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Psychosocial support to medical teams in SAMUR-Protection Civile during COVID-19

Soutien psychosocial des équipes médicales préhospitalières du SAMUR-Protection Civile pendant la pandémie COVID-19

Francisco Javier De Blas Esteban
(Scientist and member of scientific committee)
SAMUR-PC, Ronda de las Provincias, 7, 28011 Madrid, Spain

Sara Laguna Bonilla (Scientist volunteer and member of scientific committee)

Paloma Miravet González (Head of Division)
Paloma C Rey Paterna (Head of Unit)

SUMMARY
The COVID-19 pandemic has had an exceptional impact on the health system. The lack of information and resources during the first stage of the outbreak COVID-19 has also meant a change in the way we work and in the way we relate to our relatives, colleagues and, of course, our patients. This traumatic situation, due to its characteristics of total uncertainty, novelty, frequency, and high intensity, made it necessary to develop a new approach to our work, a new psychological approach to the pandemic situation that leads to acute stress, insecurity, unknown consequences, uncertainty about its duration and a desolate future. During the first wave, it was necessary to respond to the new situation. In a first phase, an intervention protocol was created for front-line pre-hospital emergency professionals and a COVID-19 psychological unit was set up in a pandemic hospital in Madrid. In a second phase, emergency actions, their conditioning and possible change due to confinement are analysed; the emotional state of front-line intervention personnel is assessed, comparing the pre- and post-first wave period, and burnout syndrome is studied in the SAMUR-Civil Protection volunteer corps.

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RÉSUMÉ
La pandémie COVID-19 a eu un impact exceptionnel sur le système de santé. Le manque d'informations et de ressources qui ont été ressentis lors du premier état d'alerte COVID-19 a également signifié un changement dans notre façon de travailler et dans notre façon d'être en relation avec nos proches, nos collègues et, bien sûr, nos patients. Cette situation traumatisante, en raison de ses caractéristiques d'incertitude totale, de nouveauté, de fréquence et de haute intensité, a rendu nécessaire le développement d'une nouvelle approche de notre travail, une nouvelle approche psychologique de la situation pandémique qui a conduit à un stress aigu, une insécurité, des conséquences inconnues, une incertitude sur sa durée et un avenir désastreux.
Lors de la première vague, il a fallu réagir à la nouvelle situation. Dans une première phase, un protocole d'intervention a été créé pour les professionnels de l'urgence pré-hospitalière de première ligne et une unité psychologique COVID-19 a été mise en place dans un hôpital pandémique de Madrid.
Dans une deuxième phase, les actions d'urgence, leur conditionnement et leur éventuel changement dû au confinement sont analysés; l'état émotionnel du personnel d'intervention de première ligne est évalué, en comparant la période précédant et suivant la première vague, et le syndrome d'épuisement professionnel est étudié dans le corps des volontaires de SAMUR-Protection civile.
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KEYWORDS
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Corresponding author.
E-mail address: deblakej@madrid.es

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INTRODUCTION

SAMUR-Protection Civile (SAMUR-PC) approached the COVID-19 pandemic with an urgent need of coping with work-related traumatic situation among health care workers, due to different factors: the newness, impact, high intensity, incidence, duration, insecurity, and unknown consequences of the pandemic.

This led to a sense of a bleak future that required a new psychological approach to care and intervention to successfully deal with the trauma generated.

Since health workers were working in all situations related to COVID-19: IFEMA (Fair institution of Madrid) field hospital, home emergencies, assistance to nursing homes, etc., the methodology to avoid this traumatic situation was developed in all its aspects of specific prevention as well as non-specific prevention.

The objective of our work was to relieve and integrate the pandemic as a new reality, facilitating positive coping resources.

FIRST PHASE

"How to deal with stressful and high emotional impact situations": Protocol, techniques and training tools

Techniques and resources are taught to deal with a high-stress situation such as that of health workers during COVID-19 pandemic. It is a personal training method consisting of videos and audios for the development of skills and abilities that facilitate a change in attitude and encourage more positive behaviour.

It is a format of tools that avoid the negative psychological impact, the blocking of the nervous system in extreme situations and the state of permanent activation from which it is difficult to disconnect with possible difficulties in stopping the activity, sleeping, getting certain images or ideas out of one’s head, or feeling dizzy and losing concentration.

It facilitates emotional discharge and the unblocking of a nervous system that has been temporarily saturated [1].

These techniques strengthen the individual’s available resources, increasing resilience, resulting in personal and functional improvement. Videos about these techniques are available on SAMUR-PC youtube channel.

The intervention protocol explains what happens in our brain when we have to face situations of high emotional stress, the emotional reactions related, and what we can do to develop skills and abilities to face positively the new pandemic situation. The protocol also teaches techniques to deal with high stress and high emotional impact situations, thought control techniques and cognitive restructuring to learn how to self-regulate the frequency of emotions, breathing techniques, change the negative thought into a neutral thought, transforming it into a positive thought, techniques for stopping intrusive thoughts that make us feel negative emotions, emotional self-control techniques like physical relaxation, when to do it and the right position. Videos and audios allow the practice of basic relaxation, positive dissociation like sunset, deep sleep, sawing and temporary concentration of negative phases.

Creation of a psychological unit

Given the urgency, a rapid response is required. A COVID-19 psychological unit was created and installed in the IFEMA contingency hospital. Several institutions participated in this project: emergency medical service (SUMMA & SAMUR-PC), psychosocial team of the Civil Protection volunteer corps, Red Cross psychologists and psychosocial court teams.

The unit supported the:

- patients in direct intervention, by telephone and face to face if possible;
- relatives: Through the daily clinical report, the need for intervention is detected and materialised by telephone and in person. For the first time, the possibility of saying goodbye to family member in person has been established, with preparation before and after the farewell that facilitates the beginning of the grieving process;
- health care workers: Individual and group interventions have been developed at the beginning of the service, at the end of the service, at any time when needed.

Prevention actions to minimise the psychological impact of the pandemic include the following: Encourage appropriate coping and facilitate recovery, provide active listening, convey safety, work to reduce reactivity to the outside world, be the bridge for union and family communication, detecting possible risk factors for psychopathology, provide information and initial psychological help, assessing and covering the needs for basic and other resources, facilitate the beginning of the grieving process, reduce future emergencies, link the patient's life history to the emergency, rescue skills and resources to cope with emergencies.

A total number of 444 psychological interventions were carried out: 116 in a face to face mode, and 328 by telephone.

SECOND PHASE

The second phase focuses on the analysis of both the interventions with patients, and their effects. As well as on the effects of the pandemic on SAMUR-PC workers and volunteers.

Emergency actions

A descriptive statistical analysis of pre- and post-pandemic emergency actions was carried out in March, April and May 2019 and 2020.

The results show that the emergency activations in the 2020 period compared to those in the same period in 2019 show a 100% increase in the care of elderly people at social risk, dead bodies in the home and in public spaces; an increase of 83.3% for psychiatric certificates. Sexual aggression has decreased in 17.24%, child abuse in 63.6%, gender violence in 66.7% and psychosomatic pathology in 64.1%. These data only include the scale of pre-hospital emergency actions.

Emotional self-report scale

A voluntary 14-variable emotional self-assessment scale by frontline health care staff was compared.

Necessary for the primary prevention of the possible emotional consequences that the management of COVID-19 could generate in the frontline work teams, was requested an ad-hoc created scale on emotional self-evaluation. Variables of the
study are to assess the presence of negative emotions in their daily lives, before and after the pandemic, after the first wave. The objective is to know the emotional state in crisis situation through a descriptive statistical analysis. The results of a total of 101 participants, the variables of stress, grief/sadness and anxiety are relevant as severe emotions, with increases of 90%, 93.7% and 76.4% respectively.

**Burnout in SAMUR-PC volunteers**

SAMUR-PC counts on both paid professionals and volunteers. The main objective of the organisation is to take care of both groups equally. For this reason, a survey was conducted on the effects of burnout in the volunteer group. A descriptive statistical analysis of the burnout and psychological impact among the volunteers of the SAMUR-PC caring for the patients of COVID-19 was carried out. The aim was to determine to what extent SAMUR-PC volunteers suffered from burnout syndrome symptoms related to the COVID-19 pandemic. Burnout syndrome can be defined as an inadequate response to chronic stress [2]. This is due to a perceived discrepancy between personal values, expectations and resources, and the reality of the organisation and what it has to offer. The main objective of this research is to determine whether burnout syndrome is present in SAMUR-PC volunteers (n = 441) using the CESQT questionnaire. A secondary objective would be the implementation of prevention and training plans for the burnout syndrome.

The origin of this syndrome lies mainly and exclusively in the working environment and conditions, working conditions, and its origin should not be identified in experiences in other areas of the person's life. Although they are subsequently affected [3]. Among the most notable risk factors are exposure to stress in harmful doses through lack of control and autonomy and uncertainty, a very hierarchical and rigid organisational structure, lack of instrumental and emotional support from the organisation, excessive bureaucracy and/or “personalised bureaucracy”, lack of participation, coordination and training adapted to the demands of the environment, lack of emotional reinforcement and/or rewards, as well as lack of professional and personal development within the organisation and seniority, the longer one has been in the organisation, the more likely one is to suffer from burnout. Age is also an important risk factor. The younger one is, the less experience and knowledge one has, and the more involved and motivated one is initially, the more likely one is to suffer from burnout [4].

Due to the personal skills in terms of involvement, desire to help and seeking to learn that SAMUR-PC volunteers tend to have in the initial stages of their volunteering, the hypothesis is that this is a population prone to developing symptoms of burnout at some point in their active life within the organisation. Participation in the study was requested on a voluntary basis and was obtained through a "Google Forms" form sent by e-mail to the entire database (BD) of currently active volunteers (n = 1,171).

The study sample consisted of a total of 441 SAMUR-PC volunteers, which represents an overall response rate of 37.67%. The overall response rate in the health care population. Population is about 39%, which is consistent with studies in the same category [4]. Of these, 256 (58%) are male and 185 (42%) are female. The age range is between 19 and 66 years, with an average of 37 years (standard deviation = 11.80). The average age of group membership is 7 years (SD = 7), and was also used as an exclusion or inclusion variable in the study. Due to the characteristics of the new recruits, it was decided that the data analysed would come from volunteers with at least one year of active service. The evaluation booklet consisted of two parts. The first part consisted of an "ad-hoc" questionnaire in which socio-demographic data and self-reported impressions of the service and treatment of volunteers are collected. The second part corresponds to the burnout syndrome assessment questionnaire - CESQT [5].

The findings are that a significant percentage of participants suffer or may suffer from burnout symptoms related to the working conditions that occurred after the COVID-19 pandemic.

The level of burnout corresponds to 14.5% in the 50-75th percentile, showing some symptoms and possibly having the syndrome in the near future, and 7.5% in the 75-100th percentile, showing symptoms compatible with the syndrome. With regard to the CESQT subscales, 13.1% of the sample showed indolence during interventions and 18.4% showed guilt after completing an intervention. Of note is the data on the work enthusiasm scale, with 8.2% of participants reporting a complete loss of enthusiasm for their work and/or the duties they perform. Finally, for the specialist teams, 20% of the participants in the CBRN team showed this symptomatology, probably associated with the performance of their tasks since the very beginning of the pandemic.

**CONCLUSION**

Negative emotions in the daily life of the healthcare workers dealing with COVID-19 patients have increased.

The actions taken with affected personnel, patients and relatives promote skills and attitudes to face the crisis in a positive way; reduce the consequences of trauma, reactivity to the outside world, integrating the emotional experiences generated by the traumatic pandemic event.

It is noted the correlation between the decrease in the number of cases of maltreatment in the emergency activations during the confinement.

**Disclosure of interest**

The authors declare that they have no competing interest.

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