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A time for self-care? Frontline health workers' strategies for managing mental health during the COVID-19 pandemic



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ABSTRACT

Frontline healthcare workers have experienced detrimental mental health impacts during the COVID-19 pandemic including anxiety, emotional distress, stress, fatigue, and burnout. But little is known about how these healthcare professionals take care of their own mental health in the midst of considerable personal, occupational and social disruption. In this article, we use qualitative data from an Australian national survey to examine the self-care strategies frontline healthcare professionals employed to manage their mental health and wellbeing during the crisis. Findings reveal how healthcare workers sought to adjust to disruption by adopting new self-care practices and mindsets, while encountering numerous personal and professional struggles that undermined their capacity for self-care. Feeling socially connected and valued were critical dimensions of caring for self, illustrating the importance of locating self-care in the social domain. These findings, we argue, highlight the need to expand conceptions of self-care away from those that focus primarily on the individual towards approaches that situate self care as collective and relational.

1. Introduction

Crises, such as the COVID-19 pandemic, represent a profound threat to the mental health of health workers on the frontline, who have experienced increased personal and work-related challenges and stresses, amidst new experiences of risk, uncertainty, and vulnerability. The detrimental mental health effects of frontline health work during the pandemic have been widely reported and include psychological distress, anxiety, stress, and burnout (Smallwood, Karimi, et al., 2021; Barello et al., 2020; Chor et al., 2021; Denning et al., 2021). Little, however, is known about how frontline healthcare workers take care of their mental health and wellbeing in the midst of considerable social, occupational and personal upheaval.

Healthcare workers are inundated with reminders not to neglect caring for their body and mind while caring for others (see for example (Hofmeyer et al., 2020; Pan American Health Organisation, 2020). Numerous self-care resources focus on the various personal coping strategies healthcare workers should employ to prevent burnout and

ameliorate anxiety and emotional distress – from getting enough sleep, exercising regularly, eating healthy meals, and limiting alcohol to practicing breathing and relaxation techniques to monitoring their workload and maintaining work-life balance (Heath et al., 2020; Hossain & Clatty, 2021; Mollica et al., 2021). But while these resources often emphasise the resilience of health professionals in taking responsibility for their own wellbeing, rarely do they recognise or respond meaningfully to the organisational or structural conditions that contribute to burnout and anxiety for frontline healthcare workers, and work against their capacity for self-care (Andrew & Krupka, 2012; Carroll et al., 1999; Sanchez-Reilly et al., 2013).

These individually focused self-care messages may also be viewed as another source of stress for already busy and fatigued healthcare workers. Simultaneously, failure to take good care of self can be construed as a failing of their personal agency. Additionally, messaging about the importance of self-care can sit uneasily with professional and cultural expectations that health professionals should be altruistic and prioritise the care needs of others ahead of their own (Andrews et al.,

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2020). The COVID-19 pandemic thus provides a critical moment to capture healthcare workers' experiences of managing their own mental health during crises.

1.1. Self-care and its critique

Self-care broadly refers to the actions that individuals take to enhance, restore or maintain health, prevent or limit illness, and preserve self (Godfrey et al., 2011; Kickbusch, 1989). Researchers have recently focused on the development of self-care interventions for health professionals and disaster first responders to cope with emotional trauma and distress associated with their work (Killian, 2008; Rodriguez-Vega et al., 2020; Sansbury et al., 2015; Smith et al., 2019). These interventions often involve personal coping strategies for individual health professionals and are informed by conceptions of self-care that emphasise personal autonomy, resilience, self-efficacy, self-control, self-actualisation, and self-stewardship (Hossain & Clatty, 2021). Yet, as some scholars have argued, individualised forms of self-care can create a moral imperative for health professionals about what they should do to take care of themselves but does little to meaningfully address the organisational or healthcare system level structures that can be obstructive to self-care (Carroll et al., 1999).

Feminist scholars have argued that the concept of self-care has been 'co-opted' by neoliberalist governments who depend on 'well-regulated citizens' taking self-responsibility for their own wellbeing as this promotes self-reliance over health and reduces dependency on others for care (Ahmed, 2014; Lupton, 2013; Michaeli, 2017; Ward, 2015). Thus, individualised self-care is highly valued, and a core component of autonomous and responsible personhood (Lupton, 2013). Feminist sociologist Inna Michaeli (2017) (Hobart & Kneese, 2020) notes that the market is heavily invested in supporting those who experience burnout and fatigue, such as frontline healthcare workers, to maintain their productivity. And this is why individuals are encouraged to engage in (and often purchase) a range of personal self-care strategies (e.g., positive thinking, commercial diets, therapies, gym memberships, wellness and fitness applications (apps) and personal devices) to become mentally and physically healthier (Hobart & Kneese, 2020; Lupton, 2020). This neoliberal (and narrow) version of self-care has been critiqued for diverting responsibility for care away from the collective responsibility of societies onto individuals (Michaeli, 2017; Ward, 2015). Thus, systemic deficiencies that create environments of hyper-stressed and overworked health professionals are reconstituted as problems of individuals to manage on their own through 'appropriate' self-care techniques (Ahmed, 2014).

Despite being co-opted by neoliberalism, the concept of self-care has a long and expansive history across intersectional feminist, queer and critical race scholarship as a powerful force of 'self-preservation', 'resistance' and 'political warfare' for living with precarity in circumstances of shared adversity, struggle and suffering (Ahmed, 2014; Lorde, 1988; Michaeli, 2017; Ward, 2015). As Ahmed (2014) writes:

... in queer, feminist and anti-racist work self-care is about the creation of community, fragile communities, assembled out of the experiences of being shattered. We reassemble ourselves through the ordinary, everyday and often painstaking work of looking after ourselves; looking after each other.

Sometimes referred to as radical self-care in feminist scholarship, these alternative ways of conceiving and practicing self-care are argued to be critical, yet often unseen and/or undervalued, for individual and collective wellbeing (Michaeli, 2017; Hobart & Kneese, 2020; Sharma et al., 2017).

Guided by care ethics, alternative understandings of self-care conceive caring for self as a relational and interdependent practice of caring for self and others together (Casalini, 2019). That is, we care for self through feelings and acts of caring for and with others (Held, 2006).

Rather than an abstract, atomised and self-serving individual self who meets their own needs as part of a personal project of *working on themselves*, feminist approaches guided by an ethic of care see the self as situated in particular histories, emotions, relationships, and circumstances (Held, 2006; Michaeli, 2017). This theorisation incorporates the emotional dimensions of care, that are sometimes less perceptible but critical forms of caregiving. Importantly this conceptualisation also draws attention to the benefit of caring for self for collective forms of caregiving, and as a form of protection against the personal and social costs of giving care (see Kleinman, 2012).

In this article we examine how healthcare professionals take care of their mental health during a time of considerable personal and occupational crisis by analysing the strategies they report using and the challenges they face, their negotiations around expectations of self-care, and how they develop new practices of self-care.

2. Material and methods

We took a qualitative descriptive approach as we were interested in exploring in-depth, the diverse experiences and perspectives of frontline healthcare workers during the COVID-19 pandemic across different professions, localities, and workplace settings (Bradshaw et al., 2017; Neergaard et al., 2009). Qualitative research with healthcare workers during the pandemic has demonstrated the importance of understanding their experiences in providing care, during periods of high risk, uncertainty and where patient deaths are anticipated (Greenberg et al., 2020; Vindrola-Padros et al., 2020). We drew on qualitative data collected from the Australian COVID-19 Frontline Health Workers Survey (<https://covid-19-frontline.com.au/>). This mixed-methods nationwide, voluntary, anonymous and single-point online survey was conducted from August 27th to October 23rd, 2020 during the second wave of the pandemic in Australia and examined the psychosocial impacts of COVID-19 on frontline health workers. Detailed information about the survey method including sample and recruitment are reported elsewhere, along with findings from quantitative data (see Smallwood, Karimi, et al., 2021; Smallwood, Pascoe, Karimi, & Willis, 2021).

Participants who self-identified as frontline healthcare workers, including nurses, doctors, allied health staff, medical laboratory, and other roles, were recruited through health organisations, professional associations or colleges, universities, government contacts, and national media. After providing informed consent, participants either directly completed the online survey or via a purpose-built website. Ethics approval was provided by The Royal Melbourne Hospital Human Research Ethics Committee (HREC/67074/MH-2020). All participants provided consent online. Information for participants was provided on the survey website, indicating that data would be stored securely and would be anonymised in reporting. As the survey was about the psychosocial impact of COVID-19, links to mental health resources were also provided on the survey website. A total of 7846 complete survey responses was received. Most participants were female (6344, 81%) and just over half (n = 4110, 52%) were younger than 40 years. Participants included nurses (n = 3088, 39%), doctors (n = 2436, 31%), allied health workers (n = 1314, 17%), and other roles in health (523, 7%) or administration (485, 6%). They worked in primary care or community care roles (n = 1250, 16%), medical speciality areas (n = 1205, 15%), emergency departments (n = 1146, 15%), anaesthetics or surgical areas (n = 824, 11%) or intensive care (n = 745, 10%). Most worked in metropolitan locations (n = 6373, 81%), while 1473 (19%) worked in regional or remote areas. Over two-thirds of participants experienced mental illness symptoms during the pandemic, including anxiety (60%), burnout (71%) and/or depression (57%). More than three-quarters reported that the pandemic had impacted on their relationships with family, friends and colleagues (see Smallwood, Karimi, et al., 2021).

The survey included four free text questions in addition to quantitative questions and psychometric measures. This provided an opportunity for participants to reveal additional insights about their experiences of

work and life during the pandemic. Qualitative data collected through open-ended survey responses are often critiqued for their purported inability to capture in-depth data (in contrast to interview data, for example). However, open-ended survey questions enable the capture of rich and intricate data and facilitate access to hard to reach, time poor, and/or geographically dispersed populations. In responding to the free text open ended questions participants were able to write as little or as much as they wished, in each free text question, and many wrote long, personal and deep accounts of their experiences, thoughts and feelings. This approach allowed us to capture insights from a large, diverse, and often extremely time-poor cohort of health professionals, including different groups of healthcare workers (e.g., nurses, allied health staff, doctors, administrative staff) working in diverse settings (e.g., public and private hospitals, primary and community care) across metropolitan, rural and remote localities nationwide. This 'wide-angle' approach (Toerien and Wilkinson, 2004) maximised opportunities for all frontline healthcare workers including those who are traditionally overlooked or marginalised in research studies to participate and share their accounts and have their voices heard, facilitating the potential to capture a diversity of experiences (Braun et al., 2017, 2020). The first of the four free text questions asked: "What do you think would help you most in dealing with stress, anxieties and other mental health issues (including burnout) related to the COVID-19 pandemic". Responses for this question form the basis for our analysis of self-care during the pandemic.

Qualitative content analysis was used to analyse the data (Bengtsson, 2016; Morgan, 1993), in line with the approach of qualitative description emphasising staying close to the data (Neergaard et al., 2009). Based on initial reading of the first 100 responses a code book was developed by two authors. This code book categorised responses broadly in terms of personal, work and social factors, with key codes identified in each. Codes were then developed iteratively as analysis proceeded. Up to three codes were applied to each free text response. Codes were discussed and refined during weekly discussions to establish inter-rater reliability and consensus. Self-care was coded as a personal factor and 1091 responses were coded as self-care. After initial coding was completed, the data within each code were sorted and compared identifying patterns and differences in ideas and concepts to develop themes (Bradley et al., 2007). The two authors systematically analysed the data coded as self-care using Excel. This involved both repeatedly and independently reading these responses and meeting regularly to discuss and refine the key ideas and patterns within the data. Differences in coding and/or contradictions in the data were discussed through weekly meetings between the two authors, and any differences in interpretation were resolved through reaching consensus in these analytic discussions (Elo et al., 2014). The key ideas relating to self-care are presented below. We found a commonality of key ideas across the workforce; and have presented this by including information about occupation, gender, and age range.

3. Results

A total of 5677 participants provided a free text response describing their experiences of mental health during COVID-19, and what would be helpful for them in dealing with mental health issues. They were drawn from across the range of health occupations, represented an even spread of age ranges, and while more women than men participated, this is broadly reflective of the demographics of the Australian health workforce.

At the time of the survey, most participants were living in a period of national and/or state-based lockdown (ranked as one of the longest and strictest in the world), that restricted how citizens participated in family, work and social life (Willis, Ezer, Lewis, Bismark, & Smallwood, 2021). Evident across responses was the disruption in the ability to participate in daily life in the ways they wanted to, and their limited opportunities to engage in their normal (pre-COVID) strategies to care for themselves. We identified three key themes from their responses. First, adjusting to

disruption required new self-care strategies and mindsets; second, the multiple struggles of caring for self during a time of uncertainty; and finally, the importance of social connectedness and self-care.

3.1. Adjusting to disruption: requiring new approaches to self-care

Responses revealed the shared experience of disruption to usual practices of self-care, and the need to find new ways of caring for mental health. Participants expressed frustration that they were unable to engage in their normal (pre-COVID) strategies for coping with work-related stress and anxiety and "to live a normal life outside work". While many expressed a strong desire to be able to return to some of their normal self-care activities, most recognised that this was impossible and unsafe. The following responses are indicative of the need to adjust, and also reveal the various forms of self-care that healthcare workers employed in coping with the challenges of working on the frontline. While disruption was variously experienced, in negative, positive and/or ambiguous ways, responses also revealed that disruption and readjustment was a shared experience.

I ease my stress by seeing family and friends; and getting out of Melbourne. None of which I can do now. I have a stressful job and I spend my days off in my tiny lounge room. With one hour alone outdoors. (Nurse, emergency department, female, age 31–40)

I need the gym to open to help me keep exercising regularly which would help. The classes keep me motivated. I don't exercise as much myself. (Junior doctor, medical specialty, male, age 31–40)

I can't use coping strategies I have previously used. Debriefing with family and friends in person, regular exercise in the form of gym classes. Going for long walks. (Junior doctor, aged care, female, age 20–30)

The uncertainty and vulnerability associated with the pandemic combined with the retraction of many of their usual coping strategies, meant that participants needed to be inventive in finding new modes of caring for themselves. Their responses highlight the variety of different ways in which healthcare workers renegotiated their self-care practices during the pandemic. As the excerpts below illustrate, their coping strategies ranged from "keeping busy" and "finding distractions", establishing new routines to manage unpredictability at work and at home, reclaiming a sense of work/life balance, carving out time and space for self to "escape" from the confines or demands of work and family responsibilities, or spending more quality time with friends and family in person or online. Some participants wrote about personal lifestyle-based regimes such as exercising, eating a healthy diet, reducing alcohol consumption or practicing mindfulness, while others said they cared for themselves by taking "time out" for rest and recovery. Illustrative of the range of strategies used are the following:

Work life balance. Maintaining strict work hours ... leaving work at work and being present at home. Getting out and walking/exercising and keeping busy with tasks/projects around the home. (Social worker, working across hospital departments, female, age 41–50)

Maintaining a routine that incorporates a balanced diet, walking/exercise, yoga (don't laugh!), contain exposure to news updates, engage the mind (reading listening to audiobooks, podcasts, play music), maintaining a flexible/kind attitude about sleep quality, connecting with family, friends, enjoying the antics and company of pets, growing stuff (legal of course) in the garden, and having hope! (Psychologist, community care, female, age 41–50)

When I feel 'I'm done', I completely slow down at home. I sleep in, read, listen to music, watch films I know. I feel I cannot think beyond each evening. I can't think too much ahead cos everything can change within hours. I feel better watching films I know. I don't have the

capacity to learn from long new films or documentaries. I've stopped listening to podcasts and reading non-fiction. It's easier and nicer to get lost in a story. (Nurse, working across hospital departments, female, age 41–50)

Mindset was important for some participants, who talked about positive thinking, optimism and calmness as important forms of self-care.

Looking into myself and bringing positive thoughts. (Nurse, respiratory medicine, female, age 31–40).

Mindset also included a desire to control certain feelings or thoughts viewed as unhelpful or harmful (e.g., worry, despondency, anger) through trying to limit exposure to “bad news” or “pessimistic people”:

... surrounding myself with optimistic people rather than pessimistic/worriers” (Paramedic, male, age 41–50)

... trying to minimise the time around the narcissists and martyrs who seem to thrive in the disaster/high attention zone.” (Senior doctor, palliative care, female, age 41–50)

In some responses, healthcare workers talked about their personal thoughts, feelings and emotions, as among the only things that were in their power to control during the pandemic. In the absence of being able to control activities in the physical sense, ‘mindset’ became an important feature of coping with adversity. Their responses reflected a logic that ‘if you want to be positive, you can be’, and that ‘you can think your way out of’ worry or sadness. Others emphasised their personal abilities to “just get on with it”; “keep strong” and “be positive” for themselves, and for others; presenting themselves as resilient in managing adversity as is illustrated in the following excerpts.

Staying focussed on the immediate. Being positive about having work, health and relationships. (Psychologist, community care, female, age 51–64)

I have developed good resilience over the years of medical training – making anxiety and burnout due to COVID-19 manageable. (Senior doctor, hospital aged care, male, age 41–50).

In contrast, other participants wrote that accepting feelings of sadness and grief as normal and reasonable emotional responses to their situation was a helpful form of care; rather than trying to fight or control these feelings. These responses reflected a different kind of logic; the idea of giving yourself permission to feel/be vulnerable, sad, worried or lonely. That these participants discussed the notion of “permission” or “allowance” to feel in certain ways also reveals that there are particular kinds of feelings and thoughts that are viewed (normatively) as oppositional to care of self, or even harmful. The following excerpts encapsulate this:

We are allowed to feel sad. We're allowed to feel worried, and we're allowed to feel stressed. The current climate makes everyone think they're nuts if they don't feel 100% happy and carefree every minute of every day. We all have bad days. It's not perfect all the time. And that's OK. (Administrative staff, emergency department, female, age 31–40)

Normalising the sense of anxiety rather than feeling guilty for feeling this way. (Junior doctor, medical specialty, female, age 20–30)

Others discussed the importance of “practicing gratitude” or sought to reframe their experience by, for instance, placing the pandemic within its wider historical and social context.

I've been working really hard, but it's given me lots of time to appreciate how fortunate I am and how fortunate we are to be working and living in Australia. It's been a return to simple life for my family and appreciating all the good things we have. (Senior doctor, infectious diseases, male, age 41–50)

Participants also talked about the value of kindness, empathy, and compassion for self, and for others. This included the importance of recognising the array of coping strategies used by different people to care for themselves during the pandemic.

Being kind to myself, lowering expectations, being compassionate to and understanding of others. (Psychologist, private practice, female, age 31–40)

3.2. *The multiple struggles of caring for self while living in uncertainty*

Participants wrote about the struggles they experienced in trying to take care of themselves and support their mental wellbeing during COVID-19. These ranged from the emotional (e.g., anxiety, fear, loneliness, fatigue), and the practical (e.g., increased demands at work and home), to the existential (e.g., uncertainty about immediate and longer-term future, loss of control over their life), the social (e.g., social isolation) and the financial (e.g., lost wages). The layering impact of these struggles in daily lives, and in particular on their ability to care for themselves, is encapsulated in the following responses, where frontline workers discuss feeling burned out, overwhelmed, unmotivated and anxious.

First COVID lockdown I used exercise to help my mental health but in Victoria during the second lockdown (currently in now) my mental health has taken a huge hit. I play video games and eat a lot of food and they are my coping mechanisms. (Nurse, intensive care, male, age 20–30)

I am feeling worn down by the need for vigilance, the erosion of relationships by reduced contact, worry that we will not see a return to 'normal' life, financial concerns, and struggling to keep a positive attitude when I just want to crawl into a cave and hide until this is all over. (Psychologist, community care, female, age 51–64)

I live alone but feel like I don't have a right to complain. I feel guilt over the thought that I could unintentionally spread COVID-19, as I'm a health care worker. I often dream that I have mild symptoms, and experience stress over whether I should be calling in sick to work, or whether I'm leaving work short-staffed at the last minute, only to wake up and realise - again - that it was a dream. I have no motivation to exercise or cook nutritious meals. I'm experiencing a higher than usual sense of self-loathing over my weight gain, and concern over how I will manage it. (Nurse, perioperative care, female, age 31–40)

These responses also show how feelings of guilt were invoked when participants were not able to think or act in ‘positive’ or ‘health-enhancing’ ways. This self-responsible approach is also exemplified, below, by a physiotherapist and a senior doctor, both working in emergency departments. Their excerpts indicate that they are grieving the loss of their former self/identity as motivated, positive and resilient.

I have had great plans to do things like on-line yoga etc, but then the days come and go, and I don't do it. Lack of motivation, even though I know it would be good for me. [...] I'm normally a positive, energetic person and am hating the way I feel now. (Physiotherapist, emergency department, female, age 51–64)

I've always thought of myself as a resilient person but no longer feel this in myself. (Senior doctor, emergency department, male, age 51–64)

Responses also indicated the difficulties that frontline health workers experienced in maintaining boundaries between work, family, and personal domains, and how this contributed to poor mental health. Notable was neglecting to take care of their own mental health due to increased caring responsibilities at work and at home. This included caring for patients and supporting colleagues in their workplace, in addition to,

extra personal caring responsibilities and home-schooling due to the closure of day-care centres and schools, especially for mothers who wrote in their responses about the difficulties of *doing* paid and domestic work, childcare and home-schooling. The colonisation of time, space and energy through caregiving was discussed by many:

I have less time to manage my own health in the context of caring for others. (General practitioner, female, age 41–50).

Further, participants wrote about the infiltration of paid and unpaid work into every domain of their lives, and the practical and emotional care that they provided to others, combined with the sense of duty or obligation that this produced leaving them feeling emotionally and physically drained. Self-care was, as these responses highlight, construed as one more job to do. Yet neglecting to care for themselves was often felt as a personal failing, rather than a normal response to the gruelling conditions that they were working within, even when they were feeling overwhelmed or unable to do so:

Due to pressures of home schooling and increased work at home, I have had significantly decreased time for self-care. (Nurse, intensive care, female, age 41–50).

I haven't got a second for myself. I am so overwhelmed with work and caring responsibilities which have all become intermingled. (Occupational therapist, private practice, female, age 31–40).

It is exhausting working in this environment without many ways of nurturing self. (Senior doctor, female, age 51–64).

Some participants discussed the mental health difficulties associated with working on the frontline, and their desire to access professional mental health services. Yet, as the following responses suggest, they felt unable to access the professional supports that they needed due to constrained resources (e.g., time or financial), feeling guilty about taking time off work, or their fears about how this might impact on their employment (e.g., stigma associated with seeking help, being labelled as “not coping”, or being diagnosed with post-traumatic stress disorder).

I should probably seek counselling and possibly look at medications which I haven't ever had before. But it just seems another thing to try and organise and navigate and I don't have the energy or brain space for it. Home-schooling three primary children and a baby and have gone back to help in emergency directly because of COVID-19. Right now, I'm not the priority. (Nurse, emergency department, female, age 31–40)

I simply don't have time to consult with a psychologist or do any of the things that I advise my patients to do for their mental health! (General practitioner, female, age 65–70).

I think speaking to a psychologist would help with my anxieties and burnout. However, I feel guilty seeking professional help. (Nurse, surgical, female, age 20–30)

The reported absence of meaningful institutional supports and resources for frontline healthcare workers (e.g., flexible working arrangements, assistance for unpaid caregiving, access to professional mental health services) seemed to place greater expectations on the individual to come up with their own coping strategies. This was evident in the responses below which reveal the disappointment and frustration felt by some participants with some of the ‘tokenistic’ self-care tools or guidelines that had been provided to them by their workplace or the government.

... there has certainly been some recognition and reduction in KPI's, but the overall organisational approach is more about directing staff to adopt psychological/lifestyle strategies rather than addressing practical issues which lead to longer, more stressful working hours. Longer working hours have led me to less energy/time to engage with

my adult children and other family. (Allied health practitioner, community care, female, age 65–70)

Advertising mental health services may be useful for some, but it also puts the impetus/problem on us on how we deal with things rather than dealing with the issue itself. (Junior doctor, general medicine, male, age 20–30)

The importance of reclaiming time and space to care for self was also evident as is illustrated in the excerpt below from an anaesthetist. She talks about how taking time to engage in activities that are relaxing, and revitalizing is important in both showing care for herself *and* care for her children, her patients and her colleagues, but also reveals her struggles in doing so because of the multiple personal, family and work-related stresses that she is dealing with. This illustrates the inseparability of care of self, and of others:

I have had way less time to exercise and do stuff that relaxes me, or just have time out. There are so many issues, I just focus on what needs to be done next. Ultimately my children are suffering now however the most important thing is that they have a mother that is healthy at the end of all of this. (Senior doctor, anaesthetics, female, age 41–50)

3.3. Social connectedness and caring for self; locating self-care in the social domain

Finally, participants articulated that feeling connected with others – friends, partners, family, colleagues – was an essential part of nurturing and caring for self. Though the disruption to “normal” valued social activities and social relationships and its rippling effects on wellbeing were not unique to frontline healthcare workers, the nature of their work did present distinct difficulties for their social lives. In particular, self- and externally imposed isolation due to the risk of infecting others with coronavirus, was an ever-present consideration in their lives; and severely constricted their opportunities for connectedness and participation in social life in ways that they wanted to. This produced considerable shifts in relational dynamics at home, and in the workplace, as is illustrated by the following responses.

... everything has changed. The things that I used to do socially that makes me happy [are] gone. We can't see our family because of the long lockdown here in Melbourne. Both me and my husband worked in [a] suspected COVID ward. We really feel isolated with everyone. It did put a strain in our relationship as well. (Nurse, surgical, female, age 31–40)

Human contact is important and impossible. I haven't touched a person in over two months without a latex glove, living alone and single, not being able to see friends. That is hard, particularly after a long day in COVID-affected nursing homes with multiple deaths and traumatic scenes. (Senior doctor, aged care, male, age 31–40)

Loneliness, isolation and the felt absence of friends and family, were particularly emotionally distressing for participants who lived alone, were single, lived away from home, or who worked on “hot wards” (for patients with COVID-like symptoms). The following responses from a nurse and a general practitioner highlight a longing for increased social connectedness to alleviate stress and feelings of loneliness and sadness.

I haven't seen my friends since March 2020 or my family since December 2019. I can keep in contact with them via social media. However, I am someone who thrives on being tactile and having proximity to those I love. I'm suffering mentally and physically. Substance abuse has been a recurring theme during my work, and I have sought help from a psychiatrist for this. It's rough and it feels like there's no end to it. [...] it almost felt like we were abandoned by our

employer and the government and our main stress relief was taken away. (Nurse, general medicine, male, age 20–30)

I don't feel that there are any strategies which would counteract the negative effects of the social distancing rules and regulations. There is nothing that can make up for not being able to have direct access to your parents and extended family and friends. (General practitioner, male, age 41–50)

Participants documented that their sense of resilience and personal agency in coping with the challenges of being a frontline healthcare worker started to be worn-down over time, with detrimental effects on their mental health. No matter the personal strategies that they attempted to deploy, as time went by, nothing worked to offset the felt loss of connection and intimacy with others, and the discomfort and distress that this produced. This is captured in the response (below) from a junior doctor who lived alone, who discusses the challenges of staying positive during a second state-wide lockdown lasting four months in which all citizens were restricted from seeing anyone outside of their immediate household. The inability for participants to *connect with* others how they wished to (due to lockdown restrictions or their fears of infecting others), made clearly visible “the importance of connection” in their daily lives.

The combination of increased workload, increased responsibility and decreased support and supervision has been very challenging [...] living alone and being a health care worker is very isolating. (Junior doctor, medical specialty, female, age 20–30)

A few participants talked about the comfort and reassurance they experienced from close physical proximity with their family and friends, while others talked about how debriefing with colleagues with shared experiences of working on the frontline (and talking openly and honestly about their worries) were important forms of care and support for their mental health, helping them feel both anchored and buoyed as well as a sense of belonging. This became even more important during the pandemic, when they said that many other people in their social network did not (and could not) understand what they were experiencing at work.

Sometimes I just want someone to hug and have a cry with. I've found it useful being with peer support, but I wish I could just be sad on a couch close to a friend. (Nursing student, general medicine, female, age 31–40)

I probably used my friends and vice versa to bounce feelings and/or have conversations about what has been going on, rather than with a counsellor, just felt that it was more relevant and meaningful to refer to someone closer and more direct to and with my experience, who knew me from a personal point of view. (Administrative staff, COVID screening clinic, female, age 51–64)

... a big thing for me was accepting help and actually telling people if I wasn't feeling okay - previously I didn't want to burden other people during a hard time. (Nurse, general medicine, female, age 20–30)

Mutual forms of recognition, empathy and compassion of others toward them (and them toward others) were important forms of caring for themselves, suggesting that their conceptions of self-care were grounded in more relational frameworks that challenge individualised notions of self-care and advocate for self-care as shared and co-constructed through interpersonal relationships.

4. Discussion

Frontline healthcare workers have been encouraged to not neglect their own mental health and wellbeing, in organisational and governmental guidelines and policies during COVID-19 and have been provided resources to help them to ‘self-care’. Yet, while self-care is an attractive ideal for helping people to cope better with emotional distress and adversity, especially in times of crisis, these tools need to be incorporated

into health professionals' everyday lives, adjusted to fit within their existing practices, social and material circumstances, and in relation to other duties and priorities – their own, and others (Mol et al., 2015; Skovholt and Trotter-Mathison, 2014).

Our analysis reveals some of the complexities and additional obligations that frontline healthcare workers experienced as they navigated caring for themselves, amid multiple other caring responsibilities, and considerable uncertainty – in the present, and for the future. These findings reveal how healthcare workers worked to find alternative avenues to care for themselves during a time of considerable uncertainty when their normal ways of managing stress and taking care of their health and wellbeing were shutdown. They indicate their resilience and how they mobilise personal and collective forms of agency in adjusting to and negotiating strategies to care for themselves under difficult conditions (Skovholt and Trotter-Mathison, 2014). Yet the unrelenting demands of working on the frontline at a time when the future was precarious, was experienced by some participants as progressively losing control over their lives and their wellbeing as they struggled to maintain effective strategies for caring for themselves. Under these conditions, mindset became paramount for some participants' approaches to caring for themselves as a means of regaining a sense of personal control.

Developing their own practices of self-care was critically important in coping with mental distress and managing the uncertainty of the pandemic for healthcare professionals. Though, their responses also highlight that taking care of self is both personal and collective; involving more than the work of the individual professional but constituted as a shared endeavour and reciprocal practice involving being valued, being recognised and caring *with others*. Revealing the interdependence of care and the importance of collective forms of caring, it was difficult for participants to separate caring for others and caring for self, as they are intertwined practices in their daily lives (Held, 2006; Kleinman, 2012).

The pandemic made visible that self-care is firmly located in the social domain, as well as the limits of personal coping tools and strategies. Participants' loss of the ability to connect with others in ways they wished reveal the importance of social connectedness and self-care as a shared experience and endeavour, rather than solely an individual act. Personal strategies and a positive mindset could not overcome shared and cumulative feelings of grief, anxiety, and loneliness. Our findings align with those of a sociological study on resilience and social media during the 2011 Norway attacks, showing that the crisis engendered a collective, cascading form of care for each other that clearly exceeded the notion of self-care often foregrounded in neoliberal approaches to self-care (Kaufmann, 2015). Our findings thus add further weight to the importance of shifting away from narrow conceptions of self-care which focus on the individual (Ahmed, 2014; Michaeli, 2017; Ward, 2015) towards approaches that embrace more collaborative and collective care practices, in supporting mental health and wellbeing.

A key strength of this study is that it is one of the largest surveys to examine the experiences of healthcare workers who were working across primary and secondary care and in multiple health professions, during the pandemic. There were also, however, some study limitations. First, data were collected at only one timepoint, rather than longitudinally, thus limiting the ability to disentangle relationships between participants' experiences of the pandemic, their mental health and their practices of self-care. As this was an anonymous online survey, only limited demographic information was collected (e.g., gender, age range, profession, location). The voluntary nature of participation may have meant that some healthcare workers (e.g., those who were experiencing mental health symptoms) may have been more likely to engage in the survey.

5. Conclusions

The conditions within which health professionals work, shape what is prioritised and valued by them, influence their perceptions of self-care, and constrain what practices they adopt to care for themselves. The COVID-19 pandemic has made these influences and constraints more

visible. Caring for self was always a relational act, supported or constrained by broader social and material care infrastructures and dynamics. Feelings of guilt about letting themselves and others down inherent in responses of these healthcare workers reveals how increasingly neo-liberal healthcare discourse and systems construct individualistic ideas of self-care (e.g., of self-reliance and self-regulation) and encourage personal responsabilisation, that shape how health professionals think about and engage in self-care.

Our findings have a number of implications for supporting mental health in the health workplace. The COVID-19 pandemic has laid bare the burden on individual health professionals when organisations do not provide the necessary time and space for looking after self. The findings highlight the challenges inherent for health professionals in looking after mental health and the critical importance of healthcare organisations in recognising and supporting frontline healthcare workers so that they do not feel alone in coping with the emotional, existential, and social difficulties of their work. The pandemic has been variously experienced by frontline healthcare workers, with different ramifications for caring for their own and others' mental health and wellbeing. Acknowledging the struggles of being on the frontline, providing time off and adequate staffing, and showing that these workers are valued by the organisation, could be an important form of self-care support to help ameliorate compassion fatigue, emotional distress, and burnout that they experience. The responses suggested that institutions should think about how time and space could be given for collectively formed groups as opportunities for sharing experiences, debriefing, and supporting each other; even though this can be challenging in a society where people are socialised into individualistic approaches (Billings et al., 2021). It is promising that many healthcare organisations have established wellbeing supports which were previously unavailable or limited, in response to the pandemic (Mellins et al., 2020). Yet, development of evidence-based programs and policies incorporating a combination of professional, peer-based and organisational wellbeing supports remain of critical importance for supporting the long-term mental health and wellbeing of the health workforce (Smallwood, Karimi, et al., 2021; Billings et al., 2021).

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Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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