Institut d'Assistència Sanitària

Key elements for successful implementation of a frontline integrated psychological intervention programme addressing professionals' needs during covid-19 outbreak

Elementos clave para la implementación de un programa integrado de intervenciones psicológicas adaptadas a las necesidades de profesionales asistenciales que afrontan la emergencia sanitaria de la COVID-19.

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ABSTRACT

The COVID-19 outbreak challenged healthcare professionals' resilience exposing them to high risk for stress. This paper identifies key elements to implement a psychological support service to frontline healthcare professionals by analysing the STEP programme and 203 questionnaires sent out to professionals. Three chronological phases associated to clinical overload were identified: the Cognitive, the Ventilation and the Recovery respectively. STEP 1.0 identified and addressed professionals' needs and concerns, identifying infection and self-efficacy as the major concerns at early stages. STEP 1.5 targeted ventilation of emotions contented during the outbreak and was able to be introduced when a sense of control was restored. Finally, STEP 2.0 addressed emotions management training, which was introduced when clinical overload decreased. Several professionals' characteristics were associated to refer for individual therapy. Proximity, face to face, during working shifts, and interventions following a chronological phases approach were the key characteristics when implementing a frontline psychological support service.

Keywords: COVID-19; mental health; health personnel; crisis intervention; stress disorders.

RESUMEN

El brote de COVID-19 puso en riesgo la resiliencia de los profesionales sanitarios exponiéndolos a alto riesgo de estrés. Este artículo identifica elementos clave para implementar un servicio de apoyo psicológico para profesionales, analizando el programa STEP y 203 cuestionarios distribuidos entre profesionales. Se identificaron 3 fases consecutivas asociadas al volumen de trabajo: Cognitiva, Ventilación y Recuperación respectivamente. STEP 1.0 identificó necesidades y preocupaciones al inicio del brote, predominando el riesgo de infección y autoeficacia. STEP 1.5 se centró en la ventilación de emociones contenidas introduciéndose cuando se restableció la percepción de control entre profesionales. STEP 2.0 se centró en la formación en gestión de las emociones cuando la carga asistencial disminuyó. Se identificaron características asociadas para la derivación a terapia individual. Proximidad, presencialidad, acceso durante turnos laborales y seguir un sistema cronológico de fases fueron las características clave para la implementación de un servicio de apoyo psicológico.

Palabras clave: COVID-19; salud mental; personal sanitario; intervención en crisis; trastornos por stress.

INTRODUCTION

The outbreak of COVID-19 has posed big challenges for healthcare systems around the world. The rapid spread of infection and the severity of symptoms have increased hospital admissions, resulting to a shortage of structural healthcare resources mainly associated to workforce and medical supplies. On one hand, professionals deployed to new areas lacking of competent skills and appropriate protection equipment. On the other hand, shortage of intensive care units (ICU) beds and ventilators, in order to provide appropriate medical care to patients infected with COVID-19 (Shanafelt, Ripp & Trockel 2020). At patient level, restriction to family contacts during hospitalisation stay have emerged emotional reactions challenging the recovery process.

Healthcare professionals concern about their own safety and that of their families because of the risk of taking the infection home as well as their ability to provide competent medical care (shanafelt et al., 2020). These concerns associated to increased workload, the lack of control of patient's outcomes due to inexistent successful treatments, the severe symptomatology, isolation of patients and cumulative set of losses, expose staff to high risk for stress. Anxiety, negative thoughts (guilt, shame …), mood disturbance, increase vigilance and lowered sleep quality prevails among frontline staff (Huang, Han, Luo & Ren Ak Zhou, 2020) aggravated by the absence of positive reinforcement from social inputs because of the isolation due to confinement restrictions (Xiao, Zhang, Kong, Li & Yang., 2020). The degree to which these personal reactions are transient and adaptive to the events experienced or become chronic psychological reactions, will depend on professionals' resilience which have been described to be conditioned by the nature of distressing experiences, personal vulnerabilities, past experiences, organizational factors related to work climate, and sociocultural factors which can modulates the understanding of events (Turner, & Kelly, 2000).

Several theories and empirically tested concepts in the field of emergency psychology have succeeded in preventing acute and chronic stress reactions and increase resilience among professionals.

Self-efficacy (Bandura, Cioffi, Taylor & Brouillard, 1988) as the perception in own cognitive capabilities to influence demands from the context and the neuropsychology approach of stress response (Arnsten, Mazure & Sinha, 2012) which focuses in what is cognitive to silent emotionally loaded reactions by the hyperactivity of amygdala have been applied (Farchi, Levy, Gershon, Hirsch-Gornemann, Whiteson & Gidron, 2018).

From a psychodynamic perspective, Defense Mechanisms play a facilitator role in managing emotional demands and preventing work-related-anxiety among healthcare professionals (Regan, Howard & Oyebode, 2009). On the other hand, when emotions have been long contented these can be activated through projective techniques when individuals try to find causes and explanations for life events (Campos 2009). Fantastic Reality (Lahad, 1995) is a projective technique, which uses images to transcend the individual into a fantastic reality while feeling in a safe cognitive space. This process can be explained by the neuropsychological mechanism through which images stimulate the visual cortex and the emotional memory simultaneously (when individuals freely associate content to the chosen image) connecting with the prefrontal cortex (when verbalising the perceived images), helping them to narrate traumatic and/or stressful experiences.

In addition, Mindfulness (Shapiro, Carlson, Astin & Freedman, 2006) and other CBT techniques such as stress inoculation, anxiety management or exposure therapy have successfully contributed to facilitate self-regulation and preventing acute stress disorder (Foa, Cahill, Boscarino, Hobfoll, Lahad, McNally & Solomon, 2005).

At organizational level, group interventions have proved to be effective in gathering a complete picture of events that individuals have been exposed to, in normalising and share emotions among members who have been through the same process, to help cognitive restructuring by which individuals acknowledge and understand their experiences, to facilitate team cohesiveness, identity, and to repair individual and team confidence (Weisaeth, 2000). In this line, quality improvement tools to improve professionals communication such as TALK for clinical debriefing© (Diaz-Navarro, Hadfield & Pierce, 2014) and the Schwartz rounds® methodology (Cullen, 2016) to normalize and share emotions, have been successfully implemented in group format. To maximise effectiveness, a multicomponent approach considering group, individual and environmental interventions have been reported to be more effective when managing traumatic stress in personal work setting. Also, when psychological support is deployed to proximity and immediacy to a crisis event it can help to exposed individuals to approximate to the pre-crisis psychological balance (Mitchell, & Everly, 2000).

The challenge, in front of a rapid and devastating health emergency is to find the relevant elements, from all this sound knowledge, and combine them in order to provide significant support to the main actors in a real world context.

In order to prevent chronic maladaptive psychological reactions among hospital healthcare professionals facing first wave of COVID-19 a tailored preventive psychological programme named Support Tools for Emergency Psychology (STEP) was developed incorporating the theories mentioned above and implemented in our setting.

The objective of this study was to analyse the STEP programme to identify key elements to implement a successful psychological support service for frontline healthcare staff facing COVID-19 emergency.

METHOD

Study design

This is a cross-sectional and qualitative study design.

Setting

Interventions took place in a state financed local hospital in Girona, Spain, which provides healthcare coverage to 147000 inhabitants with a capacity of 337 beds, which employs 733 healthcare professionals and 85 non-healthcare staff approximately (Institut Assistència Sanitària, 2018).

At the peak of the first wave outbreak, the whole hospital required a reorganization to cope with the increasing demands (see table 1). Most of the hospital beds were allocated to patients with COVID-19 and many healthcare professionals were relocated, so were the psychologists. A voluntary multidisciplinary frontline team of 8 psychologists was created to cover professionals' needs, as well as the needs of patients and their families. Their backgrounds varied from clinical psychology, palliative care, emergency psychology, neurodegenerative disorders and neuro-rehabilitation psychology. This team developed the STEP programme to provide support to hospital staff, which included individual and group interventions. The STEP programme was deployed at the frontline. Psychologists, had access to COVID-19 protection equipment and free access to all wards including the ICU and emergency care unit. They had a contact hotline available from 8:00 to 20:00, seven days a week, and a specific contact email address, which was disseminated by posting it to all wards, and through line managers. Also, had available outpatients' offices for individual interventions and team meetings. Hospital wards were distributed among psychologists for daily scan. Each ward was checked to detect the need for psychological assistance, both for patients and for professionals. Group interventions were also offered, either informally to professionals or

through line managers. The number of participants per each group were of six individuals in average. The duration of the intervention ranged from 15 to 40 minutes depending on the clinical tool implemented. Group interventions were conducted by two psychologists and took place on each ward to professionals who were working together.

To reduce variability when deploying group interventions to professionals, psychologists conducted training sessions during the first hour of each shift (ie. 8:00h and 15:00h) which implied role-playing and shadowing each other's performance.

Both, individual and group interventions were always carried out during the staff-working shifts. Attendance to psychological interventions was on a voluntary basis.

Data was collected from March to June 2020.

Participants

All hospital staff who attended the STEP programme were included. These involved clinical staff, including line managers, working at either frontline (ICU, emergency and recovery wards) or backline (preventive services, radiology, pharmacy, laboratory services, outpatients, appointment centre team, patient complaints team). Non-healthcare staff (kitchen, cleaning services and hospital hotel services management) and professionals who were reincorporated after a recovery process of a COVID-19 infection.

Data sources

Data was extracted from three data sources: 1) paper note transcriptions from the STEP programme, 2) Anonymous questionnaires and 3) focus group with psychologists.

Measurements

(1) Variables targeted by the STEP programme. Paper note transcriptions collected by the psychologists during group interventions were analysed to identify relevant variables targeted by the STEP programme.

STEP 1.0

The objective of this tool was to conduct a clinical debriefing to identify and address professionals' needs or concerns. It was based on "*TALK for clinical debriefing* ©. In addition, it incorporated principles of Mindfulness and the facilitator role of Defence Mechanisms from the psychoanalytic theory (see table 2).

Variables relevant to this tool were: 1) Concerns and needs. What were the more frequent concerns and needs that arose in STEP 1.0? 2) Resilience. What were the professionals' resilience responses emerged? 3) Support required. What professional skills were required to improve? 4) Learnings. What were the learnings professionals more often verbalised after STEP 1.0 group intervention?

STEP 1.5

The objective of this tool was to ventilate emotions while keeping awareness that the outbreak was not finished yet. Specific groups were also created to include only professionals who had been infected by COVID-19 and had already returned to work. This used Schwartz rounds® methodology (see table 3). In addition, it incorporated Fantastic Reality projective technique using 30 pictures of roads with different features.

Variables relevant to this tool were: 1) Roads features. What were the road pictures features most frequently selected by professionals to describe how they have felt a long the outbreak process? 2) Emotions. What emotions were associated to those features? 3) Thoughts. What thoughts were associated to those features? 4) Resilience. What effective coping strategies emerged as been used along the outbreak? 5) Learnings. What learnings professionals more often verbalised have acquired during STEP 1.5? 6) Did professionals who were infected with COVID-19 report differently at the group interventions than the rest of their colleagues who were not?

STEP 2.0

The objective of this tool was to increase professionals' awareness of the physical signs of the emotions, and their management during peak working times. It included principles from Mindfulness and projective techniques by using four pictures of emoticons depicting basic emotions: happiness, anger, sadness and fear (see table 4).

The variable relevant to this tool was the perception of self-efficacy on managing emotions by analysing the change in scoring when performing the body scan.

(2) Anonymous questionnaires. These were made available to clinical staff and analysed to identify professionals' preferences to receive psychological assistance.

Before introducing STEP 1.5, a questionnaire was developed and distributed in envelopes in all wards to identify professionals' needs at that stage when admissions started to decrease (see table 1). An additional envelope was provided in which to place the filled questionnaires. Enough envelopes were handed out for all shifts, including weekends. The questionnaire was anonymous and voluntary. It comprised two questions: 1) what priority areas professionals wished to receive psychological support: emotional (feelings, physical signs of stress, reverberant thinking), teamwork communication, improve skills to communicate to patients' families, and self-care. 2) What format did professionals preferred to receive support: group, online, individual, paper materials.

(3) A focus group was performed to collect psychologists' feedback on: 1) professionals' characteristics associated to professionals referred to individual therapy either who contacted the hotline phone number directly, for singled out when scanning the wards, and for those who accepted referral by their line manager, 2) Defense Mechanisms most frequently emerged in STEP 1.0.

Although an external, blinding evaluation of measurements was not possible, data was always evaluated by two psychologists.

Ethical consideration

Ethical approval was obtained from the Girona Ethic Committee for Clinical Research and Medicines (CEIM Girona).

RESULTS

Participation was of 300 professionals in 81 STEP 1.0 group interventions, 82 in 28 STEP 1.5, 8 in 1 STEP 2.0 and 30 professionals attended individual interventions. Professionals themselves requested 20% of psychological interventions.

STEP 1.0 variables

Concerns, needs and support required. The risk of infection and self-confidence on managing patients' symptoms appeared to be the most common concerns. The needs raised during the interventions were self-care advice and effective communication with patients' families and with team members.

Resilience. The key factor that professionals more often associated to resilience was working in a supportive team.

Learnings. To share and normalise concerns, to identify supportive colleagues, and to prioritise demands were the learning points emerged with STEP 1.0.

STEP 1.5 variables

Road pictures, resilience and learnings. On average, the number of pictures that each professional chose to conduct this exercise was one picture per each. A list of road pictures features facilitating projection of emotions and thoughts associated is provided as well as a list of coping strategies that they reported they were able to learn and implement (see table 5 and figure 1).

Emotions and thoughts. Pictures facilitated ventilation of emotions and were associated to thoughts when professionals rememorized the outbreak experience. For instance, fear and rage were associated to isolation when coping with the requirements of new roles. Distress and anxiety were associated to lack of protective equipment. Insecurity and anger were associated to lack of consistency in the information provided to professionals. Emotional lability, hopelessness and sadness were associated to perception of a lack of validation from managers. Hopelessness and impotence were associated to frustration about deceases.

Professionals who suffered COVID-19 infection. Emotions and thoughts did not differ but resilience responses did. They had difficulty to adapt on their return to work because of the residual symptoms of COVID-19. In addition, some of them referred symptoms of agoraphobia. They acknowledged that the infection process made them aware of the importance of positive thinking skills and stop been self-demanding. They also valued sharing their experience with other colleagues who had been through the same process.

STEP 2.0 variables

Confronting professionals with a quick body scan should helped them to experience the benefit of 5 minutes stop to focus the attention to the present, moment-by-moment, observing without interpreting to be aware of self-control. This tool was introduced to just one group who had not been through the STEP 1.5, and initial benefits were rapidly dismantled by a need to ventilate. No further implementation of this tool was possible, as de-escalation started and STEP programme was interrupted.

Questionnaires responses

Respondents were of 203 professionals among doctors, nurses, nursing assistants, admin support, pharmacists, radiologist, social workers and hotel services. Professionals stated that they needed emotional support (71%), particularly on feelings (59%) rather than thoughts

(26%). In addition, they preferred group format during working-shifts (61%) rather than online workshops after work (9%) or paper-based materials (33%); 24% preferred individual sessions.

Focus group

Professionals' characteristics associated to individual therapy. 30 individual interventions were conducted, 10 of which were requested by professionals' themselves. The average number of sessions per each professional was of three. The following factors were present in those professionals who required individual therapy: to be in charge of dependants, lack of access to childcare, to be deployed to a new professional role, communication difficulties among the members of the team, clinical workload, pre-existing anxiety or other mental health disorder, grief process due to a decease in the family, being infected by COVID-19, lack of a social network or living alone.

Defense Mechanisms emerged STEP 1.0. Initially, when professionals were high on adrenaline, the most frequently observed Defence Mechanisms were Dissociation and Denial of physical signs and emotions associated to stress.

DISCUSSION

This study showed, that initially, when demand overload capacity, self-protection and self-efficacy, particularly on managing patients' families' demands and improving communication with new team members appeared to be the main concerns. Follows a request for emotional support, particularly on managing feelings contented. In addition, working in a supportive team was associated to resilience. On the other hand, be in charge of dependents, lack of social network, living alone, experience a grief process, being infected by COVID-19, pre-existing mental health condition and unadjustments within the team were vulnerabilities for referral to individual therapy.

The STEP programme helped to identify these needs and tailored interventions based on sound knowledge on stress management at the work place during a healthcare emergency. For instance, WHO recommendations focus on the need to normalize strong emotions and stress, to address self-care, social support, clear communication and distribution of tasks and the utilization of psychosocial and psychological help without stigmatization (Petzold, Plag & Ströhle, 2020). The clinical tool STEP 1.0 provided professionals with self-care guidance, improving team communication and professionals' self-efficacy to confront patients' isolation and the requests from families. Self-efficacy (Shanafelt et al., 2020) and self-care (Liu et al., 2020) have also been reported to be major concerns in professionals deployed into new roles. The implementation of STEP 1.0 facilitated the development of targeted educational materials accordingly in order to empower professionals such as the breaking bad news protocol and the condolence phone call protocol (Institut Assistència Sanitària, 2020). The clinical tool STEP 1.5 facilitated the emotional healing which literature reports as necessary to achieve adaptive responses after the outbreak (Foa et al., 2005) (Greenberg, Docherty, Gnanapragasam & Wessely, 2020). It was a professionals' request the need to ventilate emotions, and STEP

programme facilitated bringing contented emotions to the surface and ventilate while helping to process potentially traumatic experiences. The group intervention format helped to stress the normalisation of those reactions and contributed to a constructive, rather than traumatic, narrative of the experiences that professionals had been through.

Although, STEP 2.0 could not be implemented widely, as the de-escalation process was initiated, the experience reassured us that interventions were supportive when followed a chronological phases approach with specific needs and concerns required to address. The "Cognitive" phase, at beginning, where infection and self-efficacy were major concerns and Dissociation and Denial of stress physical signs were the Defense Mechanism more active. The "Ventilation" phase, when expression of contented emotions was required, and the "Recovery" phase, when the clinical overload decreased and professionals were able to focus on emotions management training. Emotional ventilation was not found to be useful when introduced during the cognitive phase, and training on emotions management should only happen after ventilation.

In addition, consultation to professionals reported they preferred that psychological support be deployed at frontline, face to face and during working shifts.

Certainly, external and blinding evaluation of measurements was not possible, which could bias the interpretation of our results. Nonetheless, we considered that professionals' participation on STEP programme activities was high, as showed in the results section, which was always on a voluntary basis, and brought us to the conclusion that the programme contained key elements for their successful implementation. STEP programme facilitated to overcome professionals' stigma linking psychological support to mental health weakness, therefore rejecting to psychological aid. For instance, interventions based on self-administrated computer-based educational programmes have reported high levels of attrition

of about 40% (Maunder, Lancee, Mae, Vincent, Peladeau, & Beduz, 2010). The STEP programme raised that professionals' needs and demands changed along with the outbreak overload so interventions had to be tailored accordingly. Future research should analyse the impact of professionals' resilience in patients' outcomes and their satisfaction.

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Conflict of interest

The authors declare they have no conflicts of interest.

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Table 1. Descriptive data

Beds available: 337	**MARCH 2020**	**APRIL 2020**	**MAY 2020**	**JUNE 2020 De-escalation**
Clinical tools	STEP 1.0		STEP 1.5	STEP 1.5/2.0
COVID-19 patients admissions	243	309	54	9
Professionals infected	78	34	3	0
Number of healthcare professionals	733	733	733	733
Number of non healthcare professionals	85	85	85	85

Source: Institut Assistencia Sanitaria

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Table 2. STEP 1.0

INTRODUCTION
Psychologist introduction *Objective of the session*: to identify and address professionals' needs and concerns *Rules*: 15 minutes duration, confidentiality, non-judgemental, positive thinking, self-efficacy *Acknowledgement*: to transmit gratitude expressed by the hospital directorate *Open questions*: "How are you?" "What are your main concerns?"
ANALYSIS
- The analysis should end with one key issue to target for improvement - Stress positive thinking - Prioritise feasibility - Prioritise aspects to improve under the control of the group
LEARNINGS
Summary: professionals are required to list learnings from the session
KEY ACTIONS and LEADERSHIP
Solutions: Professionals agree on which actions to undertake and who will be leading
DECOMPRESSION TECHNIQUES
To shake for 40 seconds. To blow candles. Jumping on their toes. Sit on a chair and move head upside down. Tens/loosen all muscles of the body. Relax and breath on 4-2-7 + visual positive stimulus. To identify their own relax thinking style. To remember what someone close to you would tell you to relax. To identify a positive thinking and self-instructions.
SELF-CARE TRAINING
Psychoeducation: concept of stress *Techniques*: A) Allow yourself 2 minutes at the beginning of your working-shift to focus. B) Focus on professionals aspects of your work: tunnel vision. C) Allow yourself a rest every 2h: send a message to your family, decompress yourself, talk to your colleagues, think about what you will do when you arrive at home. Physical activity helps. D) Avoid talking about the same things for a long time. E) Do not forget hydration during working times. F) Accept that nobody can expect to be euthymic all the time. G) Stop if you are feeling overloaded, search for a private place and decompress. H) Remember that it is not necessary to feel broken to seek psychological support. I) Avoid moaning. J) Think about a ritual to take off the work uniform after the working-shift and understand that work has finished.

*Available in Spanish.

Table 3. STEP 1.5

INTRODUCTION
Psychologist introduction *Objective of the session*: To express contained emotions during the outbreak *Rules*: duration of 30-40 minutes, confidentiality, non-judgemental
ROAD PICTURES WHICH BETTER REPRESENTS YOUR WALK THROUGH THE OUTBREAK
Pictures of roads with different features are presented to participants with the objective to emerge contained emotions. Professionals are required to pick up one or more of those, the ones which better represent how they have felt a long the COVID-19 outbreak
REASONS FOR CHOOSING THE PICTURES
Professionals are required to share their reason for picking up each picture
SWAPPING CHAIRS
"Now, that you are in this chair, what would you tell your colleague who was sitting where you are now?"
LEARNINGS
Professionals are requested to verbalise what they have learned along the path they have walked so far with during the outbreak
PSYCOEDUCATION OF EMOTIONS
- Concept of contained emotions - Normalisation of emotions - Need for ventilation - Situations where individual therapy can be required

*Available in Spanish

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Table 4. STEP 2.0

INTRODUCTION
Psychologist introduction *Objective of the session*: increase awareness of physical signs of emotions and how to manage them during peak working times *Rules*: 30 minutes duration, confidentiality, non-judgemental
METHOPHOR
We are at a different time in this crisis. It helps to think about a marathon that started weeks ago and we cannot still see where it ends. Now we need to take a break and refuel without stopping to keep on moving and to perform and feel good. What is happening to you is what we expected to happen and what is desirable. It is normal to feel tired and to feel discomfort during this marathon. Despite the fact that it is normal and expected, it does not mean that we have to accept it without doing anything about it.
BODY SCAN
1- In a likert scale 0-10, which emoticon better represents how you have felt over last two weeks?. 2- In a likert scale 0-10, which emoticon better represents how you feel at present? (just before the body scan) 3- Guided body scan. Professionals are required to focus their attention on specific areas of the body, top-down named by the psychologist, with a non-judgemental attitude. 4-In a likert scale 0-10, which emoticon better represents how you feel at present? (just after body scan).
PSYCHOEDUCATION
Professionals choose which emotions were the most predominant and prioritise them for psychoeducation: function of emotion, adaptive and maladaptive signs, and resource bag strategies are provided (based on CBT and mindfulness)
CLOSING THE SESSIONS
Using the "Marathon metaphor" professionals are encouraged to use those emotional tools presented during the session: "Continuing with the marathon, maybe those minutes have helped you realize that you have a foot injury and that you need some time to heal it and allow yourself a longer break. Or that you need to surround yourself with people who love you and you need to feel their support. Giving encouragement and feeling that they give it to you usually helps! These resources that we have talked about are different components of provisioning. You decide which ones can help you better right now. " "We invite you to use these strategies that we have shared over the next few days and notice if they can help you. We also encourage you to practice these three steps to identify, be aware/recognise, and manage what you notice and feel, at moments like going to work, having a shower, queuing in the store, folding clothes... Stop and listen to your body, it can help you. In order to be able to continue with the marathon, these supplies are needed. * Remember to keep awareness to identify during group sessions those individuals who may need individual sessions.

*Available in Spanish

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Table 5. STEP 1.5 – Findings

Roads features most preferred	**Emotions**	**Thoughts**	**Effective coping strategies used**	**Learnings**
Isolated/empty roads	Isolation, fear, rage	What to say to patients' families, how to perform in my new professional role	- Positive self-instructions. - Pay attention to safety measures. - Relaxation when faced with the risk of infection. - Team building, cooperation, the team was protective. Friendship. - Tunnel focus on day by day. - Share and express feelings to line managers - Positive expectations towards future.	- Self-confidence -Awareness of the skills to cope in front of adversity. - New professional skills - Look after myself
City roads	Distress, anxiety	No protection		
Lots of signs pointing toward different positions	Doubtful, insecure, Anger	Chaos, many changes in protocols and professional roles, disinformation, contradictory information		
Lots of turns				
Intersections				
Ups and Downs	Emotional lability, hopelessness, sadness,	Not enough validation received from management, not enough support,		
Straight with no ending	Uncertainty, impotence, hopelessness	Frustration by deceases		