

Managing Distress in Health Care Workers During COVID-19: Lessons from a Disaster Trauma Lens

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We have learned that in order to provide much-needed social support during difficult times, organizations should prepare to take certain steps.



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Coronavirus disease 2019 (COVID-19) blindsided the world. It exposed gaps in public health emergency planning at every level, including in the strategic planning to support mental health and wellness. Studies of the SARS and Ebola epidemics as well as natural disasters have taught us lessons about the importance of planning for and responding to the mental health needs of health care and frontline workers.¹ Thus, this is a pivotal moment, a chance to implement systems and structures for staff support in every organization and advance staff wellness and resilience initiatives.

Disaster literature

The literature on disasters and public health emergencies describes pervasive emotional distress, feelings of extreme vulnerability, uncertainty, and threats to life, particularly during the rapid spread of an outbreak.² A recent COVID-19 web-based survey supports this finding. More than 40% of respondents reported symptoms of depression, anxiety, traumatic stress, substance use, and suicidal ideation. Symptoms were notably elevated in black and Hispanic individuals, essential workers, unpaid adult caregivers, and those with psychiatric conditions.³ Fortunately, evidence from disaster trauma research has shown that, ultimately, most people are resilient even after the most severe traumatic event.^{4,5} In the immediate aftermath of large-scale catastrophes, a majority of negative mental health symptoms are recognized as distress reactions to intense and overwhelming events. They are not pathologized or labeled psychiatric disorders. The disaster literature emphasizes the importance of acknowledging the normality of distress reactions, identifying high-risk populations, promoting effective coping and adaptation strategies, and encouraging overall wellness and resilience.⁶ Disaster mental health assistance during the acute phase is often more practical than psychological in nature. In this case, such assistance includes Centers for Disease Control information and updates, access to food and cleaning supplies, access to COVID-19 testing, protective equipment, financial assistance, and links to community resources.

After the acute phase of the disaster, long-term stress responses can emerge. Lancee et al.⁷ found that 2 years after the SARS outbreak, health care workers who treated these patients had elevated rates of smoking and drinking, absenteeism due to stress or illness, decreased face-to-face contact with patients, and decreased work hours. Yet rates of depression, posttraumatic stress disorder, and other mental illness were not elevated. This is consistent with existing research, which has found that the long-term impact of massive disasters is predominantly in the range of subsyndromal stress responses rather than an increase in psychiatric morbidity. Limited long-term studies suggest that post-disaster symptomatology peaks in the first year and then declines, but the course of recovery is variable.⁸ The challenge for mental health clinicians is to distinguish normal distress reactions to catastrophes from exacerbation of existing mental health susceptibilities or new-onset disaster-related pathology.

Figure 1. Psychological Phases of Disaster¹⁰

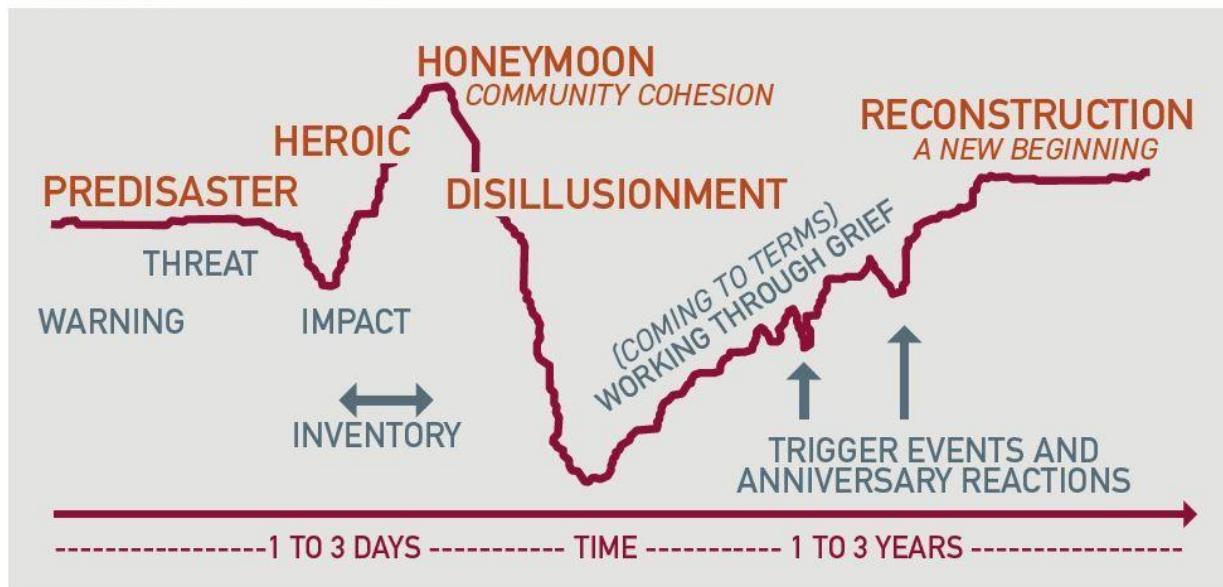


Figure 1. Psychological Phases of Disaster

Disaster trauma is characterized by exposure to personal loss and community disruption. Cultural, political, and socioeconomic factors all influence the shared experience of major disasters.⁹ Looking through a disaster trauma lens, a better understanding of the emotional stages of public reaction can help: anticipate community responses to large-scale catastrophic events (Figure 1), identify the changing goals of recovery at different phases (Figure 2), and inform mitigation strategies. It is important to note that the timing of the phases is fluid. They do not occur in an exact sequence. Phases can overlap and move forward or back across a timeline, depending on the type of disaster.

Figure 1 depicts the stages of public reactions to natural disasters like 2012's Hurricane Sandy and even the 9/11 terrorist attacks in 2001, but the community response to a pandemic seems more unpredictable. The immediate COVID-19 experience in New York state in the spring of 2020 was marked by safety concerns, deaths in the thousands, food and job insecurity, financial hardships, and anger at government response. We do, however, see a heroic phase exemplified by the emergence of heroes, such as Anthony Fauci, MD, on the national level and Governor Andrew Cuomo in New York state. We then witnessed community cohesion typical of the honeymoon phase as New Yorkers connected with each other from stoops, windows, terraces, and rooftops, all cheering for frontline workers at 7:00 PM each night to show gratitude and appreciation.

Figure 2. Changing Goals of Recovery at Different Phases of Disaster¹¹

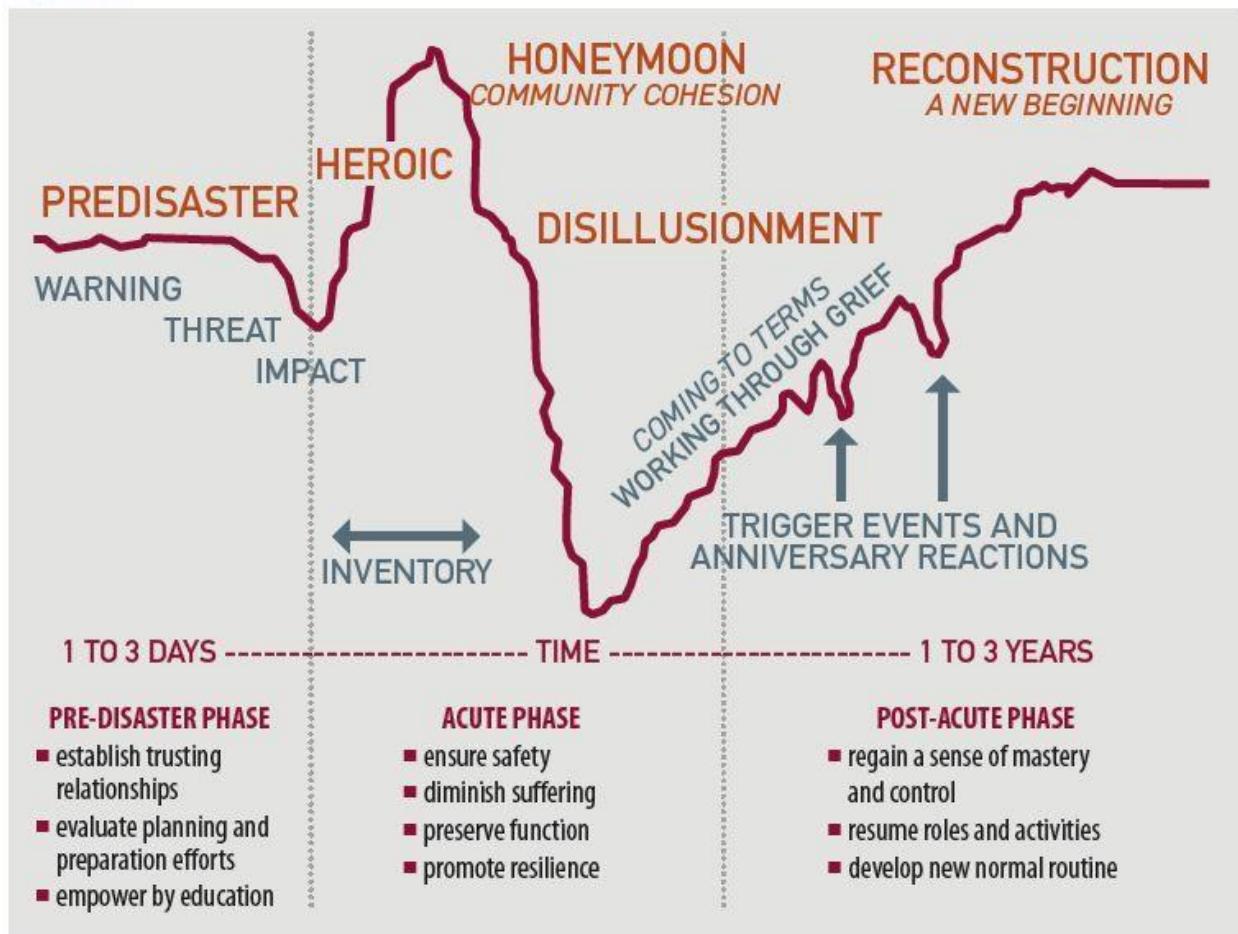


Figure 2. Changing Goals of Recovery at Different Phases of Disaster

New York successfully flattened the curve by the summer. The number of daily deaths fell dramatically, from a high of nearly 800 per day across the state down to none in New York City by June. Now the focus is shifting to economic recovery, while keeping community viral transmission low and bracing for a potential second wave. This could be the beginning of the reconstruction phase: figuring out a new normal and how to live with a persisting virus. Disillusionment is certainly felt when other states are unable to control the virus, in spite of the availability of immense resources and clear and concrete directions from world-class health experts to wear masks, avoid crowds, maintain social distance, and wash hands.

Supporting staff

Studies indicate that during an infectious disease outbreak, the operational response of an organization is likely the single most important factor influencing staff perception of both stress and safety.¹² Traumatic events can disrupt feelings of safety, trust, control, esteem, and intimacy. As a result, staff can exhibit maladaptive behaviors or experience traumatic stress

symptoms.¹³ Best practices to mitigate the disruptions and support staff during a pandemic involve 4 key elements: leadership, communication, education, and social support.

LEADERSHIP. Strong leadership and supportive teams influenced the resilience of health care workers during the SARS and Ebola outbreaks.¹² Capable and effective leadership over the course of a major disaster makes staff feel safe and supported by the organization. Best practices include:

- Visible and prepared leaders at organizational, departmental, and team levels.
- Setting the tone for a positive and supportive organizational culture.
- Skilled assessment of team strengths and weaknesses.
- Proactive outreach and crisis support from all levels of leadership.
- Creativity and innovation in increasing staff resilience and reducing stress.
- Role modeling infection control and safety practices—wear masks, practice physical distancing, and wash your hands.

COMMUNICATION. The cornerstone of infectious disease management is communication, coordination, and collaboration.¹⁴ Delivery of clear, transparent, timely, trustworthy information in a rapidly evolving situation is essential. Organizations should be prepared to:

- Communicate timely and trustworthy COVID-19-specific guidance.
- Acknowledge and normalize feelings of anxiety related to the pandemic.
- Communicate efforts to address the negative impacts of the pandemic, including financial concerns.
- Communicate supportive organizational practices (eg, working from home, flexible work schedule, reduced hours, job rotation, location rotation, availability of PPE, testing).
- Widely disseminate available self-care and wellness information and resources.

EDUCATION. Training and education on the issues of infection control, disaster mental health, and the disaster response system increases confidence and moderates the risk of stress. Just as Federal Emergency Management Agency (FEMA) provides appropriate resources and training for disaster responders before deployment, organizations have a responsibility to provide education and training to better prepare for and respond to a pandemic. Organizations should be prepared to offer staff:

- General information on disasters and pandemics.

- Education on infection control and universal precautions.
- Overview of disaster mental health.
- Targeted education on key sources of distress from COVID-19 (eg, quarantine-related distress, fear of contagion, concern for family, job stress, financial concerns, interpersonal isolation, stigma).

SOCIAL SUPPORT. Studies indicate that social support, both personal and professional, is a consistent protective factor and a strong mitigator of emotional distress in the wake of a massive disaster.^{15,16} Unfortunately, the battle against COVID-19 calls for decreased interpersonal contact. Quarantine, physical distancing, and remote and virtual work have all increased social isolation. This unprecedented public health crisis requires creativity and innovation to restore a sense of community and connectedness. In order to provide much-needed social support during difficult times, organizations should prepare to:

- Hold virtual meetings and virtual lunch/coffee breaks/happy hours to improve team cohesion and morale.
- Build in formal time during work hours for peer consultation to reduce feelings of isolation and increase feelings of efficacy.
- Use in-person or virtual service meetings and huddles to build relationships and improve responsiveness.
- Establish buddy system to check and balance each other's stress level.

The scarcity of existing research on staff support and mitigation strategies during pandemics presents an opportunity to develop new programs that can be tailored to specific organizational contexts and cultures. Evaluation of best practices and robust analysis of the impact and sustainability of staff support plans during COVID-19 can inform future strategic planning and policy recommendations for staff wellness and resilience.

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