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COVID-19-Associated Psychiatric Symptoms in Health Care Workers: Viewpoint From Internal Medicine and Psychiatry Residents

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aspects of medical illness, and it is routine to consult psychiatrists when emotional decompensation occurs. On the other hand, psychiatrists are not part of the internal medicine staff. It is thus conceived that the hospital system caring for SARS-Cov-2 patients have the "two arms" of skills crucially required for holistic treatment of SARS-Cov-2 patients, but a coordinating body integrating these arms is missing.

Over the last 25 years, a new medical discipline has emerged, Med-Psych, an interface between medicine and psychiatry. Med-Psych units are those that integrate psychiatric and medical care.[4] Our department adopted the Med-Psych approach in treating our SARS-Cov-2 patients. In addition to the standard medical therapy, mental distress was screened for, diagnosed, and treated. The following case may explain the advantage of the Med-Psych approach:

A 50-year-old healthy man was hospitalized because of slight cough after he was diagnosed with SARS-Cov-2 infection. His physical examination, laboratory tests, and imaging studies were normal. From the medical perspective, he was defined as a mild case. Shortly after admission, the patient became extremely anxious and agitated and began hyperventilating. Our integrated approach enabled us to identify the distress without the need of external consultants and while avoiding unnecessary medical intervention. Treating the patient with personal integrative psychotherapy and psychoeducational group psychotherapy allowed us to discharge the patient back home despite the lack of 2 consecutive negative polymerized chain reactions.

Summary

SARS-Cov-2 patients are hospitalized in quarantine conditions. In addition to medical care, these patients require frequent mental assessment. High index of suspicion is required to detect early signs of mental distress. Early diagnosis is beneficial as early intervention may help patients cope with this mental burden.

A Med-Psych specialist on the team or a sincere partnership between the internist and the psychiatrist should be the novel standard of care for these patients.

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COVID-19–Associated Psychiatric Symptoms in Health Care Workers: Viewpoint From Internal Medicine and Psychiatry Residents

TO THE EDITOR:

Introduction

The physiological impacts of COVID-19 are beginning to be understood. However, the psychological impacts of COVID-19, especially

among the health care workers who work with COVID-19 patients, are not well described. We assess data available from China on the impact of COVID-19 on psychiatric symptoms among health care workers to highlight the challenges currently faced by health care workers in the United States. We incorporate our viewpoints from our internal medicine and psychiatry residency programs.

Methods

We reviewed available literature as of March 25, 2020. We used the MeSH term "covid AND (psychiatry OR mental health)". We searched PubMed, Ovid Medline, and PsycInfo. As our purpose was to survey all the current literature on this topic, we did not have any exclusion criteria. The initial search resulted in 52 articles. After duplicates were removed, there are 32 articles remaining. Three articles discussed our topic of concern.

Frontline Health Care Workers

Frontline health care workers are those who interact directly with COVID-19–positive, or potentially positive, patients. These frontline health care workers are not simply working extremely hard, they are struggling to treat a new viral disease that is not well understood. This situation creates a unique psychiatric burden.

Lai et al.[1] enrolled 1257 health care workers who responded to a cross-sectional survey. General distress was present in 72% of participants, followed by symptoms of depression (50%), anxiety (45%), and insomnia (34%). Women reported more severe scores on all 4 of these categories. Nurses also reported more severe scores than physicians.[1]

Huang et al.[2] recorded responses from 230 out of 246 medical staff on self-rating anxiety scale and post-traumatic stress disorder self-rating scale. This study revealed a strikingly similar trend in comparison to the study by Lai et al.[1] The incidence of anxiety was higher among female health care staff than among male health care staff (26%, 48/187 compared with 12%, 5/43). Because this was self-reporting of anxiety, it is possible that male participants may have minimized symptoms. The incidence of anxiety among nurses, compared with doctors, was nearly 2-fold (27%, 43/160 compared with 14%, 10/70).[2]

Nonfrontline Health Care Workers

For this viewpoint, vicarious traumatization refers to psychiatric symptoms experienced by nonfrontline health care workers. As delineated previously, frontline health care workers are currently at a high risk for increased psychiatric symptoms.

Li et al.[3] analyzed the prevalence of vicarious traumatization by using electronic surveys to record responses from 740 people (214 general public, 234 frontline health care workers, and 292 nonfrontline health care workers). They developed a 38-item questionnaire subdivided into physiological responses, psychological responses, emotional responses, behavioral responses, cognitive responses, and life belief. Each item ranged from 0 (never) to 5 (always). Compared with frontline health care workers, nonfrontline health care workers scored higher for *every single category*, and each category reached statistical significance.[3]

Our Perspective as Frontline and Nonfrontline Resident Physicians

Our institutions have struggled to provide us with adequate personal protective equipment. We have limited masks available that must be continuously reused. Furthermore, policies change very frequently, leading to confusion. When we exhibit symptoms, we are directed to contact our employee health services. However, instructions are often vague, and there is limited testing provided to assess for COVID-19–positive status. Anecdotally, our colleagues are physically and mentally exhausted. There is overwhelming anxiety that we will contract the virus and infect our loved ones at home. Some residents have been living in hotels to avoid returning home.

We suggest that vicarious traumatization scores are higher among nonfrontline health care workers because of the following potential contributors: sympathy for COVID patients as well as for frontline health care workers (as Li et al. point out) and *guilt* in the avoidance of frontline work.[3]

At our institutions, emergency medicine physicians and internal medicine physicians are rapidly becoming ill with COVID-19 themselves. In response, the Accredited Council for Graduate Medical Education has transitioned to stage-3 pandemic emergency status, where resident physicians from other specialties will assist physicians on the frontline. In our psychiatry residency program, interestingly, residents

asked to have volunteers sign up to be called to duty. This behavior underscores the prevalence of avoidance and associated guilt in nonfrontline health care workers. It is possible that those who do not volunteer, especially if they observe colleagues called to frontline duty, will develop increased vicarious traumatization scores.

Conflicts of Interest: On behalf of all the authors, the corresponding author states that there is no conflict of interest.

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A Call to Arms, Not to Disarm: The Importance of Psychiatric Care in the Acute Medical Setting During the COVID-19 Pandemic

TO THE EDITOR: A shroud of panic has taken over the nation and the world as we prepare for and embrace the wave of COVID-19 patients expected to impact our health-care system. As this situation has evolved, we have been struck by the variety of responses regarding whether psychiatrists are essential personnel required to be present in-person in the hospital. Although telehealth is an excellent tool for many mental health settings, we propose that this is not ideal for consultation-liaison (C-L) psychiatry in the acute medical setting when resources are available.

The role of C-L psychiatry has been established since its inception in the early 1900s to be critical to general hospital medical care through contributing to high-quality patient care, management of hospital resources, and treatment of the emotional aspects of medical illness.[1] More recent literature has highlighted the potential for psychiatry consultations to help contain costs and decrease lengths of hospital stay, both of which are critical goals during this pandemic.[2] While respecting the needs both for social distancing, to avoid unnecessary risk of spreading the illness, and for judicious use of personal protective equipment, to preserve limited resources, our in-person care for medically ill patients is important. In addition to the aforementioned benefits regarding health-care resource management and provision of emotional support, we expect psychiatry to be essential in helping to prevent and manage the higher levels of depression and worse outcomes that have been observed in patients requiring infectious isolation in hospital settings.[3] Similar to other acutely medically ill patients, those with presentations concerning for COVID-19 are likely to be vulnerable to delirium, agitation, and decompensations of psychosis or mood disorders, necessitating psychiatric evaluation. Psychiatrists will also be needed to assist with capacity evaluations for these patients should they wish to leave against medical advice. Finally, as our medical colleagues face exhaustion, anxiety, and burnout from the increasing volume of patients and uncertainty regarding health-care resources, the need for C-L psychiatrists to provide moral support through our liaison role will be critical.

This is not the first pandemic we have seen; our mentors tell us the stories of working on the wards during the early cases of HIV/AIDS in the 1980s and the Hong Kong influenza in 1968. It is not surprising that we face similar challenges today, with fear of infection transmission among health-care professionals ranging from reasonable concern to panic. During this modern pandemic,