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Psychological Resilience in Frontline Health Care Workers During the Acute Phase of the COVID-19 Pandemic in New York City

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In the spring of 2020, New York City (NYC) was the epicenter of the coronavirus disease 2019 (COVID-19) pandemic in the United States. To date, NYC has experienced the highest number of COVID-19–related fatalities, with more than 19,000 confirmed deaths.¹ The initial surge of the COVID-19 pandemic was especially stressful for frontline health care workers (FHCWs), who endured unprecedented levels of exposure to illness and death, worked in conditions placing themselves at considerable risk, and balanced the care of their families while fulfilling their professional duties.²

Although a growing number of studies have documented the adverse psychological consequences of the COVID-19 pandemic in FHCWs,² no known study has examined the potential influence of factors associated with psychological resilience—defined as the process of adapting well in the face of adversity—in this population.

Given that acute stress may predict risk for chronic psychological difficulties,³ characterization of potential resilience-promoting factors during the acute phase of highly stressful events may help identify targets for prevention and early intervention efforts designed to promote the long-term mental health of FHCWs. We explored this question using data from more than 2,500 FHCWs during the spring 2020 acute pandemic surge in NYC.

Methods

Data were collected between April 14 and May 11, 2020, during the peak and initial decline of the acute patient surge. An anonymous, incentivized (\$25 gift card) survey was emailed to a purposively selected sample of 6,026 FHCWs at Mount Sinai Hospital, an urban tertiary care hospital in NYC. The eligible study population included health care workers most likely to be directly involved in the care of patients infected with COVID-19, as a result of either their standard practice or anticipated redeployment within the study period. The research team worked with hospital and administrative leaders to identify those most likely to be involved in frontline care prior to procuring contact information for study invitation. Of those invited, 3,360 (55.8%) completed the survey, of whom 2,579 (76.8%) reported directly providing care for patients with COVID-19 and had complete data. Supplementary Table 1 describes sample characteristics. The Institutional Review Board at the Icahn School of Medicine at Mount Sinai approved the study.

A broad range of both occupational and personal COVID-19–related stressors (Supplementary Table 1) as well as resilience-promoting factors (Supplementary Table 2) were assessed.

Psychological resilience was operationalized as low psychological distress (ie, composite measure of COVID-19–related posttraumatic stress, major depressive, and generalized anxiety disorder symptoms assessed using validated self-report measures) in the presence of high exposure to COVID-19–related stressors (details provided in Supplementary Table 1). Multiple regression and relative importance analyses were conducted to identify independent variables associated with psychological resilience scores and the variance in these scores that was attributable to each of these variables.

Results

As shown in Figure 1, relative importance analyses revealed that positive emotions (interested [relative variance explained [RVE] = 14.7%], enthusiastic [RVE = 11.2%]), self-efficacy (RVE = 13.8%), nonengagement in substance use coping (RVE = 9.9%), higher purpose in life (RVE = 7.8%), and emotional support (RVE = 6.9%) and leadership support (RVE = 6.8%) were most strongly associated with psychological resilience, collectively explaining > 70% of the

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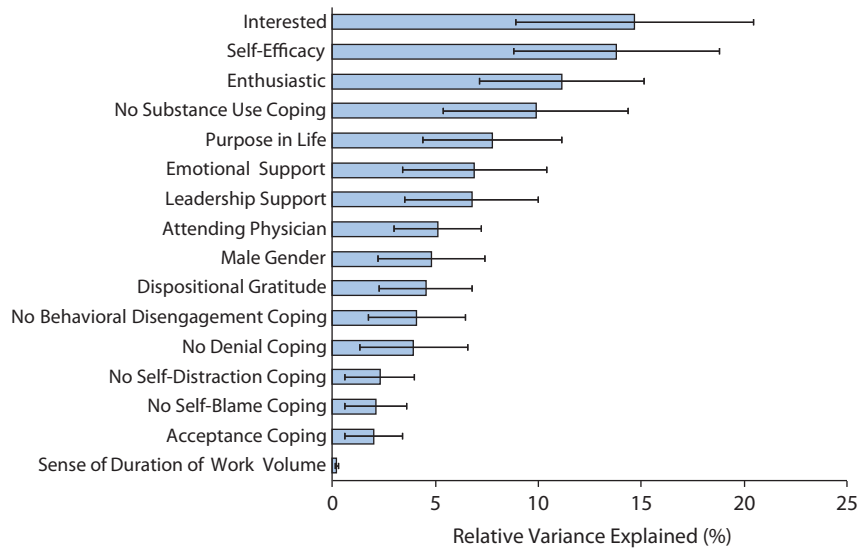
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Figure 1. Results of Relative Importance Analyses of Factors Associated With Psychological Resilience in Frontline Health Care Workers



variance in these scores. Supplementary Table 3 shows results of analyses examining factors associated with psychological resilience.

Discussion

To our knowledge, this is the first study to examine factors associated with psychological resilience in FHCWs during the acute phase of the COVID-19 pandemic.

Multiple factors—including positive emotions, self-efficacy, purpose in life, and social support, as well as nonengagement in maladaptive coping strategies (eg, substance use)—emerged as strong correlates of resilience. These findings, which are consistent with prior research in other populations of trauma survivors, suggest that emotional, behavioral, and socio-contextual factors may contribute to resilience in FHCWs during the acute phase of the COVID-19 pandemic.

Collectively, these results underscore the importance of assessing how individual-level interventions to bolster positive emotions and self-efficacy,^{4,5} as well as broader organizational strategies aimed at enhancing social support, work-related meaning and purpose, and engagement,⁶ may help bolster psychological resilience in FHCWs. Further research is needed to examine longitudinal trajectories of psychological distress and related issues such as substance misuse in FHCWs, biopsychosocial mechanisms underlying resilience, and the efficacy of prevention and early intervention strategies to enhance and sustain resilience in this population.

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Author contributions: Dr Pietrzak had full access to all of the data in the study and takes responsibility for the integrity of the data and accuracy of the data analysis. Concept and design: All authors. Acquisition, analysis, or

interpretation of data: All authors. Drafting of the manuscript: Pietrzak, Feder, Southwick, Ripp. Critical revision of the manuscript for important intellectual content: All authors. Statistical analysis: Pietrzak. Administrative, technical, or material support: Feingold, Ripp, Peccoralo, Charney. Supervision: Southwick, Ripp.

Potential conflicts of interest: Dr Feder is named co-inventor on an issued patent in the US, and several issued patents outside the US, filed by the Icahn School of Medicine at Mount Sinai (ISMMS) for the use of ketamine as a therapy for PTSD. This intellectual property has not been licensed. Dr Charney is named as co-inventor on patents filed by the Icahn School of Medicine at Mount Sinai (ISMMS) relating to the treatment for treatment-resistant depression, suicidal ideation, and other disorders. ISMMS has entered into a licensing agreement with Janssen Pharmaceuticals, Inc. and it has and will receive payments from Janssen under the license agreement related to these patents for the treatment of treatment-resistant depression and suicidal ideation. Consistent with the ISMMS Faculty Handbook (the medical school policy), Dr Charney is entitled to a portion of the payments received by the ISMMS. Since SPRAVATO has received regulatory approval for treatment-resistant depression, ISMMS and thus, through the ISMMS, Dr Charney, will be entitled to additional payments, beyond those already received, under the license agreement. Dr Charney is a named co-inventor on several patents filed by ISMMS for a cognitive training intervention to treat depression and related psychiatric disorders. The ISMMS has entered into a licensing agreement with Click Therapeutics, Inc. and has and will receive payments related to the use of this cognitive training intervention for the treatment of psychiatric disorders. In accordance with the ISMMS Faculty Handbook, Dr Charney has received a portion of these payments and is entitled to a portion of any additional payments that the medical school might receive from this license with Click Therapeutics. Dr Charney is a named co-inventor on a patent application filed by the ISMMS for the use of intranasally administered neuropeptide Y (NPY) for the treatment of mood and anxiety disorders. This intellectual property has not been licensed. Dr Charney is a named co-inventor on a patent application in the US and several issued patents outside the US filed by the ISMMS related to the use of ketamine for the treatment of posttraumatic stress disorder. This intellectual property has not been licensed. The other authors have no disclosures to report.

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Supplementary material: Available at PSYCHIATRIST.COM.

REFERENCES

1. City of New York, Department of Health. Main data page: cases, hospitalizations, and deaths. Accessed October 19, 2020. <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>
2. Sheraton M, Deo N, Dutt T, et al. Psychological effects of the COVID 19 pandemic on healthcare workers globally: a systematic review. *Psychiatry Res.* 2020;292:113360.
3. Bryant RA. The current evidence for acute stress disorder. *Curr Psychiatry Rep.* 2018;20(12):111.
4. Joyce S, Shand F, Tighe J, et al. Road to resilience: a systematic review and meta-analysis of resilience training programmes and interventions. *BMJ Open.* 2018;8(6):e017858.
5. Maunder RG, Lancee WJ, Mae R, et al. Computer-assisted resilience training to prepare healthcare workers for pandemic influenza: a randomized trial of the optimal dose of training. *BMC Health Serv Res.* 2010;10(1):72.
6. West CP, Dyrbye LN, Erwin PJ, et al. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet.* 2016;388(10057):2272–2281.

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Supplementary Material

Article Title: Psychological Resilience in Frontline Health Care Workers During the Acute Phase of the COVID-19 Pandemic in New York City

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2. [Table 2](#) Assessment of Resilience-Related Factors
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Supplementary Table 1. Prevalence of COVID-19 exposures and their association with composite psychological distress scores

	Mean (SD) or n (%)	Multivariable association with psychological distress	
		R ² =0.16	
		β	p
Number of hours worked on site per week	37.1 (17.9)	0.00	0.85
Number of COVID-19 patients assessed/treated	55.2 (83.9)	0.02	0.22
Redeployed to different unit during COVID-19 pandemic	948 (36.8)	0.00	0.85
Personal medical risk for COVID-19-related complications		0.14	<.001
Low	1,559 (60.4)		
Medium	734 (28.5)		
High	286 (11.1)		
Made difficult decision prioritizing COVID-19 patients	733 (28.5)	0.10	<.001
Number of coworkers infected with COVID-19	8.5 (10.4)	0.01	0.73
Know a coworker hospitalized or in ICU to treat COVID-19	792 (30.7)	0.02	0.30
Know a coworker who died from COVID-19	215 (8.3)	0.04	0.048
Not enough personal protective equipment	780 (30.3)	0.13	<.001
Not enough COVID-19 testing for staff	1,905 (74.0)	0.02	0.28
Not enough COVID-19 testing for patients	803 (31.2)	0.00	0.87
Occupational COVID-19 exposures			
Cared for patients in person who have gotten sick from the virus	2,016 (78.2)	-0.04	0.056
Cared for patients in person who have died from the virus	1,341 (52.0)	0.04	0.072
Cared for patients via telemedicine who have gotten sick from the virus	415 (16.1)	-0.07	0.004
Cared for patients via telemedicine who have died from the virus	180 (7.0)	0.03	0.23
Personal COVID-19 exposures			
Know a friend or colleague who has gotten sick from COVID-19 and required hospitalization	1,840 (71.3)	0.04	0.037
Know a friend or colleague who has died from the virus	898 (34.8)	0.01	0.69
Have a family member not living with me who has gotten sick but not required hospitalization	726 (28.2)	0.02	0.20
Have a family member not living with me who has gotten sick but required hospitalization	308 (11.9)	0.03	0.17

Have a family member who did not live with me who has died from the virus	186 (7.2)	0.00	0.88
Have a family member living with me who has gotten sick but not required hospitalization	296 (11.5)	-0.02	0.35
Have a family member living with me who has gotten sick but required hospitalization	22 (0.9)	0.01	0.61
Have a family member who lived with me who has died from the virus	6 (0.2)	0.06	<.001
I have gotten sick but did not require hospitalization	605 (23.5)	0.05	0.008
I have gotten sick and required hospitalization	7 (0.3)	0.00	0.70
I have gotten sick and required an ICU stay	1 (0)	0.03	0.081
Feel torn between desire/duty to help patients vs. loved ones	1,655 (64.2)	0.15	<.001
People with whom you reside are fearful to be near you due to possible COVID-19 exposure	1,365 (52.9)	0.12	<.001

Note. Of the 2,579 FHCWs, 1,408 (54.6%) were 18 to 34 years old, 581 (22.5%) 35 to 44, 330 (12.8%) 45 to 54, and 260 (10.1%) 55 and older; n=1,897 were female (73.6%) and 1,821 were married/partnered (70.6%). With regard to profession, n=1,082 (42.0%) were registered nurses, 541 (21.0%) house staff, 398 (15.4%) attending physicians, 394 (15.3%) physician assistants or advanced practice registered nurses, and 164 (6.4%) other (i.e., social workers, psychologists, chaplains). The median number of years in practice was 6.0 (interquartile range [IQR]=8.0); median number of hours working onsite was 37.5 (IQR=10.3); and median number of COVID-19 patients treated was 30.0 (IQR=48.0).

COVID-19-related posttraumatic stress disorder (PTSD) symptoms were assessed using a 4-item version of the PTSD Checklist for DSM-5 ($\alpha=0.85$); major depressive disorder (MDD) symptoms using the Patient Health Questionnaire-8 ($\alpha=0.89$), and generalized anxiety disorder (GAD) symptoms using the Generalized Anxiety Disorder-7 ($\alpha=0.91$). Psychological distress scores were derived using an exploratory factor analysis with promax rotation of COVID-19-related PTSD, MDD, and GAD symptoms (eigenvalue=2.47, 82.3% cumulative variance explained; factor loadings=0.862 for COVID-19-related PTSD symptoms, 0.923 for MDD symptoms, and 0.934 for GAD symptoms).

Supplementary Table 2. Assessment of resilience-related factors

Perceived preparedness	Sum of affirmative responses to the following questions (assessed using No vs. Yes response options): <ol style="list-style-type: none"> 1. My work and activities before the coronavirus pandemic provided me with helpful training to perform my current clinical work 2. In my current clinical setting, I am adequately informed about my clinical duties and the role I am expected to play 3. At present, I have a good idea of how long my current level/volume of work will last. 4. I am adequate trained to perform the professional tasks required of me during this pandemic.
Work pride and meaning	Sum of responses to the following questions (Assessed on 3-point scale: Disagree, Neutral, Agree) <ol style="list-style-type: none"> 1. I have felt more pride than usual to be a healthcare worker 2. I have derived more meaning from my clinical work than during life as usual. 3. I have been inspired by colleagues who I consider to be role models.
Feel valued and supported at work	Sum of standardized scores on the following questions (Assessed on 4-point scale: Not at all valued, Slightly valued, Moderately valued, Very much valued): In your opinion, to what extent do you feel valued by: <ol style="list-style-type: none"> 1. Your immediate supervisors (team leader, service chief, etc.) 2. Hospital leadership In your opinion, what is the current level of: (Assessed on 3-point scale: Low, Medium, High): <ol style="list-style-type: none"> 1. Camaraderie/team spirit among your group of co-workers in your own clinical practice team or setting. 2. Support from your hospital leadership.
Positive emotions	Score on the positive affect subscale of the Positive and Negative Affect Schedule-Short Form (PANAS-SF ¹), which assesses 10 positive emotions: interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, active.
Perceived social support	Score on abbreviated 3-item version of the Medical Outcomes Study Social Support Scale ² (Assessed on 5-point scale: None of the time, A little of the time, Some of the time, Most of the time, All of the time). How often is each of the following kinds of support available to you if you need it? <ol style="list-style-type: none"> 1. Someone to love you and make you feel wanted (i.e., emotional support) 2. Someone to help you if you were confined to bed (i.e., instrumental support) 3. Someone to give you good advice in a crisis (i.e., appraisal support)

Protective psychosocial characteristics	<p>Factor score of the following measures:</p> <ol style="list-style-type: none"> 1. Items assessing self-efficacy from the Connor-Davidson Resilience Scale-2 (CD-RISC2³; Responses on 5-point scale ranging from Not true at all to True nearly all the time): I am able to adapt when changes occur; I tend to bounce back after illness, injury, or other hardships. <p>Items assessing dispositional gratitude, optimism, curiosity/exploration, purpose in life, and religiosity/spirituality (Responses on 7-point scale ranging from Strongly Disagree to Strongly Agree):</p> <ol style="list-style-type: none"> 2. I have so much in life to be thankful for.⁴ 3. In uncertain times, I usually expect the best.⁵ 4. I frequently find myself looking for new opportunities to grow as a person (e.g., information, people, resources).⁶ 5. I have discovered clear-cut goals and purpose in my life.⁷ 6. In my life, I experience the presence of the Divine (i.e., God).⁸
Self-sufficient coping strategies	Count of engaging in the following coping strategies to help cope with COVID-19-related experiences (adapted from the Brief COPE ⁹): planning (e.g., coming up with a strategy for what to do), active coping (e.g., taking action to make the situation better), positive reframing (e.g., looking for something positive in what happened), acceptance (e.g., accepting the reality that it happened), humor (e.g., trying to find humor in the situation), religion (e.g., praying, meditating, or finding comfort in spiritual beliefs).
Socially-oriented coping strategies	Count of engaging in the following coping strategies to help cope with COVID-19-related experiences (adapted from the Brief COPE ⁹): use of emotional support (e.g., getting comfort or understanding from others), use of instrumental support (e.g., getting advice from others), venting (e.g., expressing negative feelings).
Non-engagement in avoidance coping strategies	Count of non-engaging in the following coping strategies to help cope with COVID-19-related experiences (from the Brief COPE ⁹): self-distraction (e.g., turning to work or other activities to get mind off things), denial (e.g., refusing to believe that it happened), substance use (e.g., using alcohol, nicotine, or drugs to help get through it), behavioral disengagement (e.g., giving up in trying to deal with it), self-blame (e.g., blaming or criticizing myself for what happened).

References

1. Watson D, Clark LA, Tellegen A. Development and validation of brief measures of positive and negative affect: the PANAS scales. *J Pers Soc Psychol* 1988; 54:1063–1070.
2. Sherbourne CD, Stewart AL. The MOS social support survey. *Soc Sci Med* 1991;32:705-714
3. Vaishnavi S, Connor K, Davidson JRT. An abbreviated version of the Connor-Davidson Resilience Scale (CD-RISC), the CD-RISC2: Psychometric properties and applications in

- psychopharmacological trials. *Psychiatry Res* 2007;152(2-3):293-7.
4. McCullough ME, Emmons RA, Tsang J: The grateful disposition: a conceptual and empirical topography. *J Pers Soc Psychol* 2002; 82:112-127.
 5. Scheier MF, Carver CS, Bridges MW: Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): a re-evaluation of the Life Orientation Test. *J Pers Soc Psychol* 1994; 67:1063-1078.
 6. Kashdan TB, Gallagher MW, Silvia PJ, et al: The Curiosity and Exploration Inventory-II: development, factor structure, and initial psychometrics. *J Res Pers* 2009; 43:987-998.
 7. Schulenberg SE, Schnetzer LW, Buchanan EM: The Purpose in Life Test-Short Form: development and psychometric support. *J Happiness Stud* 2010; 20:1-16.
 8. Koenig HG, Büssing A: The Duke University Religion Index (DUREL): A five-item measure for use in epidemiological studies. *Religions* 2010; 1:78-85.
 9. Carver CS. You want to measure coping but your protocol's too long: Consider the Brief COPE. *Int J Behav Med* 1997; 4:92-100.

Supplementary Table 3. Bivariate and Multivariable Correlates of Psychological Resilience in Frontline Healthcare Workers Responding to the Spring 2020 Pandemic Surge in New York City.

	Bivariate analyses (r)	Multivariable regression model	
		β	p
		$R^2=0.23$	
Age	0.14***	0.01	0.69
Male gender	0.13***	0.08	<.001
Married/partnered	0.12***	0.04	0.049
Attending physician vs. other professions	0.14***	0.09	<.001
Years in practice	0.14***	0.03	0.14
History of mental illness	-0.14***	-0.03	0.13
Perceived preparedness	0.16***	0.05	0.009
Work pride and meaning	0.11***	-0.04	0.067
Feel valued and supported at work	0.22***	0.09	<.001
Positive emotions	0.30***	0.12	<.001
Perceived social support	0.20***	0.08	<.001
Protective psychosocial characteristics	0.30***	0.12	<.001
Self-sufficient coping	0.26***	0.08	0.047
Socially-oriented coping	-0.09***	-0.01	0.79
Non-engagement in avoidance coping	0.23***	0.12	<.001
Currently receiving mental health treatment	-0.11***	-0.05	0.024

Note. Bolded values indicate significant correlates of psychological resilience scores in the multivariable model.

Psychological resilience scores were computed by regressing composite psychological distress scores onto measures of COVID-19-related stressors; residual scores from this model were then inverted such that higher scores reflected lower actual vs. predicted distress scores given higher levels of exposure to COVID-19-related stressors. Details regarding this approach to operationalizing psychological resilience are provided in: Amstadter AB, Myers JM, Kendler KS. Psychiatric resilience: longitudinal twin study. *Br J Psychiatry*. 2014;205(4):275-280.

Post-hoc analyses revealed that: Perceived preparedness: having a sense of how long work volume would last ($\beta=0.05$, $p=0.015$); Feel valued and supported at work: hospital leadership support ($\beta=0.07$, $p=0.007$); Positive emotions: feeling interested ($\beta=0.14$, $p<.001$) and enthusiastic ($\beta=0.07$, $p=0.001$); Perceived social support: emotional support ($\beta=0.09$, $p<.001$); Protective psychosocial characteristics: self-efficacy ($\beta=0.13$, $p<.001$), purpose in life ($\beta=0.09$, $p<.001$), and dispositional gratitude ($\beta=0.05$, $p=0.023$); Self-sufficient coping: acceptance coping ($\beta=0.04$, $p=0.016$); and Non-engagement in avoidance coping: non-engagement in substance use ($\beta=0.13$, $p<.001$), denial ($\beta=0.08$, $p<.001$), behavioral disengagement ($\beta=0.07$, $p<.001$), self-distraction ($\beta=0.05$, $p=0.011$), and self-blame ($\beta=0.04$, $p=0.016$) coping were associated with greater psychological resilience scores. See Supplemental Table 2 for full list of factors assessed.