COVID-19, MENTAL CONDITIONS & EMDR PROTECTING FRONT LINE HEALTHCARE STAFF'S MENTAL HEALTH

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Healthcare professionals, nurses, and doctors often have to perform complex tasks quickly in order to effectively assist people in danger. Nonetheless, over the past year, healthcare staff have also been burdened with additional stress caused by the exposition to the various critical events of the Coronavirus emergency, which constitute risk factors for the development of traumatic stress reactions.

RISK FACTORS

The events that have had a major impact on healthcare staff's psychological wellbeing and that represent risk factors for the development of stress reactions during the pandemic are (WHO, 2020b):

- managing many patients at the same time and with insufficient resources to face the emergency
- the fear of being infected and of spreading the infection
- the high mortality of patients and colleagues
- the sudden and continuous changes in work practices and procedures (most of the staff from other wards suddenly found themselves reassigned to ICUs without having the necessary experience)
- the unpredictability of the scenario
- the need to provide emotional support to patients in isolation and, in many cases, to accompany the dying ones
- social isolation (including separation from their family members) for being quarantined
- discrimination and stigma

Especially during the first phase of this pandemic, it became clear how thin was the line dividing the personal and the professional dimension in the work of healthcare staff. The fact that many colleagues had been infected or had died reduced the emotional distance doctors should keep while assisting their patients, which is important in medical work; this was not only traumatising per se, but it did not even allow the surviving colleagues to have the chance to mourn their workmates and friends.
In addition, every doctor or nurse that was infected reminded others that they could be the next, and this kind of experience represents one of the great risk factors for post-traumatic disorders.

Furthermore, the Coronavirus emergency also exposed staff to another very traumatising aspect: dealing with many patients at once and fearing that the life support equipment available will not be enough for so many people.
They had to work non-stop and without holidays, on much longer and exhausting shifts in order to support their colleagues in hospitals. They also had to maintain a constant state of vigilance due to the high number of patients, with a too short time to recover that often was not entirely restful.

In addition to this, wearing protective equipment at work was itself a source of distress, making movements more difficult and tiring, and extending the time taken to get dressed before entering a 'dirty' area.

On the other hand, some protective factors, such as the family, were no longer as present as before for some healthcare workers, due to the fear of infecting one's own relatives or parents. Simple gestures such as hugging your own children were no longer spontaneous, blocked by the fear of spreading the virus and losing them. For a doctor, the fear of coming back home, which is generally a place for decompressing all the stress experienced during the day, is a cognitively dissonant factor that does not allow to ever truly disconnect and recover physically and psychologically for the next day of work **(IASC -Inter Agency Standing Committee-guide line of risk factors for front line).**

Finally, the need to *"humanise"* was very much felt in hospital wards. For nurses, it is hard to assist a patient that is alone and unconscious; they feel that it is not fair to let people die away from their families, they feel that it is necessary to help the patients in their last moments and try to make up for the absence of their loved ones.
This aspect in particular was the most relevant in Italy, but the articles published internationally about healthcare staff's conditions during the pandemic never mentioned the stress to which they were exposed. Doctors and nurses were almost always the only means of communication with the victims' families. They had to communicate the death of a patient to relatives that could not even see their loved one for the last time; to lighten the brutality of the event, many doctors had to say that the patients had not suffered, when in fact that was not the case. Not only are the patients in pain, but they are also conscious, and doctors feel that they cannot do anything for them because this is a new disease and nobody knows yet all the implications of it.

**"Front line personnel saw the suffering and devastation in their eyes,
in an emergency where eyes and looks were the only means of communication."**

This is what happened within hospitals, but the traumatic effects of the pandemic on medical and healthcare personnel did not end there.
Outside the hospital, as a matter of fact, front line responders were confronted with the spread of Covid denialism and with a part of society that had never seen a Covid-19 ward, so was unable to perceive the tragedy that was happening there. The existence of stigmatisation of healthcare staff by the community was reported in some countries, like Taiwan, and also by the Standing Committee of European Doctors.
Doctors and nurses found themselves at the centre of an absolutely paradoxical situation: during the first wave, they were seen as heroes, while in the following waves, they became responsible for the outbreak and the death of the patients.
Therefore, for front line staff, dealing with the anger of this population became an additional emotional burden to bear on top of the one incurred in the hospital.

This phenomenon occurs because the care system for Covid-19 patients is not visible. When it comes to other diseases, family members are always involved in the treatment procedure, all information is made available to them. However, in this situation, it is not possible to see anything of what is done to the patients except through the words of the doctor or nurse that are taking care of them. This is not the case with other diseases, just as there is no such thing as denialism with other kinds of illness.

CONSEQUENCES OF STRESSFUL EVENTS ON HEATHCARE STAFF

A very important aspect to consider is that, until now, the focus has always been on the virus and on finding effective ways of treating and defeating it, but the psychological implications of the pandemic will have a huge and potentially more devastating secondary impact on the community.
In the aftermath of this pandemic, certain memories or images may remain as 'open wounds' which, if not treated with due care and with specific therapeutic protocols, are known to cause sequelae at a professional level in people affected, generating a sense of unease that may turn into a real malaise.
It is important to know that even when this emergency situation is over, for a brain that has been subjected to such high and prolonged levels of stress, it will still not be over. This type of discomfort can persist until it becomes a chronic condition of burnout which, very often, can also affect the indispensable harmony that must exist to work effectively with colleagues, members of the same team (ambulance drivers, nurses, doctors…) or of a different one (i.e., law enforcement…), thus making it impossible to use operational protocols or guidelines correctly and, above all, to assess the needs of patients with the necessary clear thinking.

Prior to this pandemic, studies carried out for example after the SARS outbreak showed significant results regarding the presence of post-traumatic symptoms among healthcare workers (1 out of 4 reported post-traumatic symptoms among other symptoms), potentially attributable to lack of preparedness to deal with the emergency (Chan and Huak, 2004; Lee et al., 2007). On this basis, we can hypothesise that also the Covid-19 emergency has the potential to trigger traumatising experiences in healthcare workers, producing a significant impact on their psychological wellbeing.

WHAT THE RESEARCH SUGGESTS

As far as emergency healthcare workers are concerned, there is a significant amount of research confirming their specific need for psychological support.
As mentioned above, various authors reported significant data on this topic already in 2003, with the outbreak of the SARS epidemic:

- Epidemiological studies have shown how previous infectious diseases cause long-term and persistent psychopathological consequences on this category (Tam et al., 2004; Lee et al., 2007). In particular, in the various pandemics that have spread over the years, high rates of anxiety, depression, stress and insomnia have been observed among healthcare workers. Many speak of 27%.
- During and after the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, frontline workers reported a lack of support in the workplace and, consequently, major psychological symptoms as acute stress (Tam et al., 2004). In particular, 20% of staff had developed PTSD.
- During the Middle East Respiratory Syndrome (MERS) epidemic in 2015, medical staff showed an increased long-term risk of developing post-traumatic stress disorder (PTSD), which led to increased absenteeism from work (Lee et al., 2018).
- During pandemic emergencies, as the Covid-19 pandemic, frontline healthcare workers deal with an unexpected workload in a context of **uncertainty and helplessness** and are more vulnerable to infection due to their direct contact with patients, which also increases the belief that they will infect their family members and colleagues (Liu et al., 2020; Ran et al., 2020).
- Healthcare workers experience feelings of uncertainty, helplessness, alienation, isolation and difficulty in managing their workload.
- They have to cope with loneliness, stigma, and rigid expectations, which can lead to important emotional and psychological consequences such as anger, anxiety, insomnia, and stress related to the uncertainty of the pandemic (Ran et al., 2020; Zhang et al., 2020).

All of the risk factors mentioned can most likely lead to an onset of burnout (Ornell et al., 2020).

Woo et al. in a meta-analysis published in the Journal of Psychiatric Research, found significant distress, especially in nurses. Burnout in the healthcare population was already 11.3% before the pandemic.

In Germany, doctors were found to have high levels of anxiety and depressive symptoms (Boehlken, 2020). As part of this pandemic, Pappa et al. also published data on doctors in the UK and Greece (Brain, Behaviour and Immunity, 2020), where significant mood and sleep problems were found. Furthermore, Zhang et al. report 36% of insomnia in China (Frontiers in Psychiatry, 2020).

These results should make us think about the fact that the emotional and psychological distress caused by this emergency has spread more than the virus: to date, we have more people affected by this malaise than by the virus itself.

EMDR THERAPY

EMDR Italy Association has conducted research on the psychological impact that Covid-19 has had on healthcare workers; this research is one of the few carried out in Italy and involved 744 subjects working in 17 different hospitals and nursing homes. The treated population had a level of post-traumatic symptoms of 62%. In this specific study, healthcare workers presented twice as many post-traumatic symptoms as in the study by Giusti et al., but the levels of clinical symptoms were similar to the study previously described. The study conducted by EMDR Italy Association showed that, at the end of EMDR treatment, the majority no longer reported a diagnosis of PTSD.

In addition, after the treatment with EMDR, ***stress, anxiety, anger, mood and sleep problems, and need for help*** of the treated subjects showed a significant improvement, an improvement that doubled the one reported by untreated subjects.

It is possible to intervene both through a short cycle of EMDR group sessions and on an individual basis, in order to allow the healthcare workers involved to process the traumatic stress and to encourage their return to a normal working, relational, personal and family life.
The aim is to help medical staff identify their own needs for psychological support in order to help improve the subjective quality of their work: in these meetings, they are given useful tools to strengthen their stress management resources and increase their psychological protective factors. During these meetings, it is important to dedicate time to the understanding of how each individual has dealt with stress, what were its psychological effects and what life changes this emergency has brought about.
It is also important to consider that these symptoms were not present before in this population, so we should not pathologise them, but explain that they are common reactions to an exceptional traumatic situation and there are intervention methods that can considerably alleviate such suffering.

Many directors of medical staff in hospitals, working mainly in resuscitation and intensive care, are aware that the personnel needs assistance and have requested specific psychological support such as EMDR. An example is represented by the General Director of the Local Health Authority *Azienda Aulss 2 - Marca Trevigiana*, who requested to activate a project of psychological support for the staff during both the emergency and the post-emergency period of the Covid-19 pandemic; the project was addressed to 9’000 employees distributed in hospitals and local facilities in the metropolitan area of Treviso (Treviso, Montebelluna, Castelfranco, Oderzo, Conegliano and Vittorio Veneto).

This work removes all those risk factors that can act as a basis for the development and chronicisation of a range of post-traumatic disorders that can invalidate various aspects of each person's life.

It is clear from our research that working with EMDR not only promotes faster recovery and offers protective factors for possible re-exposure to other stressful events, but also significantly reduces the costs budgeted for staff’s support.

CONCLUDING REMARKS

The data presented in this paper are in line with what has been seen internationally in the various publications on healthcare professionals in the context of the Covid-19 pandemic. Most are publications by Chinese researchers and authors also from the UK, Singapore, Brazil, etc. published in Brain, Behaviour and Immunity, Frontiers in Psychiatric, Journal of Psychiatric Research.
The assessment scales used in the various studies published so far are the same, especially the Impact of Events Scale.

Our data and numerous scientific studies reveal that front-line staff are a vulnerable group. It is essential to take this into account, as healthcare personnel are a vital resource for all countries. The general call from all authors is to strengthen their resilience and mitigate their vulnerability.

It is important to safeguard the morale and mental wellbeing of healthcare workers in the context of the pandemic, because there is a dissonance between their duty, their values, their altruism, and their personal fear of the risk of infection and death. All the articles confirm that what this population fears the most is not, however, getting the infection, but it is not knowing how to treat the infection and the consequent feeling of powerlessness.

Our data support and confirm that an intervention with EMDR can be very effective and convenient since its effectiveness is the same if it is done in a group or individually, in presence or online. Two meetings are sufficient to bring reactions and symptoms back into remission.
As the pandemic has increased the demand for mental health services for healthcare personnel, psychologists must play an important role in emergency planning and team management.