Rising Tide: Responding to the Mental Health Impact of the COVID-19 Pandemic

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The current COVID-19 pandemic is an invisible threat unprecedented in its global reach and extended, uncertain nature. No individual or community is left without impact, whether it is infection risks, COVID-19 illness, loss of a loved one, disrupted employment, or financial strains. Much of the world has experienced an extended and uncertain time period of quarantine and/or social distancing restrictions that substantially interfere with usual work and social routines, cultural and religious customs, work and leisure activities, and the availability of services. For healthcare and other frontline workers, there is ongoing risk of morbidity and mortality for themselves and their families as a result of their service. Although this specific pandemic is larger than previous pandemics and has resulted in more deaths than the Attacks on September 11, 2002 (Center for Disease Control, 2020), there is much that the mental health field knows from military, disaster settings, and other types of trauma exposures that can help guide how we support our health professionals working in this extremely stressful environment (VA/DOD, 2017). Investments in efforts to support mental health and provide indicated prevention and intervention may decrease long-term risk for negative mental health outcomes, including for healthcare workers and other staff on the front lines of the pandemic.

Many are predicting that the mental health impact will be grim. We agree that the mental health impact will be significant, but also feel confident that for most, the pandemic and its aftermath will be a significant stressor that people cope with in real time and even if highly distressed acutely, will eventually naturally recover and move on to a new normal and satisfying life. The mental health response must be measured and not overly emphasize a belief and expectation of an epidemic of unmanageable long-term negative mental health impacts. Instead, while planning to address mental health needs that will arise, we should project hope and have confidence that most people will recover with time. Data from the field of trauma and bereavement strongly support that resilience is the modal outcome even for severe challenges (Bonanno et al., 2002; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Nonetheless, a shortage of access to effective mental healthcare was already a problem before the pandemic and will worsen even if only a small percentage require intervention (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). As such, planning needs to consider efficient use of resources and possibly stepped care models to provide the most effective and least resource-intensive course of care to respond adequately (Richards et al., 2012; Zatzick et al., 2013). Helping people cope acutely while assuring access to those in need of higher levels of mental health intervention are critically important goals. Although the evidence base for prevention intervention is less clear about optimal approaches, there are nonetheless many helpful strategies that may help reduce both short- and long-term distress, and their targets are guided by relevant clinical and research lessons learned over many years. Key to any mental health response to the current pandemic or other extended potentially highly distressing and/or traumatic events is a response that simultaneously considers both timing (referred to as phase) and associated distress and/or functional impairment (referred to as level). As defined below, the framework includes three phases (initial, post, and longer-term) and three levels (system level, self-directed level, and mental health supported brief intervention).

The Phased Approach to COVID-19 Mental Health Response (PAC), now freely downloadable on the *Anxiety and Depression Association of America* website (https://adaa.org/sites/default/files/PhasedApproachtoCovid-19.ver1.1%20(002).pdf), is a framework for COVID-19 mental health response (see Table 1). This framework of phased interventions and resources is intended to assist health systems and programs impacted by the pandemic to plan for how to address current mental health issues arising as well as to prepare and plan for the continued needs of their communities, patients, and staff. In addition, many of the resources presented may be used by healthcare professionals and others on the front lines of care, as well as anyone being significantly impacted by COVID-19 as they see fit. The framework provides a model for response over time and across the wide range and severity of potential impact of the pandemic, including program design considerations and examples of evidence-guided resources when available. For specific areas where previous resources were not freely available, select evidence-informed brief interventions were created and are downloadable from the Framework posting on the ADAA website (mask desensitization [with colleagues from the University of Chicago, Emory University School of Medicine, and New York University]), self-directed difficult experience exposure (created by the authors and Dr. Jeffrey Cigrang), and assessment protocol with brief intervention for an MH provider adapted from Rothbaum et al. (2012).

TABLE 1. Phased Approach to COVID-19 Mental Health Response (PAC)

Phase	Level	Target Population	Content	Examples
Initial phase	System supported level 1	This first level targets all healthcare and any other frontline workers in settings with heightened risk of COVID-19 infection, such as patient care settings, as well as others impacted by COVID-19	Resources and work policies to support staff and basic information that can be made widely available to people before the start of a shift and throughout their work with COVID-19 patients.	Framework for organizational response to 5 requests from healthcare workers in the current pandemic: "Hear me" "Protect me" "Prepare me" "Support me" "Care for me" (Shanafelt, Ripp, & Trockel, 2020)
Initial phase	Self-directed level	Initial phase self-directed level targets any healthcare workers who would like self-directed preparation and support during their work as they continue to care for or provide services for COVID-19 patients or those who are having initial responses with low to moderate distress and/or interference in function but without imminent risk of harm to self or others	Content continues to focus on prevention of negative mental health outcomes but includes some specific direction on managing difficult emotional experiences workers (or impacted others) may be encountering	Face mask and PPE related anxiety (see framework) Insomnia and sleep disturbances General coping and distress Managing personal losses due to COVID-19
Initial phase	Mental health supported brief intervention	Individuals with greater distress, impairment or risk, exacerbation of pre-existing mental health conditions and/or lack of response to self-directed interventions	Evidenced-based interventions	Cognitive behavior therapy (CBT) Pharmacotherapy when indicated
Post-phase	System supported level	Recommendations for leadership and organizations	Continue the resources and follow the recommendations from the initial phase system supported level. In addition, would include access to more formal employee assistance resources with providers who are trained in how to approach COVID-19 related distress	Employee assistance and wellness resources
Post-phase	Self-directed level	Impacted people who would like to have a supported way to approach their experiences as well as others who are reporting early signs of difficulty, such as not being able to stop thinking about experiences, intense emotional reactions when they think about their experience	Evidence-informed resources that individuals can work with on their own	Making meaning of the difficult days: This is a selfdirected version of the prolonged exposure for primary care written exposure protocol that has shown efficacy in military service members to reduce PTSD symptoms when provided within the primary care environment with an embedded mental health provider as support (Cigrang et al., 2017). This modified version for COVID-19 healthcare workers and other impacted was created to provide an option for healthcare workers who want to approach difficult memories on their own (see framework)

continued

TABLE 1, *continued*

Phase	Level	Target Population	Content	Examples
Post-phase	Mental health supported brief intervention level	For those reporting stress, anxiety, or depression associated with significant distress, functional impairment, or signs of risk to self or others. This intervention is for those with an identified mental health need and may occur through contact with mental health in primary care or specialty mental health settings	Evidenced-based interventions	Modified prolonged exposure (Rothbaum et al., 2012). Early intervention may prevent the development of posttraumatic stress disorder: a randomized pilot civilian study with modified prolonged exposure
Long-term phase	All levels	Focus more closely over time on those with identified functional impairment over time	As in earlier phases	Evidence-based care such as CBT, or pharmacotherapy when indicated

Phased Approach

This proposed phased approach is intended to help guide efficient allocation of mental health resources to those most in need of assistance at the time that they need it at the level that they need it (e.g., self-directed vs. brief intervention with some support vs. traditional treatment sessions with a provider). Appropriate allocation of expert mental health resources can assist the system in providing evidence-based clinical care to those who need it.

The *initial phase* includes the period of time while we are dealing with the ongoing stressor, such as the current COVID-19 pandemic (see Table 1). This phase would end when the initial risk and impact has ended or reduced to a "new normal" or lower level of risk. The *post-phase* includes the initial responses in the period after the acute exposure to risk and loss is complete and the following 3 months when expectations are that people impacted will be having various levels of emotional reactions and response (see Table 1). The *long-term phase* covers from 3 months after the individual's experience of impact and loss is over and into the future (see Table 1). For this pandemic, the phases will overlap for individuals depending on their roles and specific impacting traumatic exposures (traumatic loss of significant others, exposure to death at work, etc.). Further, grief responses generally occur on a longer timeline with current iterations of prolonged or complicated grief utilizing a 6- or 12-month minimum for diagnosis to account for broad individual, cultural and religious variability in usual acute grief and its evolution to more integrated forms of grief (e.g., for recent commentary and treatment approaches see (Iglewicz et al., 2020; Simon et al., 2020).

Within each phase, there are different levels of response. The *system supported level* focuses on recommendations for leadership and organizations to put in place for those in the relevant phase (see Table 1). The *self-directed level* includes resources that individuals can work with on their own. These self-directed interventions are intended to be used based on either self-assessment of need or as an initial intervention for those with mild to moderate distress and/or functional impairment without imminent risk to self or others (see Table 1). Finally, the *mental health supported brief intervention level* includes brief interventions provided with entry through primary care or mental health providers for those with a higher level of need or for whom self-directed approaches are not possible and/or effective (see Table 1).

As basic principles across all phases and levels, systems and individuals engaging in mental health response are encouraged to:

(1) Ensure basic needs for food, sleep, and lodging are met. For healthcare providers and staff, this means management of risk of personal and family COVID-19 infection such as PPE.
(2) Find creative ways to safely enhance social connection and support.
(3) Provide ongoing support for people as they would like- not a single shot.
(4) Encourage people to use what positive coping strategies have worked for them in the past that they can draw on again such as talking with friends and/or family, exercise, yoga, prayer, and so forth and monitor or possibly reduce unhelpful coping such as the use of alcohol or other harmful strategies.
(5) Create opportunities for people as they are interested and able to talk about difficult experiences. This can be helpful to process them, but avoid compelling people to tell their stories, especially in groups. Let them share as they are ready and willing- be ready to listen but don't force the story.
(6) Avoid group debriefing where everyone is required to share and listen to details of death or traumatic events. This has shown iatrogenic effects in some studies of trauma and PTSD. Other types of group support efforts, however, can be helpful to provide an opportunity to build community, emotional support, psychoeducation, and reminders about resources (even if virtual).
(7) Provide information about accessible mental health resources for those who may need them.

People undergoing stress most often need support from family and community for basic needs, safety, and emotional support. Plans for mental health response in the coming months must focus on providing social support and helping people to feel in control of things they can control while focusing professional mental health resources on those who need it most. The framework offers some ideas about how to integrate a phased approach to helping support those on the front lines or anyone being significantly emotionally challenged by the COVID-19 pandemic to meet our community needs over time. Empirical examination of the evidence-informed new resources that are part of the framework will soon be underway and as we learn about needs and response overtime, this framework will be modified to address the best science available.

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REFERENCES

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., … Nesse, R. M. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. Journal of *Personality and Social Psychology*, 83(5), 1150–1164.

Center for Disease Control. (2020). *Corona Virus Disease 2019* (COVID-19) *Cases Date and Surveilence*. Retreived from https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/index.html

Cigrang, J. A., Rauch, S. A., Mintz, J., Brundige, A. R., Mitchell, J. A., Najera, E., … Peterson, A. L. (2017). Moving effective treatment for posttraumatic stress disorder to primary care: A randomized controlled trial with active duty military. *Families, Systems & Health*, 35(4), 450–462.

Iglewicz, A., Shear, M. K., Reynolds, C. F., 3rd, Simon, N., Lebowitz, B., & Zisook, S. (2020). Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice. *Depression and Anxiety*, 37(1), 90–98.

Richards, D. A., Bower, P., Pagel, C., Weaver, A., Utley, M., Cape, J., … Vasilakis, C. (2012). Delivering stepped care: An analysis of implementation in routine practice. *Implementation Science*, 7(1), 3.

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress*, 5(3), 455–475.

Rothbaum, B. O., Kearns, M. C., Price, M., Malcoun, E., Davis, M., Ressler, K. J., … Houry, D. (2012). Early intervention may prevent the development of posttraumatic stress disorder: A randomized pilot civilian study with modified prolonged exposure. *Biological Psychiatry*, 72(11), 957–963.

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *Journal of the American Medical Association* https://doi.org/10.1001/jama.2020.5893.

Simon, N. M., Shear, M. K., Reynolds, C. F., Cozza, S. J., Mauro, C., Zisook, S., … Lebowitz, B. (2020). Commentary on evidence in support of a grief-related condition as a DSM diagnosis. *Depression and Anxiety*, 37(1), 9–16.

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services*, 60(10), 1323–1328.

VA/DOD. (2017). *Veterans Affairs and Department of Defense Clinical Practice Guideline for Management of Post-Traumatic Stress*. Retrieved from https://www.healthquality.va.gov/guidelines/MH/ptsd/

Zatzick, D., Jurkovich, G., Rivara, F. P., Russo, J., Wagner, A., Wang, J., … Katon, W. (2013). A randomized stepped care intervention trial targeting posttraumatic stress disorder for surgically hospitalized injury survivors. *Annals of Surgery*, 257(3), 390–399.