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EDITORIAL

The psychological impact of COVID-19 on frontline healthcare workers 'From Heartbreak to Hope'

It is over a year since the first death of a patient in Ireland with COVID-19, and the national healthcare system continues to experience extreme levels of demand on all resources. In the context of persistently high COVID case numbers, the emergence of highly resistant strains and the possibility of a fourth wave, there remains unease about how the health system is coping. Frontline healthcare workers continue to risk infection and transmission of infection, endure increased workloads, suffer trauma through bearing witness to high levels of death and disability, and experience moral distress arising from these novel working circumstances. This is often compounded by challenges with resource allocation and the pandemic-related alterations to end of life care provision.

This editorial reflects the discussions prompted as a result of the virtual symposium 'The Psychological Impact of COVID-19 on Frontline Healthcare Workers', hosted by the School of Nursing, Midwifery and Health Systems, University College Dublin in March 2021. This event served as a forum for international experts to present their research on the subject of the psychological impact of COVID-19 on frontline healthcare staff and to highlight measures that may be of help. Prof. Neil Greenberg provided a keynote session, which illuminated the stressors faced by healthcare staff and the importance of recognition and support in maintaining well-being.

The combination of pre-existing healthcare system pressures and the demographic of frontline healthcare workers exposed staff in the UK and Ireland to the worst effects of COVID-19. It is our opinion that COVID 19 has substantially added to the disproportionate burden carried by women in health care. Specifically, healthcare workers are predominately young women, whom Greenberg highlighted are at greatest risk from the worst mental health impacts of COVID-19. The implications of shouldering this unsustainable burden can include burnout and ultimately staff attrition. Even before the pandemic, healthcare systems struggled to retain and recruit staff. Now, the psychological impact of working through the pandemic has led many exhausted staff to actively consider leaving their career.

Overall, we are concerned about staff whose workloads may become beyond 'usual' or 'safe'. It is known that chronic excessive workloads are detrimental to the quality of patient care, contribute to increased workplace errors and negatively impact work satisfaction and staff retention (Kinman et al., 2020). More specifically, our team has found that nurses working in intensive care unit (ICU) experience particularly high levels of trauma-related distress, which if sufficiently severe can impact on job performance. Those with dependent children, or those who were required to quarantine demonstrated increased vulnerability during this COVID crisis. In addition, the occurrence of moral injury (a profound cognitive and emotional response arising from events that violate one's moral code) is ever more likely as individuals struggle with the question 'did I do the right thing?'.

It became evident during our virtual session that exposure to morally injurious events is more common during this pandemic. Worryingly, this is strongly associated with mental illnesses such as depression and post-traumatic stress disorder (PTSD). The frequent occurrence of moral injury is not due to inappropriate care delivery or shortfalls in care, but due to the intensity of the working environment, the exposure to death and the changes to the work environment that has led to healthcare staff working in unfamiliar conditions.

Conversely, the virtual session reassured us that many staff will not experience moral injury, or any prolonged mental health impacts, related to their front line work during the COVID-19 pandemic. A minority will struggle, and early identification and access to occupationally focussed professional help will be essential. It is important to remember that most healthcare workers thrive in a fast-paced critical environment and may have been attracted to working on the frontline due to the dynamic nature of the work. A certain level of stress is, therefore, anticipated and staff often cope very well with this and indeed develop a level of natural resilience.

Many factors both intrinsic and extrinsic play a role in determining the impact of front line work at individual level. While perhaps obvious, facilitating staff to pay attention to basic needs including rest, nutrition, exercise and staying in touch with family and friends is a very important component of any localised support mechanisms. Attention to the fundamental human needs, such as those outlined by Maslow, serve as a foundation for positive mental health. Dr Veronica O'Doherty advocated the importance of compassionate leadership in maintaining staff well-being. Furthermore, the presence of psychologically 'savvy' managers supports effective team dynamics and good levels of resilience among the individual, team and overall system. Empowering team leaders and managers to have 'psychologically savvy' conversations with team members could have a protective impact on the mental health of healthcare workers without the absolute necessity for formalised action. These one to one interactions and support by mangers should not be limited to

return to work interviews after a period of illness or quarantine, but extend to meaningful leader led open discussion about situations that had a significant impact on staff. Fostering a sense of trust so that open, honest discussions can take place, regarding issues such as bereavement, job loss, well-being and support needs and potential moral dilemmas is important.

Resources that can enhance managers' confidence in recognising and supporting distressed colleagues include the REACT Mental Health Conversation Training, a one-hour active listening skills programme (Akhanemhe et al., 2021). Having these regular well-being conversations can demonstrate authenticity and compassion, and such training programmes may provide managers with the skills and confidence to conduct them effectively.

Of measures with proven benefit in maintaining psychological well-being, we advocate advanced preparation for the frontline role. This includes providing clear information about the risks involved from outset. If staff understand that despite their best efforts patients may die, they will be aware of the challenges ahead, should they chose to undertake the role. The term 'Psychological PPE' is now widely used to refer to mechanisms deployed to prepare staff cognitively, emotionally and practically, to enhance coping skills and to promote healthcare workforce mental health and well-being. Developing a wellness recovery action plan among the team could be encouraged by managers and involves noting what one normally does to maintain mental health and wellness and recognising that the situations we are currently facing require a back-up plan to protect mental health.

When considering what might be helpful for staff, social-support measures are known to be protective of mental health. Activities such as pairing staff up on shift to 'buddy' one another, and checking in on one another every hour, are useful examples of this. This form of peer support encourages people to listen to each other, to solve problem and to identify issues early, so help can be sought before symptoms escalate. Team resilience is enhanced when there is a sense of community and collegiality. Training for staff to support other colleagues who have experienced a traumatic, or potentially traumatic event is also useful; an example is the TRiM peer support programme. In addition, O'Doherty highlighted how the Johns Hopkins RISE® (Resilience in Stressful Events) peer to peer support programme provides healthcare workers with prompt support during times of distress or trauma, thereby preventing them from becoming 'second victims'. While peer support provides a 'listening ear' and low-level psychological intervention to a colleague, it is also a means of identifying those at risk to themselves or to others and facilitates a pathway to professional help. Competence and confidence are also protective factors for well-being; therefore, a robust training and supervision system needs to be in place for managers and staff.

Consideration of these local supportive mechanisms is important, as research by Dr. Tara Feeley has indicated that healthcare workers often have a preference for local departmental supports rather than formal measures of psychological assistance. Psychological and well-being supports can only be of benefit if they are accessed and engaged with by staff. Dr Barry Lyons explained how stigma related to mental health disorders or services can result in reduced help-seeking. In such cases, people may decide avoid seeking help due to fear of the label of mental illness and the harm it can bring. It is confirmed by Edwards and Crisp (2017) that concerns regarding confidentiality and the perception or anticipation of potentially negative social or professional judgements seem to weigh heavily on healthcare professionals. The impact of this stigma is characterised by underutilisation of services, increased symptom severity and ultimately greater damage to psychosocial functions. The characteristic tendency to conceal the diagnosis from colleagues can result in the opportunity for peer support being lost.

Lyons recounted how healthcare workers exhibit significant levels of self-stigma, which leads to negative emotional reactions including low self-efficacy, and low self-esteem, shame, isolation, demoralisation and a diminished sense of self-worth. These ultimately interfere with a persons' life goals and overall quality of life. Familiar phrases such as 'weak not sick', relating to individuals unable to work due to psychological distress exemplify the perceived lack of validity for illness not of a physiological origin. Whether this relates to the difficulty people who care for others have in acknowledging their own vulnerability, or the perceived negative effects related to receiving mental health diagnosis; stigma has potentially devastating consequences for frontline healthcare workers.

There is little evidence that any stigma reduction strategies lead to a sustained change. However, programmes that diminish stigma aim to correct attitudes and behaviours that might be pose barriers to help-seeking behaviour. The interdisciplinary research collaborative 'Shame and Medicine' of which Lyons is a member, examines the role of shame in various aspects of health and medicine. Stigma reduction strategies might include online fora facilitating open dialogue around managing the stigma health professionals feel in a healthcare environment. Anti-stigma programmes involving trained speakers with lived experience of receiving a mental health diagnosis can refute myths and assist people in speaking about their own difficulties. The normalisation of health-seeking behaviour, and prioritisation of self-care must be a focus of undergraduate and graduate education, so that psychological well-being is seen as part of healthcare professionals' professional identity and responsibility.

Consideration must now be given to the recovery phase. When it arrives, it will present an opportunity for post-traumatic growth. One method to support true healing and growth is to thank staff in a personal way, acknowledging their specific contribution and indicating what support is available if needed. A successful recovery period would be evidenced by good mental health outcomes, staff retention and satisfaction and evidence of the development of resilience or post-traumatic growth. This resilience must be seen as a feature of the whole organisation, and not just the responsibility of individuals themselves.

In terms of recovery and rebuilding, in the words of Greenberg 'We must recover our people before we recover our services'. We are much closer to the end of this pandemic than to the beginning, and now is the time to look forward. A period of rebuilding, resetting

and recovery is needed, placing frontline healthcare staff front and centre of recovery measures. We must reflect on the learnings and positive changes we have made during this time, and how we might continue these into the future. We have the tools to emerge from this crisis, and realise a period of growth, but this will not happen unless we make it happen.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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