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Unseen Struggles–Nursing and Mental Health in Times of Covid-19

A discourse analysis of online media articles on health care workers[1]

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Abstract

This article examines how nursing and healthcare workers' mental health was represented in online media during the COVID-19 pandemic, focusing on Austria, Germany, and the United Kingdom. Drawing on Critical Discourse Analysis, the study analyses 61 newspaper articles published between April 2020 and April 2021 to explore how psychological burden, prevention, and support were publicly discussed. The findings reveal widespread reporting of extreme workload, staff shortages, inadequate protective equipment, and emotional distress, including moral injury, burnout, and trauma. However, media discourse largely individualized responsibility by emphasizing resilience, heroism, and self-optimization, while structural determinants such as gendered, racialised, and neoliberal labour conditions remained underexamined. Psychological support initiatives were unevenly distributed, privileging hospital and ICU (intensive care unit) staff and neglecting mobile carers, nursing home workers, and migrant care workers. Overall, the analysis shows that COVID-19 intensified pre-existing systemic inequities in healthcare work and exposed the limits of symbolic recognition, underscoring the need for sustained structural reform and comprehensive mental health support.

Keywords: *Mental Health, Covid-19, Moral injury, Nursing, Care work, Media discourse*

In November 2020, early into the COVID-19 pandemic, the Austrian newspaper *Der Standard* inquired about the recent situation in hospitals, looking beyond the issue of bed capacity (Arora, Hagen, John, Müller, 2020, online). A call for hospital staff to describe their current working reality yielded some worrying responses. Although those affected worked in different hospitals and wards, many of the reports by care workers who all wished to remain anonymous coincided. "We feel insecure and abandoned," wrote a nurse, for example, while a doctor stated, "The overload is massive. We have our backs against the wall" (Ibid.).

In the face of the COVID-19 pandemic, healthcare systems worldwide were stretched to their limits, with hospitals facing unprecedented challenges in managing the surge of patients. While the availability of intensive care beds often dominated in public discourse, the strain on healthcare personnel, the backbone of any functioning healthcare system, reached a critical point.

This article delves into the often unseen struggles of nurses and health care workers during this crisis, shedding light on the systemic issues that exacerbated their burden. Drawing on online media articles, this paper examines the multifaceted challenges confronted by healthcare workers, including severe staffing shortages, inadequate protective equipment, systemic coordination failures, and the overwhelming emotional toll of working under such intense pressure. The discourse analysis of 61 articles published in Austrian, German and UK-newspapers online revealed a concerning reality. Staff members reported feeling insecure, abandoned, and stretched to their breaking point.

This article and its findings shall serve as a call to action, emphasizing the urgent need to address these critical issues to safeguard the well-being of healthcare professionals and ensure the continued provision of quality care. This is particularly significant considering that the identified shortages and failures were not merely a temporary consequence of the pandemic, but rather reflected chronic and systemic issues. Thus, the COVID-19 crisis has served to magnify pre-existing problems within the system, issues that may not be resolved easily and quickly. But this underlines the need for medium-term and long-term efforts and solutions.

Problem Statement and Research Question

Discussing and analysing the dire situation in healthcare contexts during the COVID-19 pandemic holds significant relevance for both society and the scientific community. For society, these findings expose the stark realities of healthcare delivery under immense pressure, highlighting critical shortcomings in resource allocation, staffing, and systemic preparedness. This awareness is crucial for fostering informed public discourse on healthcare system reform, demanding accountability from policymakers, and inspiring societal support for all healthcare workers who suffer from burnout and moral distress. This becomes even more important, since many of the identified problems and issues have a chronic and systemic aspect. Furthermore, understanding the challenges faced by healthcare professionals during the pandemic strengthens public solidarity and encourages

1 *An abstract of this article was published earlier in: Hintermayr, 2020, 20-21.*

collective action to improve working conditions and ensure quality care for all.

From a scientific perspective, this analysis of the public discourse on health care workers provides valuable qualitative data for health services research, enabling a deeper understanding of the pandemic's impact on healthcare systems and personnel. Within this study, the term "health care workers" includes (ICU) nurses, mobile carers, nurses for the elderly and the disabled, and live-in care workers. The media representation of them in form of newspaper articles can inform the development of strategies for improving pandemic preparedness, optimizing resource allocation, and supporting the mental health and well-being of healthcare workers. Moreover, interviews with care workers that were published in online newspapers—rather than conducted by the author—provide rich material for social science research. By analyzing these media-published accounts, it is possible to explore the psychological and sociological dimensions of working in crisis situations, while also gaining valuable insights for political science research on the effectiveness of healthcare policies and emergency response mechanisms.

This article addresses the following questions: What resources were mobilised to keep health care workers[2] healthy? How was their psychological burden considered in the public debate? The aim of this study is not to compare individual experiences of health care workers, but to dismantle the gendered and racist depreciation of their work(places). Which contributes into making their jobs mentally challenging and obviously only limitedly worth of prevention and support. By workplaces I do not refer only to hospital contexts, but also to care homes for the elderly and disabled, and of course private homes. The geographical focus of this study was put on Austria, Germany, and the United Kingdom (UK). This was due to the different level of pre-pandemic cost cutting in public health care and the varying spread of Covid-19 infections. De facto, the UK represented one of the worst hit countries by the virus. While Austria and Germany initially benefitted from a moderate impact and better-appointed welfare systems.

State of Research

Nursing jobs are mostly covered by women and are considered typically female. Among them we find large numbers of People of Colour or with a migration background. It's this intersection which makes them particularly prone to being overlooked. Unsurprisingly, it also shapes the poor prevention of work-related mental distress. Against this we find a workplace that has changed radically in the neoliberal era, but never lost its gendered and racialised hierarchy. Neoliberal restructuring, race, ethnicity, and immigration status even served to deepen the inequities in this diverse and demanding workplace (Hallgrimsdóttir et al., 2011, 281).

In a Europe-wide study from 2005, nurses hinted the lowest levels of satisfaction for 'psychological support at work'[3] and for 'satisfaction with physical working conditions' (Hasselhorn et al., 2005, 36).[4] The corona crisis has exacerbated existing deficits in health care. There had already been a general shortage of staff as well as a lot of pressure regarding deadlines and time. Long and in some cases even non-regulated[5] working hours have always been challenging. Equally draining have been high personal responsibility against poor renumeration. The latter has been described as the wage penalty for care work (England, 2005, 381-399).[6] Since the outbreak of the Covid-19 pandemic, the nursing staff have reported emotional and psychological strain (Re: Die spanische Tragödie, 2020). The carers had to deal with an overwhelming workload, inadequate protective equipment, and a feeling of being left alone. This had especially been true in countries like the United Kingdom, where public health care had vigorously been cut down over the past few decades (Deeming, 2019, 2077-2099).[7]

As soon as in 2005 a Canadian study reported that one in six nurses struggled with their mental health and 10% met the diagnostic criteria for clinical depression (Shields et al. 2006, online). Another study found high rates of post-traumatic stress disorder (PTSD) and burnout among Slovenian nurses (Kvas et al., 2014, online). This led Havaei et al. (online) to state in 2021: 'The mental health status of the nursing workforce has been a chronic concern predating COVID-19'. Most noteworthy, health care has experienced unprecedented professionalisation and economisation, but also precarisation in the last two decades (Power, Skinner, 2019, 134-148). Additionally, downloading and familialisation took place (Hallgrimsdóttir et al., 2011, 269-293). Thien and Dolan (2011, 27-28) explain the underlying process: 'This often means a relocation of caregiving from institutional settings to the domestic sphere, 'blurring the boundaries' between public institutional spaces and domestic spaces, relying more heavily on an existing network of informal caring and support, and transferring or downloading intimate care work onto individuals and families.'

To give a concrete example: When a patient is discharged from hospital and they need help with grocery shopping,

2 *Within this study the term health care workers includes: (ICU) nurses, mobile carers, nurses for the elderly and the disabled, and live-in care workers.*

3 *German original: ‚psychologische Unterstützung am Arbeitsplatz'*

4 *German original: ‚Zufriedenheit mit den körperlichen Arbeitsbedingungen'*

5 *This applies to the Austrian business model of the independent care contractor, who de facto live with their clients and nurse them up to 24 hours a day.*

6 *Unsurprisingly, this paradox is driven by gendered, racialised, and nationalist assumptions. Those who choose to earn a living from nursing are imputed to do so out of altruistic motivation, natural aptitude and little training time. Apart from that, they would prefer the emotional reward of caring work over reasonable wages. Thus, not only fair renumeration got downplayed, but also that this workplace is highly skilled and demanding.*

7 *Costs were scaled down through the following measures: low-skilled and support staff was saved plus investments in premises and equipment were delayed or suspended (Kaplan, Haas, 2014, online). Furthermore, procurement costs were tweaked and patient throughput was increased. Last, but not least, clinical practices underwent benchmarking and standardising.*

personal hygiene, or a change of bandages, somebody needs to step in. Since the family is considered the 'natural workplace' of a woman, it's quite often them. Both developments emerged from neoliberal policy contexts seeking cost control or reduction in welfare. Lower levels of the occupational hierarchy were most severely hit by this transformation (Ibid.). They not only had to take on more responsibilities. Disturbingly, their new scope of duties was devalued and deskilled (Ibid.).

In Austria this is exemplified by the introduction of the so-called independent care contractor ('Personenbetreuer') in 2015, who requires no professional training (Wirtschaftskammer Österreich, 2016, 4-6). Although drugs and bandages must only be administered respectively changed after a written doctor's order with briefing and instructions (Ibid., 8-12). This disregard was deliberately acknowledged by the prominent economist Martin Kocher[8] (2018, online): 'One of our basic findings is that the value [of labour, MMH] is assessed by society. Obviously, the value of nursing work is considered to be low, because it hardly requires any specific skills and there is too much supply on the labour market.'[9] Three years later he went on to become Federal Minister for Labour of the Republic of Austria.

Sampling and Methodology

Methodologically this study draws on Critical Discourse Analysis (CDA) as suggested by Norman Fairclough (1992). CDA strives to deconstruct power relations and how social meaning and order are constituted. To do so, it explores the time-specific ensemble of knowledge and the discursive and social practices (re-)produced by it. CDA draws on a dialectical discourse model. This means that discursive and social practice mutually constitute and advance one another.[10] In order to infer from the text to the social, Fairclough uses a three-level model that centers the discursive event. The event is analysed in terms of (1) text[11], (2) discursive practice (production, distribution, reception)[12] and (3) social practice (reproduction of the social order)[13]. Quintessentially, discursive practice is understood as social practice that constantly produces knowledge that, through its coupling to powerful institutions, is able to organise and shape the community.

To analyse how online media outlets discussed nursing and mental health in the context of COVID-19, a structured search strategy was employed using internal search tools. The objective was to retrieve relevant articles covering key topics related to nursing professionals and the psychological impact of the pandemic. Criteria for online newspaper selection included: editorial policy and world view, availability of a comprehensive internal search tool, wide coverage of healthcare-related news, and relevance in public discourse. The concrete sample covered the left-leaning *Der Standard* and the liberal-conservative *Kurier* in Austria. In Germany the *Süddeutsche Zeitung* (progressive-liberal and centre-left) and the *Bild* tabloid (conservative and populist tone) were included. Regarding the UK, the analysis corpus consisted of the *Guardian* (center-left) and the right-wing *Daily Mail* tabloid. To capture a wide range of articles, a combination of keywords and their variations were used: regarding the occupational focus these were 'nurse', 'carer', 'care worker', 'nursing', 'hospital', in the pandemic context these were 'Covid', 'Covid-19', 'corona', and 'pandemic', as to mental health aspects these were 'mental health', 'anxiety', 'PTSD', 'moral injury' plus derivative terms like 'post-traumatic stress', 'psychological distress', 'burnout', and 'emotional exhaustion'. Boolean operators were applied where supported by the search tool. This helped to expand the search and refine the results. Available filters were used to limit results by date range (chosen period: April 2020–April 2021), article type, and geographical focus. The initial searches retrieved a high volume of results, requiring filtering by relevance. Duplicates and unrelated articles were excluded through manual review. Attention was given to headlines, summaries, and full-text analysis where accessible. Articles were categorized based on themes such as the portrayal of nurses' roles during COVID-19, psychological challenges faced by healthcare workers, public and institutional responses to mental health concerns, policy discussions related to burnout and recovery. Following the CDA's principles of intertextuality and interdiscursivity, texts from governmental and non-governmental organisations

8 Martin Kocher was admitted as a professor of Behavioral Economics at the University of Vienna in 2017. From 2016 to 2021 he served as scientific director to the Austrian Institute for Advanced Studies (IHS).

9 German original: „Eine unserer Grunderkenntnisse ist, dass der Wert (von Arbeit, MMH) durch die Gesellschaft bemessen wird. Offensichtlich wird der Wert von Pflege gering bemessen, weil sie kaum spezifische Fähigkeiten erfordert, und es zu viel Angebot am Arbeitsmarkt gibt."

10 Fairclough explains in more detail: 'A dialectical perspective is also a necessary corrective to an overemphasis on the determination of discourse by structures, discursive structures (codes, convention and norms) as well as non-discursive structures. From this point of view, the capacity of the word 'discourse' to refer to the structures of convention which underlie actual discursive events as well as the events themselves is a felicitous ambiguity, even if fromother points of view it can be confusing. Structuralism …come to treat discursive practice and the discursive event as a mere instantiations of discursive structures, which are themselves represented as unitary and fixed. It sees discursive practice in terms of a model of mechanistic (and therefore pessimistic) causality. The dialectical perspective sees practice and the event as contradictory and in struggle, with a complex and variable relationship to structures which themselves manifest only a temporary, partial and contradictory fixity.' (Ibid., 66).

11 This covers analysis of linguistic features of the text, including vocabulary (e.g., word choice, metaphors, connotations), grammar (e.g., passive vs. active voice, sentence structure), cohesion and coherence (e.g., logical flow, pronoun use). In a next step key themes and representations are identified. Finally, an examination of how meaning is constructed through language is carried out.

12 This includes an analysis of how the text is produced, distributed, and consumed. Further, intertextuality and interdiscursivity (how the text relates to other texts and how different discourses are exploited and integrated) are explored. Also, consideration is given to how the discourse is shaped by institutional or media practices. The last step aims at identification of who controls the production and circulation of the discourse.

13 This step seeks to connect the discourse to broader social and ideological structures. What follows is the identification of how the discourse reinforces or challenges power relations. Further, the role of the discourse in social change or stability is examined. Last, but not least historical and cultural contexts that influence the discourse are considered.

mentioned in the online articles were included into the corpus.[14] The final sample covered 61 texts, which were chosen by the principle of argumentative satiation. This means, when a newspaper or organisation failed to produce any new aspect of a main discourse strand, the sampling process was halted. Via macro analysis the major discourse strands were identified. Accordingly, via micro analysis majority, but also minority arguments within a specific strand were discovered. Eventually, the discourse was analysed as to: What has (not) been said and with which words?

Findings

Moral and Mental Injuries

Distress and stressful situations have been reported from all three nations. Covid-19 stations and health care workers were particularly affected. This probably had to do with the fact that carers spent a lot of time with the patients and their relatives (Kramer et al., 2020, online). In such contexts, they were at risk to develop a so-called moral injury or, in the worst case, an anxiety, major depressive or PTS disorder (Greenberg et al., 2020, online). By moral injury is meant that a person's moral compass is damaged or lost. This can happen when they are exposed to massive and impersonal deaths without being able to do anything about it. Triage situations, scarce resources, and whopping pressures surely provided an ideal breeding ground for such an injury. The term itself was coined in the military and reflects soldiers' experiences of injustice (Litz et al. 2009). By medical standards moral injury is not considered a diagnosable mental illness. Although common symptoms like poor self-perception or deep self-disgust can feed into the development of such an illness. This points to underlying guilt and trauma. Because they wanted to help more, but couldn't do so (Greenberg et al., 2020, online).
Moral injuries are best prevented by constant support through a critical event, but also before and after it. Among others, so-called Schwartz rounds[15] provide a suitable tool (Ibid.). These structured forums aim at both, clinical and non-clinical staff, and should be held on a regular basis (Lown, 2010; Manning, 2010, 1073-81). Participants are not meant to discuss current clinical problems or bureaucratic concerns. They are rather encouraged to share and reflect their feelings and experiences from the work day. Rounds benefit compassion and mutual understanding plus reduce stress and isolation. Another positive outcome may be flattened job hierarchies and better camaraderie.
In 2021, a UK study looked into the mental health of 709 frontline intensive care unit workers and reported an alarming status (Greenberg et al., 2021, online). Altogether, nearly half suffered from clinically relevant symptoms. 6 % showed signs of major depression, 40 % suffered from posttraumatic stress and another 11 % from severe anxiety. Additionally, 7 % abused substances and 13 % experienced suicide thoughts. Significantly, nurses reported worse mental health than doctors. Regardless whether there was support or not, many carers felt obliged to do a good job, endure infections from colleagues and keep the patients happy. But for many the day was not over yet. Everyday life at home had to go on, children had to be home-schooled and comforted, contact with friends and family had to be kept, etc. These duties placed a particular burden on single mothers with a migration background and a tight household income. And even if a babysitter or a tutor would have been financially feasible, physical distancing guidelines mostly blocked such relief.

Order of Prevention and Support

Despite high drop- and burn-out rates in health care, there is little systematic prevention or support.[16] The situation has worsened with the onset of Covid-19. Studies on the Sars pandemic (2002 to 2004) and the Ebola crisis (2014) examined the distress of the nursing staff. They found to be most wearing: the high-risk environment itself, poor organisational support, and role-related stress factors (Brooks et al., 2019a, 248-257). The latter included: overwork, lack of staff, high responsibility, and bureaucratic burden. Stress, anxiety, insomnia and signs of depression were frequently observed (Stuijfzand et al., 2020, online). Most of these factors also applied to the Covid-19 pandemic; plus a (culture) racist dimension in the industrialised countries. In 2020, six out of ten Covid fatalities in UK health care had a BAME (Black, Asian or Minority Ethnic) background (Marsh, McIntyre, 2020, online). In addition, the mortality of the nursing staff was higher than that of the doctors. Nevertheless, these aspects only played a limited role in the public debate. This was also true for the improvement of working conditions or psychological support
At the beginning of the Covid-crisis, gestures of appreciation for key workers were suggested. Especially in Austria and Germany bonuses turned out to be popular with the governments and the public. Indeed, most health

14 These were: Governments of Austria, Germany, and UK, Deutscher Berufsverband für Pflegeberufe DBfK, Deutsche Krankenhaus Gesellschaft, British NHS Practitioner Health Service, PSU Helpline, Frontline19 and Our Frontline Support Services, Nursing Times, Taskforce Pflege – Gesundheit Österreich, and Vienna Hospital Association.

15 Format: 'Rounds normally take place once a month for an hour at a time with catering provided before the Round. Once the Round starts, a panel, comprised of three staff, share their experiences for the first 15-20 minutes. On each panel, there should ideally be a mix of clinical and non-clinical staff with different levels of seniority. A Round can either be based on different accounts of a case, or can explore a particular theme such as 'when things go wrong' or 'a patient I'll never forget'. Experiences are shared from the perspective of the panel member – not the patient – and the emphasis is on the emotional impact. The remainder of the hour features trained facilitators leading an open discussion. They do this by asking participants to share their thoughts and reflections on the stories. The key skill is for the facilitators to steer the discussion in such a way that it remains reflective and does not become a space to solve problems. The facilitators will remind participants that Rounds are a confidential space, in which patient and staff identities are protected.' (The Point of Care Foundation, online).

16 A German study found that elderly care workers had in 2016 to 2018 more sick days than other occupational groups, also because of mental illness (Rothgang et al., 2020, online).

care workers received a single payment of several hundreds of Euro (Republik Österreich Parlament, 2021, online; Deutsche Krankenhaus Gesellschaft, 2020, online). Nevertheless, the *Süddeutsche Zeitung* warned that chronic underpay will persist (Hagelüken, 2020, online). Thus, the so-called Corona heroes, among them many single mothers, eventually will go away empty-handed. As of March 2021 British National Health Service (NHS) nurses even threatened to go on strike to support their claim for a 15 % pay rise. The UK government instead offered a 1 per cent increase. While the left *Guardian* was very supportive of the nurses' demand, the *Daily Mail* tabloid wasn't (Robinson, Boyd, Tapsfield, 2021, online). It only showed some sympathy when it found out that a majority of the British public would support a strike and a 7 % rise.

Pre-pandemic some intensive care unit (ICU) staff in Austria had access to psychological support, varying from hospital to hospital respectively competent organisation. For example, in Vienna temporarily limited supervision had been introduced in 2003 (Martinek, 2014, online). In April 2021 this service was adapted respectively amplified. A telephone helpline for the Vienna Hospital Association's and the General Hospital's employees was launched (Lechner, 2021, online). Simultaneously the Lower Austrian State Health Agency introduced another helpline. It served all nursing professionals, but was regionally limited.

Apart from that, carers outside hospital contexts have mostly been neglected. Federal States in Austria rather decided to support another clientele, namely the receivers of home health care (Leiblfinger et al., 2021). Thus, existing websites and service lines were hastily updated. Indeed, many Austrian families were stressed by closed borders and travel restrictions and thus feared that their loved ones wouldn't be nursed any longer. Noteworthy, this job segment is mostly covered by female migrant workers from Romania, Slovakia, Hungary, and other Eastern European states. Their employment mainly follows the earlier described independent care contractor model ('Personenbetreuer') with a 2 or 4-week rota (Leiblfinger et al., 2021). When the pandemic broke out, some of these live-in carers had to stay on duty for three months ensuite. And with no support system to turn to, since their agencies merely act as brokers (Leiblfinger et al., 2021).

Turning to Germany, a psychological helpdesk for all nurses and professional carers was introduced in May 2020 (Deutscher Berufsverband für Pflegeberufe DBfK, 2020, online). In Bavaria a psychological helpline for 'particular stressful situations and serious events' in health care had already been introduced in 2013 (PSU Helpline, 2013, online). Figures from the British NHS Practitioner Health Service demonstrate that such offers were well received. Doctors and nursing staff could turn there for psychological support. The number of inquiries has doubled since the beginning of the Covid crisis (Gerada, 2020, online). Additionally, Frontline19 (2020, online) and Our Frontline (2020, online) were launched. Both services delivered support to frontline health, care, emergency, education and key workers. While the first matched its clients with professional counsellors, psychologists and psychotherapists, the latter was run by trained volunteers. This was reflective of the shortage of psychological staff, but also of recent downloading and voluntarisation in health care. The NHS Nightingale Coronavirus Field Hospital in London went even further. A debriefing was held with all employees who came out of the hot zone. They were also offered immediate and later psychological or spiritual counseling (Bohmer et al., 2020, online).

Whether single debriefing is beneficial or even harmful presents a controversial research issue (Brooks et al., 2019b, 25-34). Interestingly enough, a British online survey found that nearly 50 per cent would prefer informal peer support from their colleagues ('Are You OK? Survey on nurse mental health during and after Covid-19, 2020, online).[17] Almost 36 per cent selected individual face-to-face support with a mental health professional. And 24 per cent favoured telephone support via a dedicated helpline.

Taking all these measures into consideration, another hierarchy became obvious. Intensive care unit and frontline staff had better prospects for psychological support, but also working time restrictions and protective gear. They were followed by nursing professionals in hospital contexts. At the end of the scale were mobile carers, nurses for the elderly and the disabled, live-in care workers and nursing relatives. For those safety and prevention was either not planned or harder to access. An Austrian nurse interviewed by the *Kurier* newspaper indirectly acknowledged some of these hierarchical shortcomings: 'I believe that the area of home care and nursing homes in particular was and is not well positioned when it comes to protective clothing. That is not ideal and may has been underestimated. We must certainly learn from this.'[18] Mobile nurses and live-in carers had to suffer from another ugliness (Kuhn, 2020, online). Obviously, some of them were victimised as virus spreads and lepers by the public.

Heroes (sic!) of the Pandemic

The lack of psychological support can't be offset with being applauded or stylised as a heroine. Actually, such labels are pretty problematic, because they shift the focus. It's simply a heroine's job to do great things and wait in the wings. Or even move in with her disabled clients. A group of carers in Wuppertal did exactly this to protect their vulnerable clients. They were widely praised by the German *Bild* tabloid (Heller, 2020, online). Such images didn't leave room to call for reforms or better working conditions. In addition, they created a hurdle to point out one's own distress.

17 *The survey allowed for multiple replies per item.*

18 *German original: ‚Ich glaube, dass speziell der Bereich der Hauskrankenpflege und der Pflegeheime, Schutzbekleidung betreffend, nicht gut aufgestellt war und ist. Das ist nicht ideal und wurde vielleicht unterschätzt. Daraus müssen wir sicher lernen.'*

The *Daily Mail* also put a nurse on a pedestal (Waters, 2020, online). Hayley McLellan, a mum of four, was described 'not only a fixer: Hayley has also walked dogs, cleaned houses and cooked meals for patients too unwell to do these things for themselves. She's even given up her own time to help patients move home — literally packing and shifting the boxes' (Ibid.). She yet overcame her own crippling anxiety: 'Luckily it passed, and I learnt how to deal with my anxiety by taking long walks every morning before work.'(Ibid.). No further word helped to clarify, if she had support from her workplace, peers, therapists, or recovered, as suggested, on her own. Or ever claimed support for herself or her list of chores at home.

Noteworthy, many in health care are ashamed of needing help themselves. A British mental health survey in April 2020 found that 34 % of the nurses have needed support but felt not able to ask (Nursing Times, 2020). This is reflected by the persisting stigma regarding depression. A survey by the Stiftung Deutsche Depressionshilfe in 2019 (p. 9) reports that for 31 % of the German people Major Depressive Disorder (MDD) signifies weakness of character. Further 59 % think that MDD results from a wrong conduct of life (Stiftung Deutsche Depressionshilfe, 2019, 9). And 21 % consider pulling onseself together a proper remedy to treat MDD (Stiftung Deutsche Depressionshilfe, 2019, 13).

When mental health in the workplace was discussed, the debate was very selective. It circled around productivity loss and damage for a unique business, a whole branch or economy. The individual impact of such an illness appeared to be secondary (Rappold et al., 2021). Plus, what it implied for the work team, family and friends. Who would take care of the sick person and with which resources? Or in the worst case, wouldn't be tended to at all. Obviously, societies preferred to privatise mental illness. Thus, the necessary expenses for recovery were labelled and treated personal affairs. This put many into a strenuous financial situation, since psychotherapy had to be covered privately more often than not. Which was even more difficult, when the affected person had experienced a drop in salary or job loss due to your illness. Besides, many mental health professionals were never trained to cater to different racial or cultural backgrounds.

While the British *Guardian* emphasised the importance of psychological support for health care workers, its counterpart, the *Daily Mail*, wasn't overly committed to the case. At least the tabloid reported the findings of the above cited *Nursing Times* study 'Are you okay?' Otherwise, it shared a video of crying US health care workers who quitted their jobs over severe strain and deep frustration (A trauma nurse explains what it's like in the hospitals, online).

Nurses' mental health didn't play a significant role in the public debate in Austria and Germany. An Austrian ICU nurse suggested in an interview that her hospital was well prepared and efficient structures were created. He concluded: 'We have a good situation here in Austria' (Kuhn, 2020, online). Arguments and positions didn't differ too much in the four German-speaking newspapers. Mostly, the outlets preferred to refer to the dramatic situation in the UK, Spain and Italy. A German nurse was cited by the *Süddeutsche Zeitung* that the pictures from these countries put a huge mental strain on them (Balbierer, 2020, online). He went on to complain that worries weren't taken seriously enough by their management. Which in turn was denied by a hospital official.

In/Visibilities

Even in November 2020 when Austria and Germany were severely hit by the second wave of Covid, psychological support didn't turn into a much relevant topic. At least the left-leaning *Der Standard* asked health care workers to share their concerns and worries (Arora, Hagen, John, Müller, 2020, online). Interestingly enough, all respondents wished to stay anonymous. Most reported staff shortages, overhours, and shifts for not ICU trained personnel. Also, an increasing sickness ratio was mentioned, because of burned out staff. Many nurses touched on missing or faulty protective equipment as strenuous, but also the tedious process of getting dressed respectively undressed. Carers also suffered from the directive to not stay more than fifteen minutes in a room with infected patients. Which in return produced patients' complaints about feeling neglected. Nurses were also stressed by lacking coordination and crisis management, but also unreliable or absent Covid tests.

Nevertheless, the newspaper report stopped here and didn't went further. Thus, neither mental health prevention nor psychological support were considered or suggested. But also, bad management and working conditions came across as somehow fateful. Related with this, high burn- and drop-out rates only seemed natural. And once again, the experiences of doctors and hospital staff were privileged. This is disturbing, since many residential care homes for the elderly were severely hit by the pandemic. The very same newspaper reported that more than 3,500 persons died from or with Covid-19 in those care homes (Scherndl; Schmidt, 2021, online). Which accounts for more than one half of all Covid fatalities in Austria in 2020.

As already hinted, the gendered, racialised and nationalist hierarchy in health care also played into news coverage. Generally, doctors were more or at least equally visible than nurses, the same ratio proofed to be true for male to female health care workers. Although, the latter always outnumbered the former. Least attention was paid to mobile carers, nurses for the elderly and the disabled, live-in care workers and nursing relatives. It's exactly this segment which employs the most migrant and *non-white* workers. While most media outlets covered the high Covid fatality rate among Black, Latino, Asian, and migrant key workers in the USA and Great Britain, they didn't look into a probably likewise vulnerability in Germany or Austria.

Self-optimisation vs. cooperation

Nurses were called upon to work on themselves and to become more resistant to stress. They were advised to pick up relaxation techniques or exercise routinely (Frontline19, 2020, online; Our Frontline 2020, online). Unsurprisingly, many looked for any straw and thus were grateful for digital sleep-improvement programs or digital therapy apps (Body, Beckford, Groves, Stevens, 2021, online). In an interview a nurse from Austria argued that intensive care workers need to be handpicked (Kuhn, 2020, online). They shall have strength of character, be decisive and responsible. Additionally, ICU nurses need to tolerate distress and groom good mental hygiene. This means that the carer was once again held responsible and that the structural factor was ignored. Thus, the much-needed dialogue about this workplace and its design disappeared from the agenda. Though, it would be so important to identify and defuse stressors and to develop a healthy work environment.

First, collaborative, collegial, appreciative and participative leadership styles could help to dismantle the gendered and racialised hierarchy in health care. Interestingly enough, many Covid-stations credited an inclusive and empowered work environment with being able to step up to the plate. Especially, flat hierarchies, visible and available senior leaders, and a clear focus on the target proofed to deliver best results (Bohmer et al., 2020, online). Furthermore, psychological support and supervision should become permanently and on-site available. This should also include rooms and time slots for individual retreat and for joint team meetings. Besides, better wages and a reduction in working hours need to be addressed urgently. Last, but not least, mobile carers, live-in nurses, and nursing relatives must be included in prevention programs and feasible solutions created for them.

Conclusions

My questions concerned the following topics: What resources were mobilised to keep health care workers healthy? How was their psychological burden considered in the public debate? The core narrative woven through the discourse revealed systems buckling under immense pressure. The overarching theme was one of profound overburdening, manifesting in multiple interconnected ways. The major discursive strands were as follows: staff shortages, bonuses and pay rises, inadequate protective equipment, poor coordination and communication from the management, overwhelming influx of patients, lack of recognition and support.
My findings suggest that media coverage in each country exhibited both shared patterns and distinct differences, which are summarized here. In all three countries health care workers enjoyed heightened visibility which was due to several factors. Of course, Covid-19 was at its core a health scare, but staff also rallied and actively engaged with the discourse and demanded change. This was especially true for the UK where labour unions and interest groups used the crisis to point out the failings of the National Health Service. The prevalent cost cutting over the last decades was harshly criticized and blamed for straining working conditions and the high death toll. While in the UK a permanent pay rise was a priority in the discourse, in Austria and Germany more emphasis was put on bonuses and a reduction in working hours. Another difference was found regarding the vulnerability of BAME health care workers. At least some consideration was given to this point in the UK, but in Austria and Germany no such thing happened. A common denominator was that most attention went to the stresses and the dire working conditions of nurses in hospitals and especially on ICUs. The pressures in care homes for the elderly and disabled and in private homes weren't much discussed anywhere. Another aspect got quite neglected in all three countries. It was that many nurses were women with further care obligations in their private lives. Their additional work and mental load didn't appear to be very noteworthy.
This paper's findings suggest that the measures implemented to address the health and psychological strain on healthcare workers during the COVID-19 pandemic were a patchwork of financial incentives, psychological support initiatives, and a reliance on informal peer support. While symbolic gestures like one-time bonuses in Austria and Germany acknowledged the workforce's sacrifices, they did little to address systemic issues of chronic underpay, as highlighted by the UK nurses' demands for a substantial pay rise. Psychological support varied significantly across countries and healthcare settings. Initiatives such as helplines and counseling services were established, but their accessibility and effectiveness were uneven, often favoring ICU and frontline staff while neglecting vulnerable groups like mobile carers and nursing home workers. The reliance on informal peer support, though valuable, underscored the limitations of formal interventions. Crucially, the public discourse surrounding healthcare workers' psychological burden was largely inadequate. Despite widespread reports of moral injury, anxiety, and PTSD, the debate remained selective, often prioritizing individual resilience over structural stressors. The "hero" narrative, while well-intentioned, served to obscure the need for systemic reforms and perpetuated a culture where seeking help was stigmatized. Moreover, the discourse revealed a hierarchical structure, with doctors and male healthcare workers receiving greater visibility and support than nurses and female staff. This left many healthcare workers feeling undervalued, unsupported, and at risk of burnout.
To take a step back and reach broader conclusions, the research outcomes from other studies will be considered. Regarding remedies for the general mental health strain in nursing, trends circle around introducing more training positions, digitisation, and image campaigns (Rappold et al., 2021, 19; 21-27). Especially, people out-of-work and migrant workers are targeted to fill up the leaky pipeline (Ibid., 23-24). While technical assistance and electronic documentation systems appear to ease care work, they

need to be assessed critically. Probably, this trend is just reflective of more administration and data gathering in health care. Of course, staff needs to be trained on those systems which require permanent monitoring and updating. Thus, more time for direct and meaningful interaction with patients is not guaranteed.
Also, further outsourcing, voluntarisation, and familisation of care work, all suggested as benefitting hospital staff and/or the patient, don't solve the dilemma (Ibid., 15-17; 22). Rather, those measures just download care work and render it even more invisible. Thus, the fundamental problem is once more neglected. Care work is challenging, physically, mentally, and emotionally. Since it is all about engagement with patients and their families. Which in turn is decisive for recovery (Bohmer et al., 2020, online). Thus, nursing work requires training, expertise and supervision and those providing it need to be properly renumerated, protected and appreciated. Pushing it back to families and volunteers and thus blurring the boundaries even more, creates an opposite effect. The individual carer is exposed to an excess of physical and mental strain, to isolation, and to injury and illness.

Limitations and Outlook

Qualitative research exploring ändern auf care workers' mental health during the COVID-19 pandemic using online media articles faces several interconnected limitations. Firstly, the scope of such research is inherently restricted, as media articles may not offer a complete picture of the diverse mental health challenges experienced by all healthcare professionals, potentially overrepresenting certain groups or issues while neglecting others. This limited scope is further compounded by potential biases present in media narratives, which can skew the portrayal of healthcare workers' experiences, emphasizing negativity or promoting particular agendas, thus hindering a balanced understanding. Moreover, online articles often lack the depth necessary to fully explore the complexities of mental health struggles, failing to delve into underlying causes and long-term impacts. Consequently, the findings derived from these sources may lack generalizability, as the experiences highlighted in media may not accurately reflect the broader population of healthcare workers. Finally, ethical considerations, such as protecting individual privacy and preventing the spread of misinformation, must be carefully navigated.

Therefore, future research should adopt a more comprehensive approach, incorporating diverse data sources like surveys, interviews, and focus groups to capture a wider range of experiences. Ensuring representative samples, thoroughly investigating the root causes and impacts of mental health challenges, and developing targeted interventions are crucial steps towards a more nuanced and impactful understanding that can effectively support healthcare workers' well-being.

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