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The resulting mental health pandemic from COVID-19:

Research and resources for social workers

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This independent study project was supervised by Nicole O-Pries, LCSW, School of Social Work, Virginia Commonwealth University, for whom the author expresses endless gratitude and admiration for the significant impact on the author's learning and clinical skills.

If not for the important role the author's own therapist, Kathy, has played in her life, she would not have pursued this career change and degree. That she sits with me in the darkness and guides me to the light, is a gift for which I am most grateful.

### Abstract

The COVID-19 pandemic will have long-lasting mental health impacts on hundreds of millions more worldwide than the contagion itself. Social workers are seeing increases in depression, anxiety, suicidality, and post-traumatic stress disorder and other negative mental health impacts. Because of this, social workers in all environments and modalities of practice need to be well-trained, agile, and energized while facing the pandemic themselves. This report compiles the impacts and concerns for a variety of social workers and their clients into a single, digestible source, supplemented by the “COVID-19 Resource Compendium for Social Workers and Their Clients”. Social workers must practice self-care, maintain connections with professional resources, and seek out practical tools for themselves and their clients in order to best serve those in need long after a COVID-19 vaccine is readily available.

*Keywords:* pandemic, COVID-19, Coronavirus, mental health, social work, trauma

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### **Foreword**

*COVID Silver Lining. n.* Coined by the author in March 2020, COVID Silver Lining describes events, occurrences, discoveries, and connections that, but for the dark cloud of the COVID-19 pandemic, would not have happened. An example is the new connections the author and her 14-year-old daughter made with neighbors when the duo take their instruments and a music stand and set up in front of someone's house to play a song. This is something that brings beautiful connection to the mother and daughter and then also brings smiles and lightness to those who hear the music, something there may not have been time and space for until the COVID-19. While one can focus on the deep cover of the pandemic's cloud, the COVID Silver Lining offers the chance to remember that sometimes joy is a choice.

This report takes a different approach than the standard, wholly academic paper. By the author using the presentation of herself in textboxes throughout, reflecting on the experience of producing this report, she seeks to highlight that all social workers at this time are simultaneously asked to care for those experiencing a pandemic while experiencing it themselves. These textboxes seek to provide insight to the challenges of this vulnerable space for social workers. Sitting with clients suffering the loneliness of quarantine when the social worker may be on telehealth with the client and experiencing the same feelings, adds a new element to routine countertransference concerns, and this is not discussed in the literature. While the pandemic presents a unique challenge in this regard, it is also an inherent component in the vocation of social work.

## Introduction

The COVID-19 pandemic has challenged the limits of physical and mental health even before the World Health Organization's declaration on March 11, 2020 (Adhanom Ghebreyesus, 2020). Starting in Wuhan, China, in December, 2019, the highly contagious influenza affects the respiratory system most severely, putting older populations and those with pre-existing health conditions at increased risk of morbidity. Often missed in discussions of the influenza pandemic, is that while as of November 12, 2020, 51,547,733 people have been infected with, and 1,275,975 people have died from, COVID-19 (World Health Organization, 2020c), the world's population bears impacts even if not infected with the illness. The mental health impacts of the pandemic are estimated to be long-lasting and effect hundreds of millions more worldwide than the contagion itself.

Social workers and other mental health professionals and researchers are sounding the alarm that increases in depression, anxiety, suicidality, and post-traumatic stress disorder will be seen beyond those with pre-existing mental health conditions (Canet-Juric et al., 2020; Carbray, 2020; Gualano, Lo Moro, Voglino, Bert, & Siliquini, 2020; Walter-McCabe, 2020). There is a universal sense well is "significant life disruption" (Hansel, Saltzman, & Bordnick, 2020). The negative mental health impacts of quarantine are predicted to be increasingly dire for children, as it was in SARS and Ebola (Badellino, Gobbo, Torres, & Aschieri, 2020; Brooks et al., 2020; Canet-Juric et al., 2020; Perelman, 2020). Because of this, social workers in all environments and modalities of practice are facing the mental health impacts on clients. Unlike disasters, where outside help is often brought in, with a global pandemic, there is no "outside". This juxtaposition of the intense need for well-trained, agile, energized mental health practitioners while the same practitioners are also experiencing the pandemic, presents an acute need for

easily accessible information relevant to social workers, and resources for social workers and their clients. While resources exist for social workers and their clients, they are disparate, uncatalogued, and often lack scrutiny. This report seeks to compile the impacts and concerns for a variety of social work clients and social workers in a single, digestible source. This report is supplemented by the “COVID-19 Resource Compendium for Social Workers and Their Clients” compiled by the author, which contains links to more than 60 free resources ranging from self-care, to mobile apps, to trainings, to fun distractions. Because there will be gaps as well as changes to information once believed accurate in this fast moving situation, the resource can be considered a living document that can evolve over time. Social workers are asked to contribute resources for the compendium and sources for the reviewed literature by email to the author. With the intense demand for mental health care due to the ever increasing stressors during COVID-19 colliding with racial injustice and police brutality, white supremacy, and political turmoil, it is imperative that social workers are available, healthy, cared for, and well-trained and resourced at this time.

### **Methodology**

This report is a combination of a review of the relevant literature and a compendium of resources relevant to social workers and their clients.

### **Literature Review Approach**

The literature review began by casting a wide net to gather a large amount of material relevant to social workers. The author first searched comprehensively for sources. Next, the author performed a gap analysis to determine holes remaining after the results of the first step. Third, the author checked the evolution of information over the course of the pandemic, noting changes in recommendations, or approaches, since March 2020, to find new knowledge.

Unlike a classic literature review that has a clear defined timespan of articles, this report utilized the ever-growing body of literature as the pandemic and access to sources evolved. November 12, 2020 was the decided cutoff for daily full culling of resources. Prior to this date, the author had automatic searches scheduled daily through the university library system.

The literature review considered a variety of sources, including peer reviewed literature, grey literature, white papers, newspaper articles, reports, vetted web sources, online trainings both live and recorded, and school and public health announcements. Source organizations include, but were not limited to, academic, medical, behavioral health, international organizations, social work organizations. The author developed a comprehensive list of key words to guide the identification of relevant publications. To optimize the exclusion/inclusion criteria, the list of key words was refined as the project progressed. The keyword search was augmented by backward (including backward references search, backward authors search, and previously used keywords) and forward searches (including forward references search and forward authors search).

Keyword search terms utilized include, but are not limited to, (individually and cross-referenced): SARS-CoV-2, COVID-19, coronavirus, pandemic, epidemic, social work, social workers, therapists, clinicians, healthcare providers, mental health, mental illness, behavioral health, crises, disaster, trauma, public health, stress, quarantine, and lockdown. Manual and automatic searches occurred utilizing multiple databases available through the university system such as PsycINFO, PubMed, Social Work Abstracts, JSTOR, and ERIC to acquire peer-reviewed, scholarly sources of information (published sources) and various government and public health websites and clearinghouses to seek out non-published sources, such as white papers, grey literature, working paper series, and professional conference proceedings. Including

these non-published sources improved the ability of the project to yield more emergent issues, practices, and approaches.

This report uses the term social worker throughout. When mental health workers, clinicians, health care providers are spoken about in articles, the research is applied to social workers and will utilize that language. While an article on physicians will not be discussed as if it were about social workers, the author will extrapolate the resources and resultant ideas and apply them to social workers.

This independent study project included meetings and communication with the independent study supervisor, during which the project was designed, discussed, and finalized, followed by creation of an outline which was presented and discussed via videoconference. This was then adapted as a draft was reviewed and adjustments and edits led to the final product. adapted to response and recommendations. A videoconference was scheduled to discuss any problems prior to the draft deadline.

### **Compendium Approach**

Utilizing the approach from the literature review, the development of the compendium of resources produced items that, as handouts, tools, or recommendations, are resources for social workers to use for themselves or for social workers to provide to their clients (and sometimes both).

### **Dissemination Plan**

The author will submit this report and compendium to Scholars Compass, making them available for worldwide open access. The links will then be sent out over the VCU Student Resource Wire, the VCU Public Relations office, and to professional organizations like the national and local NASW, Greater Washington Society for Clinical Social Work, “ACEs Too



High,” and others.

### **Limitations**

This report does not claim to be so comprehensive as to address the needs of all social workers and their clients. Due to oversight, ignorance, or intentional choice, many components relevant to the lives of social workers and their clients are missing. Many others deserved more coverage and energy than they received. The author welcomes others to add to this as a living document and owns responsibility for what is missing.

## **SARS-CoV-2 Pandemic**

### **Core Concepts of COVID-19 Pandemic**

**Defining and unpacking the virus.** First cases of COVID-19 were in December, 2019 in China, and the World Health Organization (WHO) declared a pandemic March 11, 2020 (Adhanom Ghebreyesus, 2020). A pandemic is when a disease spreads worldwide, panning the globe. SARS-CoV-2, short named COVID-19 (COronVIrusDisease-2019), is characterized by a fever, dry cough, and fatigue, most often (World Health Organization, 2020b). Considering that these symptoms are common symptoms of the common cold and flu, large numbers of people experiencing these symptoms will not have COVID-19. Other symptoms can include gastrointestinal distress, loss of taste of smell, skin rashes, and more. Death from COVID-19 occurs typically from respiratory distress and failure, multiorgan failure, sepsis and septic shock, or thromboembolism (World Health Organization, 2020b). There is speculation that COVID-19 may directly affect the nervous system, having yet undetermined neurological and mental impacts (Moreno et al., 2020). Some research suspects that the COVID-19 virus itself causes stress system dysregulation which could increase mental health disorders (Steenblock et al., 2020).

**Transmission.** COVID-19 spreads most easily from person-to-person via contact within six feet through respiratory droplets that an infected person puts into the air through breathing, singing, coughing, or sneezing, even if they do not know they are sick (CDC, 2020). COVID-19 can also spread through contact with contaminated surfaces, but this transmission is far rarer than first understood. The literature continues to fluctuate on for how long a person is contagious, whether a person can be re-infected, and the success rate of personal protective equipment in preventing the illness.

**General outcome statistics.** While there are global impacts COVID-19, this report focuses on the United States. In the U.S., as of November 12, 2020, 10,124,555 have tested positive (nearly 32.5% of the population), and 238,573 have died (approximately 2.4% of those infected) (World Health Organization, 2020c). Nearly 80% of those infected globally recover without hospitalization, 15% require hospitalization and oxygenation, and 5% require intensive care (World Health Organization, 2020b). By February 2021, the Institute for Health Metrics and Evaluation (IHME) estimates 399,163 deaths in the United States (Institute for Health Metrics and Evaluation, 2020b). COVID-19 mortality is higher for the Black and Hispanic populations, with their risk at age 50 equivalent to the risk at age 65 for the non-Hispanic white populations (IHME, 2020a). Hispanic Americans are nearly 7 times more likely to die of COVID-19, and Black Americans 5.5 times as likely, than white Americans. By sex, 128,829 males have died and 109,743 females. The sex disaggregation rates vary by age across the population. Older populations are more likely to die of COVID-19 infection because of the respiratory system's challenge in recovering (World Health Organization, 2020b).

**Safety and protection guidelines.** The Centers for Disease Control and Prevention (2020) recommend washing hands frequently with hot water and antibacterial soap for at least 20

seconds, particularly after time in public, before preparing or eating food, after touching one's mask, blowing one's nose, coughing, or sneezing, after touching others including pets, before touching one's face and after using the restroom. Hand sanitizer of at least 60% ethanol or ethyl alcohol is also recommended (CDC, 2020). Mask wearing is key, particularly when outside one's home. Masks must cover the mouth and nose, and fit well and snugly across the face. Personal protective equipment (PPE) is any item meant to block transmission to or from the person wearing it. For those in certain settings, such as hospitals, or with increases susceptibility, this may mean face shields, gloves, respirators, or biohazard suits, in addition to masks.

Masking is for preventing transmission from the person wearing the mask and for the person wearing the mask from others. Physical distancing, or maintaining a minimum of six feet from another person, is recommended at all times. This includes when one is outdoors. Physical distancing, inside or outside, still should be maintained when wearing a mask. The CDC (2020) recommends cleaning and disinfecting frequently-touched surfaces like electronic devices, light switches, counters, handles, toilets, and faucets, with an EPA-approved List N product, which is predicted to be effective in killing the coronavirus (U.S. EPA, 2020). While surface contact transmission is believed less likely than earlier in the pandemic, respiratory droplets can stay actively contagious until dry therefore leading to continuation of this recommendation.

The IMHE (2020) infection rate and death estimates predict lower numbers with compliance to masking and physical distancing. Mask use and social distancing are estimated to decrease transmission by as much as 30%. This figure should demonstrate to readers that 70% likelihood of transmission remains even with these precautions, primarily because one cannot control the practices of others.

Because of recommended safety behaviors that public health officials require or

recommend, many other restrictions have occurred as a result, including schools moving to online education, health care moving to telehealth, some states banning individuals from other states, decrease in ability to travel, lack of socialization options including restaurants and bars, fitness centers, movies, bowling alleys, etc. and more. Some facilities have begun reopening since initially being shut down completely, using physical distancing mechanisms, but as this has occurred so has a steady increase in COVID-19 cases in some states (Centers for Disease Control and Prevention, 2020b). Job loss and increasing unemployment from COVID-19 have had huge financial ramifications.

#### AUTHOR'S JOURNAL

Writing about the safety instructions and restrictions is a challenge because it reminds me of the severe restrictions on my freedom that I experience. The fear of exposure, of not being vigilant enough, of being too vigilant. I was at a socially distanced birthday party recently and found myself baffled when the celebrant blew out birthday candles and then served the cake while I remained the only person who would not eat it. I felt in a dystopia. I asked a friend why she was going to eat the cake that had been blown on after wearing a mask for the party and she said, "What am I supposed to do? She's serving it to me!" There is the lack of consistency from the public health officials to contend with and then there is the lack of consistency and logic in the public. I find this so frustrating.

#### **From One Pandemic to Two: Mental Health Impacts of COVID-19**

During a pandemic, the majority of research is in the form of online surveys, historically seen as a weaker methodology. At this time, it is a necessary and needed method. The author thanks researchers for these efforts given the trying topic and demands on normalcy at this time. While this report focuses on the United States, due to the dearth of research in general, the author utilizes many international studies as well.

#### AUTHOR'S JOURNAL

I feel compelled to thank the researchers given how hard the topic is for me. They too are living in a pandemic. I only wish for more declarations of limitations of the research.

During a pandemic, public health officials, physicians, and other healthcare workers often

focus mainly on the pathogen of the virus and those affected biologically (Ornell, Schuch, Sordi, & Kessler, 2020). Due to effects of the pandemic, a mental health catastrophe is anticipated globally (Mari & Oquendo, 2020; Ransing et al., 2020). A greater mental health toll will be taken by COVID-19 than the death toll from infection (Khan et al., 2020). While psychiatric outcomes of pandemics lack research (Ransing et al., 2020), the suddenness of the virus and, in some places, unexpectedness, brought on acute stress responses from fear. Since a reliable, accessible vaccine remains elusive, increasing fear of waves of infection and/or re-infection will increase mental distress for communities (Ahorsu, Lin, & Amir H. Pakpour, 2020; Miller, 2020; Ornell et al., 2020).

The Center for the Study of Traumatic Stress explains that “every major disaster is accompanied by a behavioral health crisis” (Center for the Study of Traumatic Stress, 2020d). Fear becomes its own epidemic compounded by population-level impacts including anxiety and depression, new and recurrent substance use and misuse, and increases in interpersonal violence and child abuse. Lessons from other pandemics, like SARS and swine flu, found high levels of PTSD and depression, particularly in those who survived the infection (Copur & Copur, 2020).

The COVID-19 virus arriving to the U.S. and one’s state, is the first mental health point of impact. Second, is the recommendations for quarantine (Mari & Oquendo, 2020). Third, there are such an overwhelming number of deaths that hospitals, morgues, and funeral homes cannot handle the situation in a way that allows for culturally typical mourning rituals, leading to complicated grief and possible increases in suicidality (Reger, Stanley, & Joiner, 2020). Fourth, is the experience in the hospital for any reason, including COVID-19 infection, facing fear of hospital acquired infections, lack of personal protective equipment, ventilators, etc. which may lead to future mental health impacts including PTSD (Mari & Oquendo, 2020).

A number of researchers, including those in the *Lancet Psychiatry* journal, noted that the COVID-19 restrictions have results in well known risk factors for impaired mental health (Duan & Zhu, 2020; Moreno et al., 2020; Sommer & Bakker, 2020). Namely, social isolation, limited access to basic services, loss of income, increased access to food, alcohol, and online gambling (for some), loneliness, decreased family and social support, and inactivity. Others have cited increased time with those one needs separation from, particularly during abuse, and decreased access to food, medicine, and health care as risk factors for mental health impacts as well (Jewell et al., 2020). In an online survey in the U.S., conducted by the Kaiser Family Foundation, of adults without mental illness, 32% felt that worry and stress related to COVID-19 negatively impacted their mental health, and half of those said the impact was major (Hamel et al., 2020). Even those with common cold symptoms may feel fear and panic can emerge (Ornell et al., 2020).

Depressed and anxious feelings are an expected, normal reactions to instability and uncertainty (He et al., 2020; Mari & Oquendo, 2020; Marques, Bartuska, Cohen, & Youn, 2020; Rauch, Simon, & Rothbaum, 2020). Impacts of the pandemic on mental health include whether the person is quarantining (and whether alone or accompanied), individual risk factors for COVID-19, age, gender, education level, perceptions of economic impact, regular work, number of children, caring for older adults, number of rooms, presence of outdoor space, and number of hours spent daily on news and social media (Canet-Juric et al., 2020). More research is needed to properly understand how COVID-19 and the mental health impacts negatively impact populations by gender, race, class, LGBTQIA+, and geography (care.org, 2020; Gonzales, Loret de Mola, Gavulic, McKay, & Purcell, 2020).

Mental Health America (MHA) offers online screening tools free to the public. From January 2020 to June, there was a 406% increase in anxiety screening and 457% for depression.

Respondents cited loneliness and isolation as causing the depression and anxiety. Girls and women between 11 and 25 were particularly at risk for depression and anxiety (Brodhead, 2020). Six times as many respondents were considering self-harm or suicide. A study in Pakistan found the suicide incidents increasing due to lockdown-induced economic recession, second to fear of the infection (Mamun & Ullah, 2020). Using data from previous pandemics, Sommer & Bakker (2020) found high rates of PTSD in the general population and especially in those discharged from the hospital after recovering.

In the COVID-19 pandemic, a survey in China found that respondents reported moderate to severe depression, anxiety, and stress levels (utilizing the Impact of Event Scale-Revised [IES-R] and the Depression, Anxiety and Stress Scale [DASS-21]). In another survey, utilizing the COVID-19 Peritraumatic Distress Index (CPDI) in China, 35% of the population reported psychological distress, with higher risk factors being female, 18-30 or over 60, higher level of education, and certain high risk occupations (Copur & Copur, 2020). An online survey in China found 53.8% of respondents with moderate or severe psychological impacts including severe depression, severe anxiety, and moderate to severe stress symptoms. Respondents were more likely to report these symptoms if they were female, a student, had physical symptoms, or already were in poor health (Wang et al., 2020).

Mental health plays a significant role in collective prevention of COVID-19. During the Ebola outbreak, those with higher depression and PTSD rates were more likely to participate in risky behaviors (Reardon, 2015). Interestingly, those with anxiety symptoms were more likely to avoid risky public health behaviors. This is due to fear, not from a place of empowered choice, so the author cautions this being presented positively.

A team of researchers are exploring what they call “COVID stress syndrome,”

characterized by fear of COVID, financial worry, xenophobic fears of who is spreading COVID-19, traumatic stress symptoms due to exposure to COVID-19 directly or vicariously, and compulsion and reassurance seeking around COVID-19 (Taylor et al., 2020). The severity of the syndrome correlated with preexisting mental health concerns and with “excessive” avoidance, panic purchasing, and difficulties coping in isolation (Taylor et al., 2020). The researchers hope to enable more targeted interventions by explaining the way these manifestations interact. When dealing with a pandemic, phrases by researchers such as “excessive avoidance” sound highly subjective and potentially judgmental. They are likely based on a comparison to the tolerance of the research team for avoidance.

A crosssectional survey in Spain found 66% of respondents reporting anxiety or depressive symptoms. For those reporting less symptoms, they tended to follow a healthy diet, a routine, did not read news or social media about COVID-19 often, and pursued hobbies (Fullana, Hidalgo-Mazzei, Vieta, & Radua, 2020). This finding is key for social workers to consider for themselves, as well as to recommend to clients. These 4 potential recommendations are based on research and have positive impacts on mental health.

#### AUTHOR’S JOURNAL

I am writing this after spending hours editing. I am already having increased anxiety experienced as tightness in my chest and difficulty focusing. I began recounting behaviors that I could have done differently and wonder if they were unsafe. This is not something I did before taking on this project. I went away for the weekend to be alone and write this report, isolating myself to concentrate. Yet my pace is slow because of the heaviness of the material. And being alone, I do not have access to hugs and physical silliness. What choice should I have made? I share this since many social workers are drowning in COVID-19 in their professional world and we must be aware of the impacts in our mental health and personal world.

### **Quarantine**

Quarantine is a term typically reserved for keeping infected people away from others.



During the COVID-19 pandemic, it was been used to refer to those on home isolation even without symptoms or diagnosis. Therefore, quarantine and home isolation are used interchangeably except when research specifies. “Quarantine has significant psychological impact which includes Post-traumatic Stress Disorder, depression, anxiety and stress on the quarantined individuals in mass public quarantines” (Khan et al., 2020).

Primary stressors during quarantine are the duration, fear of infection, frustration and boredom, inadequate supplies, insufficient information (Brooks et al., 2020). From previous research on quarantines, negative psychological impacts can be expected to last for years (Brooks et al., 2020). A meta-analysis of studies on the psychological outcomes related to quarantining, the authors found that the impact of self-isolation versus obligatory quarantine was less. The duration of quarantine, availability of supplies, fear of being infected, socioeconomic status, and level of restrictions also impacted level of psychological distress. Most common were PTSD, anger, depression, irritability, sleep disturbances, stress, fear, and confusion (Copur & Copur, 2020). Quarantined children are likely to develop acute stress disorder, adjustment disorders, and grief, particularly the longer they are quarantined (Sommer & Bakker, 2020). Panic buying at the beginning of the pandemic in the U.S. and in other waves is a manifestation of trying to protect and take control (Sim, Chua, Vieta, & Fernandez, 2020).

The requirements of quarantine bring helplessness, isolation, boredom, anxiety, depression, and emotions including irritability and anger when one’s freedoms are affected. (Freedoms here are broadly defined. Those imprisoned, for instance, have also had what little freedoms there were removed). Mental health effects of quarantine compare to a traumatic event (Hawryluck et al., 2004). A study in Argentina found that depression and anxiety increased, but not greatly, within the first 2 weeks of quarantine (Canet-Juric et al., 2020). This time period

may not be long enough to measure significant change, as people are still newly experiencing the rules and restrictions.

For those with social anxiety and some depressive symptoms, there could be relief from quarantine restrictions. More practically, those not experiencing workplace or school harassment or bullying, those not commuting, and those whose lives are made easier by increased time at home this could have positive psychological effects.

Those in hospitals, particularly those with COVID-19, face restrictions of contact with loved ones, increasing the change of psychological distress (Moreno et al., 2020). Social workers and mental health professionals have attested to the “secondary harm” caused to patients and their families due to blanket restrictions at hospitals (Cranshaw, 2020). Clients with chronic conditions relapse because they cannot have contact with their caseworkers, therapists, other resources like day centers, and loved ones. For clients hospitalized against their will, they have no way to see loved ones. Very brief contact or virtual substitutes do not replace the need to physical presence and touch. Lastly, food insecurity, job and income loss, economic downturns, unemployment, and increases in social inequality, always known to increase acute stress, are impacting larger numbers of the population and hence expect a larger mental health impact.

### **Stigma**

Prior to the pandemic, there was already stigma toward those with mental health disorders. Research is needed of the impact of widespread mental health concerns on stigma and fear of stigma. Does the increase in those experiencing mental health challenges decrease the stigma? Or is a pandemic seen as a legitimate occurrence to have anxiety and stress about, so it is absolved from grouping into the typical stigmatization? Is it therefore “real”? Are those experiencing pandemic related stress and anxiety less likely to get help since everyone is stressed?

If they seek treatment and providers lack availability, does this reinforce the belief that they are not worth help? Or not bad enough? Some research promotes an approach to mental health in a pandemic where this very fear is potentially reinforced with only those with the most acute symptoms would be seen by mental health professionals (Chanchlani, Buchanan, & Gill, 2020; Chandu, Marella, Panga, Pachava, & Vadapalli, 2020).

### **Increased Demand for Mental Health Care**

While most literature cites an increased need for mental health services in a pandemic, little attention is paid to the static or dwindling capacity of those resources. Social workers are front line workers in a pandemic and should be discussed as such. The increased demand for mental health responses to the pandemic is matched with a decrease in economic capacities of individuals, institutions, and governments charged with this responsibility (Moreno et al., 2020). Those with pre-existing mental health diagnoses report increases in symptoms while access to care decreases for many (He et al., 2020; Moreno et al., 2020). In addition, the mental health care system numbers are static at the start of a pandemic and cannot surge to meet demand. If anything, the capacity/ability of mental health providers, also impacted by the pandemic, may decrease.

**Impacts on Social Workers.** From previous disasters and crises, the research shows that social workers, like other first responders and health care workers, are likely to experience PTSD and spillover issues of their work into their families. The difference with a pandemic is that the social worker is also experiencing the pandemic. Research has not explored this important difference as of yet and primarily recommends self-care for those on the front lines. While self-care is of clear importance, what might be missing from an approach to the mental health crises, when the providers are also suffering?

**Inconsistent recommendations and misinformation**

During the pandemic, countless sources offer false, confusing, or dubious information about COVID-19 transmission, incubation, and infection and death rates (Ornell et al., 2020). While this pandemic meets populations with the greatest ease for technology bringing information, many sources are sensational, inaccurate, and harmful. An example of a complicated inconsistency can be seen in the rules in the state of Connecticut. The governor banned those living in most states from traveling to the state. Exceptions were made if the person were staying less than 24 hours. Given that there is no understanding of the virus indicating that one needs to be present for over 24 hours in order for the virus to transmit, this does not make sense. In addition, a person can enter if then quarantine for two weeks or if they have a negative COVID-19 test from the last 72 hours. A negative COVID test does not mean that the person does not have COVID. It means that at the time of the test, this individual did not have COVID according to this specific test. Additionally, it must be a rapid results test, known to be less accurate (Guglielmi, 2020).

Many believe they can just cover their mouth with a mask, and not their nose. Or believe that when outside, people can be near each other and transmission is more difficult in “fresh air”. At restaurants, guests are inside with masks off while opening and closing mouths frequently while eating and talking, increasing likelihood of droplet expulsion yet allowed to help restaurants stay open and as a place for patrons to go (Ransing et al., 2020). While physical contact and proximity are important to mental well-being, this is further complicated by the “madness” of unclear recommendations.

Public health officials have recommended phased re-openings as the approach that most states are taking (Rauch et al., 2020; Sherman, Williams, Amick, Hudson, & Messias, 2020;

World Health Organization, 2020c). However, in the ways that states approach this differently, the inconsistencies lead to confusion, distrust, and inconsistent compliance within the population. One study focused on gradual reopening in Arkansas, finding that phased re-opening is also a burden as daily life disruptions continue and the resolution is unpredictable (Sherman et al., 2020). The stigma resulting from being infected or others fearing one is infected lead to social rejection (Ornell et al., 2020).

#### AUTHOR'S JOURNAL

Reading this article was heavy when I heard the authors describe me. Individuals who feel their daily lives are greatly disrupted and have a prior history of mental health concerns were more likely to have increases in depressive, anxiety, and trauma-related symptoms. I feel that starkly. I find myself repeatedly surprised that restrictions on freedom impact me the way that they do. With a well-managed mental health condition, I feel fear that the intense symptoms will return when I read articles like that. That doesn't mean this article is the first I'm hearing about this, it was hearing it over and over again and it hitting me with this article about phased re-openings in near real time.

#### **Trauma in a Pandemic/Pandemic as Trauma**

The pandemic itself can be experienced as a traumatic event (Collin-Vézina, Brend, & Beeman, 2020), though it is a series of countless daily traumatic events for some. The state of the environment during a pandemic is unpredictable, extreme, prolonged, and based on an unfamiliar danger all of which is likely to cause mental distress (Collin-Vézina et al., 2020). The pandemic lacks predictability and those experiencing it lack control, all of which strengthens the stress response. Worse still, some strategies for healing from trauma are not available when one is not supposed to leave their house (McBride & Cohen Silver, 2020). Those who have adverse childhood experiences (ACEs) are expected to have even stronger reactions (van der Kolk, 2014). Peterson states “The fight/flight/freeze response goes into overdrive. It’s like living with a fire alarm that goes off at random intervals 24 hours a day. It is extremely difficult for the rational brain to be convinced ‘that it won’t happen,’ because it already knows that is has

happened, and it was horrific” (Peterson, 2018) And the “it” may be just earlier today. There is a lack of research on PTSD in noninfected individuals during a pandemic, yet those who survived infection and their loved ones, and the loved ones of those who died are not the only ones at risk of PTSD. PTSD has been tied to quarantine in children and parents in one study (Sprang & Silman, 2013).

The Emotional Epidemic Curve, conceptualized by Ransing et al. (2020), purports that there is an initial peak of emotional distress, followed by a dipping point as people adjust, and then a second, not as high, peak due to unpredictability and continuance of quarantine. This curve may leave out those that have a continual increase as one’s tolerance of anxiety and distress decreases over time. Is there mental health in refusing to accept a new normal?

#### AUTHOR’S JOURNAL

Reading and writing about the trauma of living during a pandemic makes concentration difficult. I am so scared right now for my adolescent daughter that I wipe my tears as I type. I don’t want her to continue in this restricted, illogical time. I know our relationship has a strong foundation, but as an introvert myself, being in a house with her and my spouse is often too much for me. I am quick to startle, irritable, distracted, and quick to tears. I am, again, taking a break but I am losing time. I came here to write and all I want to do is shut the computer.

### **Adding to the Complexity of COVID-19**

#### **Increased Abuse in the Home**

Evidence from the pandemic suggests that children are more likely to experience maltreatment and be exposed to family violence while simultaneously having decreased access to the services that would typically help them (Collin-Vézina et al., 2020). The current system has failed to provide protection to the most vulnerable such as those in abusive or neglectful homes. The schools are closed, the community centers don’t operate, and social aid resources are likely closed as well.

### **Pre-existing Conditions**

People with pre-existing SMI are at risk of the pandemic's both direct and indirect effects, particularly when coupled with socioeconomic disadvantage (Moreno et al., 2020). Sommer and Bakker (2020) state that those with preexisting mental health conditions may also have increased risk for COVID-19 because of life circumstances such as severe mental illness (SMI), alcohol or drug misuse, and homelessness. Social workers must recognize that avoidance, which may have been an unhealthy coping strategy for a client previously, is now rewarded and encouraged (Moreno et al., 2020; Norman, Cuccurullo, Silva, Larsen, & Maieritsch, 2020). Moreno, et al. (2020), found that those with eating disorders, autism spectrum disorders, dementia and intellectual disabilities are experiencing increased symptoms during the pandemic and quarantine. Confinement at home impacts clients as well as social workers needing to provide services to clients. For clients with eating disorders, a survey in Spain found that the increased uncertainty negatively impacted their course of treatment, with 38% reporting worsening of the symptoms and 56.2% reporting increased anxiety (Fernández-Aranda et al., 2020).

### **Children and Teenagers**

Previous research on quarantined children found they were more likely to develop mental health issues, including acute stress disorder and adjustment disorders, than those not in quarantine (Moreno et al., 2020). Quarantined children lack space and distance from their likely stressed parents. Not able to go to school (which for some who are bullied or don't learn well in that environment could be a silver lining) for many is negatively impacting their social development.

Compounded stress will result for children in foster care awaiting visits and adoptions;

children in hospitals; children with chronic conditions that fear hospitals now; children whose loved ones die; and children who get COVID-19 themselves.

The Center for the Study of Traumatic Stress published a resource called “Discussing Coronavirus with Your Children” (Center for the Study of Traumatic Stress, 2020a) which provides parents with guidance for different ages and another that provides specific language (Center for the Study of Traumatic Stress, 2020b). They recommend that “calm and clear” parents communicate about COVID-19. This may be a big ask considering many parents are not in that space regarding the pandemic. They recommend presenting home isolation as an adventure to be enjoyed. The resource does not adjust this approach in consideration of length of home isolation nor if a family member within the home is quarantined. The resource also expresses the importance of touch for children, which is also a risk factor at this time. Resources on how to get physical touch for children and adults is critical. A more effective resource may be one for the panicked parents on how to talk to their children while activated. Similarly, for social workers, resources for how to engage with clients when the social worker is in the same tumultuous environment as the client. Vicarious trauma should perhaps be called “complex vicarious trauma” when one’s own pandemic experience is simultaneous, an important consideration for social workers.

Teenagers, who have a developmental need to separate, are struggling and the research is lacking. CSTS discusses distance learning, social life, athletics, online/social media contact, disrupted schedules, boredom, and loneliness as occurring distinctly to teenagers. In addition, wanting to go out or sneak out is different when there is a pandemic contagion. Teens may be experiencing death and fear of death without the ability to process it. They may feel increasing uncertainty about the possibilities in their future. Teens need solutions, support, routine, and



flexibility to best handle this change in their world (Center for the Study of Traumatic Stress, 2020b, 2020i). They also need physical exercise, safe technology use, shared meals, sleep, and new opportunities to engage them.

**Online school.** Social workers recommend trauma-informed online teaching during this pandemic (Marquart, Carello, & Creswell Báez, 2020). In spring 2020, most schools switched to emergency remote learning. Students are arriving to class stressed from fear the virus, worry for sick loved ones, anxiety over the future, and the intensity of racial violence, high awareness of sexual violence, and election stress. Teachers may regularly have a student with trauma who may withdraw from participating in class, struggle to focus or remember, and has anxiety about schoolwork. During a pandemic, the number of students with trauma in one class is high and the teacher may be experiencing these trauma symptoms too (Marquart et al., 2020). Trauma-informed teaching and learning (TITL) was designed for use in the college context, but can be adopted in the K-12 environment as well. These principles are meant to promote learning successfully and prevent re-traumatization.

### **Older Populations: Protected to Death**

The older population are at higher risk of COVID-19 as well as mental health related consequences, additionally burdened by increased isolation and loneliness already present in this population (Berg-Weger & Morley, 2020; Javadi & Nateghi, 2020; Moreno et al., 2020). Some are sheltered in nursing or hospital facilities so completely that their death is more attributable to loneliness than other causes. In one study on those over 45 in the U.S., older individuals reported less depression and anxiety symptoms than younger, and higher well-being scores (Jewell et al., 2020). Researchers investigated what level of fear is needed to motivate change in behaviors among the older population, finding that a high level of fear and interest in preserving health led

to preventive behaviors (Ahorsu et al., 2020). The researchers implied that therefore fear is protective, yet fear is more likely to lead to negative mental health outcomes. Jewel et al.'s (2020) findings indicate that because of high rates of depression, anxiety, and stress in the U.S. population at this time, particularly among those under- and uninsured, that clinicians and social workers should work to calm and allay fears of older clients (Jewell et al., 2020). Yet, this recommendation raises ethical questions, given that COVID-19 is not a perceived fear, but a real one. Might the alliance between the social worker and the client be hampered if the social worker tries to reassure and convince? Given the distrust of authorities rampant during the pandemic (Khan et al., 2020; Rambaree & Nässén, 2020), social workers should seek to build an alliance with client over the unknown, not provide baseless reassurances.

### **LGBTQIA+ Populations**

Given the widespread experience of many LGBTQIA+ individuals with feeling isolation and loneliness, particularly young people with unsupportive parents, the needs for discrete, online services to provide care for members of the LGBTQIA+ population are high. In surveys, many in the LGBTQIA+ population have cited high levels of distress and isolation particularly young people. Fish et al., utilized online chats with LGBTQ youth and found that synchronous, text-based online platforms led to an increase in feelings of safety “stuck at home” during the pandemic (Fish et al., 2020). Gonzales and a team of researchers (2020) discussed how the abrupt closing of universities and colleges returned LGBTQIA+ young people back to homes that they often were grateful to flee. Of those sampled, 60% were experiencing increased levels of psychological distress including anxiety and depression, related to returning to their family home. These levels were in addition to distress related to the pandemic. The authors recommend university counseling centers focus on these students providing access to additional resources

and hours of counseling (Gonzales et al., 2020).

For some members of the transgender population who seek gender-affirming treatment, delays in such treatment will likely have negative mental health impacts (van der Miesen, Raaijmakers, & van de Grift, 2020). Telemedicine for endocrinological care is incredibly important to allow transgender folks continuing or starting care to proceed. Psychological care is critical during a time of additional burden in logistics to secure the services needed and where time is additionally important. A web-based survey among the transgender population in Italy found that nearly 25% had a moderate to severe impact of the pandemic on their lives. Telemedicine was incredibly important to allow gender-affirming hormonal treatments to continue (Gava, Seracchioli, & Meriggiola, 2020).

### **Bereavement and Grief**

“Conceptually, trauma and loss of life in mass casualty events are inextricably linked” (Hansel, Saltzman, & Bordnick, 2020, p. 2) Expected surge in prolonged grief disorder (PDG) (Eisma, Boelen, & Lenferink, 2020; Johns, Blackburn, & McAuliffe, 2020). PGD risk factors include more than one death in a close period of time, no way to participate in death and burial rituals, death being believed to be preventable, and previous mental health disorders (Johns et al., 2020). The impact on children of deaths without ritual is anticipated to be intense. Touch is missing from many people’s lives during quarantine, and in the course of bereavement touch is a common practice in the U.S. that is now not possible on videoconferencing funerals. Johns et al. (2020) charge social workers with supporting hospitals that lack the resources to provide pre- and post-death interventions to families. “Never before has a beacon of light and hope been needed in a time of dark and turbulent despair currently experienced by many” (Johns et al, 2020; p. 663).

### **COVID-19 Family Members**

There are traumagenic effects of being a family member of a sick or dead COVID-19 patient, leading to long-term impact past the pandemic (Eisma et al., 2020; Moreno et al., 2020). CSTS (2020) recommendations for family members of the COVID-19 infected include children utilizing art and positive messaging for the sick loved one, and families understanding that while they must advocate for themselves to stay informed, information may be slow to come. An additional aspect is the survivors and their families coping with stigma (Eisma et al., 2020). Preparing families for delays in updates and lack of contact, particularly for older family members who care not adept at technology or have trouble hearing through available technology. Children are asked to contribute positive art for the ill loved one (CSTS, 2020).

### **News and Social Media Exposure Impact**

While many believe that the news, via television, radio, and/or internet, is a benign way to receive information, recent studies suggest that exposure to news negatively impacts ones sense of calm. Fullana, Hidalgo-Mazzei, Vieta, and Radua (2020) found that not reading then news had strong consequences of lower anxiety. Copur and Copur's (2020) meta-analysis found that high media coverage, poor information, continuing stay-at-home orders, lack of return to regular daily activities, and social media drama, can expect to lead to surges in depression, anxiety, phobias, ADHD, adjustment disorders, acute stress disorder, PTSD, and sleep issues. Ransing et al. (2020) stress the psychological impacts of "myths, misinformation, and fake news" (p. 6) and other digital impacts on the pandemic. While many people have habitual use of news and social media, and see it as a mandatory part of their lives, research indicates better health in less news and social media information, particularly around COVID-19. More research is needed on this topic.

### **Racial Injustice and Protest**

Infection and morbidity data suggests that the death rate from COVID-19 is disproportionately higher amount racial and ethnic minority groups (Hansel et al., 2020). In general, race and social injustice issues are amplified during a pandemic (Moreno et al., 2020). Yet in 2020, the racial injustices experienced through systemic racism are apparent and the protests to counter them, prolific. Multiple killings of unarmed Black individuals by police forces culminated in widespread protests; protests which, through gathering during a pandemic, may have put protesters at additional risk for contracting COVID-19, particularly where police intervention was involved. While systemic racism has received increased attention through movements such as Black Lives Matter, participation in social demonstrations is fraught with additional complications due to COVID-19. The need and right to protest exist during pandemics as well, yet cause further distress for those that cannot participate or feel additional fears from participating. These stressors impact social workers as activists and as providers of service that must be socially just (NASW, 2017). In a beautifully written article from the perspective of librarians, Gibson et al., (2020) explain through the imagery of struggling to breathe, the way in which the country is suffering multiple traumas, and that approaches to heal, and listen, should be panethnic. More research is needed on this topic.

### **Political and Election Stress**

The 2020 election brought even higher levels of stress to a population already maxed out. Divisiveness, fear, anger, frustration, and desperation combined in many already stressed about COVID-19, unemployment, racial injustice, and more. Much research about this issue is ongoing and therefore unpublished at this time. Bruine de Bruin, Saw, and Goldman (2020) noted that political ideology impacted COVID-19 personal protective behaviors. Participants saw the

election outcome as important to stopping the spread of COVID-19 as well. Calvillo, Ross, Garcia, Smelter, and Rutchick (2020) noted that political ideology impacted perceptions of COVID-19 risk among U.S. adults. In addition, the stress of the pandemic and the 2020 election was highly determined by exposure to news media and social media. Because of the way that the two major political parties in the United States are constructed as diametrically opposed, this forced separation also contributes to higher levels of stress, disconnect, and anger. That COVID-19 risk is then also used as a political pawn further divides a country in need of connection. More research is needed on this topic.

### **Pandemics and Disasters (Research) Don't Mix**

Research from financial recessions, disasters, and pandemics all demonstrate that anxiety, depression, and post-traumatic stress disorder rates are expected to soar (Hansel et al., 2020). An issue with much of this research is that it does not take into account a global crisis where everyone is potentially affected. Because of that, while it can be deduced that the negative impacts to mental health will be even greater, one doesn't presume it is simply an additive model. Add to this the preexisting conditions of social injustice, the #MeToo movement, racial violence, election and political turmoil, and a decades long mental health crisis, and the COVID-19 pandemic feels unmanageable. Marginalized populations are experiencing increasing amounts of systemic trauma (Collin-Vézina et al., 2020). Challenge using disaster response to inform pandemic response is that it is far more likely a mental health professional, too, is affected by the pandemic than a disaster. For instance, after Hurricane Katrina in New Orleans, social workers from around the country were brought in through SAMHSA's crisis response unit, but the same social stressors and quarantine rules are applied to the mental health professional and their families in a pandemic but not always in a disaster. Particularly in disasters where out of town

clinicians can be brought in. In the pandemic, few are “out of town” or “out of harm’s way”.

While some research focuses on the community phases of disasters, this author finds that problematic and inapplicable in a variety of ways. For these models, the impact is singular, such as a hurricane or an earthquake or explosion. What mental health research tells us about even a single event is that it is never a single event. In Hurricane Katrina, for instance, a single hurricane occurred, but it set off a domino of traumas each needing their own response. Because of this, the disaster model fails in that way on even a disaster. Yet with a pandemic, there is a beginning with no end (at this time). Using a model that has a decrease in intensity after “an event” is not trauma-informed nor practical.

Distress reactions such as sleep difficulties, loss of a sense of safety, somatic symptoms, irritability, and isolation combine differently in a pandemic than a disaster (Center for the Study of Traumatic Stress, 2020). During this pandemic, quarantine (seen as isolation for some) is encouraged as a positive yet the impacts are negative. With distress reactions can come health risk behaviors including substance use and abuse (including alcohol), family distress, interpersonal conflict, disruptions in life’s routine, and restricted activities and movement (Center for the Study of Traumatic Stress, 2020d; Hansel et al., 2020). Increases in complex grief, PTSD, anxiety, and depression are predicted for even larger portions of the population, further complicated by lack of access, lack of belief that they deserve to seek treatment when “everyone” is suffering, and a lack of providers with availability. The lack of preexisting models on pandemics as continual trauma begs for research, perhaps more comparable to living in an abusive environment.

### **Pande-mania: Complex Issues for Social Workers**

For social workers working in a pandemic, employers should implement infection-control

mechanisms and surveil staff, clients, and visitors, in an effort to protect clinician and client. Yet this often includes minimizing visits and contact that are crucial for mental health (and for the employment of the social worker). Physical distancing in inpatient programs means less staff and less beds available at a time when need is higher. Some clients are rapidly discharged due to space constraints yet it does not adequately address need of the client (Moreno et al., 2020). Homeless shelters close or take an even smaller number, an additional concern during summer and winter months. All of this impacts the social worker at a time when feeling empowered can have positive impacts on mental health.

Many factors contribute to the negative mental health impacts of the pandemic, and these apply to social workers, including real or perceived financial loss, loss of confidence in authorities, and lose of culture or way of life. Loss of confidence in authorities can potentially impact the clinical relationship between social workers and their clients, including what information social workers are confident passing on to their clients.

Many models for the risk factors for social workers during a pandemic are based on disaster models where an event occurs and then help comes in (Ahorsu, Imani, et al., 2020; Center for the Study of Traumatic Stress, 2020d; Sprang & Silman, 2013). A pandemic lacks a single event and functions more like repeat trauma day to day. (For further discussion on this, see “Disaster research being used for pandemic understanding” below). This differs from a disaster also in the way that news coverage warns of the illness’s approach and reach. Feelings of doom and catastrophe are not psychological symptomatology only, but are based in actuality, further complicating effectiveness of certain mental health treatments such as CBT, where therapists are trying to help clients see cognitive distortions. The actual danger of the pandemic, without access to a vaccine, is real and persistent and pervasive for many social workers.



**AUTHOR'S NOTE**

I feel worry for my clients who need to be in the gym, at school, with friends, experimenting with love interests, dating, having sex, running, interacting with strangers at the grocery store. I worry about the disconnect through telehealth, even if it also means that they got access to mental health care they may not have had otherwise. I long for the day I can sit with my therapist in her office, because I can feel the healing energy differently than I can on Zoom.

Social workers working in hospitals must make difficult decisions on prioritizing inadequate resources in ways that result in subpar care for those that are dying. This can include who gets the limited number of ventilators and who does not. These collisions with one's moral code, when a social worker is forced to take action, are comparable to military engagements and can conclude with trauma responses in the social worker (Moreno et al., 2020).

As social workers prioritize need, for clients, less acute conditions could not only become more acute but the ability for one to tolerate anxiety without regular care can lead to a rapidly increasing, desperate need to dissipate symptoms and utilizing self-harm, substances, or suicide to do so. For those who have been sober, there are increased risks for relapse at this time and therefore increased demands on their resources, including their social workers (Hansel et al., 2020).

**Telehealth**

For many social workers and their clients, the existence and availability of telehealth to provide mental health services, was a blessing. But for the existence of such technologies, however imperfect, many new and continuing clients would have been unserved for their mental health needs. This is a COVID Silver Lining. Telehealth has enabled many social workers to continue practice during the pandemic, maintaining fidelity in treatment. While many practitioners already practiced telehealth, the majority did not. The quick need to shift from in-person contact, to virtual contact presented many challenges in terms of accessibility, quality of

transmission (such as cellular and wi-fi), and moving to establishing and maintaining therapeutic alliances virtually (TherapyNotes LLC, 2020; Wayne State University, School of Social Work, 2020). While telehealth allows those with the resources and technology access to telemental health, many clients and some social workers, are left behind. Thankfully, governing body flexibility in confidentiality and HIPAA laws for telehealth have enabled greater utility.

#### AUTHOR'S JOURNAL

I began my clinical work as a student during the COVID-19 pandemic. I found myself concerned about learning to be with clients while on a computer. I was concerned about building rapport, establishing an alliance, and how to handle clients in crisis, particularly suicidal clients. My field placement also doesn't cover the cost of upgraded Zoom, for instance, which means additional cost for me. For family sessions where people are in different locations and need more than 40 minutes, this means a mandatory upgrade cost for me. I am finding the process far better than I worried. I also see this as a COVID Silver Lining, in that I would not have learned telehealth during my clinical field placement had it not been for COVID. Now, this will be a resource I can provide clients outside of the pandemic, and feel increased confidence. I am thankful for the research team of Simpson, Richardson, Pietrabissa, Castelnuovo, and Reid (2020) who helped me consider that there are benefits to telehealth in the way alliances can form which I had not considered.

The American Psychiatry Association's (2020) training "Telepsychiatry in the Era of COVID-19" recommends mental health providers acquire telehealth certifications to become aware of the importance of platforms, privacy concerns, safety, and licensure considerations. Ramalho et al. (2020) explain that telehealth is a crucial tool for clinicians, and provide a useful protocol to determine utility of telehealth for clients that is widely applicable to a variety of populations covering all WHO regions. Simpson, Richardson, Pietrabissa, Castelnuovo, and Reid (2020) present the benefits of telehealth and videotherapy in providing a neutral space for clients. They suggest that, counter to those concerns of difficulty through videotherapy, many clients may be more likely to participate, more able to attend, and feel less intimidated, hence leading to improved alliance with the therapist. The authors provide key skills for developing an alliance

over video that social workers would be well advised to read through and consider. These skills include walking the client through the technology, sharing access and control, maintaining boundaries, and the importance of a consistent therapeutic frame (Simpson, Richardson, Pietrabissa, Castelnovo, & Reid, 2020).

Questions for social workers using telehealth to consider include: What if a client does not consent to telehealth? Does one have a temporary termination? Is the social worker willing to see the client in person? If a social worker knows the client has young children home, does the social worker have to recommend childcare? If the client calls from in the car, are they parked safely? What are the impacts of clients talking about highly sensitive topics in a place where that doesn't feel safe? If clients are home with other family members including children, or abusers, how do they get true privacy?

The author designed a number of hand signals for her clients that they review at the start of telehealth. These allow the client to signal to the therapist to cease talking if privacy is compromised or if the client needs to quickly sign off the call due to a privacy concern, with rules established in advance for how follow-up will occur.

### **What Do Social Workers Need?**

**Individual level.** The Center for the Study of Traumatic Stress recommends social workers be sustained with individual and organizational actions as well as those of leaders (Center for the Study of Traumatic Stress, 2020d). At the individual level, the webinar by CSTS titled "Supporting Clinician Well-Being during COVID-19" encouraged social workers to speak up, practice self-care, take breaks, have a "battle buddy" to share with, stay connected to others, and honor the service they are doing.

For social workers in hospital setting dealing directly with COVID patients, they

experience a unique level of trauma (HCPro, 2020; Lee, Kang, Cho, Kim, & Park, 2018; Maunder et al., 2004; McBride & Cohen Silver, 2020). Case managers are facing high levels of trauma on a daily basis due to an ever-changing situation, from contagion rates, to methods, to catastrophic situations clinically and at their own homes, including lack of PPE (HCPro, 2020; Lai et al., 2020). Nearly 50% of healthcare workers in hospital settings experienced depression, 45% anxiety, 34% sleep disruptions, and 72% experienced distress in some form (Lai et al., 2020). These numbers are astounding, keeping in mind these are among the individuals with intense responsibility in helping those with COVID-19, who need to be healthiest. Compassion fatigue is high for mental health care providers and can be difficult for one to detect in themselves (Mohd Fadhli et al., 2020). This is another reason why a “battle buddy” is a helpful concept for social workers who can have a check mechanism built in. While vicarious trauma is a significant risk, there is trauma experienced by the social workers at the same time, leading to potentially different, more complicated, more intensely negative mental health outcomes (and perhaps consideration of the previously mentioned idea of complex vicarious trauma. All social workers need trauma-informed training as well as access to that care for themselves.

The CDC states that indicated signs of too much stress include feelings of overwhelm, sadness and/or depression, low motivation and concentration, and sleep challenges (Centers for Disease Control and Prevention, 2020a). The recommendation is then to step back and take a break. Yet during a pandemic, with high need clients, possible high needs in one’s household, and one’s own high needs, how this gets executed would be important practical, advice. This report provides ideas and suggestions, while acknowledging the immense challenge. While reaching out for support is key, many social workers know all too well that they are reaching out to the overburdened. Still, reach out! Choose care for oneself over increasing exhaustion.

Understand and adopt the practices and policies of SAMHSA's six trauma-informed care principles (Substance Abuse and Mental Health Services Administration, 2020), and then apply them to yourself as well. As a social worker, your strength is in knowing you are living during a series of countless traumas, and that you require care. Let out frustrations, and tears, and anger, and irritation. Let in love, and joy, and laughter, and lightness. These exist even in the presence of such darkness. Find those COVID silver linings. Your previously deflected needs are now front and center, and taking care of you will make you stronger and more capable for whatever it is you choose to do. We don't get strong just so we can take care of others. We get strong so we can feel good in our skin, strong in our resolve, and equipped for life. That others may benefit is the bonus.

*Self-care.* The "COVID-19 Resource Compendium for Social Workers and Their Clients" provides a great deal of self-care videos, mobile apps, and trainings for social workers to utilize to decrease burnout and increase mindfulness. "Care" is a term designed exclusively to refer to what a social worker does to another. So much so, that "self" needs to be appended to the word in order for care of self to be invoked. The WHO defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider" (World Health Organization, 2020a). Research points to how much social workers and healthcare providers need their own self-care practices (Canady, 2020). Mindfulness is a free, readily available practice social workers can engage in (Beck, 2020). Social worker Allison Berkowitz explains that self-care is social work (Berkowitz, 2020). She says that while many social workers are reluctant to practice self-care, that it is in fact a radical act and part of a commitment to social justice. We cannot appropriately care for clients if we are not caring for ourselves and

legitimately practicing what we recommend. The compendium for this report will provide a list of self-care resources for social workers, including mindfulness, meditations, podcasts, videos, distractions, exercises, and more.

#### AUTHOR'S NOTE

Writing about self-care and searching for helpful resources reminds me to apply this effort to myself as well. Social workers need to own their own vulnerability and need, and see that awareness as a strength. Our awareness in the room with clients is a necessary super power. This must be applied to our own health and well-being as well. This must be applied to my own health and well-being.

**Organizational level.** At the organization level, social workers should be provided training, equipment, education, policies, procedures, and resources to perform the individual sustainment factors and to feel safe and supported at work. Leaders in the organization and in the professional community are asked to be present, communicate, provide encouragement, set an example for the individual factors, normalize the struggles, provide hope, and address grief. An additional concern remains where the leaders are getting their support from. In some ways, this model is like that of the social worker where the individual factors are encouraged in clients, while the social worker is expected to be the leader.

**National level.** The CSTS recommends a national prevention strategy for the clinical workforce which includes professional societies and institutions leading the efforts (Center for the Study of Traumatic Stress, 2020d). All organizations with clinicians must implement a behavioral health plan as a mandatory component of incident response. The behavioral health plan should be multi-modal, have acute awareness of unique and shared vulnerabilities, has a hierarchy of intervention needs established, monitors for long term sequelae, and supports local, state, and federal efforts at protecting and addressing behavioral health. The federal government and leaders in research must fund a research agenda that prioritizes mental health so that the impacts of pandemics are not as stark, predictable, and preventable.

### **Further Recommendations**

During a pandemic, early intervention for mental health care is necessary. Some research recommends triaging clients to provide critical resources to those “most in need”, and use community resources for those less acute. For many social workers, this feels like a difficult choice, and could lead to the less ill becoming more ill because of this approach. Hansel et al. (2020) propose a 4-step public health approach utilizing Screening, Brief Intervention, and Referral to Treatment (SBIRT). Their approach reserves limited clinical services to those with “the most extreme reactions” (p. 4). Others are encouraged to find community resources or lay persons trained in psychological first aid. Perhaps seeing these reactions as normal reactions to abnormal events is better for meeting the client where they are, yet criticizing the research also impedes potential benefits in interventions.

Education, psychoeducation, self-care and education around self-care, and family and community supports, all contribute to a mental illness prevention strategy that is comprehensive and interagency. Food delivery, support groups (online or distanced), volunteer crews, emergency funds collection and distribution must coincide with medical and mental health care. While there is an economic crisis with COVID-19, it is important that cheap solutions to mental health issues are not appropriate solutions. Our standards must remain high even when, and especially when, desperation is high. In Ransing et al.’s study (2020), they surveyed psychiatrists around the world to gather data to inform a conceptual framework for how psychiatrists respond in a pandemic. Perhaps social work researchers can do the same, first across the U.S., and then globally, starting with a small collection of social workers from all WHO regions.

Research indicates that quarantine, while necessary from a public health perspective, should be done for a set period of time for no longer than required, and accompanied by high

quality, frequent information from reliable sources and PPE for all households (Brooks et al., 2020). “Most of the adverse effects come from the imposition of a restriction of liberty” (Brooks et al., 2020, p. 912).

More research is greatly needed, and other areas in need of research for impacts of COVID-19 on populations, and the social workers who care for them, are prisons, spiritual communities, rural areas, parents and those in already strained relationships, and trauma survivors.

Social workers will need funding, policies, coordination, communication, and a willingness to experiment, in order to appropriately handle COVID-19 and future pandemics. Digital support groups and processing groups, well managed, may serve both clients and social workers. Support Group Central, included in the Compendium, offers virtual support groups that can benefit social workers and clients. Using the community, even when physically distanced, can be a great resource to maintain a semblance of normalcy and connectedness.

### **Conclusion**

“Not only should we expect there to be long-term sequela for survivors and health-care workers, but also for the general public, especially those that lost someone due to COVID-19” (Hansel, Saltzman, & Bordnick, 2020, p. 2). A country’s focus on mental health should not start nor end with a pandemic. Psychoeducation, demystification, and affordable access should be commonplace. Efforts to this end must continue long after a safe, effective, and affordable vaccine for COVID-19 is found. The mental health pandemic resulting from the COVID-19 virus will not have a vaccine. The suffering will be long lasting and social workers must be well-equipped to provide services to clients for decades to come.

To do this, social workers need resources, support, fellow social workers, time off, and



self-care. Social workers have a built-in community of other social workers, if they choose to look up and see the richness of that support. Perhaps the Compendium can serve as a COVID Silver Lining for those that feel out of steam in the search for resources, to know that others are out there also in need, and that help does exist. The exquisite work of social workers will enable clients to heal so long as social workers remember to promote their own self-care and healing.

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