Coping during a pandemic

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2020 HAS BEEN A YEAR of unprecedented change. For many, this change has been brutal. People have lost their jobs, their social worlds and their health. Many are questioning their sense of purpose and meaning in the wake of repeated trauma and loss. As general practitioners (GPs), we have needed to rapidly adapt to emerging threats as we try to help our patients cope. As always, our most vulnerable patients suffer the most.

The ability to cope is not an inborn personality characteristic and is not bottomless; it can dissolve in the wake of sufficient trauma. Just like physical health, it needs to be nurtured with self-care and a safe environment, and some of our patients have never been safe and secure. These people need support to learn coping strategies. We need to practise them to keep ourselves well. Coping theory gives us a scaffold.[1]

Coping theory suggests there are four stages we experience when we approach a problem: appraising the situation and our own abilities to deal with it, applying problem-solving skills, using emotional management strategies and, if the problem is persistent and significant, finding meaning and purpose despite the situation to help us get through difficult times.

In order to cope, we need to appraise the situation carefully, and appraise our own capacities. Honest appraisal of the threat of COVID-19 has been difficult. Information is changing rapidly, and global communication has meant misinformation has flourished. Data are not information. As GPs, we need our skills to interpret and communicate the threats and responses for each person in our care and for our own particular context. Our teams are not immune to misinformation and emotional overwhelm, so we need to help them with honest appraisal too.[2]

In crisis, people often lose their sense of their own agency. We need to bolster a sense of self-efficacy in our patients and colleagues by reminding them of their strengths and the way they have coped in the past. People with lived experience of managing anxiety and trauma can bring great strengths to the national conversation about coping. They model survival in the wake of trauma and can articulate recovery principles in a variety of ways to a broad demographic. The democratisation of online publishing means we all have access to their lived experience narratives in the form of blogs, discussions and multimedia presentations. Hope bolsters coping, and hope is contagious.

We need to model problem-focused coping strategies for ourselves and our patients. As GPs, we are highly capable problem solvers. We can refine practice processes to manage the very real threat of the COVID-19 epidemic to the wellbeing of our patients, our staff and ourselves. We need to include self-care strategies and chronic disease management to optimise resistance to viral threats.

In times of great stress, many people will resort to emotion-focused coping strategies, which generally involve avoidance. Substance abuse, gambling and compulsive internet use may temporarily allow people to avoid feelings of anxiety but are not helpful in the longer term. Some coping strategies are dangerous. We are seeing an upsurge in domestic abuse as people redirect their emotions into violence.[3] Some of our anxious patients are showing extreme responses to guidelines: they may have stopped eating because they are afraid of shopping, or they may practise compulsive cleaning. Emotion-focused coping may also mean people avoid stress by pretending the problem does not exist, congregating on the beaches or hosting crowded parties. It is understandable that people will use emotion-focused techniques, but it is not helpful. As GPs, we have a role in modifying this behaviour where we can to keep our patients and their families safe.

Problem-solving coping has its limits in an epidemic, because the stress remains no matter how organised or focused we are. In these circumstances, Folkman and Lazarus suggest we rely on meaning-focused coping strategies to get through the days.[4] As GPs, we know how to cope with unfixable trauma, and it usually involves healthy distraction, connection and encouragement of self-efficacy. In this context, distraction is not avoidant; it is a reminder that there is more to life than trauma.

General practice brings all these meaning-focused strategies together for us. Our work brings distraction, connection and a sense of purpose. Meaning matters, and it will always help us cope.[5] Encouraging values-based activities, like community service, helps our patients survive too. Social media can enhance collective problem solving, promote social cohesion and provide distraction, but it can also help people make sense of the threat.[6] Digital social movements create communities that enhance problem solving, emotional expression and, ultimately, resilience.

However, many people in our community cannot access any of these strategies. Our patients in nursing homes have little distraction, connection or sense of self-efficacy. Neither do our homeless

patients, or our patients with significant chronic physical and mental illnesses. These are our most vulnerable patients, and they will need our primary care teams to meet some of those gaps if they are to survive this difficult time.

During an epidemic, we are not safe and we are not secure. Coping can mitigate the effects of trauma and improve our resilience, but it will not remove risk completely. Some patients have already absorbed a lifetime of trauma and have little remaining capacity to cope. They need additional support, and it is our role to support them. However, it is understandable that there are times when we need to acknowledge how vulnerable and frightened we are, and to seek our own supports when our coping resources are saturated. If we are to endure this marathon of an epidemic, we need a coping blueprint. Coping theory is the best day-by-day guideline we have to help ourselves, our teams and our patients survive these uncertain times.

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