AMERICAN PSYCHIATRIC ASSOCIATION

**COVID-19 Pandemic Guidance Document**

# CONSIDERATIONS FOR HEALTHCARE WORKERS AND STAFF EXPOSED TO COVID-19 DEATH AND DYING

*Prepared by the APA Committee on the Psychiatric Dimensions of Disaster and COVID-19*

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# CONSIDERATIONS FOR HEALTHCARE WORKERS AND STAFF EXPOSED TO COVID-19 DEATH AND DYING

Psychiatrists and other mental health providers must decide how best to support the many front line providers and staff being exposed to a high level of death and dying, some of whom may not have had significant prior experience that could help enable accommodation. This statement brings together a few key evidence-guided principles to help guide mental health responses directed towards the many healthcare workers and staff on the front lines who are being continuously exposed to death and dying during a pandemic that also threatens their own lives and the lives of their families. A separate document focuses on COVID-19 related personal bereavement and acute and/or prolonged grief.

The mounting need to care for a large population of extremely sick patients of varying ages with COVID-19 has placed an enormous burden on healthcare systems, necessitating that many healthcare workers and staff "step up" into roles on COVID-19 response teams outside of their expertise and even usual experience. The current pandemic affects all workers within the healthcare system, including administrative staff, mortuary staff, facility support personnel, and other service providers (e.g., housekeeping, food preparation), in addition to clinicians. The latter group includes a broad range of providers, such as physicians, nurses, social workers, psychologists, EMTs, respiratory therapists, chaplains, and many others supporting this critical mission. Some clinicians may treat dying patients, but not in the context of the unclear protocols available for managing COVID-19 nor confronting the fear of contracting COVID-19 infection for themselves and their families. While most health care workers and staff will be resilient, mental health clinicians might consider this an extreme stressor as best informed by experiences managing other disasters.

Principles of disaster management relevant to assisting with exposure to death and dying include:

## 1. RECOGNIZE THAT EXPOSRE TO DEATH, INCLUDING HIGH NUMBERS OF DEATHS WHEN HEALTHCARE WORKERS AND FAMILIES ARE AT ONGOING RISK THEMSELVES, CAN BE AN EXTREME STRESSOR.

Patient deaths are the most challenging outcomes in healthcare. Many clinicians who treat conditions with high rates of mortality have frequent experience with death (e.g., ICUs, oncology, palliative care, etc.) and consultations with experts such as palliative care experts can also be helpful. However, the frequency and numbers of deaths resulting from COVID-19 more closely resemble those seen in other disasters. Due to the high volume of extremely sick patients with COVID-19 presenting to emergency rooms, and requiring inpatient or ICU level of care, hospitals have created additional emergency and ICU spaces often in areas not designed for them, such as tents and conference areas, and brought in additional staff who do not normally work in acute settings to help. This may also include tasks related to the management of the high volume of deaths.

For healthcare workers and staff involved with COVID-19 response with less experience with dying patients, exposure to high rates of death from the virus may be particularly distressing. There are specific challenges associated with COVID-19 that make deaths especially challenging for healthcare providers: treatment needs to be undertaken without an adequate evidence base, and decisions

must sometimes be made because insufficient resources exist to support best practices. Adding to the challenge, clinicians are likely to feel less connected to or more disconnected from their patients and patients' families due to PPE and the need for physical distancing, as well as the exclusion of families and loved ones from the bedside.

## 2. APPLY PRINCIPLES OF PYSCHOLOGICAL FIRST AID AND WELL-BEING FOR DISASTER REPONDERS.

Relevant resources have been developed to provide general support and guidance to healthcare providers and staff for the distress they may experience in their front line COVID-19 work. For those unfamiliar with this approach or needing a refresher, more information and trainings are available through the National Center for PTSD website (for website link and provider care pdf, see resources below).

**Core principles of Psychological First Aid include:**

- Promote a sense of safety to the degree possible for healthcare providers.
- Encourage self-calming techniques.
- Promote basic self-care such as eating, hydration, breaks, sleep and sleep hygiene, and exercise when possible.
- Reinforce use of prior effective coping strategies.
- Make stress reduction techniques available (e.g., online meditation or yoga apps).
- Create a sense of connection of the healthcare team.
- Promote social support as driven by the needs of the individual.
- Support self-efficacy of individual clinicians and teams.
- Monitor individual clinicians in high distress who may need additional mental health support, and refer if appropriate.

## 3. ACKNOWLEDGE THE DEATH AND CHALLENGES ASSOCIATED WITH MANAGING DEATH.

The stress of patient deaths is heightened by the heavy workload, high fatality rates, fear for personal safety, inability to follow usual rituals with a patient death, including exclusion of families or other supports from the bedside, need to inform families by telephone, distancing with PPE, and a highly demanding schedule. It is helpful to allow healthcare personnel and any others directly impacted to voice these stresses and to acknowledge the impact of multiple deaths. It is also meaningful to recognize and honor the enormous efforts the healthcare personnel are making, in the face of many challenges. Mental health professionals can consult with team leaders with less experience to increase skills and resources for supporting their teams.

## 4. CONSIDER INDIVIDUAL RESPONSES TO DEATH, INCLUDING THE DEATH OF A COLLEAGUE.

Clinicians who round with teams should be aware that, in addition to distress related to negative patient outcomes, deaths may trigger individuals in different ways. For example, those with prior trauma or loss experiences may feel more personally impacted by COVID-19 related deaths. Reminders of prior losses may trigger emotionally distressing responses that should not be managed

in group settings. Individual referrals can be helpful when indicated (see section 6 below). For example, deaths of healthcare providers' colleagues, children, or parents are likely to also trigger fears of one's own or one's own children's or parents' death. Clarifications about realistic levels of personal risks or immediate danger may be helpful for some activated individuals if they are anxiously overestimating immediate risk of dying. Taking the time to honor the memory and contributions of deceased colleagues is helpful to acknowledge the tragedy and sadness of the loss.

## 5. IDENTIFY GUILT, DEPRESSIVE AFFECT, HEIGHTENED FEELINGS OF PERSONAL RESPONSIBILITY, AND OTHER COMMON COGNITIVE CHALLENGES.

Healthcare workers as a group take responsibility for the outcomes of their patients, but they may also overestimate their responsibility for patient deaths, which will undermine their capacity to continue to function in their roles (e.g., "I shouldn't be working here;" "I am not competent;" "If I had discussed with my supervisor earlier, the outcome would be different"). Leaders of clinical teams, with the support of mental health providers, should be alert to this problem and help healthcare providers to reframe care efforts as "doing the best they can" in an unusually challenging situation (e.g., see link below to Five for Friday Blog by Dr. Pike). Those who are unable to accept this reality or demonstrate persistent functional impairment may benefit from referral to individual care.

## 6. EMPLOY KEY PRINCIPLES OF *INDICATED PREVENTION* FOR THOSE WHO DEVELOP DISTRESS OR SEEK SUPPORT.

Providing optional support sessions may build team support and normalize responses of distressed workers, but they should not be mandatory. Indicated intervention is optimal. Leadership and employee assistance programs should regularly communicate the availability of accessible psychoeducation and other self-help resources. Suggestions for psychological support should be made with attention to not increasing stigma and to minimizing barriers to care. Depending on the needs and personal preferences of the healthcare worker or staff, consultation with a hospital chaplain or religious leader or a trusted mentor may be helpful.

## 7. MANAGE PACE OF CHANGE WITH CLEAR COMMUNICATIONS.

Rapid change in information about the pandemic, lack of clarity about best practices, the speed and rate of mortality, overburdened morgues, and the pace of administrative changes contribute to the stress for healthcare personnel. This stress can be reduced through current, accurate, frequent, reliable, and clear risk communication, as well as additional training and support when needed.

## 8. USE SUPPORTIVE APPROACHES FOR TEAMS, NOT FORCED CRITICAL INCIDENT STRESS DEBRIEFING.

Supportive approaches—as described in section 2—can be very helpful to healthcare workers confronting extreme stress. These might include things like recognizing and normalizing emotions related to the shared experience, reminders about practicing self-care, and recommendations for finding some time, however briefly, for respite and pleasurable experiences. Although exposure to

COVID-19 deaths may not meet current DSM-5 definitions of a trauma, lessons learned from the trauma field may be relevant for this extreme stressor in the case of death exposures. For example, do not utilize forced critical incident debriefing that requires groups to come together and discuss details of unusually stressful events together since it can increase risk of negative outcomes. In addition to potentially reinforcing the consolidation of emotion-laden detailed traumatic memories in those who may not have done so, it is also hypothesized that this approach does not respect individual differences in coping styles that may include healthy levels of avoidance or other strategies that support continued function in the face of ongoing challenges. These principles likely apply to some situations with front line staff who have first time and/or repeated exposure to sudden death and dying in this pandemic that also threatens the wellbeing of healthcare workers. Other group approaches to provide support to members of teams after a death that are not mandatory and do not focus on discussion of details of the death(s), however, may be helpful.

## RESOURCES LIST FOR APA FRAMEWORK FOR COVID-RELATED DEATH AND DYING: CONSIDERATIONS FOR HEALTHCARE WORKERS EXPOSED TO COVID-19 DEATH AND DYING

**Select online resources:**

SAMHSA: Tips for Disaster Responders: Preventing and Managing Stress: http://store.samhsa.gov/product/Preventing-and-Managing-Stress/SMA14-4873. Published September 2014.

Psychological First Aid Provider Care: Field Operations Guide: https://www.ptsd.va.gov/professional/treat/type/psych_firstaid_manual.asp.

- Handout for Provider Care: https://www.ptsd.va.gov/professional/treat/type/PFA/PFA_Appx_CProviderCare.pdf.

Pike KM. Mental Health on the Frontlines of COVID-19. Five on Friday, Columbia University. https://www.cugmhp.org/five-on-friday/mental-health-on-the-frontlines-of-COVID-19/. Published March 27, 2020. Accessed April 8, 2020.

**Select other useful references:**

McCarroll JE, Biggs QM. Disaster workers. In: Raphael B, Fullerton CS, Weisaeth L, Ursano RJ, eds. Textbook of disaster psychiatry. 2nd ed. Cambridge: Cambridge University Press; 2017:231-243.

Stoddard FJ, Simon NM, Pitman RK. Trauma- and Stressor-Related Disorders. In: Roberts LW, ed. American Psychiatric Publishing Textbook of Psychiatry: DSM-5 Edition, 7th ed. Washington, DC: American Psychiatric Association Publishing; 2019: Chapter 15.