Pandemic-Induced Depression and Anxiety in Healthcare Professionals

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Medical staff has been at the centre of the fight against the COVID-19 pandemic, facing diverse work-related stressors. Studies from various countries have shown that healthcare professionals have an increased risk of burnout and mental disorders during pandemic outbreaks. The present study aimed to investigate what kind of work-related stressors healthcare professionals in Germany have been facing and how they have been affected psychologically by the COVID-19 pandemic. N=300 healthcare professionals completed an online survey including the ISR symptom checklist to measure psychological well-being and questions on help-seeking behaviour. Findings were analyzed using t-tests, regression, and comparisons to large clinical and non-clinical samples assessed before and during the pandemic. Results show that healthcare professionals were most affected by protective measures at their workplace and changes in work procedures. Psychological symptoms, especially of anxiety and depression, were significantly more severe than in a non-clinical pre-pandemic sample and in the general population during the pandemic. At the same time, most professionals indicated that they would not seek help for psychological concerns. These findings indicate that healthcare employers need to pay increasing attention to the mental health of their staff, encourage help-seeking behaviour, as well as provide access to mental health support.

Keywords: Pandemics; Occupational Stress; Mental Health; Nursing Staff; Help-Seeking Behaviour

Introduction

Globally, medical staff is at the centre of the fight against the COVID-19 pandemic. In the initial phase of the pandemic, healthcare professionals received a lot of media attention and praise from the general public for their *heroic* work [1]. While many employees have started working from home or have even been barred from attending their work place, employees in the healthcare sector were affected in a dual sense: not only were they required to continue working but they were exposed to increased risks due to the nature of their jobs. This twofold burden causes global economic and medical impact on the one hand, and also increases psychological strain on people on the other hand [2].

As the pandemic spread from country to country,

studies investigated the well-being of healthcare professionals in many places, including China, Singapore, Japan, Italy, Saudi Arabia, and Switzerland [3]. The well-being of this target group is of high concern as the health systems depend on their workforces and a collapse would have severe consequences for the general public.

In this study, we set out to investigate whether healthcare professionals in Germany have been affected psychologically by the COVID-19 pandemic and, if so, what kind of work-related stress they have been facing in this new situation.

Evidence from Other Countries

As China was the first country challenged by high and wide-spread infection rates of COVID-19, the first studies that explored the well-being of healthcare staff were run in Wuhan and other regions of China from January 2020 onwards [4, 5, 6, 7]. A systematic review of 14 studies on the impact on healthcare workers in different regions of China and in Singapore has demonstrated the extensive rise in experienced stress as well as depression and anxiety symptoms. Across all studies, between 2.2%

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and 14.5% of cases exhibited severe degrees of anxiety and depression symptoms. Influencing factors included age, gender, occupation, specialization, type of activities performed and proximity to COVID-19 patients [8]. Some of these findings are based on large samples. For instance, Lai et al. [9] assessed $N=1257$ healthcare workers in several regions of China and found high levels of depression (50.4%), anxiety (44.6%), insomnia (34.0%), and distress (71.5%).

Increased mental health risks were also observed in Japan [10] and later on in Switzerland [3]. Italian healthcare professionals showed symptoms of burnout five weeks after the local onset of the pandemic [11]. In Saudi Arabia, healthcare professionals displayed a higher level of anxiety and worries as compared to previous outbreaks of MERS-CoV in the country, despite the fact that no cases of COVID-19 were registered at the time, yet [12]. Using structural equation modeling on a variety of data sources, Miller [13] demonstrated that frontline staff, who are in contact with either possible or confirmed cases of COVID-19, are exposed to even higher mental and emotional risks than other healthcare workers.

While the COVID-19 pandemic is unprecedented in regard to its extent, its rapid spread [14] and the type of protective measures applied at large scale, similar effects on healthcare staff were observed in previous outbreaks of other infectious diseases. A systematic review of 44 studies on former epidemics and pandemics showed that symptoms of mental disorders were common in healthcare workers both during and after the outbreaks [15]. Symptoms of depression were reported by 27.5–50.7%, symptoms of insomnia by 34–36.1%, and symptoms of severe anxiety by 45% of participants. Also, 11% and 73.4% reported post-traumatic stress symptoms. After 1–3 years, the level was still at 10–40%.

Stress Factors

Which individual and work-related factors are considered to increase or decrease the risk of developing clinical symptoms? Many healthcare professionals worry about infecting family members, experience fears and uncertainty concerning the mortality and morbidity of the disease, and some are confronted with the death of colleagues [14, 16, 17]. Surprisingly, the fear of becoming infected themselves seems to be less prominent than the fear of infecting their families [18]. Intolerance of uncertainty has a strong impact on mental well-being in a pandemic setting. This is significantly mediated by rumination and fear [19].

Key individual protective factors include social support and self-efficacy. Social support increases self-efficacy and sleep quality which in turn reduces anxiety

and stress [20]. It has been widely demonstrated that self-efficacy beliefs are an important moderator of the impact of work-related stressors [e.g., 21]. Self-efficacy is also one of the key concepts of the Health Belief Model [22] and a good predictor of health behaviour. Self-efficacy can reduce infection-related worries [23] and insomnia [20]. However, the pandemic situation is characterized by high levels of uncertainty and rapid changes in both work and social life. A general climate of wariness and uncertainty has been observed, as there is still a lack of knowledge about the disease and no cure or vaccine is available yet. Thus, the treatment healthcare professionals can actually provide is still limited. Healthcare workers have raised concerns about not being able to provide competent care [14, 7, 17]. This kind of situation is detrimental for self-efficacy.

Work-related organizational factors that increase the risk for the development of clinical symptoms among healthcare professionals include depletion of personal protective equipment [16], lack of other resources such as specific drugs, ventilators and intensive care unit beds as well as communication issues such as rapidly changing information or a lack of up-to-date information [14]. Changes in work practices such as having to adjust to wearing protective equipment and redeployment are also key concerns [24]. Frontline staff working with (possibly) infected patients has shown to be more affected by changes in work practices and stress than healthcare professionals who work with non-COVID-19 patients [15, 13]. For detailed information on protective factors for healthcare professionals during epidemics and pandemics, see Preti et al. [15].

Mental Health Support for Healthcare Professionals

In order to improve the mental health of healthcare professionals during the COVID-19 pandemic, various intervention strategies have been proposed. For instance, healthcare providers may establish an *emotional support plan*, including strategies for information and screening, providing emotional support and building support networks [24]. Regular interaction among teams can help to discuss critical situations and check on mutual well-being [25]. Healthcare workers and their team leaders can also learn to apply and support self-care strategies through e-Learning programs [26]. In several countries telephone hotlines were established to provide immediate crisis support [27, 28, 29].

However, despite the severe impact on healthcare professionals, some staff members have proven reluctant to accept mental health support. According to Chen et al. [18] professionals tend to claim not having any problems and just needing some rest without interruption.

In Germany, the pandemic took a somewhat differ-

ent course of events than in many other countries. A strategy of early and extensive testing [30] resulted in less drastic lockdown measures than in other European countries [31] and avoided an overload of the health system.

We aimed to find out why and to what extent healthcare professionals in Germany experienced psychological distress related to the pandemic and which factors shaped their help-seeking behaviour.

Method

We created a cross-sectional online survey in order to assess healthcare professionals' mental well-being and the perceived stress factors they are experiencing.

Instrument

The first section of the survey explored participants' demographics such as age, gender and profession.

For the second section, a list of potential stress factors was compiled based on literature and informal discussions with nurses and administrative staff. Participants were asked how strongly they were affected by each stress factor using a 5-point Likert-scale from *not at all* to *extremely*. Participants could also indicate if the factor *does not apply* to their situation.

Psychological well-being was measured with the self-report questionnaire ICD-10-Symptom-Rating [ISR, 32]. The ISR was originally developed to assess symptoms of psychological disorders in the German-speaking area based on the well-known ICD-10 [33] including subscales for depression, anxiety, eating disorder, obsessive compulsive disorder, and somatoform disorder symptoms as well as an extra-subscale with various symptoms. It comprises a total of 29 items which are rated on a 5-point Likert-scale from 0 (*does not apply*) to 4 (*extremely*). Item ratings are averaged to compute subscale scores (three resp. four items for each disorder and 12 items for the extra subscale) as well as a total score. The ISR total score has been shown to have very good internal consistency (Cronbach's $\alpha = .92$). The internal consistency of the subscales is also good (Cronbach's $\alpha = .78 - .86$) [34]. High retest-reliability for the individual scales ranging from .70 to .94 has been reported in different clinical and non-clinical samples [35]. The scale has good ability to differentiate clinical group ($N = 12265$, $M = 1.22$, $SD = 0.65$) from non-clinical control group ($N = 2512$, $M = 0.40$, $SD = 0.45$), with 84%-88% sensitivity and 71%-75% specificity [36]. It also highly correlates with similar but longer instruments such as the symptom checklist SCL-90-R [37].

We chose ISR, because large clinical (C+) and non-clinical (C-) norm samples are available for Germany. These were assessed before the pandemic (P-) [32, 38]

Table 1

IDs and sample sizes of ISR reference groups

	context	
	before pandemic	during pandemic
clinical sample	R_{C+P-} $N = 12265$	—
non-clinical sample	R_{C-P-} $N = 2512$	R_{C-P+} $N = 1744$

and are referred to as reference groups R_{C+P-} resp. R_{C-P-} in our study. We also included a large sample of the general public (C-) assessed at the peak of the first wave of the pandemic (P+) in Germany [39] which we will refer to as reference group R_{C-P+} (see Table 1).

In the third and last section of the survey, we explored whether participants would consider different types of mental support and which barriers they experienced to seeking help for psychological strain.

Sample

Participants were recruited through healthcare providers, a press release and personal contacts between 22 May and 22 July 2020. At that time, the most severe lockdown measures to date had been lifted again across Germany, i.e., shops and restaurants were allowed to operate again and schools were slowly re-opening, but social distancing and other restrictions were still in place. No incentives were given for participation and no personally identifiable information was collected. Neither IP addresses nor GPS data were stored. All participants gave their informed consent for participation and storing responses electronically. We obtained institutional review board (IRB) approval from PFH Private University of Applied Sciences Göttingen for this procedure.

In total 300 participants completed the survey. One case had been removed previously as it was identified as a test answer. No outliers were detected. The majority of participants was female (81%). Participants' age ranged between 17 and 65 years ($M = 40.65$, $SD = 12.9$). The majority lived in Lower Saxony (59%), North Rhine-Westphalia (9%) and Hesse (9%). Most of the participants were working in inpatient nursing care (35.7%). Table 2 provides an overview of the distribution of professions among participants.

Using the statistics software R [Version 4.0.2; 40] in RStudio [41] and numerous helper packages, we computed basic descriptive statistics, followed by t-tests and chi-square-tests where group comparisons were war-

Table 2

Distribution of participants' professions by gender. N=4 participants did not indicate their gender.

profession	f	m	N	rel
inpatient nursing care	92	12	104	35%
inpatient elder care	23	5	28	9%
non-medical health sector	21	7	28	9%
physical therapist	18	8	26	9%
home care	24	0	24	8%
social worker	15	6	21	7%
inpatient physician	6	6	12	4%
physician's assistant	12	0	12	4%
psycho therapist	7	1	8	3%
independent physician	5	2	7	2%
pharmacist	7	0	7	2%
dentist, dental nurse	4	2	6	2%
paramedic	1	4	5	2%
midwife	1	0	1	0%
other	4	3	7	2%
Total	240	56	296	100%

f=female, m=male, N=total, rel=relative percentage

ranted. Importance of stress factors were estimated via (multiple) linear regressions after checking the test prerequisites. Odds ratio of seeking help was estimated by binary logistic regression. Our anonymized data set and codebook are available for download via the open science framework (OSF) website at: <https://doi.org/10.17605/OSF.IO/EHM67> [42]

Results

Stress Factors

Participants reported that they were most affected by protective measures to avoid spreading of the virus as these impede both patient contact and work processes in general. The pandemic also led to various changes in work procedures. Table 3 provides an overview of the stress factors mentioned.

Mental Health

When analyzing the ISR scores, we first checked the internal consistency. The results were almost identical to previous findings with Cronbach's α ranging between $\alpha = 0.78$ and $\alpha = 0.9$ for the subscales and $\alpha = 0.94$ for the total scale.

The observed severity of clinical symptoms was high on all scales (see Table 6 and Figure 1). In particular, the frequency of depression and anxiety symptoms was

unexpectedly high, with 9 % reporting severe depression symptoms and another 65 % light to medium symptoms. A total of 41 % reported at least light symptoms of anxiety while in reference group R_{C-P-} , assessed before the pandemic, only 21 % displayed these levels of symptoms.

For all symptom scales, healthcare professionals scored significantly higher than the reference group R_{C-P-} before the pandemic ($df \geq 331.53$, $t \geq 5.36$, $p < .001$), but also lower than the clinical group R_{C+P-} ($df \geq 314.92$, $t \leq -9.08$, $p < .001$). However, the increase cannot be explained by the lockdown measures alone. Healthcare professionals also showed significantly more symptoms than the general population reference group during the pandemic (R_{C-P+}) on both the depression scale ($\Delta M = 0.5$, 95% CI [0.39, 0.61], $t(2072) = 8.88$, $p < .001$) and on the anxiety scale ($\Delta M = 0.35$, 95% CI [0.23, 0.47], $t(383) = 5.83$, $p < .001$). Most notably, the rate of severe symptoms was significantly higher on both the depression scale ($\chi^2 = 1022.99$, $df = 1$, $p < .001$) and the anxiety scale ($\chi^2 = 1024.29$, $df = 1$, $p < .001$).

Which stress factors contributed to anxiety and depression? A multiple regression of the ISR depression score on the eight stress factors ($R^2 = 0.211$, $F(8, 284) = 9.47$, $p < .001$) revealed that *job insecurity* was the single most important predictor of depression symptoms (see Table 4). While on average, participants felt that job insecurity hardly affected them ($M = 1.15$, $SD = 1.24$ on scale from 0 to 4), high levels of job insecurity were strongly associated with psychological symptoms. *Anxiety about infection of family members* and *protective measures that hinder work processes* were also good predictors of the level of depression symptoms. A second regression of the ISR anxiety score ($R^2 = 0.16$, $F(8, 284) = 6.75$, $p < .001$) showed a similar picture. Again, *job insecurity* and *infection of family members* were associated with anxiety symptoms. An *increasing number of serious illnesses and deaths* also contributed to anxiety (see Table 5).

Professionals with direct contact to patients ($M = 0.86$) did not report more severe symptoms than those in administration (as categorized based on profession, $M = 1.03$, $t(50.1) = 1.36$, $p = .91$, $1 - \beta(d = 0.5) = 0.91$). However, as people with pre-existing medical conditions are at higher risk, those with a condition were significantly more worried ($M_{yes} = 1.13$, $M_{no} = 0.75$, $t(253.5) = 3.36$, $p < .001$) and reported more severe symptoms overall ($M_{yes} = 1.04$, $M_{no} = 0.76$, $t(260.2) = 3.88$, $p < .001$).

Help Seeking

Overall, the majority of participants described themselves as experiencing symptoms of depression and anxiety. Meanwhile, when asked whether they would like to receive psychological support to deal with the crisis,

Figure 1

Comparison of the relative frequency of severity levels for the ISR scales. Error bars indicate 95% confidence interval of the respective proportion.

Table 3

How strongly are you affected by the following aspect during the COVID-19 pandemic at your work place? (0=not at all;4=extremely)

stress factor	N	M	SD
protective measures hinder patient contact	285	2.76	1.03
protective measures hinder work processes	297	2.58	1.00
changes in work procedures	298	2.57	1.04
need for childcare in own household ^a	91	2.36	1.51
anxiety about infection of family members	290	2.30	1.25
limited contact to colleagues	287	2.18	1.13
anxiety about self-infection	285	1.78	1.18
increasing number of serious illnesses and deaths	243	1.29	1.18
job insecurity	234	1.16	1.25

N=total, M=mean, SD=std. deviation

^athis item was presented conditional on response to previous question about having children; number of children not assessed.

Table 4

Multiple regression of ISR depression score on stress factors

Predictor	<i>b</i>	95% CI	<i>t</i> (284)	<i>p</i>
Intercept	0.45	[0.12, 0.78]	2.67	.008
changes in work procedures	0.03	[-0.07, 0.13]	0.61	.542
protective measures hinder work processes	0.12	[0.01, 0.23]	2.23	.026*
protective measures hinder patient contact	0.07	[-0.02, 0.16]	1.56	.119
limited contact to colleagues	-0.01	[-0.10, 0.07]	-0.31	.759
anxiety about self-infection	0.04	[-0.06, 0.13]	0.73	.465
anxiety about infection of family members	0.15	[0.05, 0.24]	3.03	.003**
job insecurity	0.16	[0.07, 0.24]	3.73	< .001***
increasing number of serious illnesses and deaths	0.03	[-0.05, 0.11]	0.67	.506

Note. *b* = unstandardized regression coefficient; CI = confidence interval; **p* < .05, ***p* < .01, ****p* < .001, $R^2 = 0.211$, adjusted $R^2 = 0.188$, $F(8, 284) = 9.47$, $p < .001$

most participants declined (see Table 7). Out of the 300 participants, 209 (70 %), scored 0.5 or higher on the ISR total scale which is considered *suspected* clinical diagnosis or more severe. However, only 84 (40 %) of these said that they would consider seeking psychological help. A binary logistic regression revealed that the higher the ISR score the more likely participants were to seek help ($b = 1.61$, $OR = 5.01$, $z = 6.54$, $p < .001$).

Why are those who supposedly need help not seeking help? 100 (48 %) of the 209 participants who are supposedly in need claimed that others would need the support more urgently. 70 (33 %) were not aware of suitable support services or offers. 66 (32 %) felt that they were not distressed enough to require support. And 52

(25 %) claimed that they did not have time for seeking help. The majority—with 82 % of all participants and 79 % of those who supposedly need help—indicated to have sufficient social support outside the work place.

Discussion

Consistent with reports from other countries and with our expectations, healthcare professionals in Germany report high levels of depression and anxiety during the pandemic. Severe levels of depression symptoms were reported by 9.3 % and severe symptoms of anxiety by 5 % of participants. These values were consistently above those reported by a general population sample during the pandemic and below a clinical sample prior to the

Table 5*Multiple regression of ISR anxiety score on stress factors*

Predictor	<i>b</i>	95% CI	<i>t</i> (284)	<i>p</i>
Intercept	0.19	[-0.18, 0.55]	1.00	.316
changes in work procedures	-0.01	[-0.12, 0.10]	-0.17	.868
protective measures hinder work processes	0.03	[-0.09, 0.15]	0.45	.653
protective measures hinder patient contact	-0.01	[-0.11, 0.09]	-0.11	.910
limited contact to colleagues	0.03	[-0.07, 0.12]	0.60	.546
anxiety about self-infection	-0.02	[-0.12, 0.09]	-0.32	.751
anxiety about infection of family members	0.19	[0.08, 0.30]	3.55	< .001***
job insecurity	0.13	[0.04, 0.23]	2.91	.004**
increasing number of serious illnesses and deaths	0.12	[0.03, 0.21]	2.51	.012*

Note. *b* = unstandardized regression coefficient; CI = confidence interval; * $p < .05$, ** $p < .01$, *** $p < .001$, $R^2 = 0.16$, adjusted $R^2 = 0.136$, $F(8, 284) = 6.75$, $p < .001$

Table 6*Severity of symptoms in ISR in comparison to the three reference groups.*

scale	group	none	suspected	light	medium	severe
anxiety	healthcare professionals	52.3%	6.3%	24.7%	11.7%	5%
	C+P-	5.4%	2.5%	20.2%	32.1%	39.8%
	C-P+	70.7%	5.9%	12.8%	7.4%	3.2%
	C-P-	71.8%	7.2%	16.1%	4.2%	0.7%
depression	healthcare professionals	18%	7.3%	40%	25.3%	9.3%
	C+P-	6.5%	3.3%	24.2%	35.5%	30.5%
	C-P+	42.3%	10%	29.1%	13.7%	4.8%
	C-P-	68.1%	8.9%	17.1%	4.8%	1.1%
compulsion	healthcare professionals	56.7%	9%	22%	9%	3.3%
	C+P-	8.8%	2.6%	18.4%	32.9%	37.3%
	C-P+	67.4%	7.9%	13.8%	6.9%	4%
	C-P-	75.9%	8%	12.8%	4.2%	0.7%
somatoform	healthcare professionals	42.3%	30.3%	9%	15.3%	3%
	C+P-	22.7%	10.4%	38%	17.3%	11.6%
	C-P+	69.4%	18.9%	4.6%	5.1%	2%
	C-P-	62.3%	12.1%	22%	3.2%	0.4%
eating disorder	healthcare professionals	30%	12%	31%	20.3%	6.7%
	C+P-	16.9%	7%	24.1%	27%	25%
	C-P+	43.1%	11.8%	25.1%	13.6%	6.3%
	C-P-	52.8%	12%	22.6%	11.2%	1.4%
ISR total	healthcare professionals	30.3%	9%	20%	29.3%	11.3%
	C+P-	12.1%	4.2%	15%	41.5%	27.2%
	C-P+	58.7%	6.1%	14.4%	15.7%	5%
	C-P-	68%	6.8%	11.5%	10.2%	3.5%

Table 7

Frequency of responses to ‘Would you like to receive psychological support to deal with the crisis?’ categorized by supposed need for support based on ISR scale.

Would you seek psychological help?	in need		total
	no	yes	
No, I am fine.	53	35	88
No, I get sufficient support.	25	54	79
No, I prefer to deal with it on my own.	6	36	42
I will consider it.	7	60	67
Yes, but not psychotherapy.	0	14	14
Yes, psychotherapy.	0	10	10
All	91	209	300

‘no’ means $ISR < 0.5$; ‘yes’ means $ISR \geq 0.5$

pandemic; yet reported help-seeking intentions were low.

The reported severity of symptoms is in line with previous studies on the mental health effects of the COVID-19 pandemic on medical staff from other countries [e.g., 7, 6], which, according to a review, place the prevalence of severe symptoms between 2.2% and 14.5% [8]. German healthcare workers’ level of strain is even more elevated than that of the general population during the pandemic assessed a few weeks before our sample. This is particularly concerning. As the pandemic reached its first peak across the globe, even countries which had been under-funding and neglecting their healthcare systems were forcibly made aware of the crucial importance of healthcare workers. Politicians and members of the general public expressed their appreciation for *system-relevant* or *essential* workers—medical frontline staff representing a key group among them. In light of this, it seems crucial to take measures to reduce psychological strain on these workers—particularly because both the pandemic and the consequences of the psychological distress caused by it are expected to persist for the foreseeable future. Depression and fatigue are correlated with perceived medical errors. In a study with medicine trainees, the odds ratio associated with a positive depression screen was $OR = 2.22$, i.e., those screened positively were much more likely to report an error [43].

However, in spite of the severity of reported psychological strain, reported help-seeking behaviour and help-seeking intentions were consistently low. Many healthcare professionals are not seeking help, citing either concern for the distribution of resources (i.e., based on the assumption that a limited amount of psychological support is available, they stated that others needed it more than they did, they themselves were not distressed enough to require support, and/or they already had a

sufficient support network) or accessibility issues (not having time to seek help, not being aware of a service that meets their needs).

This points to two underlying issues: Firstly, while several employers, public agencies and private non-profit organizations hurried to create mental health services to support healthcare staff during the pandemic, e.g., telephone hotlines like *Talk2Us* [29] and free-of-charge psychotherapy provided to nursing staff by the German professional association for nursing staff [44], it seems that these were overall not accessible enough or did not meet healthcare staff’s perceived needs. One issue was, most likely, awareness; since most of these support services were set up at the beginning of the pandemic and had, therefore, only been active for a few months at the time we conducted our survey, they were not well-known and established among healthcare workers yet. This would explain why about one third of our sample claimed not to be aware of a suitable service. Just over a quarter of participants stated they did not have time to seek help, which might indicate that current service offers do not fit with demand. Future research should investigate how support services should be designed to meet healthcare staff’s needs, e.g., by being flexible to suit the staff’s schedules, being less time-consuming than current services are perceived to be and being more easily accessible.

Secondly, the large portions of our sample claiming that they were not in need of support in spite of the severely elevated levels of mental strain, that they already had sufficient support and that others needed it more urgently seem to be indicative of a climate that discourages help-seeking behaviour and speaking out about mental health issues in the healthcare community. A work culture pervaded by the general expectation to

prioritize patient care before personal well-being and to refrain from acts that could be interpreted as displaying weakness, such as admitting to being overwhelmed or seeking professional help [45], could be a crucial factor inhibiting help-seeking behaviour.

It is crucial that future research also investigates the work-climate and culture in the healthcare sector and the norms it sets around mental health; explorative qualitative studies seem warranted. While social norms of this kind are complex and slow to change, it is crucial they be identified and addressed, because if stigmatization of help-seeking behaviour truly is prevalent in the healthcare community, improving the accessibility of support services alone is bound to have very limited effects on the rates of healthcare workers seeking help. What our data, alongside various other studies, have done is establish that there is a need to provide mental health support to the healthcare community; the question that research must target next is why and when this need does and does not translate to a demand.

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