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# Mental Health, COVID-19, and the Invisible Pandemic on the Horizon



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The novel coronavirus, severe acute respiratory syndrome coronavirus 2, continues to spread, causing global disruption and infecting the world with strong emotions such as fear, anger, and sadness. Now is the time to recognize the expanding emotional pandemic, to use empirically derived strategies aimed at mitigating the effects of trauma, and to engage proactively with the goal of improving mental health outcomes (Table 1).<sup>1,2</sup>

In the tradition of the biopsychosocial model, we emphasize that the psychosocial costs of this disaster will parallel the biomedical ones, and these costs are accruing by the day. Although we advocate for mental health integration as part of a broader public health strategy, our comments focus on the clinical aspects of three populations directly affected by the surge of coronavirus disease 2019 (COVID-19). We conclude by reviewing the mental health needs expected to arise in the aftermath of the surge and by reflecting on the potential for posttraumatic growth.

## SECLUDED PERSONS IN THE COMMUNITY

Two types of seclusion include quarantine — for those with known disease exposure — and isolation — for those with disease. Although personal factors (eg, culture, setting, and finances) inform an individual's response to seclusion, common responses include confusion, anger, and posttraumatic stress symptoms.<sup>3</sup> Those with pre-existing psychiatric or substance use disorders, even where previously well-managed, are especially vulnerable to symptom relapse. Other psychologically vulnerable individuals include those already relatively isolated (eg, living alone, with limited access to

technology or limited technological literacy): many of these individuals are older adults — commonly with cognitive or functional impairment — who are more likely to rely on, and may now have more trouble receiving, home-based services for basic needs.

Through public messaging and while delivering care, all clinicians can help counter seclusion by encouraging patients to ensure adequate supplies, setting routines, planning at least a week in advance, engaging in physical activity, and maintaining digital relationships.<sup>4</sup> Mental health referrals should be provided as indicated. Telehealth and tele-mental health have also been expanding during this time of social distancing and may offer enhanced access to care despite seclusion. Because social isolation is a risk factor for suicide, it is imperative that clinicians pay close attention to the risk of suicide during this pandemic<sup>5</sup>: this means performing suicide risk assessments, creating collaborative safety plans for those at risk (as part of this, providing the National Suicide Prevention Lifeline, attempting to reduce access to lethal means, and seeking assistance from family or friends), and making mental health referrals. Optimistically, though, seclusion can be an opportunity to get organized, indulge a long-neglected hobby, develop a new skill, or find creative ways of serving others. In fact, seclusion might well be reframed and reflected to patients as altruistic — foregoing some personal liberties and incurring hardship as a means of serving one's community.

## HOSPITALIZED COVID-19 PATIENTS IN ISOLATION

Being in hospital isolation can be terrifying, especially where illness onset is abrupt and



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**TABLE 1. Principles of Psychological First Aid and Trauma-Informed Care**

Psychological first aid <sup>1</sup>	Trauma-informed care <sup>2</sup>
A model designed as an analog to medical first aid to complement humanitarian responses to public health disasters to mitigate acute traumatization.	A tiered clinical framework that aims to recognize and respond to the effects of trauma, to personalize care, and to support an individual's coping strategies
Eight core actions	Universal trauma precautions
1. Contact and engagement	1. Screening
2. Safety and comfort	2. Understanding one's own history and reactions
3. Stabilization	3. Inter-professional collaboration
4. Information gathering	Trauma-specific care
5. Practical assistance	1. Understanding the health effects of trauma
6. Connection with social supports	2. Patient-centered communication and care
7. Information on coping	
8. Linkage with collaborative services	

symptoms escalate quickly. Additionally, personal interactions with health care professionals shrouded in full-body personal protective equipment may feel unnatural. Loved ones may be restricted from visiting. Physical symptoms such as pain, cough, and air hunger can cause fear, and may be amplified by loneliness, uncertain prognosis, and fear of dying. Even individuals with ordinarily healthy adaptive strategies (eg, exercise and socialization) may have trouble coping where these strategies are inaccessible. Importantly, the psychological impact of isolation with severe illness can persist: for instance, depression, anxiety, and posttraumatic stress disorder (PTSD) were still often present more than a year after acute infection with the two recent severe coronavirus outbreaks.<sup>6</sup>

Clinicians should practice trauma-informed care. This includes not exploring details of prior traumas, avoiding comments that draw attention to threat (“you nearly died”), identifying and limiting exposure to trauma cues, normalizing routine aspects of care, and focusing on concrete goals. Additionally, they should encourage healthy behaviors (eg, digital socialization and sleep hygiene) and distraction (eg, apps for meditation and games), as well as recommend mental health care when indicated. Older adults with COVID-19 are especially vulnerable to developing delirium. Thoughtful adaptation of traditional nonpharmacological interventions may be required for patients in isolation but may help prevent and manage behavioral features of delirium (eg, beds that stand patients upright, simulated/virtual family presence, or items for sensory enhancement, cognitive stimulation, and sleep promotion).

#### FRONT-LINE HEALTH CARE CLINICIANS

This pandemic threatens to accelerate clinician burnout. Clinicians are at risk of being ostracized by family/friends who fear contamination. They also may have concerns about personal protective equipment adequacy, may fear contracting and then spreading coronavirus unwittingly, or may over-interpret normal bodily experiences as evidence of infection. Similar to patients, clinicians can have persisting psychological symptoms as well. Moral distress has also been on the rise.<sup>7</sup> High-stakes triage is required when clinical needs outstrip available resources (eg, deciding which patients receive ventilators or which patients are admitted). Add to this a high volume of patients, prolonged hours, and in some communities the sheer number of fatalities, and the distress can become considerable.

Several things may help.<sup>7</sup> Clinicians should have realistic expectations and embrace altruism. Further, clinicians and clinical teams must take care of each other. Clinical team leaders have special roles, by providing safe settings for team members

across disciplines to discuss patient care challenges and distress. Special attention should be given to team members who do not attend such group discussions because avoidance may be a symptom of trauma and therapeutic avoidance can lead to poorer outcomes. Clinicians can engage peers to give and receive support (eg, focusing on resilience, clear communication and empowerment, and de-stigmatization of experiencing stress), and would do well to be open to seeking mental health treatment as needed.

### AFTER THE SURGE

Research on a range of disasters (eg, the 9/11 attacks, tsunamis, and airline accidents) describes several trajectories of emotional symptoms, such as PTSD (Table 2).<sup>8,9</sup> Most people are either resilient or recover shortly thereafter, but a considerable number can develop chronic psychiatric symptoms or experience a delayed onset of symptoms. For example, among World Trade Center responders, 23% developed chronic PTSD and 6% developed symptoms with delayed onset.<sup>8</sup>

Even in regions where COVID-19 is declining, health care providers should proactively evaluate patients for psychiatric symptoms including depression, anxiety, and PTSD, as well as pay attention to risk factors for them (Table 2). Early

intervention (eg, increasing support, helping access supplies, more frequent visits, use of psychotropic medication, and mental health referrals) may be important to mitigate evolving or lasting psychiatric sequelae.

### REFLECTIONS

The pervasiveness of the virus' disruption on life is profound. Superimposed on this pandemic is a psychosocial dimension that threatens far more than just physical health. The emotional toll of this crisis resembles the virus itself: it is invisible to the eye and has an uncanny ability to spread virally by social means. Strong negative emotions such as fear, anger, and grief disseminate quickly and widely through social channels and can have long-term impact, yet we should pursue reasons for realistic optimism.

Indeed, care provision that attends to mental health and wellness offers a reason for such optimism. We should take the long view and recognize the tide of psychiatric sequelae on the horizon. The emergence of telehealth, with its potential to reach those with otherwise limited access, may be a silver lining in response to social distancing. By being psychologically minded, health care providers can create public awareness of both the immediate and longer-term mental health impact of this crisis. We can also ensure that mental health care is integral to our response now and also in the future by thoughtfully identifying those at risk of ongoing or delayed-onset symptoms. A humanistic approach among health care clinicians can help shape local and global narratives.

Additionally, traumatic moments can be personal opportunities for growth through deliberate re-evaluation.<sup>10</sup> Such moments can prompt us to reshape our personal identity, strengthen social ties, and develop a richer appreciation of life. Even from the pain of 9/11 arose positive emotions such as gratitude and love. Every clinician has a role to play, to sound notes of resilience rather than despair.

**TABLE 2. Selected Predictors of Psychological Outcomes From Disaster Research**

Predictors of outcomes:

- Chronic symptoms: more severe disaster exposure and subsequent loss
- Delayed onset symptoms: significant partner problems and substance abuse

Predictors of symptom severity:

- *Pre-disaster factors*: limited psychosocial support, being at either end of the age spectrum, a personal history of trauma, significant psychiatric illness
- *Disaster-related factors*: more severe disaster exposure and subsequent loss
- *Post-disaster factors*: significant job/financial hardship or losses, serious relational difficulties, limited psychosocial support

## CONCLUSION

The COVID-19 pandemic guarantees enormous psychosocial costs. Beyond the biomedical needs, the psychosocial needs demand attention. Those in seclusion require particular vigilance, and telehealth may be a welcome and convenient means of doing so. Clinicians should also embrace trauma-informed care as part of a clinical approach to mitigate longer-term mental health problems for patients in isolation. As clinicians, we should also attend to our own needs by strengthening our connections with one another. Finally, just like widespread testing for severe acute respiratory syndrome coronavirus 2 informs a public health approach to the pandemic, identifying and engaging with those at risk for chronic or delayed-onset psychiatric symptoms should guide our mental health approach. It is a rare moment that we as a global community have a common mission, but to achieve this most effectively we must do so with mental health and wellness in mind.

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