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Editorial: h

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5-7 keywords: bereaved parents; outcomes; Post Intensive Care Syndrome (PICS); anxiety; depression; post-traumatic stress disorder (PTSD); acute stress disorder (ASD)

In this issue of *Pediatric Critical Care Medicine*,  Logan et al (1) report on their investigation into the incidence of new mental health diagnoses, use of psychotropic medication and mental health service use in a sample of 95,070 parents, following their child’s intensive care treatment.   In an innovative interrogation of a large dataset, they report elevated rates of formal diagnosis of post-traumatic stress disorder (PTSD), acute stress disorder (ASD), anxiety and depression in parents in the six months after PICU discharge, as compared with the six months prior to admission.

The authors examined a commercial database of medical insurance claims over an eight year period, linking a set of parents’ records to those of children admitted to PICU between 2006 and 2013. Parents whose children died during the admission were excluded from the analyses, but those whose children who died within six months of discharge were found to have the highest rates of new mental health diagnoses (most commonly depression), and new prescriptions for anti-depressants and/or anxiolytics, consistent with the finding that over half of this particular sub-group of parents report complicated grief reactions (2).

Overall Logan et al (1) found approximately double the incidence of new mental health diagnoses in the period studied as compared with the previous six months, with higher rates of diagnosis and new prescriptions for psychotropic medication in mothers than fathers. However the proportion of parents receiving new outpatient mental health support was very low, suggesting that even with a formal diagnosis, the treatment most often provided was medication. This is of potential concern in relation to the treatment of PTSD, for which drug treatments are not recommended as a first-line option (3).

Limitations to this study include the lack of a separate control group of similar adults (ideally also parents) whose children were *not* admitted to PICU over the period studied.  This would have made it possible to isolate the impact of the passage of time, in relation to the normal accumulation of mental health problems in this age group of adults, with causes other than the critical illness of a child. (The comparison data on 12 month incidence of mental health diagnoses in the community are helpful up to a point, but somewhat misleading as they will have included unemployed and older people who have higher rates of mental health problems.)

The authors also acknowledge that a formal diagnosis of a mental health condition is quite a blunt measure of distress and likely, a priori, to represent an underestimate of the true prevalence of emotional difficulties in this population. As they point out in their literature review (1), research studies which have systematically assessed cohorts of parents going through this experience have found much higher rates of symptoms (4) than the current study, which was only able to identify those who went so far as to seek formal assessment. However it is also possible that the parents who take part in such studies may be atypical in some way – ie that more distressed parents may be more likely to self-select into these surveys – which would mean that previous estimates of the prevalence of distress in this population are over-estimates.

The authors also concede that their sample, though unusually large, was relatively affluent in the sense that , by definition, all had access to employer sponsored medical insurance (1). Such a group might be expected to fare better than families with with less access to resources, on public insurance or no insurance. But this serves to make their results all the more compelling. If relatively well off parents are found to be at greater risk of mental health problems after their child’s critical illness, this is likely to be an even bigger issue for the more disadvantaged, who tend to over-represented in the PICU.

This study’s findings add to a growing body of literature testifying to the emotional burden on the parents of children admitted to PICU.  As Hoehn (5) has pointed out, given what we now know, we have a ethical obligation to move on from simply describing symptoms to finding ways to screen parents for risk of developing psychological adjustment difficulties. We also need to work out how best to intervene preventatively, where possible, and to offer timely treatments, where distress is particularly high or prolonged (6). This is not only in order to support parents directly but also because of the documented impact of their distress on the risk of poorer adjustment in their recovering children (7).  The evidence base for interventions is still small (8), but there is recognition in the wider research community that this is an important area on which to focus in future, if we are to improve long term outcomes (9).

Possible fruitful avenues in this regard could include the provision of PICU diaries to help parents communicate better with their child about what happened (10,11). This form of intervention been associated with improvements in symptoms of post-traumatic stress in the caregivers of adult ICU patients (12). Multi-disciplinary PICU follow up clinics might also provide a useful mechanism for monitoring the wellbeing of patients and family members (13), and have the potential to offer them the outpatient support they do not seem to be accessing currently, according to this interesting study’s findings (1).

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