Kintsugi mind

How clinicians can be restored rather than broken by the pandemic

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The world breaks everyone and afterward many are strong at the broken places. But those that will not break it kills.
Ernest Hemingway, *A Farewell To Arms*

While the harms and losses due to the pandemic are disheartening, it is possible to reintegrate what is broken and emerge from the experience whole. Such is the philosophy behind the ancient Japanese art called *kintsugi*. When a piece of pottery is broken, the craftsperson repairs it with gold or silver. Thus, it is more beautiful than in its original intact state. Can we engage in *kintsugi mind* and thereby emerge from the pandemic stronger? How to do so is the crux of this commentary (**Box 1**).[1,2]

Whom has the global pandemic broken?

There are various types of trauma, including acute or type 1 (resulting from a single incident, such as injury following a car accident) and chronic or type 2 (eg, from prolonged unemployment or complex posttraumatic stress disorder [PTSD]). The latter occurs when a person is exposed to prolonged and repeated harmful experiences (eg, sexual abuse). Having type 2 trauma renders a person at higher risk of type 1 trauma, and these conditions may coexist.[3]

Yuan et al[1] note that it is possible to have a delayed onset of PTSD. This was found in patients who survived sudden acute respiratory syndrome in 2003, as well as in 29% of health care professionals (HCPs) 6 months into the COVID-19 outbreak.[1] Posttraumatic stress disorder can disrupt relationships as well as people's ability to work and function. Without diagnosis and treatment from a mental health professional, people with PTSD are at greater risk of depression, anxiety, eating disorders, and suicidal ideation.

Symptoms are grouped into 4 classes: intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions.[4] Comorbid disorders (eg, substance abuse) may result from maladaptive efforts to cope.[5] Further, PTSD cases vary from mild to disabling, rendering diagnosis challenging, especially for HCPs who may be experiencing moral injury, stress-related syndromes, or burnout.

Another type of trauma is called *secondary* or *vicarious*. This occurs when a person bears witness to suffering and death but remains powerless to change it. Many clinicians have experienced this during the pandemic. Vicarious trauma may coexist with or cause PTSD if it is not addressed. It manifests as emotional depletion, insomnia, and impaired interpersonal relationships in both personal and professional settings. Finally, there are also collective traumas, where many people are exposed to similar horrors (eg, genocide). The COVID-19 global pandemic is a case in point.

Concern about HCPs' distress emerged soon after the pandemic hit China. Li et al[6] reported that reserve medics in China experienced high levels of depression (46.7%), anxiety (35.6%), and stress symptoms (16.0%) while deployed in Wuhan in response to the crisis. Upon returning home (ie, delayed onset), the overall prevalence of PTSD symptoms was 31.6%. Yalçın et al[7] studied 257 hospital workers in Turkey. Rates of depression, anxiety, and stress and PTSD symptom levels were significantly higher in women than in men (P=.001, P=.008, P=.004, and P=.026, respectively), and PTSD symptom levels were higher in workers in the emergency department (P=.010), where many family physicians work, compared with those in other departments.

While these cross-sectional studies differ in prevalence rates and methodology, they alert us to mental health problems that may go beyond distress and burnout. Another means of gaining insight into the predicament of HCPs is to read their stories. While acknowledging tragedy, some front-line physicians have discovered silver linings. For example, Dr Tsuchiya,[8] a palliative care physician in Yokohama, Japan, mused in a narrative published in the *International Journal of Whole Person Care (IJWPC),* "I would say people became kinder with themselves and others as they recognized how precious we all are."

Similarly, in *IJWPC* Dr Messier,[9] an emergency physician in Montréal, Que, expressed optimism despite his initial

Box 1. Keys to employing kintsugi mind

- Pandemic-related posttraumatic symptom and disorder rates are high (29% 6 months into the pandemic) among HCPs.[1]
- HCPs who are experiencing distress or PTSD symptoms may heal by practising the 6 *R*s: relating, resourcing, repatterning, reprocessing, reflecting, and ritual.[2]
- Kintsugi mind occurs when posttraumatic growth and the 6 *R*s lead to integration and recovery from tragic events.
- Leaders in the health care system are called upon to implement programs enabling HCPs to be transformed rather than broken by this crisis.

HCP—health care professional, PTSD—posttraumatic stress disorder.

fears that emergency department services would collapse under the weight of countless infected patients: "Hope emerged; perhaps this situation would be a catalyst for new ideas and transformation [of the emergency department]."

How can we heal?

Posttraumatic growth is evident when there are positive psychological changes following exposure to traumatic events. A transformation in the person's world view and their place in it may transpire. Resilience, in contrast, involves returning to one's former level of functioning rather than being altered by the experience.

Such posttraumatic growth manifests in 5 areas: appreciation of life, relating to others, personal strength, recognizing new possibilities, and spiritual change.[10] "Healing the healer" in the emergency department is called for by Wong et al,[11] who show how Maslow's hierarchy of needs can be applied to front-line workers in a practical manner. Not only are there recommendations for individuals, but administrative actions are spelled out as well.[11] While 5 levels of need (physiologic needs, safety, love and belonging, esteem, and self-actualization), pandemic-related concerns, and strategies for each are described, I would add a sixth level of need: self-transcendence. At its core, self-transcendence is realizing that you are one small part of a greater whole and acting accordingly.

Further, physicians and other HCPs experiencing moral injury or PTSD may heal by practising the 6 *Rs*[2]: relating, resourcing, repatterning, reprocessing, reflecting, and ritual. First, relating to others in a trusting manner is crucial. This could be with a support group led by a qualified trauma-focused therapist. Second, resourcing involves strengthening neural networks associated with positive sensations, emotions, and cognition (eg, via breath work, which activates the parasympathetic nervous system). Third, somatic exercises (eg, yoga) can repattern connections between the mind and body. Fourth, reprocessing can help one interpret what has happened and challenge faulty memories (eg, it was my fault the patient died). Fifth, reflecting helps one come to terms with what happened and find meaning in what appeared incomprehensible at the time. Finally, engaging in rituals can lead to closure.

Using the metaphor of kintsugi mind, the Physician Wellness Task Force at our institution (of which I am a member) asked physicians, "What are the golden cracks of the pandemic?" Here are some of their answers:

- Being forced to prioritize and focus on essential meetings, tasks, and activities.
- Everything we have been able to accomplish leading to better care and improvements.
- Getting to know colleagues from other divisions and working together as a team toward a common goal.
- Not sitting on the sidelines of this world crisis!
- Research has been accelerated with unprecedented international cooperation.
- Telemedicine reduced risks of exposure.
- Recognition of the importance of mental health in HCPs.
- Acknowledgment of racial injustices.

Dr Lemos,[12] a family physician in Toronto, Ont, wrote in *IJWPC,*

> This pandemic has brought to the fore how connected and yet, so isolated, we all are .... In these difficult times, it is my hope that we rebuild our communities, redefine what it means to be family and reach out to those on the edges of our circles. That we begin to think of the collective, not just the individual. Life is too short not to be shared and too long to be lived alone.

What can leaders do to support physicians and other HCPs?

The distress felt by HCPs occurs within the context of their work environments. Moreover, we must acknowledge syndemic effects—ie, when 2 or more epidemics (eg, COVID-19 and PTSD) interact synergistically. This contributes to an excess burden of disease in a population that needs to be recognized when planning resource allocation.[13] While health care systems vary across jurisdictions, one conclusion that could be drawn from the 2021 International Conference on Physician Health (a joint initiative of the American Medical Association, the Canadian Medical Association, and the British Medical Association) is that top-down initiatives are required to enable those on the front lines to cope well with this unprecedented crisis.

Benham et al[14] ask policy makers to identify aspects of clinic management (eg, surge capacity, shift work) that create a higher propensity for emotional distress. A collaborative and standardized process for end-of-life decision making, including a plan for dealing with high death rates, needs to be established. The authors suggest screening for HCPs in need of intervention, providing avenues for peer support, and introducing a consultation group to whom staff can turn when faced with moral dilemmas. Higher levels of distress in non-White HCPs must also be recognized,[14] highlighting the need for an intersectional approach.

Similarly, Greenberg et al[15] provide suggestions for the National Health System of the United Kingdom to protect clinician mental health. First, it is helpful to provide appreciation, both written and verbal, from leaders. Second, conduct return-to-normal-work interviews with supervisors who are willing to talk about their own mental health issues (ie, reduce stigma). Third, survey staff regularly. Fourth, offer group discussions to help staff develop a meaningful narrative that reduces risks of harm (eg, Schwartz rounds[16]). Leaders' support needs to be provided within a climate of trust that is built on transparency regarding how decisions are made and the way people are treated. Rather than outsourcing assistance, institutions should provide evidence-based,

trauma-focused care[17] and tailor interventions with an intersectional approach.

Given HCPs' courage and sacrifices, it is the least we can do for them. Because wellness requires both individual and systemic action, leaders should include both approaches such that clinicians may be restored and made stronger rather than be broken by the pandemic.

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