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Resilience Is Spreading: Mental Health Within the COVID-19 Pandemic

Emma K. PeConga,
Department of Psychology, University of Washington

Gabrielle M. Gauthier,
Department of Psychology, University of Washington

Ash Holloway,
Department of Psychology, University of Washington

Rosemary S. W. Walker,
Department of Psychology, University of Washington

Peter L. Rosencrans,
Department of Psychology, University of Washington

Lori A. Zoellner,
Department of Psychology, University of Washington

Michele Bedard-Gilligan
Department of Psychiatry and Behavioral Sciences, University of Washington

Abstract

The COVID-19 global pandemic is in many ways unchartered mental health territory, but history would suggest that long-term resilience will be the most common outcome, even for those most directly impacted by the outbreak. We address 4 common myths about resilience and discuss ways to systematically build individual and community resiliency. Actively cultivating social support, adaptive meaning, and direct prosocial behaviors to reach the most vulnerable can have powerful resilience promoting effects.

Keywords

resilience; COVID-19; mental health

"Mental Illness Is Our Epidemic Within the Coronavirus Pandemic" (Miller, 2020). Headlines such as this decry a new danger on the horizon. Anxiety, depression, and substance use are at heightened levels (Liu et al., 2020), and there are valid concerns about the long-term effects (Galea, Merchant, & Lurie, 2020). But these dire predictions likely underestimate the impressive human capacity for resilience. Why not forecast an epidemic of resilience? After all, resilience is the normative and modal response to trauma (Bonanno,

Correspondence concerning this article should be addressed to Emma K. PeConga, Department of Psychology, University of Washington, Box 351525, Seattle, WA 98196, epeconga@uw.edu.

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Westphal, & Mancini, 2011; Zoellner & Feeny, 2013). Below, we combat four common myths about resilience and discuss ways to systematically build individual and community resiliency. Ultimately, this is a time to foster resiliency, not only protecting the most vulnerable but also facilitating the mental health equivalent of "herd immunity."

Myth 1: Trauma Exposure Inevitably Means Mental Illness

Resilience and recovery are, in fact, the modal responses to even the most severe trauma and adversity (Galatzer-Levy, Huang, & Bonanno, 2018). As a striking example, the media and scientists alike anticipated high rates of posttraumatic stress disorder (PTSD) following the World Trade Center attacks. Yet, eight years after 9/11, a large-scale study showed the vast majority (~86%) of police first responders demonstrated an absence of clinically significant PTSD symptoms (Pietrzak et al., 2014). Similarly, three years after the SARS outbreak, only 10% of Chinese health care workers reported PTSD (Wu et al., 2009). Thus, although the COVID-19 global pandemic is in many ways unchartered territory, history would suggest that long-term resilience will be the most common outcome, even for those most directly impacted or those on the frontlines of the outbreak.

Myth 2: Resilient People Do Not Have Bad Days or Weeks

Resilience need not be a steadfast, linear trajectory of mental health or happiness. It is not the maintenance of a threshold of well-being, but the constellation of behaviors that prompt individuals and communities to persist and move forward despite adversity (Masten, 2018). Resilience can, and should, vary greatly. In the face of significant stressors, such as loss of income, risk of homelessness, witnessing death or multiple deaths, or having a loved one become sick, resilience might have many different appearances: simply putting one foot in front of the other every day, active problem solving, seeking social support, sharing with others that you are struggling right now, tolerating uncertainty, or generating hope for the future. Engaging in adaptive behaviors *while* struggling and *while* experiencing intense fear, anxiety, or grief, is resilience. Indeed, the most resilient among us will have bad days; it is not the absence of negative emotions but our response to them that matters. Increased anxiety, loneliness, and sadness are normative experiences during a pandemic and do not preclude resilience. We should not mistake pain for suffering. Resilience means continuing to show up and move forward, even when we're at our lowest.

Myth 3: Resilience Is Something You Either Have or You Do Not Have

Rather than representing an individual's fixed disposition, resilience is actively constructed and shaped by dynamic behavioral, cognitive, and environmental processes. Preevent characteristics like family history and preexisting psychopathology are consistently poor predictors of resilience (Feder, Fred-Torres, South-wick, & Charney, 2019). Resilience is most strongly predicted by the cultivation of social support (Ozer, Best, Lipsey, & Weiss, 2003) and adaptive meaning making (Burton, Cooper, Feeny, & Zoellner, 2015), suggesting it is learned and acquired. Individuals and communities can influence one another to cultivate resilience. In the wake of the COVID-19 crisis, crafters are sewing and donating masks, messages of "we're in this together" abound, collective thank-yous to health care

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workers occurs on a nightly basis, and homegrown support networks are popping up in apartment complexes and neighborhoods. This "social capital" can bolster resilience to psychopathology by bestowing a sense of purpose and adaptive meaning associated with surviving a crisis. Strong communities are essential conduits for material and emotional resources when individuals need them the most. When ordinary sources of reward and fulfillment are cut off, prosocial acts of tolerance, support, and kindness can strongly buffer against negative effects.

Myth 4: The Risk to Mental Health From COVID-19 Is a Hoax

Undoubtedly, mental health risks associated with COVID-19 do exist, particularly in the short-term. Emerging data from China suggests that one half to three quarters of health care workers are reporting depression symptoms or distress in the immediate aftermath of their country's outbreak (Liu et al., 2020). We expect to see short-term distress, especially in those most directly impacted. This cannot and should not be ignored. There are also "secondary" mental health effects of the COVID-19 pandemic. Some people are isolated in unsafe environments, such as homes with partner or child abuse or substance use. Access to in-person mental health care and social services has slowed. Stay-at-home orders may be reinforcing unhelpful coping patterns in those with preexisting mental health problems. These secondary effects call for careful community surveillance and education about when normative, acute difficulties shift to persistent, functionally impairing symptoms of a mental disorder. The former should be normalized, and the latter may need some form of professional-level intervention. That said, even the latter is not the sole responsibility of professional mental health workers. We, as a society, have an opportunity to identify those who are hurting and evoke processes we know foster resilience such as creatively providing persistent, positive social support and making collective meaning during these times.

Ultimately, we need to honor the innate human capacity for resilience in the face of tremendous adversity. Actively cultivating an attitude of togetherness and translating this into direct prosocial behaviors, particularly reaching out to the most vulnerable in our communities, can have powerful effects on mental health resilience. We can apply these principles to the diverse narratives of the COVID-19 crisis: the overworked health care providers who feel scared to go to work, the unemployed who are struggling financially, the bereaved who cannot hold funerals for loved ones lost, and the lonely who are socially isolated, to name just a few. It simply takes intention and action. Do something for someone else: a friend, a neighbor, a stranger. These behaviors change the mental health of others but also change us in important ways, including what we value, where we find meaning in life, and potentially having protective mental health effects for ourselves. As trauma-focused researchers and practitioners, we know intimately both the horrors that many of us experience in a lifetime and the incredible capacity to adapt and heal from adversity. We all can contribute to building hope and making adaptation and healing the path forward from COVID-19 for as many individuals as possible. Aggressively building this community resilience now can permanently change us individually and collectively for the good for years to come.

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