Managing COVID-19 related psychological distress in health workers: field experience in northern Italy

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Northern Italy was one of the first sub-regions of western Europe hit by the coronavirus disease (COVID-19) pandemic.[1,2] Taking care of COVID-19 patients, healthcare professionals had to deal with profound ethical dilemmas and with fear of infection for themselves and their families,[3] evidenced by 172 doctors and 40 nurses died due to COVID-19 by the 13th of July, (portale.fnomceo.it). Based on lessons learned from previous pandemics (e.g. SARS),[4] such an exceptional and unexpected stressful exposure was likely to exert both acute and long-lasting effects on psychological well-being of medical/health professionals, as reported by earliest mental surveys in China.[5,6]

The mitigation of such psychological distress is a crucial component of current Italian national health system reaction to the pandemic. In this perspective, we report the experience of the Azienda USL-IRCSS of Reggio Emilia, a health system serving half-million inhabitants catchment area in Emilia Romagna Region. The experience involves a program of psychological support to healthcare personnel, aiming to mitigate the emerging distress related to COVID-19 case management. The intervention is led and supervised by one of the authors (LT) and is specifically based on Eye Movement Desensitization and Reprocessing (EMDR).[7] This evidence-based psychotherapeutic approach is aimed to alleviate the symptoms and emotional distress induced by disturbing life experiences, whose related memories progressively may lose their negative emotional charge in terms of intrusiveness and physical arousal. EMDR is included in the *WHO Guidelines for the management of conditions specifically related to stress,*[8] and among other stress-management techniques (e.g.

debriefing and defusing), was considered by the psychological staff as better adaptable to an ongoing stressful situation, whose features were not common for all exposed individuals, with the need of self-identified individualized therapeutic targets. In particular the EMDR intervention was applied through the Integrative Group Treatment Protocol (EMDR-IGTP)[9,10] for healthcare workers, i.e. a specific variant of the broad EMDR approach aimed at rescuers, medical and nursing staff in emergency-urgency contexts.

Since the first cases of COVID-19 patients appeared, EMDR-IGTP sessions in person (based on bilateral self-stimulation through tapping), or individual EMDR treatments sessions (bases on bilateral stimulation with eye movements) have been proposed weekly to healthcare workers. Group sessions were requested by the whole staff of most exposed departments, such as intensive care units; groups included 12-15 participants and each group session had a duration of one hour and half (90 minutes) and was conducted by 2 psychotherapists of the hospital-based psychological staff, that included 5 EMDR-trained employee psychotherapists. During the sessions, after explaining the protocol, healthcare professionals were invited to choose the most disturbing memory for them and then guided in the individual processing. Individual sessions were requested by clinicians feeling more traumatized and stressed.

During the first weeks of the COVID-19 emergency, main issues brought by healthcare professionals were mostly linked to the distress of intensified working shifts and fears of contagion for themselves and their families; sometimes they were concerned of not being helpful enough for the staff (especially for MDs or nurses not usually working in intensive care units, and for those feeling blocked by anxiety). Over the subsequent weeks, the thematic issues raised by professionals as major concerns were more related to the suffering of hospitalized people, including expressions of pain and

fear, loneliness, and sense of helplessness as well as forced isolation from their families. Three month and half later (beginning of July), about 200 health workers underwent group and individual EMDR interventions and most of them have already asked for subsequent individual support once the emergency will be completely over. Overall, along the course of the pandemic, in the reports of health personnel, the state of alertness and distress characterizing the early days of the emergency gradually receded, replaced by feelings of compassion, sadness and helplessness related to patients who they could not or will not be able to save. Such thematic shifting of thoughts and emotional experiences from individual (fear for oneself and work stress) to social consequences of the COVID-19 pandemic (pro-social emotions related to sadness, mourning, loneliness, and impotence towards others), seems to follow a typical pattern.[3]

In conclusion, given that COVID-19 pandemic is spreading internationally with different zonal and regional time-scales, local field experiences developed in early hit areas such as Northern Italy, may guide or facilitate the timely implementation of analogue interventions in other health care systems, thereby contributing to the global containment of the sequelae of COVID-19 outbreak. In this respect psychological support for healthcare workers, might prove an important strategic asset to insure the endurance of the ongoing adaptational effort of national health systems.

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