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Beyond Burnout and Resilience: The Disillusionment Phase of COVID-19

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ABSTRACT

In caring for patients during the COVID-19 pandemic, nurses are experiencing a crisis of emotional highs and lows that will have lasting implications for their professional and personal well-being. As a result, much attention has been focused on nurse burnout, but the range of nurses' experiences is more nuanced, complicated, and profound. With the recognition that the nursing workforce was already experiencing burnout before the pandemic, this article explores how individuals respond to disasters and the detrimental effects of the repeated surges of critically ill patients, which have led nurses to experience an extended period of disillusionment that includes secondary traumatic stress, cumulative grief, and moral distress. This article describes the range of psychological responses to the COVID-19 pandemic so that nurse leaders can better identify resources and interventions to support nurses.

Key words: burnout, compassion fatigue, COVID-19, cumulative grief, moral distress, nursing, resilience, secondary trauma

As registered nurses, we anticipate challenges and experience a range of emotions in our practice, from painful suffering to unbounded joy. However, the contemporary health care environment compounds these challenges with unnecessary administrative burdens, unhealthy work environments, incivility, and heavy workloads. As a result, before the pandemic, nurses experienced depression at nearly double the rate of other professions: 35% to 40% of nurses had symptoms of burnout, and about 20% of nurses in high-acuity specialties such as critical care and emergency nursing had signs of posttraumatic stress disorder (PTSD).[1-3] The events witnessed by nurses during the COVID-19 pandemic are far beyond any experiences encountered or even imagined in the past. In addition to the challenges brought on by the pandemic, nurses in the United States are facing periods of civil unrest, extreme economic concerns, natural disasters, and political divisiveness. Numerous studies have shown that the COVID-19 pandemic is having a significant impact on health care worker mental well-being, and the data demonstrate that nurses are suffering in record numbers.[4-7]

An Italian study analyzing a "second wave" of COVID indicated that as many as 60% of nurses experienced some degree of burnout, with 45% exhibiting symptoms of depression.[8]

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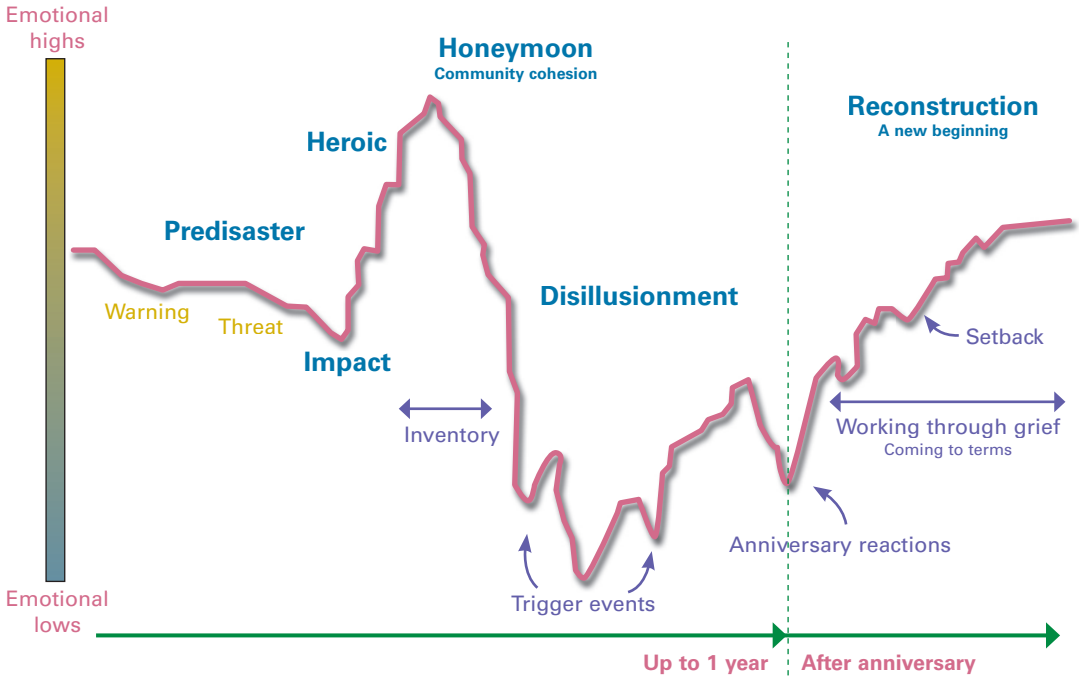

Figure 1: Phases of a disaster.[10]

The well-being of nurses, the profession, health care organizations, and the patients we care for are all affected. Compounding the underlying issue of burnout, nurses may also be experiencing secondary trauma, compassion fatigue, moral distress or injury, anxiety, depression, PTSD, and cumulative grief. Not surprisingly, these complex issues cannot be addressed using strategies that we relied on in the past. The purpose of this article is 3-fold: (1) to describe how individuals typically respond to disasters, compared with the unique nature of the COVID-19 pandemic, and specifically how repeated workload surges for nurses have extended the "disillusionment phase" of the disaster response; (2) to help caregivers understand the interplay between this extended disaster phase and the resulting complex emotional response of nurses; and (3) with this clarity, to help nurses and nurse leaders better align strategies and interventions with nurses' actual needs to support their well-being.

Emotional Response to the Phases of a Disaster

The normal emotional highs and lows experienced during a disaster are well documented.[9] However, the emotional reactions to a disaster have been studied largely as people respond to a onetime natural or man-made event such as a devastating hurricane, earthquake, nuclear accident, or terrorist attack. Clearly, the COVID-19 pandemic is an unprecedented disaster; however, the typical pattern of responses in a disaster (Figure 1) can be informative and can reinforce to nurses that what they and the general public are experiencing is normal, helping to promote healthy growth and recovery from the disaster.

The predisaster phase of a "typical" disaster is characterized by fear and uncertainty. Looking back at the start of the pandemic, whether nurses worked in the part of the world that experienced the early onrush of patients or waited and prepared, knowing that a surge was imminent, their feelings of vulnerability, lack of control, and inability to protect themselves, their family, and their patients are typical of the predisaster phase. Once the COVID-19 viral spread was active and evident, many nurses experienced the emotions of disbelief and confusion that characterize the impact phase, in which the focus is on doing what is necessary to survive. Soon after, the emotional high of adrenaline-induced rescue behaviors that define the heroic phase were experienced, with people rallying to help, even self-sacrificing to make a difference.[9]

Celebrations of nurses as heroes by the public were abundant, and people generally banded together to tackle the challenge. The inordinate cooperation and support of the heroic phase typically lead to the honeymoon phase, in which community bonding is high and, for a short period, people experience a sense of relief and optimism that the crisis will be navigated together.

Inevitably, as individuals reflect, the reality of the situation and the limits to their ability to make a difference become clear. The initial optimism gives way to the disillusionment phase. Discouragement, fatigue, and exhaustion set in as the demands of responding accumulate, layers of impact become apparent, and limitations of resources become evident. During the experience of COVID-19, widespread disillusionment, fatigue, and exhaustion, along with the divisiveness associated with issues such as use of masks and administration of vaccinations, contributed to the deterioration of the community camaraderie experienced in the early phase; the cameraderie was replaced by disagreement and hostility. Normally this phase is punctuated by "trigger events" experienced by individuals that reinforce a sense of disillusionment; during the pandemic, such triggers included a new surge, a colleague dying, or a family member becoming ill. Exacerbating stress for nurses and many others were personal impacts such as homeschooling children and feelings of helplessness over societal behaviors that hampered ability to contain the viral spread. At this phase in a disaster, people often feel abandoned or resentful as they watch the larger community, which is less affected, return to "business as usual." A distinct feature of this situation for nurses was that, as life returned to "normal" and most people resumed their prepandemic activities, cases resulting from viral variants increased, and many nurses were in environments where the disaster raged on. The prolonged nature of the pandemic, coupled with the repeated waves of patient illness due to emerging variants, exaggerated the disillusionment phase for nurses and everyone.

Typically, people eventually begin to come to terms with a disaster and work through the experience. This reconstruction phase requires working through the grief resulting from loss of the "old normal" to begin recovery. Growth can occur through a reexamination and realignment of life priorities and recognition of personal strengths. Failure to process the experience often leads to the emergence of disaster-related emotional dysfunction or psychopathology. Clearly, the disillusionment and recovery phases associated with the COVID-19 pandemic will be different from those of onetime disasters. The COVID-19 pandemic, with its multiple surges, variants of the virus, and no clear ending point, extends the disillusionment phase and delays and muddles the reconstruction phase.

Nurse Disillusionment

The normal emotional response to disasters has been complicated for the nursing profession by underlying depression, burnout, and PTSD and the recurring surges of critically ill patients.[11-15] The compounded stressors and extended period of the pandemic crisis will likely lead to an extended and nuanced disillusionment phase for nurses and others. As the true extent and impact of the disaster become more evident, nurses are experiencing a range of potential responses that must be clearly labeled to ensure that appropriate resources are provided to them. Here we describe burnout, secondary traumatic stress (STS), cumulative grief, and moral distress. Accurately labeling these concepts can help nurses begin to address their experience.

Exacerbated Burnout

Burnout is the result of cumulative environmental stressors that lead to emotional exhaustion, depersonalization and cynicism, and loss of a sense of personal accomplishment.[16] Of particular concern in the pandemic is that negative symptoms of stress and burnout experienced by an individual may influence the experience of colleagues and even the shared work environment. Being around people who are stressed, especially coworkers, can affect an individual's own nervous system. Research has shown that for 26% of people, just observing someone who is stressed increases their cortisol levels.[17] Extremely heavy nursing workloads, which can have a variety of causes, including the surge of critically ill patients and insufficient nurse staffing levels, are exacerbating underlying burnout by adding intensity to already existing environmental stressors. However, what nurses are experiencing now may be considered unavoidable occupational suffering, whereas traditional burnout could

be considered avoidable occupational suffering.[18] The pandemic is resulting in widespread anxiety, a sense of being overwhelmed, and excessive fatigue.[19] The intensity of the experiences of nurses during the pandemic may be resulting in something "beyond burnout," a stage of exacerbated burnout that requires the profession to reexamine traditional supportive strategies and develop more comprehensive approaches. Thus, doubling down on evidence-based measures to reduce burnout for frontline nurses and those in leadership roles is more important than ever. Fostering a culture of gratitude, practicing meaningful recognition, attentively listening to nurses' concerns and fears, and relying on professional governance structures to enable nurses to control their practice may go a long way toward easing some of the burnout that is prevalent in the current work environment.[20]

Secondary Traumatic Stress

In their normal caregiving, health care workers are at risk for STS as they support people who are vulnerable and in need of compassion.[21] Figley[22] first described this condition as part of compassion fatigue. Secondary trauma can be regarded as a "cost of caring," or the unintended deleterious effects of caring for others. A normal part of the caregiving process is to observe the suffering, pain, and trauma of others. When caregivers experience the emotional stress of patients, families, and the overall health care organization, they are experiencing secondary trauma. Not only has the COVID-19 pandemic increased nurses' exposure to STS, but the extended disillusionment phase has reduced their capacity to cope with it.[15] The cumulative stressors of caring for critically ill patients with an unknown illness and the need to learn and adapt to new care regimens, the exposure to frequent patient deaths without the support of loved ones at the bedside, and nurses' concerns about illness or death of their own loved ones, colleagues, and themselves, have all overwhelmed normal coping mechanisms. Previous evidence from the influenza A/Texas/36/91 (H1N1) pandemic of 2006 demonstrated that nurses were especially prone to pandemic-related PTSD, most likely owing to their continuous contact with suffering patients and families,[23,24] indicating the greatly increased risk for nurses during COVID-19.

Much can be done right now to mitigate the potential impact of STS on nurses. Anxiety can be reduced by health care leaders' offering honest and timely information, including being transparent about their own emotional well-being. Additionally, education and structures, such as professional governance, that help nurses take control of their practice and feel prepared will help reduce stress and anxiety.[12] Encouraging nurses to join and be supported by a professional nursing organization has also been shown to increase personal resilience and reduce burnout.[2]

Self-care activities that help build resilience, including mindfulness practices, gratitude, peer support, and self-compassion, are critical in addressing STS and preventing PTSD.[25-27] These activities are helpful for all individuals, and professional organizations should help nurses engage in them. Psychological first aid programs such as postevent pauses, a "Code Lavender" response (eg, a postevent crisis debriefing intervention[28]), general postevent debriefing, and access to employee assistance programs (EAPs) and behavioral health services should be "hardwired" into organizations for nurses to help them deal with stressful situations.

Leaders can offer support through empathetic and active listening and by providing a space for nurses to share feelings and be heard. Increasing leadership attention to nurse well-being or using "compassion cart" rounding to provide self-care resources can facilitate conversation between leaders and team members.[29] Leaders should watch carefully for workplace incivility and promote team building or EAP involvement to provide professional support for teams under stress. Additionally, the use of gratitude, recognition programs, and "going home checklists" (Figure 2) enable the expression of sincere acknowledgment of the challenges nurses face every day and appreciation for their efforts, reminders to check on colleagues and oneself, and encouragement of a mental transition from work to home.[30,31]

In a sense, STS is a repetitive stress injury. Of particular concern is that unaddressed STS can devolve into PTSD.[21,32] As a result, nurses, especially during this difficult time, should be observed and screened for the impact of witnessing high levels of trauma; nurses at the highest risk should be screened for PTSD, and appropriate treatment must follow for those identified as vulnerable. Signs of PTSD may include disrupted sleep, increased irritability

and anger, inability to concentrate, the occurrence of intrusive or repetitive memories (such as of a difficult patient), substance abuse struggles, decreased energy and motivation, and tendencies to withdraw from others or experience feelings of hopelessness.[33,34]

Cumulative Grief

When loss occurs, it is natural for an individual to grieve or feel distress. Grieving can help a person reconstruct their view of the world to incorporate the absence of whatever has been lost. Individuals have their own grieving process and pace, which are influenced by personal, familial, and cultural factors.[35] During the pandemic, however, losses are occurring in a context unfriendly to the space needed for grief, creating a dynamic present in the disillusionment phase of cumulative grief. Cumulative grief occurs when death and loss accumulate faster than the pace of a person's natural grieving process.[36,37] Cumulative grief can manifest in different ways. An individual may feel persistent sadness or anger, which may be experienced as vague and dull, or a sense that "I can't take another hit"; or it might be specific and sharp—an experience such as "I can't forget the look in her eyes as she died." Cumulative grief can be felt physically as exhaustion or described spiritually as a loss of hope. The longer the crisis, the greater the burden of the accumulation of loss and therefore the weight of grief (Table 1).

To process cumulative grief, individuals and organizations can promote authentic connections and create rituals. Authentic connections occur when we share our experience with trusted others. Evidence-based peer support models can be focused on the variety of types of losses experienced by members of a treatment team, allowing colleagues to share and normalize their grief. One-to-one interactions between peers or between an individual and their leader, a spiritual care provider, or an EAP professional also allow for compassionate listening that can help ease the burden of cumulative grief. Organizations should not only make these programs available but also establish processes to make access and use as easy as possible.

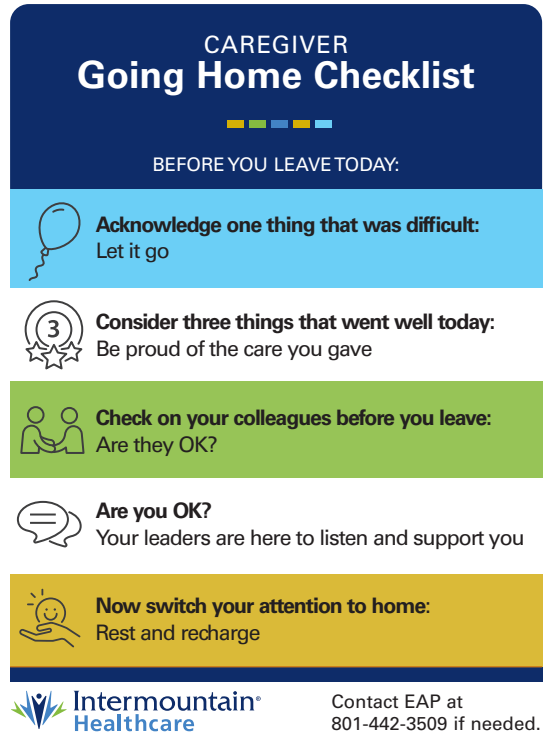

Figure 2: Caregiver Going Home Checklist. Courtesy of Intermountain Healthcare. Reproduced with permission.

Table 1: Grief as a Sack

During the pandemic, grieving was happening, but for many, it was overwhelmed by the amount of loss that was accumulating. It is as if each of us has a sack on our back. Every time we experience a loss, we put stones in that sack. The more significant the loss, the more stones we place in the sack. The sack has a small hole in it through which stones constantly dribble out. This hole represents our natural grieving process. With cumulative grief, we are putting stones in our sack faster than they are dropping out. The load continues to build. Fortunately, there are some interventions that can help.

Respite occurs when we consciously choose to set the sack down for a period. Respite involves temporarily stepping away from the burden of our grief and restoring our strength. Rest, recreation, creativity, social interaction, laughter, mindfulness practices, prayer, athletics, and engagement with nature are among the myriad ways to take a break from our active grieving process and find healing. At the end of a time of respite, we step back into the reality of our grief. We place the sack on our back again, but now with renewed energy.

Rituals can also be used to process grief. Rituals use symbolic activity to reflect emotional, physical, and spiritual experience. Rituals can be communal or personal and can involve traditional religious and cultural procedures or incorporate creative and innovative ways of expressing our experience. Prayer, burning of incense, religious rites, and periods of specific mourning are all traditional ways of responding to loss. Writing goodbye letters, creating a meaningful sacred space or altar, and drawing in the sand are more modern forms of ritual behavior designed to support grieving. Organizations can create opportunities for interested individual employees and groups to acknowledge their losses and have moments of solace, developing rituals that meet the team's needs and style. A ritual's impact can be subtle or dramatic; healing occurs in sometimes ineffable ways.

Moral Distress and Moral Injury

Moral distress is the experience that nurses have when facing a situation that conflicts with their morals or ethics. They know what for them is the right thing to do, but something over which they have no control prevents them from taking this action. Or sometimes, a person has 2 sets of competing morals.[38] Competing morals could include the desire to avoid harm, respect family wishes, follow medical care guidelines, provide patient autonomy, and adhere to all hospital policies. Inhibitors to completing the moral action could include lack of resources (time, finances, staffing), lack of power or authority, lack of skills, institutional policy, or other hindrances. Individual contributing factors may include personality, authority and skill level, personal experiences, and worldview or mindset.

The COVID-19 pandemic has given rise to more factors that lead to moral conflict, thus increasing the number of nurses experiencing moral distress.[39,40] Early on, systemwide lack of personal protective equipment increased personal safety risk, forcing nurses to balance the demand to deliver care in an unprotected state with fears of contracting the illness or spreading it to their family members or friends.[41,42] The burgeoning demand on health care services limited triage abilities and led to more morally challenging events such as rationing supplies, deprioritizing or underserving patients, and being forced to stay home from work when other providers and patients needed help.[41] The inability to relieve the suffering of both patients and families impacted by visitation restrictions also results in moral distress and moral injury. Although nurses intellectually know that the infectious nature of COVID-19 requires limits on visitation, they experience pain in watching their patients suffer and die alone. Even the innovative solution of connecting a patient with a family member using a tablet or phone can still leave a distressing gap in caring at a devastating time.

The ongoing nature of the disillusionment phase and the COVID-19 pandemic will require nurses to evaluate their ability to advocate for patients during politically polarized times. The frustration of observing "preventable episodes of suffering" is only compounded when nurses learn about colleagues who are electing not to vaccinate themselves[43] or care for patients who failed to take advantage of available vaccines. This moral distress may lead to increased guilt, negativity, anger toward others and self, cynicism, exasperation, and a lack of action—all potentially extending disillusionment. Possible interventions include individual and/or team education, helping nurses to seek moral support, and creating forums that include nurses, families, nurse leaders, and policy makers to share concerns.[44]

Similar to moral distress, moral injury results from engaging in activities or observing events that violate "moral codes and personal values," which, if not recognized, can negatively affect health.[42,45] The definition and primary symptoms come from military experiences, with the original definition emphasizing witnessing violence and human carnage. Although *moral injury* as a term has roots in military experiences and PTSD, the term resonates with health care providers. Thus, the definition has been expanded to include the intensely negative effects of witnessing an event that goes against deeply held morals. Negative effects of moral injury include difficulty functioning, as well as intense psychological, behavioral, social, religious, spiritual, and biological impacts. Research has shown that trauma from moral injury has different trajectories and outcomes than other types of trauma, but some PTSD treatments may be effective for moral injury.[46,47]

Talking with colleagues who have been through the same or similar experiences offers the greatest opportunity for learning

and growth during the process of recovery from moral distress and moral injury. Nurses can process and learn to manage their internal, often debilitating, distress. Growth requires grappling with negative emotions and dark beliefs. Thus, nurses need a safe space in which to express their emotions and disclose their thoughts. They may need to give voice to feelings of loss and grief, anger at colleagues or at the health care system, or disappointment with societal apathy about the pandemic. Organizations can facilitate local and immediate psychosocial first aid for individuals at this stage by recommending use of an EAP or a formal peer support program involving those trained to listen and react. For teams, facilitated group support sessions could prove beneficial so that nurses can safely face their fears and express their concerns and wishes. Building on the collegial rapport of "we are all in this together" that many nurses experienced during the pandemic may offer a foundation for strengthening collegial relationships over the long term.

Continued Support of Personal Resilience

The nursing profession is facing an extended disaster disillusionment phase as the pandemic wears on, with accumulating burnout, STS, cumulative grief, and moral distress. Nurses have been encouraged to practice resilience during this traumatic time. Strengthening resilience, or the ability to bounce back from a difficult situation, is a legitimate approach to dealing with these adverse conditions and traumatic experiences of caring for patients with COVID-19. It is important to note, however, that while building resilience, or personal strength, facilitates development of coping mechanisms and awareness and promotes growth after trauma, it is equally if not more important for organizations to design structures and processes that create a work environment that is protective of nurses.

Certainly, evidence-based personal resilience-building behaviors, such as mindfulness practices, gratitude, peer support, self-compassion, and engaging in hobbies or time in nature should be encouraged and supported. It is true that the work environment and patient care experiences nurses are facing today are unlike any encountered before, so there are few proven interventions to address the disillusionment and accumulating burnout, STS, cumulative grief, and moral distress that nurses are experiencing. Yet our knowledge of the science of well-being and experience surviving other difficult times as nurses offer reliable guidelines (Table 2).

Organizations can support nurses as they cognitively process their pandemic experiences, finding personal meaning and creating new mental schemas. By helping these nurses create meaningful narratives and understand their experiences, organizations can foster growth. When adverse conditions threaten the well-being of an individual, resilience becomes a shield for the stressors, creating a hardiness. But we must recognize that burnout is an occupational phenomenon that emerges from the work environment. Personal resilience will buffer and protect nurses but will not address the source of the problem, burnout and stress. Organizations must support nurses by providing the space, opportunity, and resources for them to grapple with the complex factors that contributed to an overwhelming work environment (Table 2). Nurses need an opportunity to redesign core processes and practices to eliminate hurdles to their caregiving and barriers to their own well-being. During this unprecedented time, health care organizations and leaders may consider actively reaching out to nurses and other clinicians who may be at risk for mental distress—for example, those working in intensive care units, emergency departments, and other departments where patients with COVID-19 and other critical illness are frequently encountered.

Conclusion

The current problem is more than burnout; health care providers have been living in the disillusionment phase of a disaster for many months now and are suffering the consequences. A large recent study of health care workers found that nurses were affected the most by the COVID-19 pandemic, with many stating that they planned to reduce their working hours in the future and as many as 40% reporting that they intended to leave the profession altogether within the next 2 years.[48] Health care organizations and leaders should consider prioritizing caregiver well-being with a sense of urgency to prevent significant harm to the systems we all rely on to maintain our health and wellness.

Being members of the largest and most trusted health profession also means that nurses

Table 2: Recommendations From Nurse Experts

There are no known interventions to combat what we are facing today, so we make the following suggestions based on our knowledge of the science of well-being and experience surviving other difficult times as nurses. Many of these activities focus on an individual's self-care or personal resilience to address secondary traumatic stress, grief, and moral distress; however, organizations can support these efforts by the provision of space, opportunities, and resources.

1. Focus on **self-kindness**. Do not judge yourself or tell yourself you are weak or not good enough. Treat yourself and talk to yourself with your "inner voice," the way that you would speak with one of your patients. Promote kindness and optimism among colleagues, patients, and the community.
2. Realize you are not alone in this. The **common humanity** of this situation tells us that caregivers all over the world are experiencing the same extreme emotions. Your anxiety and fear during this time are normal feelings and part of a common human experience. You are not alone. Create, engage in, and promote peer support, small-group activities, and shared experiences.
3. Practice **mindfulness** by acknowledging your feelings in the moment and then simply stopping and taking 1 or 2 deep breaths. This is an evidence-based method of promoting self-compassion. Encourage mindful moments throughout the workday.
4. **Remain in the present**. We cannot do much right now about the future of the pandemic, but we can focus on our patients, our professional practice, and each other.
5. **Remember our strength**. Nurses have encountered disasters, staff shortages, and disillusionment in the past, things got better, and nurses are recognized as the most trusted profession today. Remember why you became a nurse and what you love about nursing. Create opportunity within the workplace to share these thoughts and experiences with others.
6. **Concentrate on compassion**. Compassion satisfaction, the joy we receive from providing care for our patients, will help combat compassion fatigue; compassion for yourself, including a focus on positive internal dialogue, can help control negative self-talk.
7. **Practice grateful actions**. Make efforts every day to express gratitude to your patients, your colleagues, and your family. Create campaigns to practice gratitude together, varying the practices.
8. **Enjoy nature every day**. Mindfully spend at least a few minutes each day in the outdoors in nature, in a park, in your yard, or in a garden; it is even better if you can walk, hike, or exercise in nature.
9. **Help one another**. Nurses are experts at assessing the needs of our patients. We can use those same skills to check in on each other, listen, and take steps to provide support if needed. Implement the Caregiver Going Home Checklist at work (Figure 2).
10. **And just breathe**. We focus on the breathing of our patients in caring for them every day. Our own breathing is just as important. Simply stopping and focusing on taking 1 or 2 deep breaths will reduce our anxiety and calm our autonomic responses.

carry a tremendous amount of responsibility. Nurses and other caregivers have been on the front lines of this historic health care crisis and are now suffering from the demands of the pandemic, which have compounded pre-existing burnout and stress. Clearly distinguishing burnout, traumatic stress, cumulative grief, and moral distress can help nurses better understand and manage interventions to mitigate their stress and recover from the experience. Intervening now can not only minimize their suffering but also create a work environment that fosters mental and emotional recovery from the ongoing challenges of delivering patient care.

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