Levin Taras I. Algorithm of complex therapy and prevention of emotional burnout in doctors-psychiatrists during the war and its effectiveness. Journal of Education, Health and Sport. 2024;62: 253-268. eISSN 2391-8306. https://dx.doi.org/10.12775/JEHS.2024.62.016
https://apcz.umk.pl/JEHS/article/view/53045
https://zenodo.org/records/12635999

The journal has had 40 points in Ministry of Education and Science of Poland parametric evaluation. Annex to the announcement of the Minister of Education and Science of 05.01.2024 No. 32318. Has a Journal's Unique Identifier: 201159. Scientific disciplines assigned: Physical culture sciences (Field of medical and health sciences); Health Sciences (Field of medical and health sciences). Punkty Ministerialne z 2019 - aktualny rok 40 punktów. Załącznik do komunikatu Ministra Edukacji i Nauki z dnia 05.01.2024 Lp. 32318. Posiada Unikatowy Identyfikator Czasopisma: 201159. Przypisane dyscypliny naukowe: Nauki o kulturze fizycznej (Dziedzina nauk medycznych i nauk o zdrowiu); Nauki o zdrowiu (Dziedzina nauk medycznych i nauk o zdrowiu).

The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 08.04.2024. Revised: 03.06.2024. Accepted: 14.06.2024. Published: 28.06.2024.

ALGORITHM OF COMPLEX THERAPY AND PREVENTION OF EMOTIONAL BURNOUT IN DOCTORS-PSYCHIATRISTS DURING THE WAR AND ITS EFFECTIVENESS

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Abstract. The purpose - to develop and determine the effectiveness of the algorithm of complex therapy and prevention of emotional burnout (EB) among psychiatrists during the war, to resolve the issue of its recommendation for wide implementation in the system of mental health care institutions. The research sample, which was formed in compliance with the principles of biomedical ethics and based on informed consent, included 120 psychiatrists who worked in the city of Kyiv in the period from February 24, 2022. During 2022, the persons under examination were divided into three groups: the first group included 37 persons (30.8%) – doctors with no signs of professional maladjustment (PMA), and a low level of EB; the second group consisted of 57 persons (47.5%) with signs of professional PMA, and a moderate level of EB; the third group consisted of 26 persons (21.7%) and they were respondents with clinically established and pronounced PMA, and a high level of EB. As a result of the study, the personal, psychopathological, psychosocial, professional and emotional-interpersonal factors of the formation and progression of EB among psychiatrists during the war were established, and their interrelationships in its genesis, on the basis of which the basic principles of a comprehensive approach to the therapy and prevention of EB were formulated for psychiatrists (complexity, personalization, phasing and availability), the main goals of treatment and prevention measures are defined and 4 therapeutic strategies of diagnosis, therapy and prevention are proposed within the framework of providing specialized medical care to psychiatrists during the war. These are

recommended to be implemented taking into account the degree PMA as a key descriptor of EB, and in accordance with the key vectors of pathological changes in the respondents. The implementation and further evaluation of the effectiveness of the mentioned measures proved their effectiveness in eliminating manifestations of EB and PMA, normalization of mental state with levelling of psychopathological symptoms, improvement of social and psychological adaptation and quality of life of psychiatrists. The results obtained make it possible to recommend this algorithm for wide implementation in the practice of mental health care institutions.

Key words: professional maladjustment; emotional burnout; mental stat; levelling of psychopathological symptoms; doctor- psychiatrist

Burnout and emotional exhaustion of medical workers have recently been considered as one of the most significant factors preventing their effective activity and harmful to health, besides it stops the overall successful functioning of various health care institutions. At the same time, therapeutic strategies aimed at solving the problem of burnout are largely inconsistent with the results of research on the prevalence and clinical features of emotional burnout (EB) in various areas of health care [1, p. 1429].

Vachon M. L. S. et al. (2015) note that a physician experiencing burnout may find it difficult to make a decision to quit (or continue) their work; at the same time, although short-term refusal and rest from work can be effective in the short term, the long-term effect on eliminating EB can be achieved only through mastering ways to cope with stressful factors at work [2, p. 969].

MountB.M. et al. (2007) emphasize the importance of establishing therapeutic relationships in EB eliminating process. The authors rely on the concept of "healing bonds", which postulates that isolation and a sense of disconnection are most associated with suffering and distress, and doctors with professional burnout and related conditions often describe an existential vacuum, a crisis of meaning and the inability to find solace or stability of the inner world, express feelings of victimization and the need for control [3, p. 372].

Neville K, Cole D A. (2013), Wilkinson H. et al. (2017) suggest that clinicians working with ith burnout symptom patients should work to develop these connections in their lives within and outside of their work environment; at the same time, self-development practices and increased empathy can reduce the risk of burnout among these professionals [4, p. 384; 5, p. 18].

Halifax J. (2018) proposed two related models of therapy aimed at developing and cultivating compassion. The first was the ABIDE compassion model:

1) attention and affect (A), which means the ability to maintain attention without distraction;

2) balancedness (B), meaning the attentiveness necessary to perceive the reality of suffering without becoming immersed in it, and the desire or motivation to alleviate suffering;

3) insight (I) refers to perceptual knowledge, which is an integral part of development

4) discernment (D) in difficult situations as part of the cognitive process. Embodiment, interest, and equanimity (E) indicate an innate desire to communicate with other people; however, the intention to alleviate suffering is a trait that distinguishes compassion from empathy when the motivational or behavioral component is contested.

The second was the GRACE model - an active contemplative practice aimed at cultivating compassion during interaction with others: attracting attention, recalling the intention, being attuned to oneself and others, attentiveness (openness to understanding and recognizing what can benefit the patient, and ethical involvement (acceptance) and completion of interaction [6, 304 p.].

Lamothe M. et al. (2016) reported the effectiveness of mindfulness-based stress reduction (MBSR), a protocol-based intervention that involves teaching mindfulness and stress reduction techniques, with an estimated number of approximately 8 sessions per week. The benefits of this technique are improved perspective taking and new ways of thinking and feeling about situations that cause anxiety. Although many other interventions may also include mindfulness techniques, MBSR is a specific form of mindfulness training that has an adequate evidence base for preventing and reducing burnout [7, p. 225].

Akoglu H. (2018) reports the high effectiveness of teaching interpersonal interaction through the use of feedback and manipulative methods in Balint groups, the purpose of which is to improve emotional intelligence (EI). At the same time, situations of negative events of professional activity are acted out in role-playing games and communication between group members. This allows them to analyze and feel the causes of complex and conflicting cases in professional activity and adverse changes in the emotional state, to identify deficiencies in the process of communication from the point of view of cognitive self-emotional regulation. Work in groups helps medical workers better understand, respect and accept the emotions and behavior of patients, improve their own EI and communication skills in situations close to real practice, reduce the number of conflicts, help doctors cope with important professional needs and challenges using the capabilities of EI [8, p. .100].

Fillion L. et al. (2017) recommend the use of meaning – centered psychology (MCP), a protocol-based, time-limited group or individual therapy that has been shown to be effective for

patients experiencing existential distress. MCP is based on V. Frankl's works and adapted for use in clinical situations related to diseases, including EB in doctors [9, p. 18].

Johnson B. (2014) notes that health care professionals, especially those who works in emergency and primary care, have to deal with both acute and chronic stressors associated with burnout states. In this situation, immediate short-term intervention, which alleviates the impact of difficult clinical situations can be useful, and it is the main tool for maintaining the mental health of staff; but such interventions should take place in real time [10, p. 10].

The resources for maintaining and restoring mental health should be readily available for medical personnel who are constantly exposed to severe occupational stress. At the same time, it should be understood that medical workers, especially those who work in the primary care sector, feel enormous pressure, which prevents them from ensuring proper and adequate control of their experiences, and efforts aimed at facilitating the working process and expanding the possibilities of providing psychological assistance can reduce stress at the workplace and prevent burnout [11, p. 674].

DoolittleBR. (2021) notes the important role of educational institutions that train doctors in providing them with knowledge and skills to create a favorable working environment and productive cooperation in medical teams, which will not only have a positive effect on the normalization of the psycho-emotional state, but will also bring a significant economic effect due to the reduction of medical personnel turnover, the number of medical errors, costs of insurance companies for compensation of the consequences of unsatisfactory treatment, as well as reduction of the duration of treatment and incapacity of patients [12, p. 361].

In general, it can be confidently stated that the treatment of EB has also remained underdeveloped. The effectiveness of individual approaches, confirmed in research, requires the integration and systematization of available scientific data, and the identification of promising ways to improve the treatment and rehabilitation of medical workers exposed to EB.

The purpose: to develop and determine the effectiveness of the algorithm of EB complex therapy and prevention in psychiatrists during the war with its further wide implementation in the system of mental health care institutions.

Contingent and research methods. The sample was formed in compliance with the principles of biomedical ethics and based on informed consent, and consisted of 120 psychiatrists who worked in the city of Kyiv starting from February 24, 2022. The examinees were divided into three groups: the first group (OG1) consisted of 37 persons (30.8%), namely doctors without signs of professional maladjustment (PMA) and a low level of EB; the second group (OG2) included 57 persons (47.5%) with signs of professional PMA and EB of

moderate level; the 26 persons (21.7%) formed the third group. Its respondents had clinically defined and pronounced professional PMA, and a high level of EB.

Clinical-psychopathological, psychometric and psychodiagnostic research methods were used to assess the state of the parameters that make up the components of EB. The clinical-psychopathological component of EB was studied using A. Beck's depression questionnaire (Beck Depression Invertory, 1961); methods of research of reactive and personal anxiety C. Spilberger in Yu.L. Khanin (1979) ; M. Hamilton's depression and anxiety scales (Hamilton Rating Scale for Depression - HRDS, Hamilton Anxiety Rating Scale - HARS) (M. Hamilton, 1959; 1960); questionnaire on expressiveness of psychopathological symptoms Symptom Check List-90-Revised - SCL-90-R (L. Derogatisetal., adaptation of N.V. Tarabrina, 2001). The psychosocial component of professional PMA and EB was assessed according to the state of social and psychological adaptation/maladaptation (according to C. Rogers and R.F. Dymond method), and quality of life (QoL) (according to H. Mezzich scale adapted by N.O. Maruta).

The characteristics of psychiatrists coping behavior were studied using the questionnaire "Coping Behavior" by R. Lazarus, S. Folkman (2007). The study included measures of emotional awareness, the ability to control and manage one's emotions, as well as self-motivation and level of empathy.

The statistical analysis of the results obtained was performed using the non-parametric Mann-Whitney test (determination of differences) and the method of Spearman's rank correlations (estimation of correlations).

Research results and their discussion. Psychiatrists working during the war in Kyiv showed a wide spectrum of EB manifestations and violations of professional PMA - from their absence to a high level. In the majority of the persons under examinatio (47.5%), the EB and PMA symptoms corresponded to a moderate level which requires medical and psychological assistance from rehabilitation specialists. The specific weight of doctors with a low level of EB and professional PMA was also significant (30.8%) – for them preventive consultative work may be recommended.

The proportion of doctors with pronounced and high levels of EB and PMA was significantly lower (21.7%). These persons require the mandatory intervention of specialists to apply urgent medical and psychological measures, carry out a program for readaptation or change professional activity.

Psychiatrists with manifestations of EB and professional PMA of various severity showed signs of depressive and anxiety disorders, while anxiety manifestations were more expressive than depressive ones. In doctors with individual manifestations of PMA, depressive symptoms corresponded to a mild level, and anxiety symptoms corresponded to an average level, while in

doctors with an established PMA, signs of depressive disorders were found at a close to moderate level, and anxiety indicators were of a medium or high level.

The expressiveness of psychopathological symptoms was ***significantly inversely*** correlated with indicators of social and psychological adaptation and QoL of the examinees. Indicators of socio-psychological adaptation, depression and anxiety (both objectively and subjectively assessed) had a statistically ***significant inverse correlation***, while QoL indicators revealed significant inverse correlations with the expressiveness of psychopathological symptoms. The closest of them have been obsereved in the field of subjective well-being/satisfaction, less tight – in the sphere of fulfilling social roles, and the least tight – in the sphere of external living conditions.

It was established that in the genesis of the development and progression of EB among psychiatrists during the war the personal, psychopathological, psychosocial, professional and emotional-interpersonal indicators of their life activities are involved. Moreover, professional PMA we consider as a basic descriptor of EB, because it is the sign of the first negative manifestations of the imbalance of professional duties performing and internal resources, the integrity of which will ensure their optimal implementation.

That is why determining the state of professional PMA and its prognosis makes it possible to improve the quality of detection of its manifestations and to prevent the development or progression of EB in psychiatrists, as well as to prevent the development of other adverse changes from the side of psychopathological, psychosocial, etc. components of EB.

Based on the data obtained that the main descriptor of EB is professional PMA, we proposed a mathematical model of its development in psychiatrists. The model is based on non-linear modeling methods (multiple linear regression analysis with a linearized model).

The mathematical model of professional PMA for psychiatrists looks like this:

Professional PMA =97.757 + (0.254 A) + (-0.411 C) + (-0.731 P) (1),

where A is an indicator of the affective cluster;

C – indicator by socio-demographic cluster;

P is an indicator for the psychosocial cluster.

The coefficient of multiple correlation of the model was 0.962, the coefficient of determination was 0.961. The level of statistical significance of the model was more than 99.9% ($p<0.001$). Reference values of indicators of professional PMA when using the model:

- standard indicator 45.2±28.3 points;

- indicators for the selection of risk groups with the development of PMA (by quartiles): low risk of PMA: up to 25 points;
- moderate risk of PMA: from 25 to 44 points;
- high risk of PMA: from 45 to 64 points;
- very high risk of PMA: 65 points and above.

Based on the possibility to identify 4 risk groups for the development of PMA, as a basic descriptor of EB, which is provided by the use of a mathematical model of its development, 4 therapeutic strategies of diagnosis, therapy and prevention are proposed within the framework of providing specialized medical assistance to psychiatrists during the war.

The algorithm of therapy and prevention of EB in psychiatrists is based on the following key principles:

1. Complexity of measures, which involves a combination of psychopharmacological, psychotherapeutic and psychocorrective influences, as well as social and psychological adaptation;

2. Personalization of corrective measures taking into account each of the clusters of adverse changes we have identified;

3. Clear phasing and sequence of psychopharmacological, psychotherapeutic, psychocorrective and adaptation measures, taking into account the individual characteristics of manifestations and dynamics of EB;

4. Availability of correctional programs for psychiatrists.

The main goals of medical and corrective measures for manifestations of EB in psychiatrists are:

1. Formation and strengthening of sustainable motivation to eliminate manifestations of EB, readiness for long - term consecutive treatment and rehabilitation measures;

2. Correction of pathocharacterological and pathopersonalological changes that contribute to the development and chronicity of EB;

3. Leveling and prevention of adverse changes in the affective sphere;

4. Full psychosocial adaptation and restoration of comprehensive psychosocial functioning;

5. Elimination of manifestations of professional DA and improvement of professional implementation;

6. Support of a high level of EI and use of its opportunities to overcome and prevent manifestations of EB.

We recommend to carry out a complex of measures to correct psyhiatrists' EB in a differentiated way, taking into account the degree of maladaptation (absence of signs of PMA,

presence of individual signs of PMA, or established PMA), as well as in accordance with the key vectors of pathological changes.

For PMA free psychiatrists, the set of measures for the diagnosis of EB includes periodic screening examinations using the EB, EI assessment method and PMA diagnosis method. The complex of diagnostic, corrective and preventive measures is implemented according to the following vectors in accordance with the key clusters we have identified:

1) according to the individual-psychological cluster - psycho-educational and psycho-corrective measures to identify and mitigate individual-psychological traits that can create favorable conditions for EB, as well as reducing stress through rational planning of the work and rest regime, psychological recovery, etc.;

2) according to the psychopathological cluster – correction of existing changes in the mental sphere (depressive, anxious, signs of neuroticism, addictive behavior, etc.);

3) according to the psychosocial cluster – psychoeducational and adaptation measures for social adaptation and restoration of full-fledged social functioning;

4) for the PMA cluster – a set of measures for rational planning of working hours and professional workload, reduction of the impact of professional stress, rational regime of work and rest, resolution of problematic issues related to professional activity;

5) according to the EI cluster - psychoeducational measures, as well as training in the use of emotional intelligence for solving professional tasks, social functioning, improving well-being and reducing stress.

EB prevention in this group is aimed at creating favorable conditions for professional activity, rational planning of the work and rest regime, psychoeducational activities and periodic screening control of the state of EB.

For psychiatrists with individual manifestations of PMA, the set of measures for the diagnosis of EB includes measures that are used for PMA-free psychiatrists, as well as:

- determination of the coping repertoire and evaluation of the features of coping behavior;
- diagnosis of problems in the affective sphere using depression and anxiety questionnaires;
- diagnosis of the state of social and psychological adaptation.

A complex of diagnostic, therapeutic, corrective and preventive measures for EB in the presence of individual manifestations of PMA is recommended to be implemented according to key vectors:

1) according to the personological cluster - in addition to measures applied at the previous level, psychocorrective and psychotherapeutic measures aimed at correcting and

leveling pathocharacterological traits and non-constructive coping strategies that contribute to EB;

2) by psychopathological cluster – psychotherapeutic measures for correction of depressive, anxiety and other psychopathological manifestations, comorbid addiction, neurotic, dyssomnic and other manifestations;

3) by psychosocial cluster – in addition to measures used at the previous level, family correction and psychotherapy, social communication training, support at various levels of social functioning;

4) by professional cluster – in addition to the measures applied at the previous stage, analysis of the causes and mechanisms of PMA in a given psychiatrist, drawing up an individual program of professional adaptation, simulation trainings for modeling complex and conflict situations in the professional sphere;

5) according to the emotional-interpersonal cluster - in addition to the measures recommended in the absence of signs of PMA, EI training, identification of weak elements of EI and their purposeful development, as well as integration of EI into a complex of treatment, rehabilitation and preventive measures.

The complex of preventive measures for certain signs of PMA should include control of the dynamics of EB manifestations, the state of the affective sphere, professional and social-psychological adaptation, as well as psychoeducational and corrective measures aimed at EB preventing.

For psychiatrists with an established PMA, the set of diagnostic measures for EB should include, in addition to the previously recommended ones:

- research on personal anxiety;

- clinical-psychopathological examination with assessment of the level of depression and anxiety and other psychopathological phenomena;

- assessment of QoL and social and psychological adaptation.

The complex of treatment, rehabilitation and preventive measures is recommended to be implemented according to five key vectors:

1) according to the personological cluster - in addition to the measures applied at the previous level, complex systemic psychotherapeutic and psychocorrective intervention aimed at correcting pathocharacteristic changes and preventing their development and chronicity;

2) by psychopathological cluster – psychopharmacological intervention to eliminate manifestations of depression and anxiety (antidepressants from the groups of selective serotonin reuptake inhibitors, selective serotonin and norepinephrine reuptake inhibitors, normotimics, non-benzodiazepine tranquilizers, atypical neuroleptics, sleeping pills, etc.), psychotherapeutic

interventions in a complex of treatment measures and rehabilitation for affective pathology, obsessive-phobic, neurotic and other disorders; treatment and prevention of comorbid addictions to the use of psychoactive substances and other forms of addictive behavior.

3) by psychosocial cluster – in addition to measures used in the presence of individual signs of PMA, complex family psychotherapy and psychocorrection, individual and group training of social skills and communication, constant psychological support and support at all levels of social functioning;

4) by professional cluster – in addition to the measures applied at the previous stage, a comprehensive evaluation of the mechanisms of PMA, development of an individual program of professional rehabilitation and adaptation, group and individual situational trainings;

5) according to the emotional-interpersonal cluster - in addition to the measures recommended for individual signs of PMA, comprehensive EI training, determination of individual EI development programs in the context of existing problems and features of EB.

Preventive measures in the case of EB and the presence of formalized PMA, in addition to those used for individual signs of PMA, include systematic control of manifestations of EB, the presence of psychopathological symptoms, professional and social maladjustment, quality of life and social functioning, periodic short-term psychotherapeutic and psychocorrective interventions aimed at elimination of identified problems, as well as comprehensive professional and social readaptation measures.

A mandatory stage of the study was the evaluation of the effectiveness of the proposed EB correction algorithm and accompanying adverse changes in the psycho-emotional sphere and psychosocial and professional adaptation in groups of psychiatrists with different degrees of PMA.

During the implementation of the complex algorithm and subsequent follow-up, several psychiatrists dropped out of the observation due to reasons unrelated to the implementation of the algorithm. As a result, the number of observations per group was:

- in the group of psychiatrists with no signs of EB and PMA - 37 persons at the beginning of observation, 34 persons at the final stage;

- in the group of psychiatrists with separate signs of EB and PMA – at the beginning of observation there were 57 persons, and 51 persons at the final stage;

- in the group of psychiatrists with established EB and PMA - 26 persons at the beginning of observation, 24 persons at the final stage.

In general, significant positive dynamics were found in all groups under study at the influence of medical and corrective measures.

The proposed algorithm showed high efficiency, first of all, in relation to EB symptoms (Table 1).

Emotional Burrnout Symptoms Dynamics under Therapy

Indicator	Indicator value, points (M±m)						p		
	Before correction			After correction					
	Without PMA, n=37	With separate signs of PMA n=57	With established signs of PMA, n=26	Without PMA, n=34	With separate signs of PMA, n=51	With established PMA, n=24	1	2	3
1.1. Tension. Experience of psychotraumatic circumstances	3,32±2,24	11,45±9,63	27,04±3,04	0,53±0,90	3,45±3,43	5,42±1,38	0,000	0,000	0,000
1.2. Tension. Dissatisfaction with oneself	3,47±2,60	11,00±4,22	14,54±2,62	0,85±2,06	5,37±3,53	6,08±1,77	0,000	0,000	0,000
1.3. Tension. Feeling of being “caged”	1,29±1,71	9,71±9,67	14,33±4,65	2,24±2,63	4,80±5,04	8,42±3,83	0,000	0,000	0,000
1.4. Tension. Anxiety and depression	3,94±1,86	11,80±8,49	20,75±5,01	2,00±3,42	4,20±4,20	9,25±2,71	0,000	0,000	0,000
2. Tension	12,03±4,43	43,96±26,37	76,67±8,39	5,62±6,55	17,82±13,52	29,17±5,82	0,000	0,000	0,000
2.1. Resistance. Inadequate emotional selective response	2,59±3,73	8,10±6,41	16,92±2,98	0,82±2,29	1,78±3,72	7,04±2,58	0,000	0,000	0,000
2.2. Resistance. Emotional and moral disorientation	7,82±4,58	5,39±4,21	11,38±5,12	3,26±2,86	0,59±1,20	2,67±3,99	0,000	0,000	0,000
2.3. Resistance. Expansion of the sphere of saving emotions	9,21±6,03	24,16±10,54	25,08±5,72	2,85±2,02	14,63±9,75	13,83±5,60	0,000	0,000	0,000
2.4. Resistance. Reduction of professional duties	9,79±5,77	9,31±7,85	15,83±1,90	1,68±1,79	3,24±3,38	5,83±1,90	0,000	0,000	0,000
3. Resistance	29,41±9,30	46,96±9,18	69,21±3,15	8,62±4,13	20,24±6,72	29,38±4,38	0,000	0,000	0,000
3.1. 3.1. Exhaustion. Emotional deficit	2,18±2,75	7,37±4,40	13,75±4,62	0,68±2,06	1,86±3,27	3,83±4,53	0,000	0,000	0,000
3.2. Exhaustion. Emotional detachment	6,76±2,43	13,92±3,13	14,17±2,32	3,76±2,43	6,92±3,13	4,17±2,32	0,000	0,000	0,000
3.3. Exhaustion. Personal detachment (depersonalization)	3,26±3,10	11,65±8,04	21,88±1,48	1,59±1,73	6,18±6,31	9,21±4,31	0,000	0,000	0,000
3.4. Exhaustion. Psychosomatic and psychovegetative disorders	2,18±1,09	9,98±7,34	21,71±5,09	0,15±0,36	4,78±5,29	11,71±5,09	0,000	0,000	0,000
4. Exhaustion	14,38±4,66	42,92±15,53	71,50±6,82	6,18±3,43	19,75±12,15	28,92±8,21	0,000	0,000	0,000
The overall indicator of emotional burnout	55,82± 10,21	133,84±42,15	217,38±7,46	20,41± 9,09	57,80±22,67	87,46±8,04	0,000	0,000	0,000

As can be seen from the Table. 1, the proposed complex therapy algorithm made it possible to significantly reduce the expressiveness of EB in all groups. In the group of psychiatrists without signs of PMA, the majority of people managed to achieve a complete absence of burnout symptoms, and in the rest of the persons under observation the symptoms were minimally expressed. The overall indicator after correction in this group corresponded to the absence of EBsigns.

In the group of psychiatrists with certain signs of PMA, it was possible to achieve a 1.5-fold decrease in EB index, and after correction its value in a large part of the doctors was able to be reduced to normal values, and in the rest this index corresponded to the minimum expressiveness of burnout.

In the group of psychiatrists with an established PMA, indicator of EB before the start of treatment was very high and corresponded to pronounced signs of burnout. Despite this, in the course of treatment, it was possible to reduce EB expressiveness in almost all psychiatrists to the minimal value, and this indicator average value was reduced by 2.5 times, which can be considered as a significant success of the therapy.

The proposed algorithm turned out to be very effective in terms of PMA (Table 2).

Table 2

Dynamics of manifestations of professional maladaptation in the process of therapy

Indicator	Indicator value, points (M±m)						P		
	Before correction			After correction					
	Without PMA, n=37	With separate signs of PMA n=57	With established signs of PMA, n=26	Without PMA, n=34	With separate signs of PMA, n=51	With established PMA, n=24	1	2	3
Indicator of PMA	14.21±10.66	11,45±9,63	27,04±3,04	0,53±0,90	3,45±3,43	5,42±1,38	0,000	0,000	0,000
Emotional shifts	1.35±1.94	11,00±4,22	14,54±2,62	0,85±2,06	5,37±3,53	6,08±1,77	0,000	0,000	0,000
Features of individual mental processes	1.24±1.84	9,71±9,67	14,33±4,65	2,24±2,63	4,80±5,04	8,42±3,83	0,000	0,000	0,000
General activity decrease	0.26±1.71	11,80±8,49	20,75±5,01	2,00±3,42	4,20±4,20	9,25±2,71	0,000	0,000	0,000
Fatigue	2.26±2.00	43,96±26,37	76,67±8,39	5,62±6,55	17,82±13,52	29,17±5,82	0,000	0,000	0,000
I. Deterioration of well-being	4.59±5.15	8,10±6,41	16,92±2,98	0,82±2,29	1,78±3,72	7,04±2,58	0,000	0,000	0,000
II. Somatovegetative disorders	4.88±3.49	5,39±4,21	11,38±5,12	3,26±2,86	0,59±1,20	2,67±3,99	0,000	0,000	0,000
III. Violation of the sleep-wake cycle	6.38±1.63	24,16±10,54	25,08±5,72	2,85±2,02	14,63±9,75	13,83±5,60	0,000	0,000	0,000
IV. Features of social interaction	1.03±2.22	9,31±7,85	15,83±1,90	1,68±1,79	3,24±3,38	5,83±1,90	0,000	0,000	0,000
V. Decrease in motivation to work	0.62±1.52	46,96±9,18	69,21±3,15	8,62±4,13	20,24±6,72	29,38±4,38	0,000	0,000	0,000

Under the influence of therapeutic and corrective measures, not only a significant decrease in the indicator of PMA in all groups was revealed, but it was also possible to achieve a low level of PMA indicators.

The corrective algorithm proposed made it possible to significantly reduce the expressiveness of depressive and anxiety symptoms in psychiatrists (Table 3).

Table 3

Dynamics of affective disorders according to M. Hamilton's depression and anxiety scales at the correction process

Indicator	Indicator value, points (M±m)						P		
	Before correction			After correction			1	2	3
	Without PMA, n=37	With separate signs of PMA n=57	With established signs of PMA, n=26	Without PMA, n=34	With separate signs of PMA, n=51	With established PMA, n=24			
M. Hamilton Depression Scale									
General indicator of depression	6,21±1,97	9,82±4,69	14,54±7,08	3,91±3,18	6,20±4,71	10,21±7,52	0,000	0,000	0,001
Idicator of adynamic depression	5,85±1,83	8,43±3,77	11,17±4,47	3,71±2,97	5,51±3,96	8,13±5,33	0,000	0,004	0,136
Idicator of agitated depression	2,09±1,26	3,37±2,06	5,83±3,43	1,35±1,52	2,02±1,87	3,92±3,08	0,000	0,000	0,001
Idicator of depression with fear	2,32±1,15	3,96±2,24	6,83±3,43	1,38±1,58	2,45±2,22	4,79±3,59	0,000	0,000	0,001
Indicator of undifferentiated depression ï	0,53±0,61	1,86±1,82	3,13±2,27	0,29±0,58	1,02±1,33	2,13±2,17	0,013	0,000	0,004
M. Hamilton Anxiety Scale									
Overall score on the scale	15,41±3,31	19,63±5,33	23,13±5,77	11,79±5,29	15,33±6,24	18,58±7,47	0,000	0,000	0,001
Indicator according to the cognitive-affective subscale	10,41±2,57	12,80±3,23	13,38±2,89	8,15±3,53	10,31±3,96	11,04±4,34	0,000	0,000	0,001
Indicator by subscale of somatic manifestations of depression	5,00±2,61	6,82±3,02	9,75±4,02	3,65±2,76	5,02±2,98	7,54±3,88	0,000	0,000	0,001

At the same time, in the groups of psychiatrists without signs of PMA and with its individual signs, the average index of depression after treatment corresponded to the absence of signs of depression, and among doctors with established PMA it was close to the absence of signs of depression. Similarly, the anxiety index under the influence of correction in the groups of PMA-signs free doctors and with individual signs of PMA decreased to normal, and among doctors with established PMA it was on the borderline of normal and mild anxiety.

The proposed complex algorithm of corrective measures made it possible to significantly improve the QoL of psychiatrists with manifestations of EB and various degrees of PMA DA (Table 4).

Table 4

Dynamics of indicators of quality of life of psychiatrists during the therapy course

Indicator	Indicator value, points (M±m)						P		
	Before correction			After correction			1	2	3
	Without PMA, n=37	With separate signs of PMA, n=57	With established PMA, n=26	Without PMA, n=34	З окремими ознаками ДА, n=51	З оформленою ДА, n=24			
Physical well-being	7,03±1,42	6,43±1,54	5,42±1,69	7,50±1,56	6,94±1,63	5,92±1,77	0,000	0,000	0,001
Phychological (emotional) well-being	6,65±1,63	5,18±1,77	3,79±1,06	7,15±1,69	5,69±1,83	4,29±1,27	0,000	0,000	0,001
Self-care and independence of actions	7,41±0,86	6,33±1,57	5,13±1,73	7,91±1,06	6,84±1,63	5,63±1,97	0,000	0,000	0,001
Work capacity	6,94±1,79	5,61±1,58	4,71±2,18	7,38±1,76	6,10±1,60	5,13±2,19	0,000	0,000	0,004
Interpersonal interaction	7,85±1,10	7,08±1,31	5,83±1,79	8,32±1,25	7,57±1,35	6,33±1,90	0,000	0,000	0,001
Socio-emotional support	8,68±1,68	8,24±1,75	6,92±2,04	8,97±1,64	8,57±1,63	7,33±1,99	0,004	0,000	0,004
Public and official support	8,35±1,01	6,67±1,38	4,96±1,43	8,79±1,07	7,18±1,48	5,46±1,53	0,000	0,000	0,001
Personal fulfillment	7,47±1,33	6,61±1,55	6,25±2,03	7,91±1,29	7,12±1,53	6,75±2,15	0,000	0,000	0,001
Spiritual realization	8,91±1,06	7,94±1,45	7,67±1,27	9,24±1,02	8,41±1,36	8,08±1,25	0,003	0,000	0,004
General perception of life	6,53±1,74	4,88±1,45	3,75±1,33	7,03±1,87	5,39±1,50	4,25±1,29	0,000	0,000	0,001
Subjective well-being/satisfaction	20,21±2,63	16,49±3,82	12,96±3,39	21,68±3,21	18,02±4,06	14,46±3,67	0,000	0,000	0,001
Performance of social roles	29,68±3,79	25,63±4,69	21,92±5,86	31,53±4,15	27,63±4,87	23,83±6,60	0,000	0,000	0,001
External living conditions	25,94±2,56	22,84±2,97	19,54±2,78	27,00±2,76	24,16±2,96	20,88±3,00	0,000	0,000	0,001
Quality of life index	7,58±0,63	6,50±0,92	5,44±1,00	8,02±0,80	6,98±0,98	5,92±1,17	0,000	0,000	0,001

The most important is the improvement of quality of life in the key areas of psychological (emotional) well-being, work capacity, interpersonal interaction, personal fulfillment and general perception of life, as well as in the integral areas of subjective well-being / satisfaction and fulfillment of social roles.

Conclusion. Thus, the application of the proposed complex algorithm of therapy and prevention of psychiatrists' emotional burnout manifestations of various degrees and professional disadaptation allowed to significantly reduce their signs, regardless of the severity, to de-actualize affective psychopathological symptoms, as well as to improve quality of life and

social functioning of doctors. On this basis we can recommend the specified algorithm for use in healthcare practice.

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