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Time out to check in

South London HFNS Forum

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Objectives

1. Get together and check in
2. Health and well being of healthcare workers incl. MI and PTSD
3. Looking out for each other
4. Looking out for ourselves
5. Where, when and how to get support
6. Overview of coping responses and adjustment in face of stress and distress – individual, team, society.

+/- scrap all the above and talk about what you want to.

Ground rules

1. Confidential and safe space
2. Discuss/ share only what you want to
3. We can talk about whatever we like- please shape where our conversation goes today!

How are you doing?

Is there anything specific you would like to talk about today?

Part 1: Discussion and information

- Health and well being of healthcare workers during COVID 19
- Some information and discussion

Context- Things are not ok.

- Concerns that risks in short and longer term to healthcare workers psychosocial well being.
- - ICU staff – n= 709 healthcare workers from nine English ICU surveyed 06-07/2020 45% displayed symptoms of "probably clinical significance"- severe depression, severe anxiety, problem drinking, thoughts of self-harm and suicide, and PTSD
- - Other staff NHS Check: Similarly, high rates
- BUT: waiting for validation studies distress vrs disorder
- BUT: we are still in the middle of this
- BUT: healthcare workers have higher levels of unmet mental health need at baseline- never mind during a pandemic

Predicted impact on us?

- Unclear
- Potential impact- behavioral responses to stress, absenteeism and presenteeism, reduced patient contact, reduced working hours (SARS and MERS) +/- de novo mental illness
- Opportunity to advocate for resources and support that have been missing and, that we might really need
- Current levers- National anxiety! + People Plan, funding for well-being and resilience hubs, pump funding to SEL, increased investment in occupational health and psychological therapies…
- Gap (in my opinion)- Addressing the baseline organisational factors that influence our experience at work and determine our health and well being

Concerns

- Distress
- Burn out
- Depression
- Anxiety
- Behavioral responses – self harm, alcohol, drugs, self neglect, relationships, risk taking
- Moral Injury
- PTSD

Discussion: Would you recognize the signs in yourselves, in your colleagues?

- Distress
- Burn out
- Depression
- Anxiety
- Behavioral responses – self harm, alcohol, drugs, self neglect, relationships, risk taking

Moral injury

Discussion: What do you know of or, think of this term and concept?

Moral injury

- 'The profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code'
- *Psychological harm that comes from the wrongness of a thing*
- Morally injurious events - acts of perpetration, acts of omission or experiences of betrayal from leaders or trusted others.
- Not a mental illness.
- Experiences of potentially morally injurious events (PMIEs) can lead to negative thoughts about oneself or others as well as deep feelings of shame, guilt or disgust.
- These, in turn, can contribute to the development of mental health problems, including depression, PTSD and anxiety
- See: https://www.bmj.com/content/368/bmj.m1211
- Neil Greenberg's work: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/ccqi-webinar-slides---qnfmhs-qnpicu-greenberg-tracy---4-june-2020.pdf?sfvrsn=5058b88a_2
- .

"Everyone has a moral code and when it's violated strongly enough its going to have an effect on you possibly for a while.."

https://www.youtube.com/watch?v=AybMPLVbtvg

"Because the world feels so wrong- this feeling becomes global – it's not just this one thing- its everything- it feels unfixable and they can't bear to be in it – especially if someone feels they've done something wrong.

So they turn away- they are not quite present . You'd see their disengagement- with you- the rest of the team- it's a bit like a kind of greying out of their personality and their involvement in the world….

Feelings of shame and guilt make us turn away- retreat".

Table 1.
Potential risk factors for moral injury

1. Increased risk of moral injury if there is loss of life to a vulnerable person (e.g. child, woman, elderly);
2. Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff;
3. Increased risk of moral injury if staff feel unaware or unprepared for emotional/psychological consequences of decisions;
4. Increased risk of moral injury if the PMIE occurs concurrently with exposure to other traumatic events (e.g. death of loved one);
5. Increased risk of moral injury if there is a lack of social support following the PMIE.

NB: just as not all individuals who experience trauma necessarily develop PTSD, exposure to PMIEs does not automatically result in moral injury

https://academic.oup.com/occmed/article/70/5/317/5814939?login=true

Ameliorating MI?

- 1. Frank briefings and preparation
- 2. Reach out early – use informal supports
- 3. Reach out early- use professional supports
- 4. Leadership check ins
- 5. Allow others to check in with you- small group reflection

- Barriers- Reaching out is not easy. The system, our culture, the psychological impact of these experiences and provocation of feelings of guilt and shame

PTSD

- What do you know about PTSD? Would you know the signs in yourselves or others?

What's normal, what's not

- * Following a traumatic event it is not unusual to experience feelings of fear, distressing unwanted memories of the event, sleep difficulties, feeling low or numb, increased irritability, less interest in socialising or hobbies. Perhaps even depersonalisation/ derealisation.
- **Acute Stress Disorder** – symptoms usually begin to subside a few days after the trauma / when the danger is over
- **Adjustment disorder** – preoccupation with stressor and its consequences, rumination, failure to adapt, typically resolves within 6 months of stressor ending
- But, if symptoms persist for more than 4/52, or worsen, and include **re-experiencing** the event as if it is happening now, consider **PTSD**

- *** Notes by Caroline Harrison CADAT**

Post-Traumatic Stress Disorder

- Exposure to an extremely threatening / horrific event(s).

Characterized by all of the following:

- **Re-experiencing** the traumatic event(s) -vivid intrusive memories, flashbacks, or nightmares. Typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations.
- **Avoidance** of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s)
- **Persistent perceptions of heightened current threat**, indicated by hyper-vigilance or an enhanced startle reaction to stimuli such as unexpected noises. Mood changes, numbing, sleep disturbance, withdrawal.
- **Onset at least 1 month after the trauma**, symptoms persist at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Managing Psychological Symptoms

- Information giving – normalize symptoms and explain causes
- Support emotional distress
- Plug into social support
- Active monitoring - at least 4 weeks to see if symptoms persist
- Are there re-experiencing symptoms or just rumination and preoccupation?
- If so, and symptoms have persisted for more than 4 weeks, client can self - refer to IAPT
- IAPT can refer onto CADAT as required.
- OTHER resources for healthcare workers- TBD

- Discussion: What would you do if you thought a colleague was suffering- how would you know and, what action would you take?

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How to respond to someone in distress
(If you don't have the reserves to do this - get help)

1. Don't panic	Do not think that you need to fix it.
2. Go somewhere quiet	Invite them somewhere quiet and let them sit down – in their own time – don't force or rush them.
3. Let them express their feelings	Let them cry or shout if they need to. Don't hush or stifle the emotions they are expressing.
4. Reassure and validate	**Reassure** them they can take their time. **Validate** their distress – say: '*It's OK to be upset.'*
5. Listen to what they are saying	Try to ignore your own thoughts about 'what you need to do/getting it right'. Just listen. Hear what they are saying.
6. Use your body	Your body can show someone you are listening – make eye contact, focus on what they are saying, notice their facial expression and mirror it, let go of a defensive posture - face them, turn in towards them, uncross your arms.
7. Show them you have you listened and heard	*Open questions, summarise, reflect, clarify, encourage, react*. • **Summarise** what they told you*: 'It sounds like you felt so scared and overwhelmed.'* • **Clarify:** when people are distressed, they talk quickly or unclearly. Get them to expand: *'Tell me more.' or 'Help me make sure I've understood this right: you told me that…'* • Don't pretend you heard or understood when you didn't: *'I'm sorry I didn't fully understand what you said about X, can tell me again – I want to understand.'*
8. Follow up	**If you have more concerns ask them:** *'Are you ok to go home? Who is going to be there? Do you want to stay a it longer here with me/a colleague/the team?'* **Ask if you can call them tomorrow and check they are OK.**

- Discussion- what strategies are you using/ can you use to build the resilience, cohesion and support in **your team**?

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Checklist for leaders and managers working under uncertainty and change

All teams are under enormous stress. How and where we work is changing.

This checklist will remind busy leaders and managers how to make their team feel safe.

1. We ask the team how they are feeling and reassure them it is OK to feel this way

2. We remain aware that each staff member has different stuff going on at home that we may not know about

3. We ensure the team knows they can ask for help, support and guidance and that this will be responded to

4. With increasing levels of illness in the community and fewer resource to help them, teams know their leaders have full trust in them and that they are doing the best they can

5. The team knows the best resource we have is each other and we need to prioritise supporting each other

6. The team knows who is in charge each day even when consultants and managers are absent

7. The team knows how to communicate with patients including key messages about services, medication, symptoms, and where to get help

8. The team knows every day, who to ask for clinical advice and support

9. We have replaced 'corridor conversations' with regular, pre-arranged virtual huddles

10. The team keep in touch and stay connected through virtual MDMs/WhatsApp. This includes those who have been redeployed to other teams

11. Leaders and managers of this team know the importance of looking after themselves, and how to let others lead so they can get some rest

12. The team know there is a Staff Wellbeing Hub on site – open daily for food, breaks and to decompress

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A word on debriefs…

It is good to talk!

Team based reviews and debriefs

An end-of-shift operational review

- What went well.
- What didn't go well.
- What can be done next time.
- How is everyone.
- Who needs a bit more support.
- Additional 1:1 support should not focus on re-processing the incident but supporting the individual to access their coping resources and support systems.
- People should never be **required** to talk about their feelings.
- This method is incorporated in the **end-of-shift** checklist.

A leader-led operational/team review

Focus should be on:

- Identifying the reasons for specific outcomes
- Identifying ways of improving practice.
- This is a semi-structured regular facilitated meeting giving an opportunity for the team to come together, reflect on the experience of working together, build a shared understanding or narrative of what happened, support and foster connection as a team and think about both operational processes and self care needs.
- Attendance should not be mandated but encouraged.
- These sessions should not involve anyone being mandated to talk about their thoughts or feelings.
- Ad hoc arrangement rather than regular is acceptable.
- Ideally these should be co-lead with regular clinician and experienced MH professional.

Staff support initiatives

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Responses/ interventions to provide staff support

Individual, team and leader and primary to tertiary prevention

- Self care information and signposting to services
- Education training to leaders and managers
- Morale boosters/ treats
- Food, parking, salary access, childcare
- Rotas, breaks, leave, thoughtful redeployment
- Hubs – connection, information and food
- Ward buddies/ well being partners
- Reflective practice- Groups, Schwartz, team time
- Counselling, brief psychological interventions
- Case finding- ensuring prompt access to evidence based care
- + Increased resources to support your patients (befriending, extra staff, distraction packs)

The problem

- Evidence
- What we thought they wanted
- What they wanted
- What they needed
- What we gave them …..

Discussion

- How would you like to have been and be supported?
- What do you need currently?
- What strategies have you found to look after yourself/ your team?
- What would you like to 'keep'?
- What would you like to change?
- What would you like to be different following this?

Taking responsibility for looking after ourselves

- Not rocket science (but oddly hard to do sometimes!)
- Healthcare workers can be VERY good at looking after other people and pretty bad at looking after ourselves….

- Make a **plan to look after yourself** : This has to be a conscious and active commitment!!
- Identify your **support system** and use it: family, friends, colleague(s), online group, coach, therapist
- Eat, rest, hydrate, exercise, reduce digital media, and say when you need time out

➢Caution alcohol, nicotine, caffeine.. other props we use to manage emotions

➢Caution problematic relationships and influences ….

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Taking responsibility for looking after ourselves

- Acknowledge that you will **make mistakes**. We are learning whilst doing. Mistakes may happen:
  - clinically
  - in communication with patients, their families
  - in communication with your staff and team
  - with your family
- **Mistakes are OK. Forgive yourself. If or where possible: laugh at yourself, say sorry**
- Understand and forgive **others making mistakes**. Being the best version of ourselves at this time is very hard
- Be aware: SARS-COV 2003: >10% of clinicians came to work with symptoms
- If you are struggling to look after yourself: Remember, **this isn't just for you, it's for your patients and your team**
- **Take time out. Take a break. Tell someone when you need help.**

Part 2

- **Psychological responses to stress and distress – defense mechanisms**

How do we respond to stress and threat? Some psychological theories

- Useful to recognize in ourselves
- Useful to know about in respect of our patients
- Interesting to discuss and observe what's going on within us and, around us

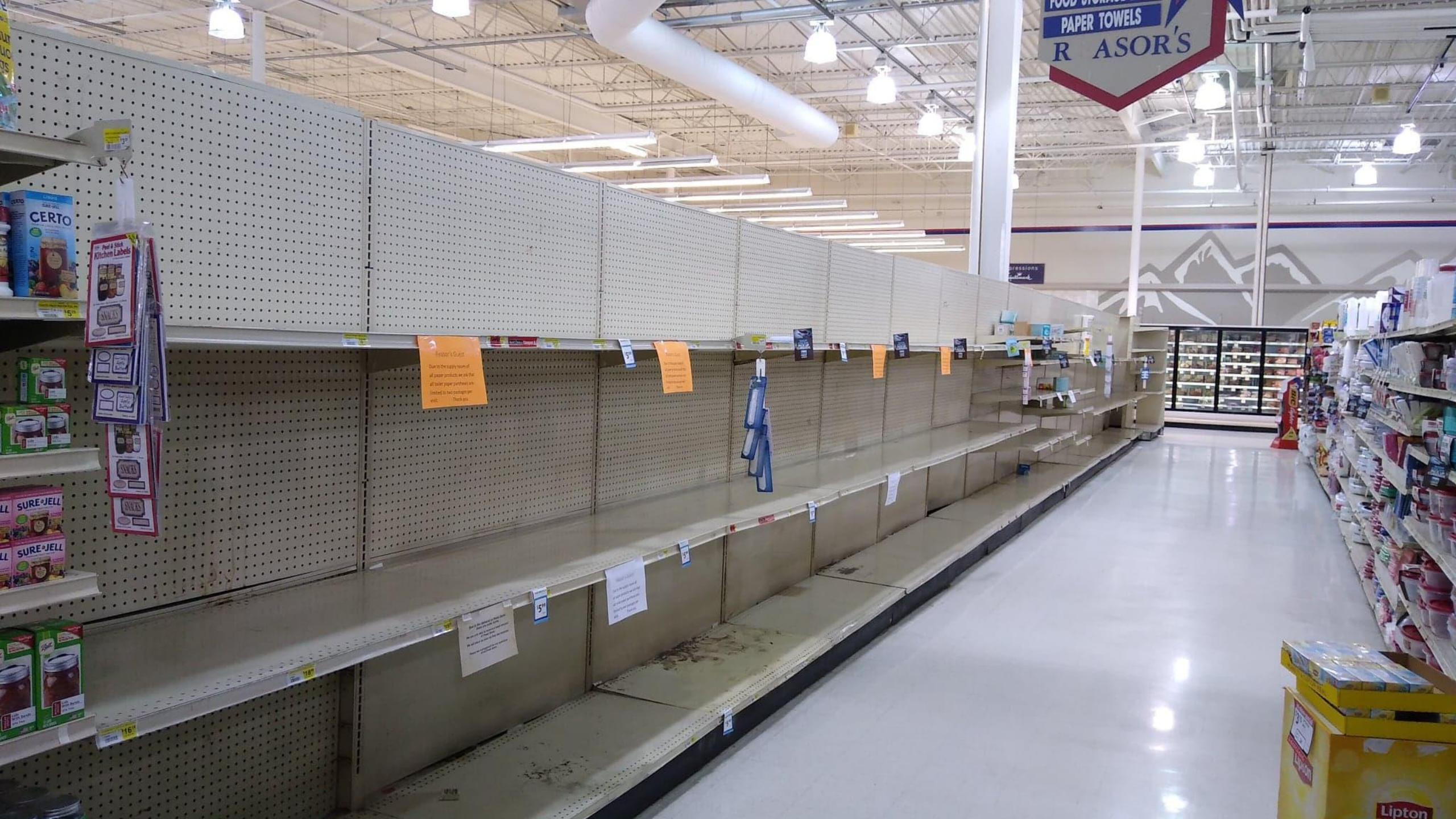
Psychodynamic theories

- Rest on premise that we have an unconscious and an inner world
- AND that we unconsciously use defense mechanisms to protect ourselves from pain
- AND that our defense mechanisms, the way we cope are highly influenced by our childhood, attachment patterns ad relationships and experiences over our life course
- They focus on the things people do (often without being aware of it) to protect themselves from upsetting thoughts and feelings that are the result of experiencing a stressful event (defense mechanisms).

They also provide a lens on societal behaviors

- "Psychodynamic processes are important for understanding and managing individual and group/public mental health problems and behavior associated with pandemics such as the spreading panic, stigmatization, xenophobia, maladaptive behaviors, defensive reactions, under-reactions, and over-reactions, socially disruptive behavior, hoarding…. "

- https://pubmed.ncbi.nlm.nih.gov/32303024/


PAPER TOWELS
CERTO
SURE JELL
SURE JELL
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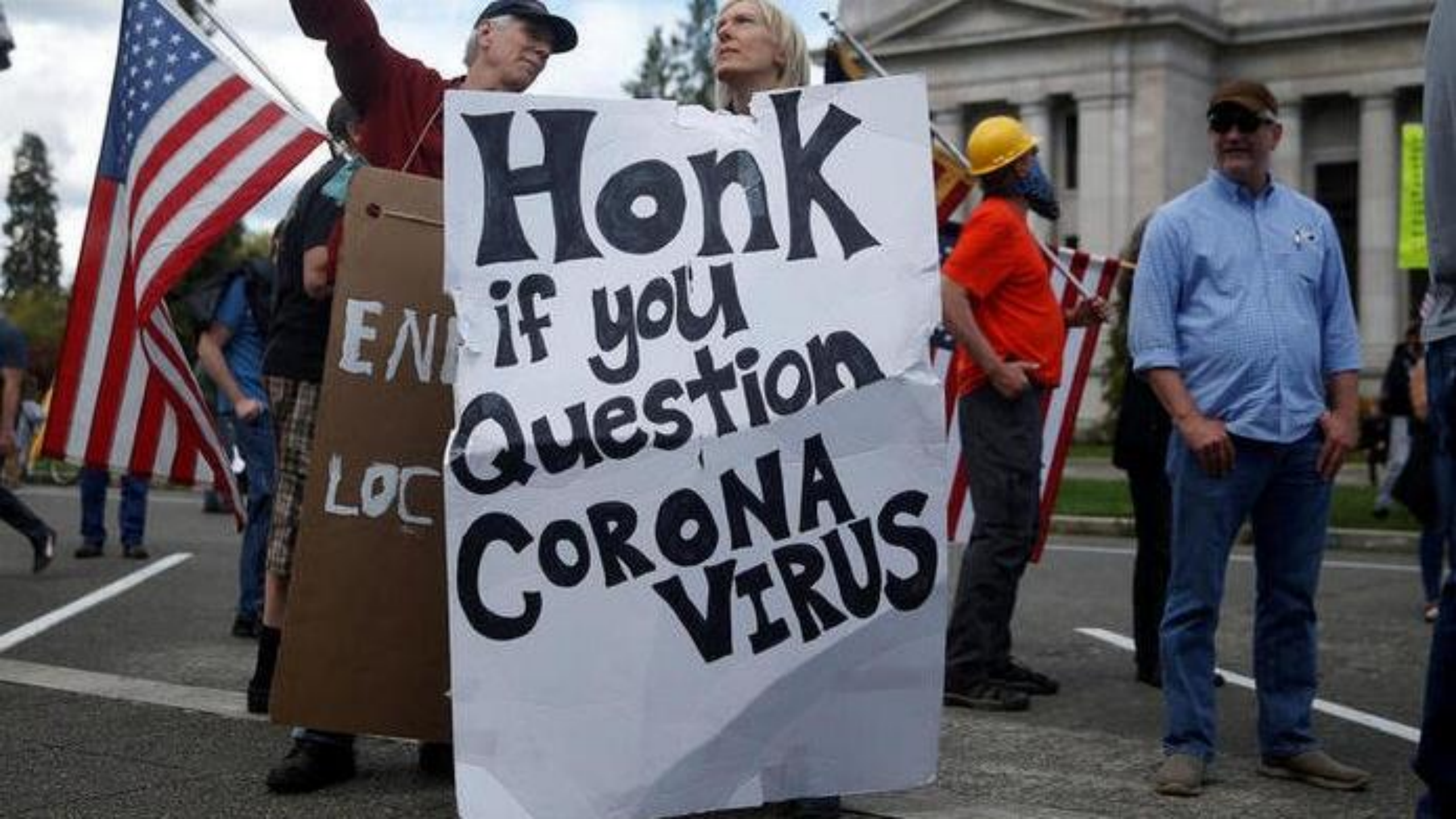
Defense mechanisms

- The unconscious mind
- Where upsetting feelings, urges, and thoughts that are too painful for us to directly look at are housed.
- Even though these painful feelings and thoughts are outside of our awareness, they still influence our behavior in many ways- defense mechanisms

Repression/ denial

- Its not happening
- Inability to tolerate the anxiety of being present to what is going wrong; to be vulnerable; to experience feelings of guilt or shame; or to be with the uncertainty of the situation and therefore simply not knowing

- How might we see this in society, organizationally, in a team, with a patient?


Honk
if you
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Suppression

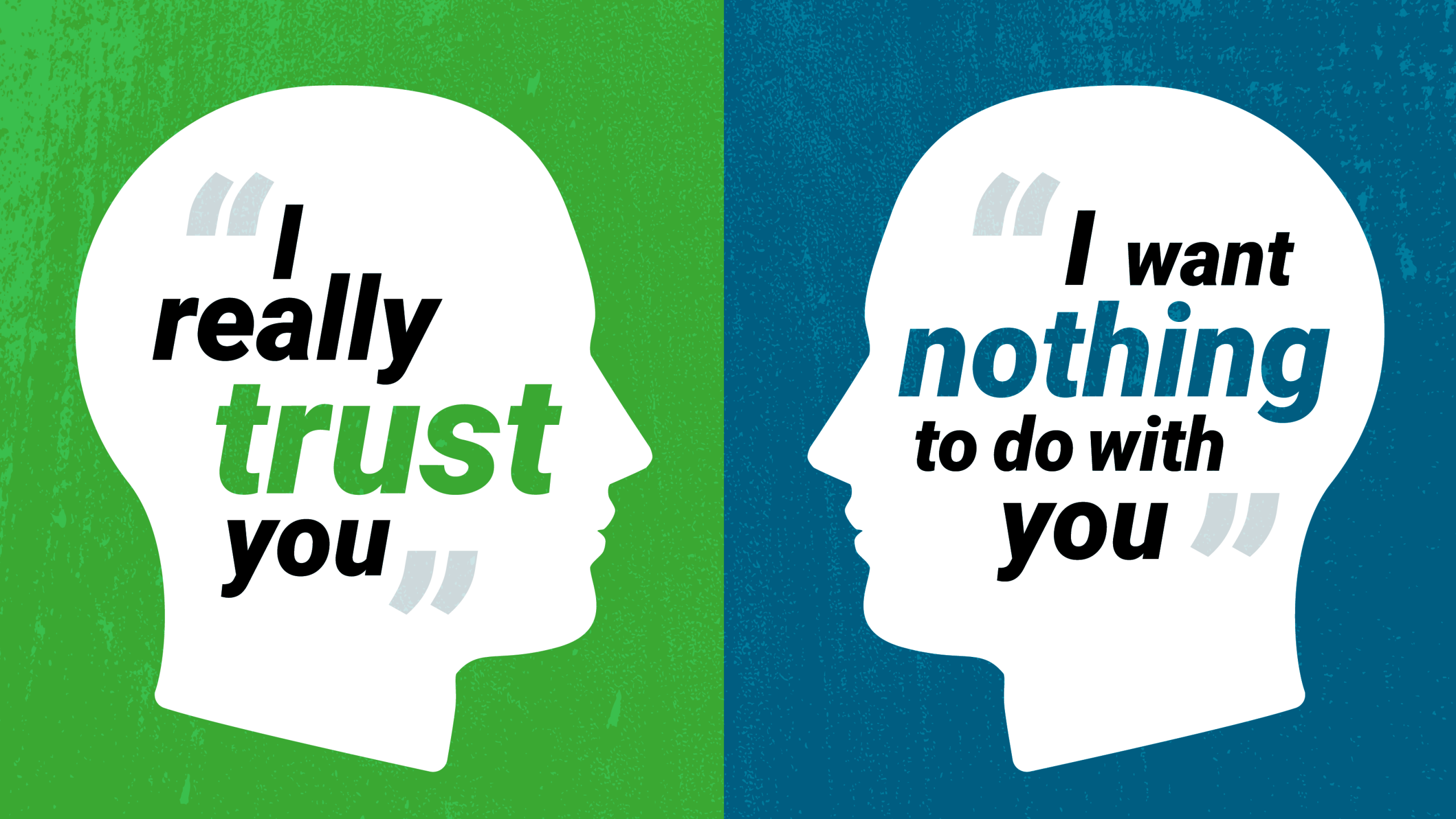
- Suppression means intentionally **engaging distractions** to eliminate from consciousness any thoughts of the threatening reality.

- How might you see this at work?

Projection and splitting

- Projection is based on incorrectly attributing to others any objectionable thoughts or actions (putting blame on others)
  - e.g. competence, powerlessness, hate, guilt, anger, greed, envy.

- Splitting refers to fragmenting, isolating, and **focusing on only certain elements of the threatening reality**, instead of considering the complexity brought about by the crisis as a coherent whole.


"I really trust you"
"I want nothing to do with you"

Splitting

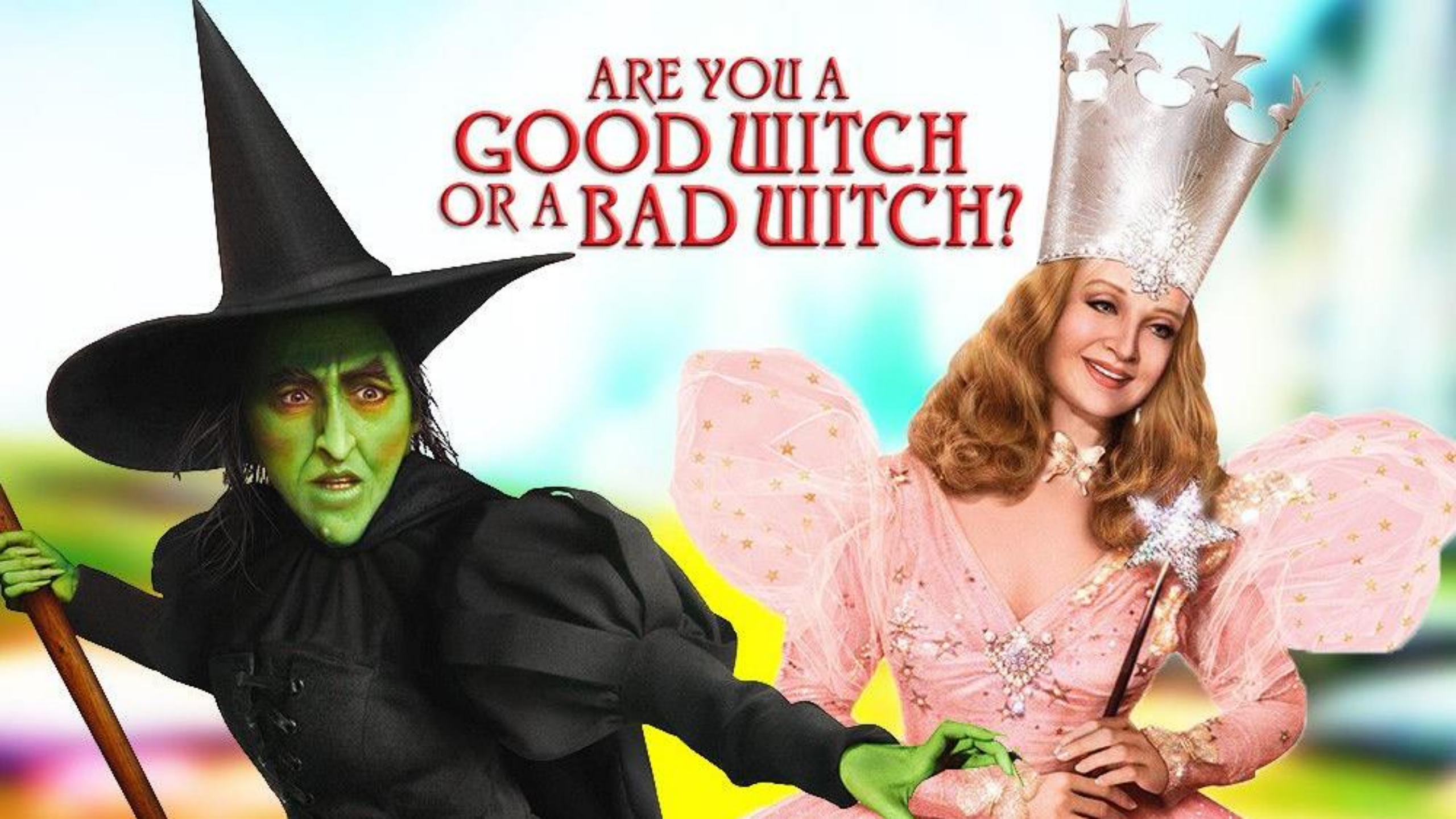
- How we relate is influenced by primary relationship with mother
- As infants – the inner world split between love and fear (nothing in between)
- Perception of external world also split into 2 parts - Good part of the mother that provides food and comfort and bad part of mother that denies them
- BUT: None of our needs can be met all the time
- Infant developmental stage *good fairy* and *nasty witch*
- This early primitive experiences and primary relationship creates a script of how we relate
- As we get older we start be able to **navigate a space in between-** world is not just good or bad but, there is grey and colours in between – complexity in people and relationships

100% BAD

100% GOOD

REALITY IS THE MIDDLE GROUND

(The Grey Area)


ARE YOU A
GOOD WITCH
OR A BAD WITCH?

Splitting

- NOT pathological (but can become that way)
- When under pressure/ anxiety stress this primitive way of relating can resurface
- A defence mechanism to deal with painful and confusing feelings
- Split the world into **good guys and bad guys**
- Splitting protects us from having to deal with complexity of situations and feelings

- Can you think of examples?

Projection

- An infant is inclined to make pleasant experiences part of themselves (introjection)
- Those feelings/ thoughts that are painful are wished away- projection
- People grow up transferring these repressed feelings onto others
- Simple projection occurs when a person unconsciously attributes to another person a characteristic or feeling that is actually their own

Example

- I don't like my patient. I am angry with them,
- BUT these feelings are difficult for me- I am a nice good doctor and I don't want to not like my patient. It would be so much easier if I liked them!
- I am not aware of this dramatic tension and conflict going on inside me BUT I have a brilliant inbuilt knee jerk defence mechanism - I can can transfer or project my uncomfortable feelings onto the patient! My sense of reality becomes: '**the patient does not like me!'**
- I am not aware of what I have done so this becomes **the truth** and I act accordingly in the context of a patient who I know dislikes me and is even angry with me. This may lead to awkward behaviour and my prophecy is fulfilled. The patient really doesn't like me!!!
- We can terminate our relationships as they are not working with the plan or getting better. I can discharge them.
- It is easier to tolerate that these **bad feelings come from outside of me** than within me

Introjection

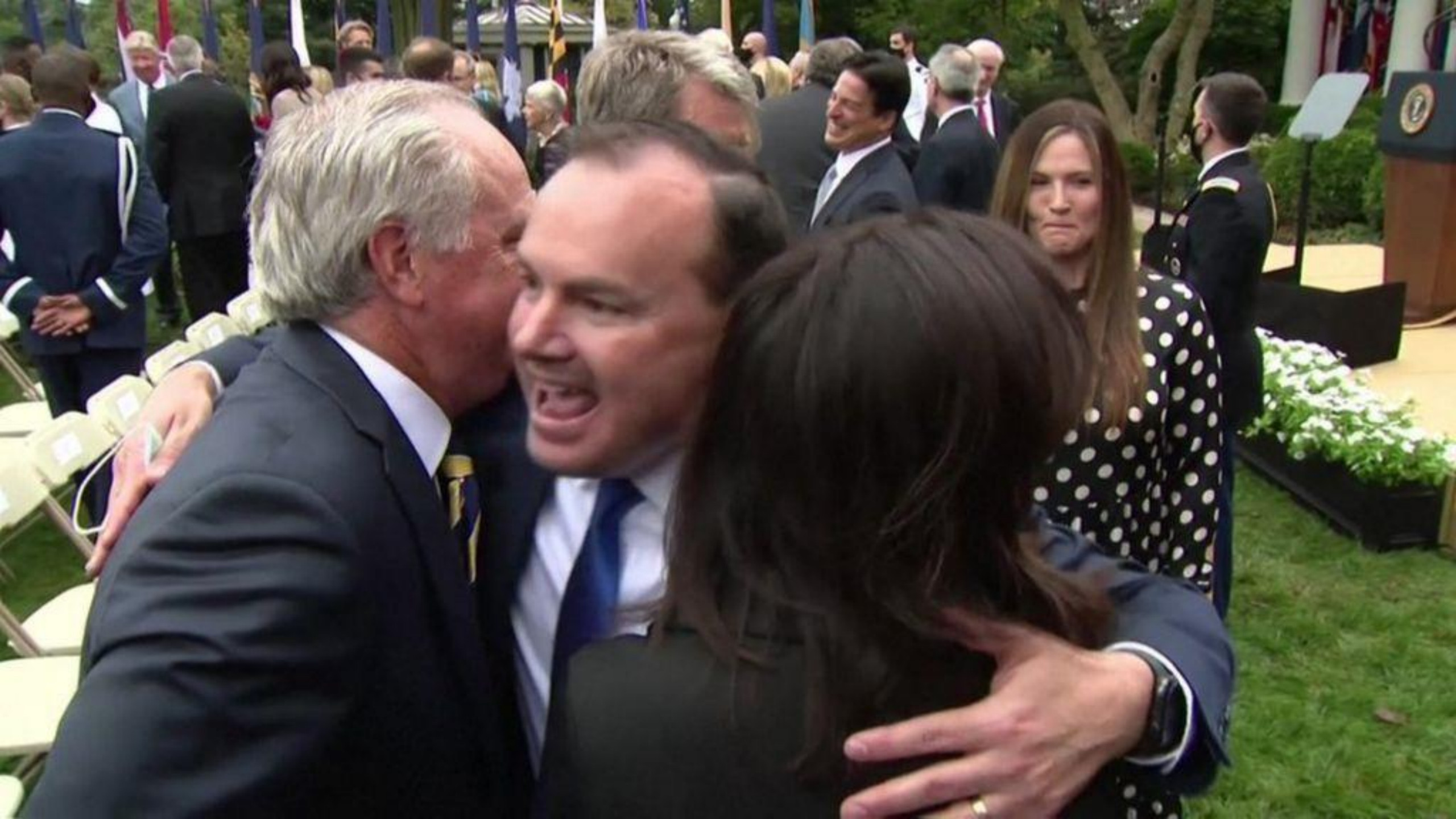
- When the person you have transferred (projected) your feelings ono accepts these feelings
- E.g. Patient whose parents had not been kind/ consistent- can easily take up feelings that they don't like someone
- How people respond to or introject feelings projected onto them relates to templates from childhood- which projections they feel comfortable assuming and which they do not
- NB- others are completely unaware they are taking on these feelings (which are actually yours)
- We have a personal valency or disposition to accept some projections more readily than others that depends on our earlier experiences e.g., anger, guilt, shame, fear.

Dissociation

- Stressful event or trauma could cause dissociation or an altered state of consciousness.
- Great emotion or traumatic event could cause a split in consciousness whereby the ego repressed the traumatic experience
- Dissociation obscures the traumatic event that is almost always behind the split in consciousness

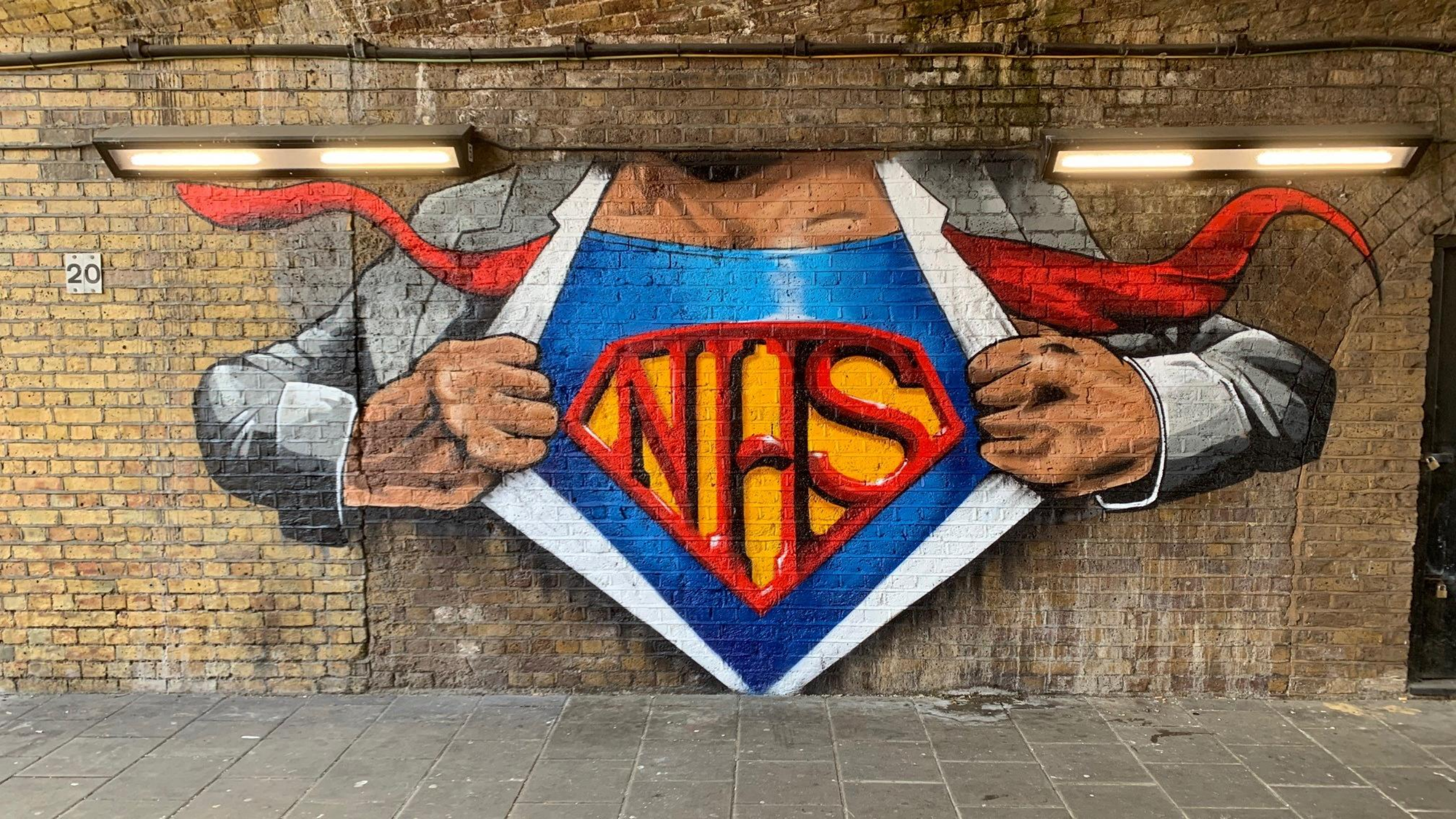
Grandiosity/ Narcissistic defenses

- Grandiosity presents in crisis when there is an exaggerated feeling of power or influence over the threatening reality (so-called narcissistic defense).
- Narcissistic defenses are those processes whereby the idealized aspects of the self are preserved, and its limitations denied.
- They tend to be rigid and totalistic and could create negative emotional atmosphere.
- They are often driven by feelings of shame (and guilt) on conscious or unconscious level.



Idealization

- Idealization includes ascribing power or influence to an existent or imaginary "savior" (doctor or nurse in crisis time).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Repression	Repression is an unconscious mechanism employed by the ego to keep disturbing or threatening thoughts from becoming conscious.	During the Oedipus complex aggressive thoughts about the same sex parents are repressed
Denial	Denial involves blocking external events from awareness. If some situation is just too much to handle, the person just refuses to experience it.	For example, smokers may refuse to admit to themselves that smoking is bad for their health.
Projection	This involves individuals attributing their own unacceptable thoughts, feeling and motives to another person.	You might hate someone, but your superego tells you that such hatred is unacceptable. You can 'solve' the problem by believing that they hate you.
Displacement	Satisfying an impulse (e.g. aggression) with a substitute object.	Someone who is frustrated by his or her boss at work may go home and kick the dog,
Regression	This is a movement back in psychological time when one is faced with stress.	A child may begin to suck their thumb again or wet the bed when they need to spend some time in the hospital.

Table 8.1 Some of Freud's Defense Mechanisms

Defense Mechanism	Description	Example
Repression	Unknowingly placing an unpleasant memory or thought in the unconscious	Not remembering a traumatic incident in which you witnessed a crime
Regression	Reverting back to immature behavior from an earlier stage of development	Throwing temper tantrums as an adult when you don't get your way
Displacement	Redirecting unacceptable feelings from the original source to a safer, substitute target	Taking your anger toward your boss out on your spouse or children by yelling at them and not your boss
Sublimation	Replacing socially unacceptable impulses with socially acceptable behavior	Channeling aggressive drives into playing football or inappropriate sexual desires into art
Reaction formation	Acting in exactly the opposite way to one's unacceptable impulses	Being overprotective of and lavishing attention on an unwanted child
Projection	Attributing one's own unacceptable feelings and thoughts to others and not yourself	Accusing your boyfriend of cheating on you because you have felt like cheating on him
Rationalization	Creating false excuses for one's unacceptable feelings, thoughts, or behavior	Justifying cheating on an exam by saying that everyone else cheats

Where we have been today

1. There are real risks to you all at the moment
2. There is a need to ACTIVELY and INTENTIONALLY look after yourselves – make a plan, stick to it
3. There is a need to ACTIVELY and INTENTIONALLY look after each other and the team - make a plan for your team and stick to it
4. If you are experiencing problems- PLEASE PLEASE reach out early
5. Be aware of the wide range of defenses we use to protect ourselves against pain- this may give you more awareness of what is happening within us and, around us
6. I would like to send you all GOOD information on where to get support and advice- please let me know anything specific that would be useful

PS- It was just lovely to see you

- And moreover- thankyou. For all you do.