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Perspective

Support Groups and Individual Mental Health Care via Video Conferencing for Frontline Clinicians During the COVID-19 Pandemic

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Background: *The current coronavirus disease 2019 (COVID-19) pandemic has put an enormous stress on the mental health of frontline health care workers.* **Objective:** *Psychiatry departments in medical centers need to develop support systems to help our colleagues cope with this stress.* **Methods:** *We developed recurring peer support groups via videoconferencing and telephone for physicians, resident physicians, and nursing staff, focusing on issues and emotions related to their frontline clinical work with COVID patients in our medical center which was designated as a COVID-only hospital by the state. These groups are led by attending psychiatrists and psychiatry residents. In addition, we also deployed a system of telehealth individual counseling by attending psychiatrists.* **Results:** *Anxiety was high in the beginning of our weekly groups, dealing with fear of contracting COVID or spreading COVID to family members and the stress of social distancing. Later, the focus was also on the impairment of the traditional clinician-patient relationship by the characteristics of this disease and the associated moral challenges and trauma. Clinicians were helped to cope with these issues through group processes such as ventilation of feelings, peer support, consensual validation, peer-learning, and interventions by group facilitators. People with severe anxiety or desiring confidentiality were helped through individual interventions.* **Conclusions:** *Our experience suggests that this method of offering telehealth peer support groups and individual counseling is a useful model for other centers to adapt to emotionally support frontline clinical workers in this ongoing worldwide crisis.*

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Key words: COVID, health care workers, mental health, support, telehealth.

INTRODUCTION

The current coronavirus disease 2019 (COVID-19) pandemic is placing an enormous emotional stress on frontline health care workers.[1–4] Psychiatrists and other mental health professionals are being called upon to address the mental health threats posed to several clinicians of different disciplines, in numbers to which they are altogether unaccustomed. Never before has the mental health profession been faced with delivering such help on this scale. At the same time, the threat of contagion requires that such help be delivered from a distance via virtual means, a challenging departure from traditional psychiatric intervention. This calls for innovative service delivery. Data are sparse in this area because of the short time since this devastating pandemic started. Nevertheless, there are suggestions for individual interventions and systems interventions.[3–7] To our knowledge, group intervention in this area has not been described in detail in the

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literature so far, although some systems in the United States, including ours, have begun offering them.[7] Here, we report the methods we have developed at the group and individual levels to help our peers and describe in a qualitative manner our preliminary experience.

METHODS

Since March 28, 2020, our University Hospital of Brooklyn has been designated as a COVID-19–only facility by New York State. From late March 2020, our department of psychiatry began offering support groups and individual video conference sessions to help our frontline attending physicians, resident physicians, nurses, and other health care professionals and students. Later, we began support group conference calls by telephone for our nurses as they preferred this modality over video conferencing. Participation in our groups is voluntary.

A support group is defined as "a group of people with common experiences and concerns who provide emotional and moral support for one another."[8] Our groups for attending physicians are organized around their roles and specialties, such as hospitalists, emergency medicine physicians, and pediatricians redeployed into adult COVID units. While in the beginning we thought it might be advantageous to have separate groups for attending physicians and residents, later we relaxed that policy at the request of the attending physicians who desired their residents to be included. This has not presented any problems, probably because in this crisis, they both face similar issues and have a sense of solidarity in a desperate fight against a common enemy. In fact, attending physicians provided great solace and a calming effect to their junior colleagues.

We have 2 facilitators per group, drawn from psychiatry faculty and residents. For the nursing group, there is also a nursing leader serving as a cofacilitator. The groups meet weekly for about 40 minutes. In the meetings, we emphasize that these are peer-support groups, encourage spontaneous expression of thoughts and feelings, and acknowledge that some may not feel ready to talk but they can still benefit by listening. The supportive interventions that we use are explained in the Discussion section.

We have also set up a system to provide individual counseling sessions to any employee or student in our medical center in a confidential manner. All licensed faculty members in our department have made themselves available during certain periods for these sessions via telehealth. Our institution's employees or students can leave a voice or text message in a confidential manner at a dedicated telephone number or send an email to a dedicated email address. Senior psychiatry residents screen the messages and schedule an appointment for the caller with a faculty clinician, based on availability and the knowledge of each clinician's areas of expertise. The faculty clinician can initiate a video conference call from the scheduling software, do a brief evaluation, provide counseling, and, if necessary, schedule additional sessions, issue prescriptions for medications, or make outside referrals.

RESULTS

We estimate that about 40 attending physicians, 40 residents, and 50 nurses, all frontline health care professionals, have participated in the group sessions, and 57 people have used the individual sessions. Some times more than one person use the same computer or speakerphone. All our nurses participated by audio conference only. Six attending psychiatrists and 10 psychiatry residents facilitated the groups. Ten attending psychiatrists, one psychologist, and one psychoanalyst-social worker provided individual sessions. The number of participants in various group sessions has varied from 5 to 14. The number of weekly sessions needed by many groups to terminate with a sense of adequate emotional healing and strength has generally been 4–7. The number of individual sessions for a person has generally been 2. Both the group and individual sessions have been found to be helpful by the participants, as told to us by them in the group and individual sessions and to their peers by them, who in turn told us. For example, 2 residents disclosed in their individual sessions with one of the authors (M. M.) that they have found both individual and group meetings helpful. A few nurses, physicians, and administrators not involved with the groups have told us that they have heard from the participants how helpful the groups were. We did not collect formal measures of distress or outcome data as these were not patients or research subjects, and the interventions were performed

TABLE 1. Examples of Group Intervention Techniques or Therapeutic Factors

Technique or factor	Individual's statement	Intervention
Acceptance by group	"I cried. What will others think of me?"	Group members: "You are human. We love you and respect you the way you are."
Acceptance of situation	"I'm just trying to get used to the uncertainty of all of this. There's no algorithm and that makes me anxious."	"Me too. It's hard when so many of the tools we use to help others just aren't working, or aren't even indicated."
Altruism	"I'm really uncomfortable being called a 'hero', I'm just doing what I'm trained to do."	"That's fine. Others on the front line feel just like you. What's important is for the public to be able to thank you for your service."
Catharsis	"I'm really angry that this is happening so fast and we really weren't prepared. I'm terrified of getting it myself, I worry for my husband at home and my 9-month-old daughter."	"It's good that you're in touch with those feelings. They are normal and common. And it's healthy to be able to share them openly in this group with your colleagues."
Consensual validation	"I am worried if I would transmit coronavirus disease to my family."	Group members: "We also have the same worry." ("You are not alone in feeling this way".)
Guidance	"I'm finding it hard keeping up with the text messages from my mother asking if I'm okay."	"How about telling family members that you appreciate their texts, but don't expect a response to all of them right away?"
Insight	"I'm grieving for the patients I've lost, and I didn't even really have time to get to know them. They died so fast."	"That's normal. You care. And it's hard not to think that this could be 'my father or grandmother.'"
Instillation of hope	"What keeps me going is remembering my patients who aren't quite so sick, and who might be getting a wee bit better."	"That's very important. Doing that prevents you from getting overwhelmed or submerged by those who aren't so fortunate. And you conserve energy for them. And optimism."
Interpersonal learning	"I've been thinking about what Ahmed said last week in our group, about the responsibility he feels for his parents in Iran. My situation is different but a couple of his strategies have helped me a lot with helping my mom who lives alone in California."	"That's good to hear. Are there others here today who have anything they'd like to share about what you're gaining from listening to each other?"
Peer support	"Sometimes I am so overwhelmed at work that I feel a need to decompress".	Group: "Speak to the supervisor about being given a short break in those situations. We will support you."

during a dire period of life-threatening collective crisis. The individual sessions tend to be used by people who do not want to participate in support groups because the problems they are experiencing are sensitive, they want to preserve confidentiality, or their issue is of a nature or severity that cannot be adequately dealt with in a peer support group. They are also used by employees who are not frontline clinical workers. The presenting symptoms have been mostly anxiety-related, including some work deployment issues. Because of the private nature of these sessions, we are not giving here details of the discussions in these sessions.

In the physicians' and nurses' weekly groups, the content of the discussions evolved over time. At first, they focused on anxiety related to contracting COVID-19 and fear of spreading it to one's family and friends; on the strain imposed by taking extraordinary precautions to prevent this, including social distancing and isolation from one's own family, wearing masks at home, and taking care one's clothing or the places one touches do not place the family at contagion risk; and guilt over putting one's family at risk. Some individuals opted not to go home at all after work but instead stay in the hospital or a hotel or rental apartment to reduce contact risk to their families. Many disliked being bombarded by news and conversations about the coronavirus when they were off work. People also complained of the difficulties and discomfort imposed by having to wear full personal protective equipment all the time for long hours in their clinical work and the interference with their collegial relationship at work because of it. There was also anger and dismay at the shortage of personal protective equipment. People used the analogy of soldiers being sent into the battle without armor or arms.

In later sessions, a prominent theme has been the threat to the intimacy of the doctor-patient or nurse-patient relationship. Physicians and nurses are concerned about dehumanized interactions with patients because they wear their personal protective equipment

at all times, which conceals their facial expressiveness and identifying features as a human being. They spoke of how this deprives very ill or anxious patients of the personal comforting they need from their health care professionals and frightens the cognitively impaired. Some are also afraid that communicating traumatic news often in quick succession is making them become numb or robotic in such interactions, and they fear an erosion of their humanity. Because of institutional policies aiming to reduce the risk of contagion, they have been prevented from allowing family members to be with their loved ones in their dying moments. This has been heart-wrenching for physicians and nurses to bear, as they are used to the role of being a bridging and consoling presence between dying patients and their families.

Physicians and nurses also struggle with a feeling of lack of control and a sense of futility, in that with many patients, they can do little to halt the progress of this disease. While attending physicians may have more experience with this clinical dilemma than trainees, it has never been on such a massive scale. Exacerbating this sense of lack of control is the fact that there are limited data on prognostic factors in hospitalized COVID-19 patients that they can rely on, for their own guidance or to reassure patients and families. Many patients deteriorate unpredictably and quickly and die. Death of their own colleagues and family members of colleagues from COVID resulted in intense bereavement-focused sessions. The deaths of a critical care specialist physician and an emergency department nurse, both of whom had worked in our medical center for decades and were widely beloved, were especially hard to bear. Those who got COVID and stayed at home for a period of time felt guilty that they were not at the frontline helping when their colleagues were overworked. People also expressed guilt about getting free food from well-intentioned donors while they knew that many people in the community they serve were food-deprived. People were appreciative of the enormous outpouring of community support and the support they received from their colleagues and the institutional leadership.

DISCUSSION

How do we, as mental health professionals, respond in a therapeutic manner to these themes? We use reflective listening, clarification, reassessment of perceptions using Socratic dialog, and relabeling of emotions. An example—Emergency physician: "The patient was dying. I knew his wife was just outside the emergency room in the waiting area. Yet I could not bring her to the dying person's bedside. It tore my heart". Facilitator: "So it was heart-wrenching for you that you could not do a basic humane thing, and had to let your patient die without family at bedside" (reflective listening). Some other examples are given in Table 1. We have existential discussions on control, meaning, and purpose in life, use spiritual coping in those who are so inclined, and encourage focus on positive aspects of one's personal and professional life. We teach affect regulation and mindfulness. One of us (R.V.) ends each session with a 3-minute meditation using slow, deep breathing, with instructions as follows (abridged): "Close your eyes. Pay attention to your breathing. Notice the rhythm of your breathing. Slow it down. Breathe in deeply and slowly. Breathe out gently prolonging your exhalation. As you continue to breathe deeply and slowly, focus on the movement of air through your nostrils. If you would like, you may also focus on a word or phrase sacred or meaningful to you, as you are focusing on your breath. (after a minute of doing so) While continuing to focus on your breath, reflect on the things you are grateful for, both in your personal life and in your professional life."

We encourage people to take minibreaks during their stressful work and use brief mental relaxation strategies during the course of their work, such as the meditation outlined previously. We emphasize the importance of proactively looking after one's physical and mental health, including physical exercise, sleep, healthy nutrition, recreation, and social connectedness. We advocate limited or titrated exposure to COVID-19 media "breaking news" programming.

To counteract the relentless feeling of powerlessness expressed by some physician participants, simply reminding them of the basic tenets of the doctor-patient relationship goes a long way. We urge them never to underestimate how much they help their patients and their families by their presence, commitment, and acts of kindness. We lauded one physician who in response to his patient's plaintive query "Doctor, am I going to die?", said "We are going to do everything we can to treat this, to help you." Although the patient did die within a few hours, there was a collective sense in the group that his physician's words provided some solace,

without the physician being untruthful. We have to keep in mind that our health care professionals have not faced before deaths of their patients on such a massive scale in such a rapid manner. As of May 27, 2020, Kings County (Brooklyn), New York, where our hospital is located, had recorded 5035 COVID-19–related deaths, the highest number among all the counties in the United States.[9] This happened in a period of two and a half months. This is bound to have a demoralizing effect.

Group interventions help reach a larger number of people with a limited number of mental health professionals and can offer some additional healing elements that individual approaches do not. Such therapeutic factors include sharing experiences in a peer setting, consensual validation, support and learning from peers, and building a sense of solidarity and camaraderie with fellow group members.[10] Examples are given in Table 1. All our nurses prefer audio-only groups over audio-visual groups. Some nurses have told us that they and their colleagues would not want to show their faces when they are emotionally upset "because it is not in their culture." We do not know how much of this preference has to do with differences between nursing culture and physician culture in our institution, accessibility to a private space in the work place where computer or smart phone use is feasible, or cultural issues related to demographics. Even in the physicians' video conference groups, about half the participants keep their video muted (they are not seen) even though their identity is visible, and some selectively unmute their video so that they can be seen at times. Because of the crisis nature of these support groups, we did not do a deeper investigation of this issue. What is most important is to honor and implement whatever format helps.

As pointed out previously, some people and problems require individual sessions. Telehealth interventions minimize the risk of contagion to providers and participants, which is important during the COVID pandemic. They also facilitate access. People can participate without losing too much work time or rest time.[11] Telehealth support groups for patients have been successfully deployed before.[11] They would be easier to set up to help health professionals.

Some of the pointers other institutions can take from our experience: Psychiatrists and other mental health professionals are not peripheral to this COVID-19 crisis but can be at the front and center, helping frontline health care professionals preserve their mental health while being effective in helping the patients and the community. Both group and individual sessions need to be offered. Groups work best if one member of the clinical service takes responsibility of organizing the weekly video conference or teleconference and serves as the group's liaison with the group facilitators. One has to be flexible with some traditional ways of running groups. Some people may participate by telephone or computer audio only, and some listen without uttering a word but still seem to be benefiting by such participation. The groups need to be offered at different periods of day and evening to accommodate different work schedules. Weekly groups at set times work well. The employer needs to give time for the employees to participate in these groups, recognizing that this wellness intervention ultimately helps patient care. Some people prefer participating while they are on site, and some others while they are off work. The sessions need to be shorter than the traditional 90-minute sessions because of the time constraints imposed by conducting them during work hours. Our groups typically run for about 40 minutes.

CONCLUSION

We hope that peer group support and individual interventions such as these will help protect the mental health of a number of clinicians who are doing such commendable and courageous work so that they can continue to effectively help the countless severely ill patients with COVID-19. Other institutions can adapt these methods to their own needs. This is a significant way the field of behavioral health can assist in this moment of world crisis.

Conflicts of Interest: The authors declare that they have no conflict of interest.

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