**Nurses Supporting Nurses: A Model for Providing Mental Health Services During War**

**Abstract**

Nurses routinely face psychological challenges as part of their jobs. Understanding their mental health needs following exposure to patient trauma is essential not only in their daily work, but perhaps especially during times of national crisis when nurses may treat many severely injured and dying patients. As this study shows, while the need for such support is well-documented in the literature, mental health support programs aimed at healthcare workers, even when they are available, are often underutilised, especially by nurses. To learn more about the mental health supports needed for nurses, this qualitative descriptive design study examines a program launched in the aftermath of a surprise attack on Israel on October 7th, 2023, resulting in thousands of deaths and injuries and precipitating the ensuing Israel-Hamas war. The program deployed 30 volunteer nurses trained in cognitive behavioural therapy, trauma support and mental health first aid to offer up to three, anonymous, 30-minute online therapy sessions nurses around the country during this time of national crisis. This study involved follow-up focus groups with 22 therapist nurses, lasting 60-90 minutes each. The discussions were recorded, transcribed, and analyzed thematically to gain insights into the mental health experiences of nurses during war. The findings highlighted cultural and organizational barriers to providing mental health support to nurses. The importance of normalizing the seeking of mental health support in nursing education and ensuring availability of support in healthcare organizations was emphasized.

**Keywords: cognitive behavioural therapy, mental health support, nursing, qualitative research, war**

**Introduction**

The Israel-Hamas war began on October 7, 2023, with a surprise Hamas attack on Israeli Gaza border communities. Over 1,200 Israelis were killed, nearly 5,000 injured, and 240 abducted into Gaza (Elyoseph et al. 2023). Not surprisingly, it also caused significant mental distress throughout Israel, among Israeli Jews and Arabs alike. For example, a survey published in *The Lancet* found that in a representative sample of Israeli Arabs and Jews, probable Post-Traumatic Stress Disorder (PTSD) rose from 16.2% in August 2023 to 29.8% five to six weeks after the attack (Levi-Belz, Groweiss, Blank & Neria 2024). War related stressors exposures among parents in Ukraine, revealed high correlation for PTSD criteria (Karatzias et al. 2023); In addition, Ukrainian adolescents who have exposed to war violence were 4 times likely to develop PTSD symptoms (Seleznova et al. 2023).

Another study described the extent to which hospital staff went above and beyond the expectations of their routines to treat the wounded and support their families (Givaty, Ovadia & Saban 2023). Although estimates are not yet available, it is reasonable to that healthcare workers are experiencing even higher levels of mental health distress, given their increased and direct exposure to the aftermath of the brutal attacks (Givaty et al. 2023). For example, a study that examined the effect of prolonged war exposure to war stress and comorbidity of PTSD and depression among health workers found them to be highly significant. Nurses found more in risk compares to physicians (Palgi, Ben-Ezra, Langer & Essar 2009). In response to the clear need for mental health first aid among nurses following the attacks and the ensuing war, the Israeli Association of Mental Health Nurses (IAMHN) launched a new initiative called the ‘Nurse for the Soul Program’,which deployed volunteer nurses trained in cognitive behaviour therapy (CBT) and trauma support to provide online therapy to nurses around the country of Israel*.* This study conducted focus groups with 22 of the 30 volunteer nurses using qualitative methods.

The study explores the unique position of CBT nurses, who navigate dual roles as healthcare professionals and psychotherapists. We aim to better understand:

1. The mental symptoms experienced by nurses during wartime

2. Barriers preventing nurses from accessing regular psychological support as part of their professional routine.

**Background**

The literature has documented the impact on healthcare system workers of exposure to distressing scenes. Studies have found that war negatively affects healthcare workers' mental health. Direct exposure to traumatic events increases PTSD, while indirect exposure leads to higher workload, distress, and emotional exhaustion. (Freedman & Mashiach 2018; Luftman et al. 2017; Shamia, Thabet & Vostanis 2015). In addition, healthcare workers caring for patients and families in time of crisis are more likely to suffer from emotional exhaustion, PTSD, anxiety, depression and increased detachment of workplace and lower self-efficacy (Islam et al. 2021).

The literature further indicates that nurses are more likely than physicians to suffer from negative mental health effects after experiencing multiple kinds of a disasters (Sirois & Owens 2021; Preti et al. 2020). Such differences may stem from variances in the professional training of the two groups, along with the possibility that nurses form deeper emotional connections with the victims than do physicians (Naushad et al. 2019).

Various studies have shown that providing emotional support to medical staff from within an organisation can be effective in reducing secondary trauma and burnout (see, for example, Lane et al. 2018). These studies underscore the crucial importance of prioritising the mental health of medical teams during emergencies to prevent the development of post-traumatic stress disorder (Søvold et al. 2021; Naushad et al. 2019). Initiatives have been implemented globally in healthcare centres offering psychological interventions and online courses to medical staff in addressing common psychological challenges (Chen et al. 2020).

Healthcare professionals frequently neglect to seek the mental health support they require after encountering distressing events, and utilisation of available services has been limited. Various reasons have been proposed, from concerns about anonymity (Webb 2020) to the potential stigma associated with seeking support (Weston & Nordberg 2022; Bakes-Denman, Mansfield & Meehan 2021). Additional reasons emerged during the COVID-19 pandemic. One study revealed that some healthcare personnel refrained from seeking assistance, first, because they had limited exposure to written and visual psychological advice resources, such as brochures or psychological guidance in digital media platforms that could inform them that help was available. As a result, they lacked information about the available resources. Second, they were more inclined to seek personalised, one-on-one and confidential counselling as their preferred therapy option rather than group options offered within the healthcare system where they worked (Kang et al. 2020).

Another study found that both physicians and nurses often prioritise providing patient care and addressing their own families’ well-being over addressing their own needs, and may perceive themselves as not needing treatment, even when experiencing distress symptoms (Chen et al. 2020). Instead, the assistance healthcare professionals say they require includes acquiring skills to effectively address patients’ anxiety, panic and emotional challenges. Further, they expressed a preference for having mental health professionals readily available to support patients (Chen et al. 2020).

***Mental health first aid during the Israel-Hamas war***

One therapeutic recognized as a first-line psychological recommended method for PTSD and mental health support is Cognitive Behavioural Therapy (CBT) (Martin et al. 2021) has been improved as a successful therapy for reducing PTSD symptoms (Jensen, Braathu, Birkeland, Ormhaug & Skar 2022; Ross, Sharma-Patel, Brown, Huntt & Chaplin 2021). CBT principles are based on the assumption that individuals can enhance self-awareness through training, motivation and attention. From the CBT perspective, the way individuals perceive events influences their emotional and behavioural reactions. Therefore, people can enhance their functioning and adaptability in various circumstances by intentionally adjusting their cognitive and behavioural responses (Beck & Dozois 2011). CBT has the additional advantage of being a well-established treatment for depression and anxiety that can be delivered rapidly with positive effects, including improved wellbeing, daily functioning and quality of life (Biagianti, Foti, Di Liberto, Bressi & Brambilla 2023). CBT is also a well-known intervention facilitated by nurses for a wide range of patients experiencing symptoms such as stress and depression (Ekeblad, Holmqvist, Andersson & Falkenström 2023; Van Lieshout et al. 2020).

In developing its response to nurses’ need for mental health support following the October 7th attacks and the ensuing war, the Israeli Association of Mental Health Nurses (IAMHN) recruited 30 volunteer nurses for a new initiative called the ‘Nurse for the Soul Program’*.* The program offered the services of 30 volunteer nurses trained in CBT and trauma support to nurses employed in the country’s healthcare system. Up to three 30-45 minutes, anonymous, online mental health sessions were made available to nurses through the program. The goal was preventing or, at least mitigating the risk of developing acute stress disorder, post-traumatic stress disorder and secondary trauma (Segalovich, Levi & Segev 2024).

Prior to the program’s launch, the CBT nurses were provided with guidelines by the IAMHN and attended preparatory meetings scheduled to clarify procedures and to address any of their questions. The nurses received three refresher training of two hours each on mental health first aid and engaged in regular peer training sessions from the program’s launch. The CBT nurses could meet and consult among themselves and with the program manager. Their training emphasized the identification of support systems, functional changes in eating, sleeping and social habits, receiving mental treatment or other therapy, and focus on the reason for seeking help from the recipient nurse. IAMHN program managers supplied the CBT nurses with a structured conversation format to guide the therapy sessions (Figure 1). The treatment approach focused on short term therapeutic principles, such as normalisation, validation, activation and resource connection of the stressful event. The CBT nurses assisted nurses in identifying and analysing the stressors they were facing, focusing on the most troubling aspects and offering validation and normalization of the emotions and impact these events had on them (Boelen, Eisma, Smid, Keijser & Lenferink 2021). In addition CBT nurses used listening skills for ventilation, self-exploration by training mindfulness and breathing techniques for increasing stress regulation (Grasser & Marusak 2023).

Invitations to participate in the IAMHN program, emphasising professional and collegial responsibility, were disseminated via national television channels and in social media platforms such as Facebook, Instagram and WhatsApp. Interested nurses from all clinical disciplines throughout the country could register for the service free of charge through a digital link provided in the published bulletin invitation and the television and social media advertising. An IAMHN program manager oversaw the registration process and facilitated connections between applicants and the volunteer CBT nurses therapists.

**Methods**

Given the importance of improving mental health support for nurses experiencing secondary trauma associated with their professional roles, the IAMHN program provided a research opportunity not only to achieve a deeper understanding of the challenges nurses encounter during war, but also to gain insights from the experience of the program’s volunteer nurses that may help improve future mental health support programs for nurses.

***Study Design***

The study employed a qualitative descriptive design using focus groups, in keeping with the goal of directly exploring and examining the experiences of individuals who are undergoing a specific phenomenon (Bradshaw, Atkinson & Doody 2017). The use of focus group discussions in this study provided a rich and in-depth understanding of the CBT-trained nurses’ experiences and perspectives related to the program. The Zoom format also allowed for a convenient and accessible platform for participants living throughout the country to engage in the discussions.The interactive nature of the focus group discussions facilitated the generation of new ideas and the sharing of sensitive information that may not have been as easily elicited through individual interviews (Kruger, Rodgers, Long & Lowy 2019).

A discussion guide helped to ensure consistency across the three focus group sessions and guided the conversation towards specific topics of interest. It included questions asking participants to describe preparations made prior to the beginning of the program, their role in the program, challenges they faced and how they dealt with them and any thoughts or insights they wanted to share from their experience with the program for example: " what was your role as a care giver in the program?"; "What challenges have you faced in the program?"; "What kind of lessons have you learned from this program?".

***Study Participants***

After obtaining permission from the IAMHN program manager, we reached out to all 30 of the volunteer CBT nurses who participated in the program, of whom 22 (one man and 21 women) agreed to participate in one of three 60–90-minute Zoom focus groups. The groups consisted of 9, 8 and 5 participants, respectively (see Table 1). They were small enough to promote meaningful interactions and productive discussions; additionally, the Zoom platform facilitated the participation of CBT nurses from various locations nationwide. During the focus groups, only participants and the researchers, acting as interviewers, were present, thereby fostering an open exchange of ideas. The discussion took place in December 2023, two months after initiating the program and after more than 100 nurses had participated in at least one therapy session.

***Data Collection and Analysis***

One of this study’s authors guided the focus groups, introducing the researchers and the study aim before guiding the conversation’s flow. To ensure that the data collected were accurate and could be analysed thoroughly, all focus group discussions were recorded with video and audio and later transcribed verbatim. The transcriptions were professionally translated from Hebrew to English and back to Hebrew. Researchers carefully reviewed all transcripts and conducted thematic analysis to identify, analyse and report patterns within the data (Vaismoradi, Jones, Turunen & Snelgrove 2016). This followed a structured process involving seven phases by organizing the research materials in chronological order: (1) data preparation and organisation by gathering the recorded focus groups discussions; (2) data transcription verbatim; (3) familiarisation with collected data by rereading the data; (4) generating memos of the data by writing self-notes; (5) data coding-giving a short descriptive phrase assign meaning of the data; (6) converting codes into categories and categories into themes by broadening the interpretations; and (7) preparing a transparent analytic process by mapping the theme and sub-theme tree (Lester, Cho & Lochmiller 2020). In addition, by adhering to the COREQ 32 reporting checklist (Tong, Sainsbury & Craig 2007), the authors demonstrated a commitment to transparency and rigor in the reporting of their study by reporting in details its process and describing the findings in details and giving supportive quotes from research participants.

*Ethical Considerations*

All participants were provided with written information outlining the study’s objectives and were required to sign a consent form indicating their agreement to participate and have their responses recorded. Anonymisation in publishing their content was guaranteed. The access to the data was restricted to the researchers only. The study received approval from the XXX-XXXX University Ethics Committee (No. 0007636-1).

**Results**

The study provides valuable insights into challenges faced during a mental support program for nurses, highlighting the importance of such programs while also discussing the difficulties in encouraging nurses to accept support. The findings shed light on the need for and barriers to mental health programs for nurses, especially during times of crisis. The study identified three main themes and seven subthemes that offer a deeper understanding of planning mental health programs for nurses. The main findings of the study revolved around three main themes: the rationale for the mental support for nurses, the challenges the program faced and the lessons learned from it. Additionally, seven subthemes were identified (see Table 2).

***Theme 1:*** ***The rationale for providing mental health services to nurses***

This study sheds light on the essential role of mental health support for CBT nurse therapists, highlighting the importance of such programs during times of national stress like wartime. The participants emphasized the need for regular, ongoing support for nurses, emphasizing its significance in maintaining their well-being. Through the focus groups, two key subthemes emerged.

*Subtheme 1: Routine mental health challenges*

As part of their daily work routine, nurses regularly encounter difficult and unsettling situations. Despite the shared understanding among nurses that these challenges are a natural part of their work, there is typically no expectation of receiving mental health support. The CBT nurses were keen to stress the importance of implementing a program that provides support not just during emergencies but also on a regular basis. For example, they shared this need from their own nursing experience: one participant (#3) noted that, as part of their roles, nurses must ‘continue to work and work very hard, both with empathy and inclusion’.

 Participant #12, with an oncology nursing background, continued:

 In an oncologic department of young people between the ages of 18 and 44, we witness of death on the left and right, unfortunately, [leaving] no room for emotional processing; I’m supposed to contain this and absorb it [together] with all other cases.

Similarly, Participant #6 recalled a case [in which] she had a problem with a patient’s smell:

There is no such thing choosing the patient. We work hard; we are the gatekeeper. We [the gatekeepers] come right in front of the patient; there is no such thing as wanting or not wanting to [care for a specific patient].

Participant #21 added:

The exposure of the nurses to difficult situations and the obligation to contain these situations completely without receiving validation for the distress that accompanies them causes a variety of difficulties, in both personal and professional lives. The inability to unpack and process the experiences the nurses face is reflected in a variety of [ways]. For example, I know a few nurses who suffered from emotional [stress] eating, and others with post-traumatic symptoms after exposure to harsh injuries. Another nurse [I know], who worked many night shifts, couldn’t hold on to his relationship with his wife.

In sum, participants thought the mental support program is essential for nurses in every day routine work.

*Subtheme 2: Mental health challenges encountered in wartime*

The focus group participants highlighted the unique psychological challenges experienced by nurses during the Hamas attack and war, which added to their already demanding responsibilities another layer of stress. In addition to the emotional strain of caring for numerous casualties in workplace, nurses also faced uncertainty and fear for the safety of their loved ones serving in the military reserves in their private sphere. The constant threat of missile attacks further compounded their stress, leading to disruptions in their children's education as schools were forced to limit hours or close entirely, particularly in the northern regions of the country, even after five months of conflict. Participant #10 noted that such circumstances ‘exacerbated everyone’s personal problems’, so that with the war, the nurses needed more support than that would ideally be provided routinely to nurses in healthcare settings.

Participant #1 added:

A nurse told me, ‘I [feel] distress all the time and I don’t understand it’. I explained to him that this now affects all of us and it is very reasonable to feel this way, and that one of the things that really [exacerbated it], mainly during the first weeks, were …the hours [spent on social] media and watching TV.

Participant #9 recalled a discussion with a struggling nurse who had turned to her for help:

She worried about her husband’s safety during his service in the reserves while she stayed home alone with their young children for months. This had consequences for the entire family. The participant explained that this nurse’s anxiety was directed towards the children... The children were very rowdy.

Participants emphasized the mental exacerbation of nurses during crisis times in which the need for peer mental support is intensified.

*Subtheme 3: Motivation for volunteering for the program*

After detailing the mental health challenges nurses face, the focus group participants highlighted the importance of providing additional mental health support. They then explained their personal high motivations for volunteering for the program, with some feeling a sense of duty to support their colleagues during wartime, while others saw it as a way to give back to peers and improve their own resilience in the face of ongoing challenges. As recalled by Participant #2: ‘At the moment I saw the program’s call bulletin, I jumped on it. I wanted to contribute to the people I worked with, to the people that stand at the healthcare system’s front line, who usually do not receive such support’. Participant #9 added: ‘It felt great to volunteer. It [contributed to] a strong feeling of experiencing this hard time together and [that] we will overcome it stronger together’.

Participant #22 continued, emphasising the value of volunteering for the program:

I understood that ‘the doing’ is a part of resilience that protects us and that we, the nurses, are deeply [part] of the doing. Sharing experience with other colleagues reduces the mental health burden for nurses.

The participant's motivation for volunteering for the program was both intrinsic in keeping them busy by doing and then maintaining their resilience and extrinsic in contributing to their nurses' colleague building and maintaining resilience during stressful national times.

***Theme 2: Program challenges***

While there was a clear justification for starting a mental health support program for nurses during wartime, the implementation of the program encountered challenges, particularly at the beginning of the war. Participants highlighted the low participation rates among potential recipient nurses and some organizational difficulties with implementing the program.

*Subtheme 1: Low uptake from nurses*

The CBT nurses participating in the focus group expressed disappointment in the lack of inquiries about the program they received. Additionally, they noted that while many nurses applied for counselling sessions, they found themselves constantly chasing after recipients to schedule sessions.

Participant #21 described instances of trying to reach out to nurses shortly after they had left a message indicating their willingness to participate in the program: ‘There were a few nurses that I called over and over, and even when I called them [at the time they indicated was] convenient time, they did not answer the phone’.

Such situations were encountered by many participants. Participant #17 added:

 I saw in my department nurses who were [experiencing] major stress. I told them about the program [and] I emphasised that it is anonymous and that the sessions are with a CBT nurse [who does not work] at their hospital, but they still avoided it.

The gap between the nurses' needs for mental support and their compliance de facto was stood up with the CBT nurses' disappointment. They thought that an anonymous mental support program would encourage nurses to share and participate in higher participation rates.

*Subtheme 2: Organisational implementation difficulties*

The focus groups revealed that there were challenges with implementing the organization's initiatives, likely due to the compressed timeline for learning and development. These difficulties arose because the urgency of the situation necessitated a faster implementation process. For example, Participant #8 said she did not know exactly what was expected of her at each therapy session: ‘I had to find out what the expectations were for a one-time meeting vs. three meetings. What [should be] the goals for [each]?’.

Participant #5 agreed and added:

We went through some kind of quick preparation. That was the nature of [the program] because we were in an urgent situation, as you know. [Everything] was on the move [and needs were changing fast] for all the psychologists, and all the social workers…. We had to characterise the immediate difficulties [experienced by the nurses who participated in our sessions] and respond now. First of all, [we had to provide mental health] first aid.

The CBT nurses had emerged in the mental support program fast during the first days of the war after the attack but overcame organizational barriers and improved their response after initiating the program.

***Theme 3: Lessons from the program***

Despite the challenges faced by CBT nurses during the program, they emphasized the program's significant impact on over 100 recipient nurses. They believe mental health support is lacking for nurses, highlighting the importance of the program. Two major lessons learned from their experience could inform future planning for mental health support for nurses in routine and emergency situations.

*Subtheme 1: Normalising the provision and uptake of mental health support among nurses*

The focus group participants repeatedly stressed the importance of re-educating the nursing profession to prioritize seeking mental health support throughout all levels of nursing education. They highlighted the lack of attention to emotional needs among nurses and called for a shift in the curriculum to address this issue from the early stages of study.

In Participant #2’s opinion:

I think it should be like in a social work school. It needs to be rooted in the general culture of learning – part of the fact that you are studying the profession. [Students should be able to expect] someone to emotionally accompany you when you start working and after you finish your studies, [beginning] even … during your studies.

Participant #7 continued:

I believe this is a promising initiative [program], but it is still in its early stages and requires further development. We need to provide re-education for the entire nursing staff to encourage open communication, not just during wartime. There should be a dedicated service for nurses to seek mental health support. Currently, individual private care is available, but as a collective, nurses lack a comprehensive solution. With our deep understanding of the challenges we face, nurses are well-equipped to take action in this area. This support system should be expanded and sustained beyond wartime.

By implementing mental support in education and routine care, the participants believed it would be normalized and be united as a part of the nurse's professional reality.

*Subtheme 2: Building healthcare organisational cultures that value staff mental health*

Furthermore, the focus group participants stressed the necessity of establishing a new organizational culture that prioritizes mental health support for nurses. This culture would include providing assistance as a foundational component of the organization. Implementing such a significant shift would involve changing the current organizational culture in nursing, which currently promotes the idea that nurses should internalize and manage their emotions without seeking proper outlets for release. Additionally, the existing system fails to recognize the importance of addressing emotional needs. Addressing both of these issues is crucial for creating a more supportive and nurturing safety environment for both nurses and patients. The participants reiterated the importance of integrating mental health support into the organizational framework for nurses throughout the focus groups.

As Participant #11 described the current situation: ‘The organisational view is that we are already used to [dealing by ourselves with mental health issues at work]’. She stressed the importance of the program as a new development that challenges the existing and undesirable situation: ‘But here now a new voice is rising that says, “No, that this is not the way things should be conducted. We stand up and say: “we need it”’.

Participant #14 added:

It is a blessing to have a [guide to help with mental health issues] and the nursing director must understand that it is not possible [to provide this] in a vacuum. If we [continue] working [like] automatons, it eventually explodes, it flies on something, it jumps on something.

Participant #11 also observed: ‘We have excellent mechanisms [for coping], but they also have limits’.

Participants believed that both intrinsic professional conceptual change and the healthcare system's organizational change are needed to accept the implementation of mental support as part of nurses' rights to a safe and healthy work environment.

**Discussion**

This qualitative study sought to explore the experiences of volunteer nurses who were trained in CBT, trauma support, and mental health first aid in providing support to other nurses during times of war-related stress. Through three focus group discussions with 22 out of the 30 participants, three main themes emerged: the reasons behind offering mental health services to nurses, the obstacles faced in the program, and key insights gained from their involvement.

Participants giving rationale for founding nurses' mental support

In the focus group, participants expressed a strong belief in the importance of providing mental health support to nurses. They discussed the emotional challenges faced by nurses in both routine and wartime situations, highlighting the significance of addressing both. Additionally, participants emphasized their eagerness to volunteer and provide support as a way of showing empathy and solidarity with their colleagues in the nursing profession.

Nurses' work environment and mental health

 Workplace conditions for nurses are known to be stressful, with adverse effects on nurses’ health and well-being (Cranage & Foster 2022; Xie et al. 2021; Mitchell 2018). The more often medical professionals were exposed to stressful patient-related situations, the more likely they experienced stress-related issues. Specifically, emotionally challenging and aggressive/conflict situations were the primary factors contributing to emotional exhaustion (de Wijn & van der Doef 2020). In emergency settings, the presence of factors like violence, critical incidents, and a stressful work environment contributes to high levels of occupational stress among nurses. Prolonged exposure to this stress can lead to physical ailments such as heart disease, aches, and mental health issues like anxiety, depression, and anxiety disorders. a strong correlation have been found between high levels of stress and the development of conditions like burnout, compassion fatigue, PTSD, and secondary traumatic stress. This phenomenon is influenced by factors such as job satisfaction, working conditions, role ambiguity, and job stress. Ultimately, this stress adversely affects the work environment by diminishing morale, increasing absenteeism, reducing productivity, and elevating staff turnover rates (McDermid, Judy Mannix & Peters 2020). Although, many adopted positive attitudes toward the stressful situation without having any organised mental health support from their workplaces (Marey-Sarwan, Hamama-Raz, Asadi, Nakad & Hamama 2022).

 Consistent with our findings, studies have shown the importance of nurses supporting their peers and have even shown the positive impact of such support on improved job satisfaction (Karadaş, Doğu & Kaynak 2022) and reduced turnover rates (Zhang et al. 2019). Despite the widespread recognition of the need to provide mental health support to nurses, especially during times of emergency, there are still too few of such essential services (Foli, Forster, Cheng, Zhang & Chiu 2021; Leng et al. 2021; Maben & Bridges 2020). Moreover, to the best of our knowledge, the impact of mental health therapy offered by nurses to nurses has not been described in the literature.

Challenges of nurses' mental support program's implementation

The program’s implementation challenges were the second theme extracted from the focus groups. Participants mentioned an unexpected unwillingness among nurses to take advantage of the therapeutic support. Such resistance may be explained by a fear of stigmatisation (Weston & Nordberg 2022) or a fear of colleagues judging them as being unable to cope with job demands (Bakes-Denman et al. 2021). Potential barriers to seeking mental support may also stem from the fear of facing negative repercussions when reaching out for help. This fear may be rooted in the shame and reluctance to admit to one's mistakes, as well as the workplace culture that values showing no signs of weakness (Halms et al. 2023). In addition, reported barriers in seeking help among Australian health professions were wanting to independently address the issue and apprehension regarding potential ramifications under the Australian Health Practitioner Regulation Agency's mandatory reporting guidelines (Edwards & Crisp 2017).

Participants further noted some organisational implementation difficulties, particularly around preparation for different numbers of therapy sessions (one to three sessions were possible). This may be attributable in part to the sense of urgency in providing services rapidly. But it may also be due to the pioneering nature of the program. To the best of our knowledge, this program may be among the first nurse-to-nurse peer mental health therapy support programs. Opportunities for improvement would therefore not be surprising.

There is a precedent for this model, although one not focused on providing mental health support, particularly during wartime. A longstanding model in health care is the structured and systematic supervision provided to nurses by their peers. Research conducted over the years has consistently shown that such supervision significantly enhances the quality of patient care and therapeutic outcomes. Additionally, it fosters a sense of well-being and professional awareness among nurses while also serving as a preventive measure against burnout (Tulleners, Campbell & Taylor 2023; Brunero & Stein-Parbury 2008). Consistent with our findings, the provision of peer support has been found essential in healthcare organisations (Bakes-Denman et al. 2021; Kelly, Fenwick, Brekke & Novaco 2021).

The needs and gaps in implementing mental support programs for nurses

The third theme emerging from the study involved several program lessons. The focus group participants repeatedly emphasised the need to integrate the importance of, provision of and use of mental health services by nurses throughout the course of nurses’ education. They further noted the organisational culture changes that ought to make seeking mental health support a normal part of good nursing practice. In one study, nursing students argue that mandatory mental health first aid training is essential for all nursing students toward a better understanding of health literacy and better preparation for their future nursing practice (Saito & Creedy 2021); however, its focus on improving nursing-patient practice in mental health. Although, To the best of our knowledge, the literature has not discussed the importance of incorporating seeking mental support within nursing studies. This study enable a deep overview on this topic and highlight new insights for improving mental health nursing field in the future.

***Limitations***

The study’s few limitations primarily relate to its focus on the experiences and perceptions of the nurses providing the therapy. This one side perception only describes the experiences of the nurses' therapists' point of view but could not evaluate the programs' contributions on the recipient nurses. Another limitation is related to the Zoom format conducted in the interviews. Although it enabled safety meetings during time of crises and saved interviewers' time and expanses of travel and despite not formally incorporating participant observations into our research methodology, we had difficulties observing participants' facial expressions and body language and identified the individual speaker among the group in such ways we had to watch the recorded interviews over and over. Although difficult to implement, studies evaluating the impact of such therapy using interviews with the nurses who participated in the therapy sessions would be extremely valuable. In addition, we argue that mental health needs among nurses are intensified in times of national crisis. Enlarging this study beyond one country’s experience with one kind of national crisis could broaden our understanding of the needs of healthcare professionals in different circumstances and cultures.

**Conclusion**

The current study is the first to explore the provision of nurse-to-nurse mental health support. It showed the importance of establishing such programs not only in times of national emergency but also as part of routine work. The findings also reveal the challenges therapist nurses encounter in encouraging other nurses to participate, suggesting the importance of mitigating this issue with reforms in nursing education and culture changes in healthcare organisations.

**Relevance for Clinical Practice**

Due to the current lack of proactive seeking of mental first aid assistance among nurses dealing with day by day workloads and under time pressure and exposure to difficult sights of patients, wounds and death, especially during national crises, we recommend health stakeholders to establish a confidential process for providing mental support to nurses. This support should be anonymous to encourage uptake in which educators and health stakeholders may consider using our program and its insight for implementing mental support programs for nurses and other healthcare providers in their organization. Through open communication, providing ongoing training and support for mental health issues, and implementing policies that prioritize mental well-being in the workplace by raising employees' awareness and acceptance, creating an integration of mental health services in health institutions, establishing diverse, dedicated teams, and promoting the culture of discussion and resolution. These changes aim to create a more supportive and understanding environment for nurses and healthcare professionals, ultimately leading to improved mental health outcomes. Furthermore, we suggest conducting a follow-up study to evaluate the impact of this psychological assistance on nurses. This study should assess clinical indicators such as mental health symptoms, burnout rates, and retention within the healthcare system. In addition, the study highlights the significance of nurturing an open approach to seeking and receiving professional mental health support among nursing clinicians, especially during national crises. Nursing educators can use this study as a model to develop programs, simulations, and workshops aimed at overcoming stigma and encouraging nursing students to prioritize their mental well-being throughout their studies and careers. This approach is vital in promoting best practices in nursing care.

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