-2022
Enrollment:	360
Type:	Actual

Ethics review

Approved WMO Date:	06-01-2022
Application type:	First submission
Review commission:	METC Erasmus MC, Universitair Medisch Centrum Rotterdam (Rotterdam)
Approved WMO Date:	08-12-2022
Application type:	Amendment
Review commission:	METC Erasmus MC, Universitair Medisch Centrum Rotterdam (Rotterdam)

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL73417.078.20