

Examining and Supporting Frontline Mental Healthcare Professionals (FMHP) during the COVID-19 Pandemic and its Aftermath

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Abstract

Novel coronavirus-19 (COVID-19) stealthily began its march across the globe at the tail end of 2019 in Wuhan, China and within months had reached all corners of the planet in devastating fashion. (Rajkumar, 2020; Galea, Merchant Lurie, 2020). The COVID-19 pandemic has impacted people of all nations, races, socioeconomic groups and genders. The ferocity of the virus led governments to take the unprecedented steps of closing schools, courts of law, businesses and entire communities. Shelter-in-place orders and physical distancing mandates have been implemented worldwide (Shanafelt, Ripp Trockle, 2020; Galea, Merchant Lurie, 2020). While COVID-19 is a virus which leads to respiratory illness, medical distress and sometimes death, the physical health manifestations of the virus are just the tip of the iceberg of this pandemic. The seeds of a major global mental health crisis are germinating (Hotpof, Bullmore, O'Connor Holmes, 2020). COVID-19 appears to be easily transmitted via close person-to-person contact, impacts large swaths of the world's population, and there is no known cure or vaccine.

Index terms—

1 Introduction

Novel coronavirus-19 (COVID-19) stealthily began its march across the globe at the tail end of 2019 in Wuhan, China and within months had reached all corners of the planet in devastating fashion. (Rajkumar, 2020; Galea, Merchant & Lurie, 2020). The COVID-19 pandemic has impacted people of all nations, races, socioeconomic groups and genders. The ferocity of the virus led governments to take the unprecedented steps of closing schools, courts of law, businesses and entire communities. Shelter-in-place orders and physical distancing mandates have been implemented worldwide (Shanafelt, Ripp & Trockle, 2020; Galea, Merchant & Lurie, 2020). While COVID-19 is a virus which leads to respiratory illness, medical distress and sometimes death, the physical health manifestations of the virus are just the tip of the iceberg of this pandemic. The seeds of a major global mental health crisis are germinating (Hotpof, Bullmore, O'Connor & Holmes, 2020). COVID-19 appears to be easily transmitted via close person-to-person contact, impacts large swaths of the world's population, and there is no known cure or vaccine. In the early part of 2020 global health care, economic and social welfare systems were essentially brought to a standstill (Horesh & Brown, 2020). Even more alarming, moving forward, COVID-19 looks to be the foundation for an unprecedented large-scale mental health catastrophe.

Frontline Mental Healthcare Professionals (FMHP) (social workers, case managers, therapists, psychologists and psychiatrists) are the first form of defense that society has, to combat the coming psychosocial consequences of COVID-19. As such the mental health of the FMHP needs to be considered. FMHP are presently and for the foreseeable future working under extreme pressure, stressful conditions and hoping to accomplish near impossible tasks. During the course of helping clients navigate the pandemic, they experience stressors from innumerable sources, and are profoundly vulnerable to their own mental health disruptions, as their occupations require them to come in contact with human suffering on an epic scale day in and day out.

Author: e-mail: jreddin@adelphi.edu Throughout COVID-19 FMHP are charged with the tasks of responding to increasing levels of child abuse and domestic violence (Krasniasky, 2020), supporting clients who have lost loved ones and are forced to forego traditional burial rituals, compounding their grief (Miller & Lee, 2020), and assisting families to avoid housing displacement due to financial hardship due as a result of job/income loss (Krasniasky, 2020).

Compounding professional stressors FMHP face stressors from society, their workplace organizations and from their own personal life. Supporting FMHP begins with examining the pressures that they experience. Understanding the stressors can in turn instruct policies and practices which can support FMHP, the organizations they work for and the clients they serve.

Given the unprecedented nature of the COVID-19 pandemic there is a lacuna of data regarding research pursuits. As such, this essay will rely on research from other national disasters and catastrophic events to extrapolate how FMHP have experienced stressors and how they can be supported in the continuing aftermath of COVID-19.

2 II.

3 Epistemological Considerations, Positionality & Theoretical Lens a) Social constructivism and Relativism

Social constructivism is a paradigm with a subjectivist epistemology, which puts forth the theory that individuals interpret and construct meaning based on their experiences and evolved beliefs. "Meaning is not discovered, but constructed" (Crotty, P. 9). All findings are a report not of what "IS" but what is experienced by the creator of the research (Guba 1990). Social constructivists posit that subjects impose all understanding & knowledge upon objects, and that all understandings, scientific or non-scientific are a form of constructed knowledge, created via the understanding of the viewer and knower (Crotty, 1998). Constructivists put forth the notion that it is impossible for a researcher to inquire from an objective or distant position, as the truth is, the researcher and her subject are fused into a reciprocal loop of understanding & information, which is constantly informed by subjective understanding and developed information (Guba, 1990).

Social constructivism and subjectivism are a good fit with social issues and the complexities of social work practice, given the specific character of social work, as a profession with roots in understanding and helping people, pursuing social justice and recognizing the importance of human relationships. The values and underlying mission of social work, which seeks to recognize the individual worth of each human, the development of support for oppressed populations and the growth and empowerment of society in general are all supported by the inclusive and introspective nature of subjectivist epistemology. In essence being "objective" when dealing with human problems is near impossible, which is the most compelling argument as it relates to the strength of the subjectivist epistemology.

The ontology that informs constructivism is relativism, which espouses the idea that all knowledge, scientific and otherwise is construed through social structures and relationships. Relativists understand that the amount of possible interpretations of reality are limitless and assert that various interpretations can coexist. (Guba, 1990) Relativism advances the position that all knowledge exists in relation to culture and that there is not and cannot ever be an independent objective reality. Creating reality, via examining relationships and point of view, rather than seeking to understand the one true reality is an ideal fit for social work, given the complex, ever evolving and truly human nature of the profession, as well as a study about stressors experienced by FMHP in the wake of COVID.

Ontology and epistemology influence methodology, as it depends whether as a researcher you see participants as subjects or active contributors to the project. Given my epistemological location, the most powerful approach to this research is participatory action research (PAR). PAR assumes that clients have the most information to explain the problems they are struggling with. It recognizes the knowledge and the power FMHP have and credits their experiences and points of view as valuable parts of the research journey (D'Cruz and Gillingham, 2017). Participatory research is a self-reflexive inquiry that enlists participants as partners rather than subjects and is action oriented, requiring research, action and further research (Baum, MacDougall and Smith, 2006). My scholarly interest in these issues arises from a very personal place in that many of my family members have been on the frontline of the war against COVID-19 and I seek to understand their experiences and support them in the most meaningful way possible.

4 b) Compassion Fatigue and Moral Injury

Much of the research in the area of stressors experienced by FMHP view the issue through the theoretical lens of compassion fatigue, also known as secondary traumatic stress, which posits that over time formal caregivers develop a reduced capacity to be empathetic towards clients (Adams, R. Boscarino, J. and Figley, C., 2006). The theory advances the framework that the cumulative and transformative effect of stressors experienced by FMHPs who serve traumatized clients is an expected occupational hazard (Buchanan, M., Anderson, J., Uhlemann, M., and Horwitz, E. 2006), commonly referred to as the "cost of caring" (Killian, K., 2008). While the theory of compassion fatigue/secondary traumatic stress can be effective in measuring long term impact upon mental

health professionals, as there are developed scales and long-term research, it does not precisely enough match the examination of the experiences of FMHP during the COVID-19 pandemic. In that COVID-19 is a phenomenon that has had a sudden and generally unexpected onset. The volume of death and suffering due to the virus and its aftershock has been global, intense, and unprecedented in modern times. A theory that does not account for the immensity of the issue will lead to incomplete research.

Another limitation of compassion fatigue/ secondary traumatic stress is that the theory negatively appraises the experiences and reactions of mental health professionals. Use of a theory that normalizes the suffering experienced by FMHP during this crisis is more appropriate, as FMHPs should not be pathologized. COVID-19 is a global mass trauma that brought the world to a standstill. Stress, anxiety and fear in the face of a mass traumatic event is expected and predictable. A more suitable theoretical lens to view research of stressors facing FMHP during the COVID-19 pandemic and its aftermath is moral injury theory.

Moral injury theory is one that can be used to examine the psychological, social and spiritual pieces of individuals. Moral injury is the distress that individuals feel when they witness, fail to prevent or commit acts that transgresses their core ethical belief system (Litz, B., Stein, N., Delaney, E., Lebowitz, L., Nash, W., Silva, c., and Maguen, S. 2009). As a result of moral injury individuals may experiences guilt, shame, anger and self-condemnation (Borges, L., Barnes, S., Farnsworth, J., Bahraini, N. and Brenner, L., 2020). Moral injury additionally includes an aspect of failure of leadership in extreme high stakes situation, and the impact it has on individuals (Shay, 2014). It was first recognized in a military context and is a theory used to explain the cost of processing moral pain and the enduring nature of Post-Traumatic Stress Disorder (PTSD) in soldiers returning from war (Ayyala R., Taylor, G. and Callahan, M., 2020; Shay, 2014).

The basic progression of moral injury begins with a potentially morally injurious event (PMIE), which is a situation occurring in an intense or extreme environment, that is perceived by an individual as a violation of his/her own moral values (Farnsworth J., Drescher, K., Evans, W. and Wasler, R., 2017). The perpetrator of the violation can be one's own self or another, such as a supervisor or someone who holds authority in the situation (Shay, 2014). Examples of PMIEs in military situations are use of deadly force on civilians and failing to or being unable to provide aid to fellow services members (Farnsworth et al., 2017). Within the context of COVID-19 and FMHP, actions and inactions which could be PMIE could be excluding loved ones from a dying patient's bedside or failure to make a home visit to provide services to a homebound client due to social distancing protocol.

As a result of MIEs individuals can experience moral pain, immediately, later or never. Moral pain is the natural, non-pathological shame, guilt, culpability and self-condemnation that individuals can experience as a result of being exposed to MIEs (Farnsworth et al., 2017).

Examples of experiences FMHP could have during COVID-19 potentially include shame of not providing necessary housing referrals to victims of domestic violence, who were then forced to shelter-in-place with their abusers, guilt over the need to discontinue face-to-face psychotherapy for clients, and self-condemnation for avoiding human touch and physically distancing from clients, due to a fear of infection and subsequent transmission. Moral injury is the suffering of one's psychological, social and spiritual self, as a result of unresolved moral pain (Farnsworth et al., 2017).

A limitation of moral injury theory in this context is that there has not been much application of the theory in non-military personnel (Borges et al., 2020). Although limited research has shown MIE in non-military settings, may expose members of civilian occupations to profound experiences that can be viewed via a moral injury lens (Williamson, V., Greenberg, N., and Murphy, D., 2019).

COVID-19 seems to be an extreme situation, in which FMHP are handcuffed by a lack of resources and are unable to deliver care in the way they have been trained to and expect of themselves (Ayyala, R., Taylor, G. and Callahan, M., 2020). Conflicted allegiances, to self, clients, occupational organizations and national public health may all be at odds for FMHP in COVID-19, who may feel compelled to sacrifice individual client needs for their own, or for the sake of the greater good.

The intersection of a worker's competency, expectations of herself, client's needs, her agency's resources and public health requirements seem precisely the point where moral injury lies.

Given the uniquely personal perspective of moral values, the theory of moral injury seems to fit within a social constructivism paradigm and a subjectivist epistemology. Additionally, the aspect of the theory that considers an individual's spirituality, also aligns with my own positionality as a social worker, researcher and human.

5 III.

6 Literature Review

Stressors that FMHP face can be organized into four areas of focus, categorized according to the source of the stress. While there seem to be overlapping ideas in each sphere, this area of research can be likened to a compass, with the FMHP in the center experiencing stress from all directions. First, there are individual or personal factors; examples of such work and life balance issues and personal history. Next, there are stressors which originate from clients, including clients requiring higher level of care, due to the pandemic and increased caseloads. Additionally, organizational workplace stressors are impactful, which include agency culture and climate, agency offerings and supervision support. Finally, at a broader level, environmental or societal factors must be considered. Societal

9 C) WORKPLACE STRESSORS

stressors include workers perceptions of the way they are regarded by the public, and how those attitudes are internalized, along with issues of race, systematic oppression, marginalization and intersectionality.

7 a) Individual factors

Personal history and current life experiences of FMHP have been examined and found to be stressors that impact psychological outcomes of FMHP.

Research has shown that FMHP who had a personal history of negative life events experience a higher level of distress, as a result of their work with clients focused on the aftermath of trauma (Adams, Boscarino & Figley, 2006). Similarly, Buchanan and colleagues found that therapists with an acknowledged personal history of trauma experienced elevated levels of compassion fatigue (Buchanan et al, 2006). Compassion fatigue has been explained as the cost of caring, when professionals experience emotional exhaustion as a result of vicarious trauma or secondary trauma, after absorbing the traumatization of clients (Ray, S., Wong, C., White, D. and Heaslip, K., 2013). Compassion fatigue was also found in a study of FMHP, who identified key stressors in the development of their compassion fatigue, including a personal history of trauma, a lack of self-awareness (Killian, K., 2008).

Perceived lack of social support has also been found to be a reliable factor associated with negative psychological outcomes in disaster responders. (Guilaran, de Terte, Kaniasty and Stephens, 2018). Further, research supports that FMHP who had financial problems, poor self-perceived health and outside personal problems are more likely to experience burn out and a lack of job satisfaction (Ray et al, 2013).

During the first weeks of the COVID-19 pandemic, researchers found that sources of anxiety for FMHP were their current life situations, including personal access to food and hydration during extended work shifts, access to childcare during increased work hours, the fear of being exposed to the virus and taking it home to their family members. This fear led to physical isolation from family members. Further, the physical strain of the vital protective gear for hours at a time, was physically taxing for personnel (Shanafelt, Ripp & Trockel, 2020).

In support of such, research after the outbreak of severe acute respiratory syndrome (SARS) found that fear of infection and subsequent transmission to family members struck an overwhelming level of fear in frontline health care staff (Chong, Wang, Hsieh, Lee, Chiu, Yeh, Huang, Wen and Chen, 2004).

8 b) Client stressors

Stressors that emanate from client interaction needs to also be considered. Frontline hospital workers identified client related stressors of failing to meet clients' needs and excessive workload (Hall, D., 2004). Similarly, high caseload demands were found to be the most pressing risk factor in developing work stress and compassion (Killian, K., 2008). Caring for patients who were experiencing extreme and life-threatening medical situations has been shown to be a triggering stressor for hospital staff (Yoder, E., 2010). Additionally, situations involving a demanding patient, or an onerous family were identified as stressors related to compassion fatigue (Yoder, E., 2010). Given the isolation protocols many hospitals implemented during the COVID-19 pandemic, it is expected that the tensions between public health priorities and wishes of patients and their families regarding quarantine will be a source of client related stress for FMHP.

Another factor contributing to mental health care professionals stress is emotional exhaustion, from absorbing the trauma of clients and continually providing unanswered giving and attentiveness (Ray et al., 2013). FMHP often experience exhaustion due to perceived work as a "caregiver" and experienced a sense of hopelessness working with clients (Adams, Boscarino and Figley, 2006).

Further, researchers should be mindful that clients will continue to have social and mental health needs unrelated to the pandemic, during the crisis, which could cause clients to be in need of even more support from FMHP, creating increased stress from clients (Krasnisky, 2020).

9 c) Workplace stressors

Workplace related stressors encompass organizational factors and social aspects of the workplace.

Regular access to supervision and a reported positive relationship with supervisors were both found to be moderators of occupational stressors for FMHP (Ray et al., 2013). Similarly, professional autonomy, as measured by being able to exercise control over professional decisions, diminished occupational stress in FMHP (Ray et al., 2013). Lack of a supportive work environment, including managers, colleagues and subordinates diminishes the quality of the social context in which FMHP serve, which acts as a significant stressor (Ray et al., 2013).

Similarly lack of role clarity and absence of trust in leadership were deemed among the largest sources of workplace stress (AdibIbrahim, M., Abdul Aziz, A., Suhaili, N., Zahid Daud, A., Naing, L. and Abdul Rahman, H., 2019). Workers with ambiguous roles were less confident and consequently experienced a more negative workplace experience. During the COVID-19 pandemic many agencies experienced a reduction in staff owing to illness. This creates the possibility of workers to be redeployed to new areas and having to undertake new roles (Miller, V. and Lee, H., 2020). It can be anticipated that this will be an occupational stressor experienced by FMHP during and as a result of COVID-19.

10 d) Societal Stressors

Societal stressors originate in the global community and can weigh heavy on individuals. The COVID-19 crisis has been reported on within the 24-hour news cycle for months and months. This protracted media coverage has the potential to have an intense impact on those who are working in the thick of it. Research after the SARS outbreak showed that the intense media coverage of the virus heightened the perceptions of personal danger among front line healthcare workers (Bai, Y., Lin C., Lin, Y., Chen, J., Chue, C. and Chou, P., 2004). It also led to a perceived stigma, in that others would fear being in contact with frontline workers who were caring for SARS patients (Bai et al., 2004). The stigma related to COVID-19 and frontline workers, who are more likely to have been exposed, can lead to isolation, depression, anxiety and public embarrassment (CDC-Stigma 2020). Specific racial groups, namely Asians and Asian-Americans are also likely to experience such stigma (CDC-Stigma, 2020).

Larger societal systems have also been found to be impactful upon FMHPs. Social workers, after the 9/11 attacks, were found to have experienced a sense of hopelessness and powerlessness, regarding judicial and social welfare systems, that were failing their clients (Killian, K., 2008).

Systematic and institutional racism and sexism are societal factors that need always be considered in research. Racial and ethnic groups such as, Blacks and Latinx people are historically at a higher risk of illness and death as a result of national public health crises and COVID-19 is no exception (CDC Racial & Ethnic Minority Groups, 2020). During this current pandemic people of color are being hospitalized and dying as a result of COVID-19 in disproportionately high numbers (Wadhera, R.K., Wadhera, P., Gaba, P., Figueroa, J., Joynt Maddox, K., Yeh, R. and Shen, C., 2020). Living conditions, such as institutional racism within public housing and racially segregated housing; work circumstances, such as having no sick leave or having an employment position which requires face-to-face work, such as grocery store and factory workers; and health circumstances, such as being un- or underinsured, all create a greater risk of infection for minority populations (CDC Racial & Ethnic Minority Groups, 2020). Adding to the panoply, unemployment within the United States is currently at an unprecedented high, reaching the highest level in the post-World War II era (Kochhar, R., 2020). Examining the disparity via race, highlights racial disadvantages, in that approximately one-in-five Asian, Black and Hispanic workers were unemployed, {Asian, 20.3 %, Black, 19.8% and Hispanic 20.4%} as compared to only 13.5% of white workers (Kochhar, R., 2020). All of this is compounded by the fact that the United States is navigating and absorbing the nation's largest burst of civil unrest since the 1960s as a result of countless police actions against people of color, which came to a head in the midst of COVID-19 (Galea & Abdalla, 2020).

Gender is a significant societal factor as well, being that 70%, a vast majority of frontline health and social care workers are women (Boniol, M., McIsaac, Xu, L., Wuliji, T., Diallo, K., and Campbell, J., 2019). Coupled with the data which reveals that in May 2020 the unemployment rate for women was 17.8 % as compared to 14.5% for men (Kochhar, R., 2020), reinforces the need to conduct this inquiry with consideration of intersectionality.

11 e) Methodological Critiques

My search strategy began with terms including COVID-19, coronavirus, mental health implications, social workers, compassion fatigue and disaster. After narrowing articles down I then utilized snowball searching by checking references lists of the publications that I found useful and looking at what new work cited articles that I originally found useful. All of the studies had to be reviewed for academic rigor, validity and reliability.

Guilaran, de Tete, Kanisty & Stephens' (2018), publication was a systematic review of twenty-four studies. Initially, it must be noted that no original research was generated, but it did offer a rigorous systematic review. The authors identified a clear objective gave explicit criteria for publications selected to be included in the review, offered a thorough analysis and clear presentation of studies and offered practical conclusions for future research.

Krasniansky, A. (2020); Miller, V. & Lee, H. and Wadhera, et al, (2020) are similarly publications that offer insight, but not original research. These articles are all commentaries and editorial pieces, which seek to address the COVID-19 pandemic, by offering opinions and extrapolating ideas from prior research. Shanfelt, T., Ripp, J. & Trockel, M. (2020) published an exploratory study, which was based on eight listening sessions, held at Stanford medical school, of 69 clinicians during the first week of COVID-19. The information gained from these sessions was instructive but lacked academic rigor. The authors acknowledge such, but sought to begin discussions and produce knowledge early in the pandemic.

Adams R., Boscarino J. & Figley, C. (2006), conducted a cross-sectional mail survey of 275 NYC social workers, working in clinical practice after the 9/11 terrorist attacks. Given the cross-sectional nature of the study, no causal effect could be determined. The stated purpose of the study was to assess the predictive validity of a compassion fatigue scale and support the validity and reliability of that scale. Only NYC members of NASW were included in the study which impacts the generalizability/external validity of the study.

Bai, Y., Lin C., Lin, Y., Chen, J., Chue, C. and Chou, P. (2004), reported on a study that investigated stress reactions in staff members of a hospital after a SARS outbreak. The questions related to DSM-IV acute stress disorder criteria, so it appeared to have facial validity, although the authors used a self-designed questionnaire, with no reported test/retest reliability, which is a significant limitation.

Buchanan, M., Anderson, J., Uhlemann, M., and Horwitz, E. (2006) published a report of a Canadian study examining compassion fatigue of mental health providers. The self-report questionnaires used included the Impact of Event Scale and the Compassion Fatigue Self-Test for Practitioners, both scales had reported high internal consistency and reliability, as evidence by .89 and .89 test/retest results. Although the survey was sent

to 1,200 potential respondents and only 280 completed the surveys, which leaves the possibility of a threat to external validity/generalizability, given the self-selection bias of the respondents.

Chong, M., Wang, W., Hsieh, W., Lee, C., Chiu, N., Yeh, W., Huang, T., Wen, J. & Chen, C. (2004), conducted a mixed method cross-sectional study seeking to assess the immediate psychological impact of SARS in a hospital in Taiwan. Participants included 1310 hospital workers for the quantitative portion of the study and 285 senior level staff members for the qualitative portion. Limits of the study are that the scales used for the quantitative portion of the study (Chinese language Impact of Event Scale, and Chinese Health Questionnaire) had no Cronbach's alpha listed, which limits the ability to analyze internal validity and reliability. The qualitative portion of the study were essentially debriefing sessions which were supportive in nature, where the researchers provided assurances and utilized supportive group psychotherapy techniques. While this may have been purposefully done for ethical reasons to protect the well-being of the participants it could be a threat to the objectivity and credibility of the study, as these assurances may have had an impact on results.

Hall D. (2004) conducted a qualitative study of 10 nurses in a hospital where she was employed, that focused on work related stressors and coping mechanisms. The author's employment at the hospital creates a threat to the confirmability of the research, given her connection to the institution and the staff. Additionally, there were two raters, which creates a potential for inter-rater inconsistency, although they did employ a peer member check to strengthen interrater reliability.

Adib Ibrahim, M., Abdul Aziz, A., Suhaili, N., Zahid Daud, A., Naing, L. and Abdul Rahman, H. (2019) researched psychosocial work stressors in relation to a healthy workplace. 225 health and allied health professionals from a large hospital in Brunei were included in a cross-sectional study. The Copenhagen Psychosocial Questionnaire and Healthcare Productivity Survey were utilized and were shown to be valid and reliable via .91 and .93 Cronbach's alpha. A limit of this study is its external validity/generalizability, given the cultural and religious components of absolute Islamic monarchy, that may be specific to Brunei.

Killian, K. (2008) conducted mixed method cross-sectional study seeking to assess the therapists' stress and coping in work with trauma survivors. Participants included 104 trauma therapists for the quantitative portion of the study and 20 trauma clinicians for the qualitative portion, no information was provided as to how the 20 subjects were chosen. Within the quantitative portion of the project the Social Support Index, the Maslach Burnout Inventory and the Emotional Self-Awareness Questionnaire were used, and Cronbach's alpha reliabilities were reported as good, ranging from .80 to .91. A limitation of the study can be seen in the administration of the questionnaires which was done at employee's workplaces, which could impact internal validity in that pressure from the location of the survey could be an extraneous source impacting results.

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020) conducted a very recent study at the beginning of the COVID-19 outbreak in Wuhan China. The cross-sectional study included 1257 healthcare workers in 20 hospitals in the epicenter of the COVID-19 outbreak. Measurement instruments utilized were Patient Health Questionnaire, General Anxiety Disorder Scale, Insomnia Severity Scale and Impact of Event Scale. The study doesn't report the validity or reliability of these scale within the report, but to say they are all "validated measurement tools". This is a limitation, but certainly could be owing to seeking to complete the study and publish as immediately as possible. All data was collected within 6 days, and from that time only 6 weeks elapsed until publication, generally this would certainly seem rushed, but given the unprecedented and extreme nature of the outbreak it is not surprising.

Ray, S., Wong, C., White, D. and Heaslip, K. (2013) conducted a study of 169 FMHP in Canada, via a mail survey, which included the compassion satisfaction and compassion fatigue subscales of the Professional Quality of Life Questionnaire, the Areas of Work Life Scale and the Maslach Burnout Inventory General Survey. The reliability of each scale is represented by Cronbach's alpha ranging from .77 to .92. The limits of the study include its cross-sectional nature, making causality and internal reliability difficult to assess. Additionally, the self-report nature of all the scales acts as a common but noteworthy limit.

Yoder, E. (2010) published a mixed method study regarding compassion fatigue, of 106 nurses in a Midwest hospital. Her working definition of compassion fatigue saw the anger and helplessness experienced by respondents as a response to watching experiences that their patients went through. This is limiting as it does not consider how the respondents' own actions or inactions would impact their feelings. The qualitative portion of the study consisted of only two questions, seeking short-answer replies, thereby lacking the depth necessary to insure credibility. Lastly, the researcher was an employee at the hospital, known to many of the respondents, which has the potential of impacting the accuracy of their replies and the objectivity of the study.

12 IV.

13 Policy Implications

Utilizing the systematic comparisons based on welfare regimes models and social policy developed by Esping-Anderson (1999), the United States operates under a residual welfare model, where individuals and families are responsible for managing social issues and the state interposes in exceptional cases of need. This model is woefully ineffective in addressing social and mental health concerns of individuals and of FMHP. In essence, it requires there to be an identified problem before an intervention can be put in place. The United States must

understand that FMHP will be expected to suffer as a result of COVID-19 and need to enact a comprehensive plan immediately, rather than wait until the situation becomes dire.

Moral injury theory is one that normalizes the feelings of pain and suffering during and after traumatic events, rather than pathologizing them. Understanding the issue of stressors experienced by FMHP via a lens of moral injury makes it obvious that mental health support is essential for FMHP and should be viewed as a human right. Doing so requires a much-needed shift to a social democratic model, which begins with an initial understanding that the state should play a larger role of support for the whole population, before it starts to fall apart. This is also consistent with the International Federation of Social Workers (IFSW) platform which frames health and mental health as a fundamental human right (IFSW, 2008).

Best practices require a whole-of-society approach, which is advanced and supported by the United Nations, which entails the incorporation of mental health care in disaster management plans; the availability of widespread mental health and psychosocial support for and a proactive plan for populations particularly in danger, such as FMHP in an effort to relieve suffering and encourage recovery. (UN Policy brief, 2020).

V.

14 Practice

Practice interventions based in both individual and macro systems theories can be used to impact and improve the experience of FMHPs during the COVID-19 pandemic and its aftermath.

Acceptance & Commitment Therapy (ACT) is trauma related treatment that is related to and born out of cognitive behavior therapy (Farnsworth et al., 2017). ACT is an evidence based behavioral intervention that involves disclosure of and connection to feelings regarding a past traumatic experience and a cognitive restructuring of a clients' understanding of her experiences (Farnsworth et al, 2017). ACT involves a ceaseless process of self-reflection and refraction and encouragement for the individual to make new meaning of their traumatic history, along with self-forgiveness (Farnsworth et al, 2017).

Self-care is another individual practice which is informed by moral injury theory. Practices which can be included in healing from moral injury are mindfulness, meditation and development of a resilient mindset through acceptance and self-compassion (Miller, J., Lianekhammy, J., Pope, N., Lee, J., and Grise-Owens, E.2017).

A larger system theory that can be utilized within the moral injury framework includes weaving care and compassion into the workplace. Understanding the connection that individuals, specifically FMHP have to their workplace and their identity as FMHP is vital from an organizational point of view. Workplaces and agencies need to create policies and protocols that seek to understand and address workers suffering, as a result of working through COVID-19. Examples of such practices are team discussions for decision making, to decrease perceptions of personal culpability for individuals and social support resources to foster team connectedness, boost self-awareness regarding PMIE and encourage workers to support each other. Examples of these would be "Check You, Check Two" and "Code Lavender", which are programs within organizations that encourage workers to seek and offer social support to co-workers during difficult times (Tracy, D., Tarn, M., Eldridge, R., Cooke, J., Calder, J., and Greenberg, N. 2020; Johnson, B., 2014).

Lastly, and bringing the discussion back to the beginning, hearing and acting on the needs of FMHP requires listening to their experiences. Supporting participatory action research allows FMHP to develop, collect and analyze data, so that they can reflexively drive the research, lead the inquiries and suggest and implement subsequent actions (Shanafelt, T., Ripp, J., & Trockel, M. 2020).

15 VI.

16 Conclusion

COVID-19 looks to be the foundation for an unprecedented large-scale mental health catastrophe, greater than we have seen in generations. FMHP will be charged with navigation countless crisis' without being destroyed in the process. Supporting FMHP begins with examining the pressures that they experience. Understanding these stressors can in turn instruct policies and practices which can support FMHP, the clients they serve, the organizations they work for and society as a whole.

[Baum et al. ()] , F Baum , C Macdougall , D Smith . *Participatory Action research. Journal of Epidemiol Community Health* 2006. 60 p. .

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