

Psychological Trauma: Theory, Research, Practice, and Policy

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COVID-19 Emergency in the Hospital: How the Clinical Psychology Unit Is Responding

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The present commentary describes the main care services implemented by the clinical psychology unit of an Italian hospital to cope with the COVID-19 emergency outbreak. The unit's main goal has been to support and protect health care professionals, relatives of hospitalized patients, and patients themselves from further psychological distress. Details and insights are shared.

Keywords: COVID-19, hospital, psychological care services

Nowadays Italy is the third most affected country in the world from coronavirus, after the United States and Spain (Dong, Du, & Gardner, 2020). According to U.S.-based Johns Hopkins University, which is tracking the disease globally, at the current date (April 20, 2020, exactly 2 months after the outbreak), 108,237 people in Italy have been treated either at the hospital or at home for the COVID-19 virus, and more than 24,000 people have died (Dong et al., 2020). These numbers are only partially reliable, because people who died at home or in private care facilities are not included; therefore the number of COVID-19 victims may be even higher. Northern Italy has been hit the most: One third of all confirmed coronavirus cases are located in the region of Lombardy, where the COVID-19 mortality has been significantly above everywhere else so far (Department of Civil Protection, 2020). Lombardy health care capacity is under pressure, and hospital intensive care units are saturated, potentially explaining the impressive mortality rates in the area (Favero, 2020).




Because of this situation, the Italian population is under strain, especially those living in Lombardy and dealing with the emer-

gency from the front line: health care professionals, COVID-19 patients, and their families. As psychologists, we are observing a wide range of (ongoing or latent) psychological responses from these groups of individuals: from hypervigilance to emotional avoidance and moral distress, which could develop in an acute stress disorder or a posttraumatic stress disorder (PTSD), because the extreme circumstances may not allow an emotion process of the ongoing traumatic experience (Horesh & Brown, 2020).

The present commentary aimed to describe how the clinical psychology unit of one of the biggest public hospitals in the regional capital of Lombardy (Milan) has been working to support the groups most involved in this emergency: the health care professionals, the relatives of the COVID-19 patients, and the patients themselves. The psychological care services have been constructed and activated with an emergency logic, which aims to react to the immediate ongoing clinical needs but also to anticipate the next ones. Moreover, to offer psychological support coherent with ongoing clinical priorities and needs, such emergency-related psychological services have been coordinated with the hospital medical practice as much as possible; for example, by ensuring direct phone lines with operators of the COVID-19 units. The clinical psychology unit's main goal (at the moment) is to cure and prevent psychological distress, in particular acute stress disorder and PTSD, of health care professionals, families of COVID-19 patients, and patients.

For health care professionals, two types of psychological support were organized: the decompression room and the small-group sessions. The decompression room is a physical and mental space that has been created to offer them a safe place where they can "decompress" (i.e., reflect, relax, get in touch with emotions and express them) during and after work: It has music and cozy armchairs, and there is a psychologist ready to listen. The room allows health care professionals to think about what is happening to them and how the situation makes them feel. This is important especially in the beginning of an emergency, when everybody is in a constant rush, physically activated by adrenaline, focusing on

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only what to do next (Selye, 1950). Nevertheless, the room is also helpful in the second phase of the emergency, when the adrenaline fades away, leaving depression and fatigue and other negative feelings to be addressed. The small-group sessions work in a complementary way: The psychologist goes to the doctors' and nurses' room to debrief and defuse about what is happening. All together they share their recent clinical experiences, enhancing their mutual help resources. In both the decompression room and the small groups, moral distress (Lamiani, Borghi, & Argentero, 2017) is one of the key themes addressed: In emergencies, it is normal to think that what one is doing is not enough. The clinical psychology unit aims to make it a shared experience and not something that professionals have to deal with alone.

The second area of intervention is the one concerning the relatives of the hospitalized COVID-19 patients, who are not able to be near to their loved ones due to social distancing and quarantine, even in the extreme, but not so rare, case of death. Death is a part of the process of caring, and the aim of the hospital is not only to offer the cure. So we decided to have an active role in taking care of death and dying. Among other calls to support families, psychologists have been implementing a phone call to the relatives' next of kin approximately 48 hr after the death of their dear one. This phone call has different meanings: First, it aims to help the mourning process and enhances the family's emotional resources. It also helps the family in finding a creative way to say goodbye to the dead nowadays, when funerals are not an option. Moreover, it lets the family know that their loved one was not alone in the process of death, because the hospital staff was with them as a part of the hospital institutional mandate. Furthermore, it lets the family itself know that they are not alone: Psychological care is available to help them if they need it. Eventually, the phone call also aims to relieve the medical staff: Doctors feel less lonely in the relationship with the patient's family if they know that a psychologist is also caring about them.

Last but not least, the clinical psychology unit has been taking care of COVID-19 hospitalized patients themselves. This was not possible straight after the emergency breakout because there was so much to do on a practical level by nurses and doctors that there was no space to even think to the psychological needs aside of the medical ones. Nonetheless, after a couple of weeks in which the medical emergency became more stable, the psychologists were able to start attending those patients too, either because the patients themselves started to ask for a psychological intervention or because the health care staff was able to detect a psychological needs from them. These COVID-19 patients have been offered private sessions with the psychologists about their ongoing situa-

tion to better understand and process their feelings and emotions. Many patients suffer from anxiety and depression, which compromise their physical wellness even more. A lot of them suffer from their condition of isolation that the COVID-19 requires. Other patients are dealing with the mourning process of someone recently died from the same conditions they are fighting. Last, the patients who recover and go home may experience survival guilt and other negative feelings from the shock of their traumatic disease experience.

These are some of the key actions that the clinical psychology unit has currently prioritized and mobilized to take care of the emergency-related hospital needs and to the COVID-19-related distress among those in greatest need. Such actions are revealing critical areas that clinical psychology can tackle to contribute to mental health promotion and response. We expect that such areas and related needs may change and will require an ongoing process of adaptation and adjustment of psychological action to care for those who are most in need.

References

- Department of Civil Protection. (2020, April 20). *Coronavirus: La situazione dei contagi in Italia* [Coronavirus: the state of the infections in Italy] [Press release]. Retrieved from http://www.protezionecivile.gov.it/media-comunicazione/comunicati-stampa/dettaglio/-/asset_publisher/default/content/coronavirus-la-situazione-dei-contagi-in-ital-2
- Dong, E., Du, H., & Gardner, L. (2020, February 19). An interactive web-based dashboard to track COVID-19 in real time. *Lancet*, *20*, 533–534. [http://dx.doi.org/10.1016/S1473-3099\(20\)30120-1](http://dx.doi.org/10.1016/S1473-3099(20)30120-1)
- Favero, C. A. (2020). Why is COVID-19 mortality in Lombardy so high? Evidence from the simulation of a SEIHCRC model. *Covid Economics (Issue 4)*, 47–61. Retrieved from <https://cepr.org/sites/default/files/news/CovidEconomics4.pdf>
- Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call to close critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*, 331–335. <http://dx.doi.org/10.1037/tra0000592>
- Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology*, *22*, 51–67. <http://dx.doi.org/10.1177/1359105315595120>
- Selye, H. (1950). Stress and the general adaptation syndrome. *British Medical Journal*, *1*, 1383–1392. <http://dx.doi.org/10.1136/bmj.1.4667.1383>

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