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Provision of mental health care to healthcare workers during COVID-19: A call for the practice of vulnerability

Significance:

The Commentary outlines the lived experience of a liaison psychiatrist working as part of a frontline COVID-team in a large public hospital in Cape Town, South Africa and explores several important themes including vulnerability in health care, connection with patient experience, group processing of trauma, reintegration following trauma, and the importance of embedded mental health care in all health systems. The frontline psychological experience has been similar to wartime combat and the collective stressors experienced by healthcare workers must be recognised as such to ensure appropriate support is provided to help them recover.

> *The human soul doesn't want to be advised or fixed, it simply wants to be seen, heard and companioned exactly as it is. When we make that kind of deep bow to the soul of a suffering person, our respect reinforces the soul's healing.*
>
> Parker Palmer

The mental health impact of COVID-19 on patients admitted with COVID pneumonia and on healthcare workers is well established and a number of supportive interventions have been described.[1] However, little experience has been shared from low- and middle-income countries like South Africa, where the burden of the pandemic has been compounded by the burden of HIV and TB[2], COVID-19 vaccine inequities[3], an already fragile health system, and, critically, a social context of inequality, normative violence, and national infrastructure challenges[4]. This Commentary outlines the experience of a liaison psychiatrist working in a COVID-19 frontline team of a large public-sector hospital in Cape Town (Groote Schuur Hospital), to reflect on key lessons for supporting the mental health of patients and staff in challenging contexts.

In a pre-COVID-19 pandemic world, it might have been harder to explain that thoughts, feelings and emotions are inextricably intertwined, not only with the body and illness in general, but with society as a whole. Every person reading this, whether you have personally had COVID-19 or not, understands what it means to live through a pandemic. Everyone has experienced anxiety and fear, and has at times found it challenging to think clearly. The COVID-19 pandemic has launched a global mental health crisis, with unprecedented numbers of individuals meeting criteria for depression, anxiety and other mental health disorders in response to a range of intense stressors.[5]

The co-occurrence of mental health symptoms in patients admitted for COVID-19 is common, with studies reporting many patients experiencing significant distress, fear and anxiety.[6] The experience at Groote Schuur Hospital in the high-flow nasal oxygen (HFNO) high care units and intensive care units (ICUs), mirrors these observations. My role was to provide face-to-face support and a sense of safety for patients requiring HFNO or ICU care. In part, this role was to manage the acute psychological stress which was negatively impacting physical status but also, in providing containment, to mitigate the long-term risk of developing post-traumatic stress disorder (PTSD) post-discharge. Higher levels of anxiety and depressive symptoms during COVID-19 hospitalisations and feeling socially disconnected have predicted higher PTSD symptoms following discharge.[7] Early on, we recognised the link between panic and fear and worsening symptoms of COVID-19 pneumonia including breathlessness and oxygen requirements. We deployed brief interventions to manage fear, anxiety and distress effectively, mostly using psychological first aid[8] and also drawing on therapies such as mindfulness, cognitive behavioural therapy, problem-solving and motivational interviewing. In a modest proportion of patients, this therapy needed to be supplemented with medication, including antipsychotics and antidepressants.

Fear and anxiety are pervasive in COVID-19 high care/HFNO environments, which are described by many of our patients as 'terrifying'. HFNO failed in just over half of our patients, and the mortality in the patients who received mechanical ventilation was very high.[9] Fear was particularly marked in those who had never been admitted to hospital before or who were experiencing a severe illness and vulnerability for the first time in their lives, such as younger people who had never had to confront their mortality before. Patients themselves battling COVID-19 pneumonia witnessed many deaths and intubations and were hyperaware of what was happening to others around them in the unit, all struggling with the same condition. This situation is a stark contrast to usual inpatient care in which patients are admitted for a variety of different conditions, allowing them some degree of emotional distance from the suffering of others. Nothing before COVID-19 could prepare one for high care wards with the loud hiss of oxygen flowing at speed, the beeping of so many machines, the breathlessness of patients – these are the sounds of COVID-19. Everything is fast-paced, the tension is palpable and the reality that seconds and not minutes matter is hard-hitting.

Fear and anxiety not only impact respiratory function but also decision-making capacity. Many patients declined intubation and mechanical ventilation, even though it was desperately needed, due to fear. Creating space to listen and allow those fears and concerns to be expressed without judgement was critical to support and facilitate an improvement in capacity, facilitating consent for intubation and ICU admission. This care extended to attendance at intubations for those patients who were overwhelmed or who requested additional support. This was very common in younger people and pregnant women who not only needed intubation and ICU admission, but prior to admission

to ICU, would need a Caesarean section and were faced with the terrible reality that they may not meet their babies. A similar approach was used in patients wanting to discharge against medical advice despite being critically ill and needing HFNO. A clinical ethics consultation goes beyond issues of legal capacity and theoretical ethical principles; it also requires a knowledgeable clinician who has an understanding of the role of psychological factors in the resolution of the conflicts that are inherent in making life-and-death decisions.[10] Liaison psychiatrists are ideally placed to manage these difficult situations which tended to be more common in people who rejected scientific explanations of COVID-19 and its treatment and disclosed conspiracy theories. It was also important to support the team through complex ethical and moral dilemmas, which pose a high risk of moral injury[11] – a trauma to which doctors are particularly vulnerable.

Listening to the stories of how patients experienced this new infectious disease, learning from them and bearing witness to their journey was a fundamental component of providing care. Seeing and understanding the individual for whom we care provides meaning and purpose, and the act of connecting with these personal experiences improves clinical care and outcomes. These connections brought incredible joy when patients survived and went on to thrive. However, making these connections required tremendous courage, as we also suffered innumerable losses.

An overwhelming experience to stand in that space now quiet, empty and waiting for the next wave – and allow yourself to feel everything that happened. Crushing, it takes courage.

– Jackie Hoare

Photo by Prof. Marc Mendelson, University of Cape Town Groote Schuur Hospital

It is well established that in medical culture there is pressure to become an expert and to demonstrate ability to fix difficult situations, while remaining in control.[12] Medical cultural norms do not support healthcare workers to stand alongside their patients in their suffering or to grieve them when they die. Vulnerability and emotional pain may be experienced as humiliating, shameful, and something to be hidden.[13] In holding the pain of our patients and their loved ones, many of our COVID team were neglecting to address their own. This created an acute psychological crisis – a conflict between being a guardian of suffering and suffering – that demanded extensive emotional support. My colleagues were experiencing the unimaginable and the unspeakable.[14] However, traumatised groups isolate themselves and are difficult to access. The only way they could begin to express what they were going through was through me having an embodied experience of what they had experienced.[14] I had to become part of the COVID-19 team, I had to face the same traumas and anxieties myself and bear witness to the same suffering and death.[14]

In addition to me becoming a part of the COVID-19 team, my psychology colleague and I ran a weekly peer support group. We came to see that the many sets of tools such as resilience training, which have been developed to help medical personnel cope, although they have their place, may be experienced as positioning our colleagues as incompetent and lacking, that they needed to 'fix' something in themselves, when in fact the primary issue was not clinicians 'not coping' but a situation which was until then incomprehensible and impossible to manage.[14] Once this had been acknowledged and normalised, then there was space to reflect and share experiences. The function of the groups was to make a space where the team could feel safe and connected, not alone, to put our experiences into words and thereby address the isolation that trauma brings.[14] We created a mirror: the role of healthcare workers was to bear witness to patients' suffering and loss, the role of the groups was to bear witness to each other's suffering and loss. We understand from the literature that trauma can isolate one from those who have not been through the same experience, while at the same time binding together those who have.[14] Participating in the group also normalised and promoted individual mental health care seeking, particularly when the narrative of 'we are all navigating impossible terrain' was internalised.

The groups provided a safe space to acknowledge that we were not okay, that the masks we wore for physical protection could not shield us from the grief and loss we faced continuously. Trauma isolates; the group re-created a sense of belonging.[15] As we allowed ourselves to be vulnerable with each other, we saw the true extent of our pain. It was not 'stress': we were stressed, but our pain was not stress. We needed the right words to define our experience, we needed the right words to have the conversations that matter and to access help that would be meaningful. It was grief and it was trauma. We were grieving, mourning innumerable losses and sad. At times it was overwhelming. Without safe spaces to process, grief can fester, be rendered complex and erode our mental health.

How do we as healthcare workers dare to be vulnerable and allow ourselves to feel, when doing so opens the door to our own pain? How do we allow room for emotional processing when we have learnt to minimise feelings in order to function? We needed to process our pain to heal in the slow and uneven way that grief heals. The trauma we felt was real. But collective grief and collective trauma demand collective healing. Experiencing trauma can feel shameful and stigmatising; however, the group bore witness and affirmed.[15] We needed to deconstruct the cultural medical narrative that vulnerability is weakness and learn a different way of functioning – one where grief is acknowledged and even actively processed while still going about our work. If we allowed the reality of grief to exist, we could focus on helping ourselves and supporting each other. What sustained us, and what we will hold onto during and after this extraordinary time, are the colleagues who survived this with us. We looked out for each other and faced this catastrophe together. The solidarity of the team provided the strongest protection against despair and the strongest antidote to the frontline experience.[15]

During the waves we were driven by the intensity of the work, fuelled by a common purpose and the adrenaline rush that characterises emergency care. We were trying to minimise suffering and save lives. We adapted to survive; the immediacy of the work focused our minds and our bodies. However, between the waves, we have experienced different sets of difficulties in returning to 'normal life'. We are not simply a burnt-out workforce. We have felt separated, isolated and disconnected from the world around us. The world outside of these COVID-19 high care wards feels anaemic, slow and lacking in meaning. While this sense of dislocation may be a cognitive distortion and we are able to recognise it as such, it cannot always stop the feeling. Our lives are full of meaning, our work outside of COVID-19 full of purpose. But the exposure to the trauma of the COVID-19 wards changed us. We found it hard to connect and explain to others what we were feeling. The feelings of otherness, numbness and disconnection are barriers to reintegration between waves. Low mood, irritability, tiredness, and difficulties with eating, sleep, attention and concentration have been experienced by many. We have tried to manage these symptoms by staying connected with each other and talking about it. Normalising these experiences is important to minimise self-stigmatisation and isolation – these are all understandable reactions to traumatic experiences. A similar phenomenon has been described for soldiers returning home from deployment.[16] Now we begin

a new journey of creating a new self, of mourning the old self that the frontline experience has disrupted. Many of our relationships have been tested and forever changed by the trauma, and the old beliefs that gave meaning to our lives have been challenged.[15]

Our experience argues for the importance of integrating liaison psychiatry within COVID-19 frontline teams, and during future emergencies and health system shocks, thereby facilitating trust and a space for providing emotional support to patients and colleagues founded in shared experience.[14] Connecting with our patients as people proved vital in achieving good clinical outcomes, but carried a high emotional cost, as many did not survive. Bearing that cost was made difficult by social healthcare norms of not being allowed to suffer with and for your patients. Connecting with colleagues as people and not only co-workers and normalising vulnerability eased this difficulty. The frontline psychological experience has been similar to wartime combat and the collective stressors experienced by healthcare workers must be recognised as such to ensure appropriate support is provided to help them recover. We are practising medicine in complex and challenging times. For us to be good at our work means that we must reject false distinctions. For example, we cannot focus on the mind and exclude the body or focus on the body and exclude mental health; we must not try to choose between good mental health care and good health care – they are the same thing. Another key binary is that between us as clinicians and our patients, we are all vulnerable and all have care needs – it is this common humanity, which is in our brains, our bodies, and our lives, that should form the basis of good health care.

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Competing interests

The author has no competing interests to declare.

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