



Assuaging COVID-19 Peritraumatic Distress Among Mental Health Clinicians: The Potential of Self-Care

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Abstract

Undoubtedly, the 2019 novel coronavirus, also known as COVID-19, has put mental health clinicians under stress. Despite the promise of self-care in assuaging stress, very few, if any, studies have investigated the impact of self-care on stress among mental health professionals. This *exploratory* study examined COVID-19 related distress, self-care, and the predictive relationship between the two. Primary data were collected from a sample of mental health social work clinicians in one southeastern state (N = 1568). Results indicate that participants were experiencing mild peritraumatic distress associated with COVID-19. Participants who were married, identified as heterosexual or straight, financially stable, and in good physical/mental health were experiencing less distress than other mental health clinicians in the sample. Analyses revealed that higher self-care practices predict significantly less distress. Overall, data suggest that self-care can be integral to assuaging distress among mental health clinicians. This study offers insight into how to support mental health practitioners during COVID-19.

Keywords Self-care · COVID-19 · Social work · Clinicians · Mental health · Distress

There is wide-ranging consensus that the 2019 novel coronavirus, better known as COVID-19, has contributed to unprecedented strain on mental health service structures and practitioners. Recent estimates show exponential surges in the need for mental health services (Czeisler et al., 2020; Huang, & Zhao, 2020; Rajkumar, 2020). What's more, public mental health needs are becoming increasingly complex and multifarious because of emerging complications, to include risk of exposure and social/physical isolation, as a result of COVID-19 (Moreno et al., 2020). Indubitably, these factors have effected mental health social work clinicians and practitioners in unique and unexpected ways.

Concomitantly, there is growing attention to self-care as a requisite for dealing with COVID-19 related occupational stress. A plethora of authors have suggested that self-care can be integral to assuaging stress, vicarious trauma, and burnout (e.g., Bloomquist et al., 2015; Bonifas & Napoli, 2014; Cox & Steiner, 2013; Lee & Miller, 2013; Miller & Grise-Owens, 2020; Miller et al., 2020; Smullens, 2015). Recently, entities such as the World Health Organization

(WHO, 2020) and Centers for Disease Control and Prevention (CDC, 2020) have touted the importance of self-care in addressing distress emanating from the pandemic. Indeed, there appears to be unanimity that self-care can be a valuable tool in dealing with distress, in general, and that associated with COVID-19, specifically.

This *exploratory* study examined COVID-19 related distress, self-care, and the predictive relationship between the two. Primary data were collected from a sample of mental health social work clinicians (e.g., Licensed Clinical Social Workers) in one southeastern state (N = 1568). This is the first known study to the authors to explicitly examine this area of inquiry. After a brief review of literature, this paper will present results, discuss findings, and identify salient implications for mental health clinician practice, education/training, and research.

From the outset of this paper, we, the authors, want to acknowledge that this study took place in the context of broader social unrest and injustice associated with several police killings of people of color. Whilst this study focused on peritraumatic distress associated with COVID-19, it is possible, if not plausible, that factors associated with racial injustice may have compounded COVID-19 related distress.

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Background

The occupational challenges facing mental health clinicians are well-documented. Collectively, research has suggested that mental health clinicians may be at increased risk for compassion fatigue and professional burnout, among other problematic consequences (Dreison et al., 2018; Kim et al., 2018; Morse et al., 2012). As well, mental health professionals may also be tasked with evolving practice standards, cumbersome bureaucratic processes, and resources restrictions related to community mental health services (e.g., Acker, 2012; McCormack et al., 2018).

In many ways, COVID-19 has exacerbated these challenges. While research is in the nascent stages of development, several authors and entities have discussed the negative impacts of the pandemic on mental health practitioners. One such impact is the sheer growth in need for mental health services. According to a recent report from the CDC, the need for mental health services has increased three-fold from 2019 to 2020 (see Czeisler et al., 2020). This surge in need has undoubtedly put strain on the mental health workforce (e.g., Panchal et al., 2020).

In addition to increased need, the format and structure of mental health services have fundamentally changed. Many mental health practitioners quickly transitioned to virtual and remote service delivery options as a result of distancing guidelines. These transitions may have been the source of financial and regulatory compliance concerns, both of which may have contributed to distress (e.g., Miller, 2020a, 2020b; Ojha & Syed, 2020). Moreover, many mental health agencies may have been ill-equipped or unprepared to support virtual service delivery or remote employees (e.g., de Pablo et al., 2020). It is imperative to underscore the fact that mental health clinicians have simultaneously dealt with client needs and the needs of their own families (Pfefferbaum & North, 2020). Tosone et al. (2012) described these impacts of shared trauma. Indeed, the psychological toll and burden placed on mental health providers during the pandemic is immense.

Perhaps, the impact that COVID-19 has had on clinicians is not surprising. Previous research related to disasters has illustrated a host of problematic consequences for those providing mental health services. For example, in a study that assessed the impact of 9/11 on clinicians in Manhattan, Tosone et al. (2011) found that the event was a significant predictor of shared traumatic stress. Culver et al. (2011) concluded that mental health providers experienced significant vicarious trauma after Hurricane Katrina. It is pertinent to note that the challenges experienced by clinicians disproportionately impact those in private practice (e.g., Boulanger et al., 2013).

Responding with Self-Care

Self-care can be defined as the “multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being” (Dorociak et al., 2017, p. 326). There is growing recognition about the importance of self-care to helping professionals, to include mental health providers (Miller & Grise-Owens, 2020). Several authors have proffered that self-care can assuage stressors, occupational and otherwise. In a study of psychology students, Myers et al. (2012) concluded that self-care practices were linked to reduced stress among a sample of more than 400 students. Cohen and Gagin (2005), in assessing social workers employed in hospital settings, asserted that self-care is integral to assuaging or reducing professional burnout. Sanso and colleagues (2015) linked self-care to professional efficacy among palliative care professionals. A plethora of additional authors have touted the importance of self-care as a way to deal with inimical employment challenges and associated consequences (e.g., Bloomquist et al., 2015; Bush, 2015; Miller & Grise-Owens, 2020; Newell, 2020; Powers & Engstrom, 2020, etc.).

Despite clarion calls related to the importance of self-care in assuaging inimical consequences associated with the pandemic, empirical studies that examine self-care among mental health clinicians is sparse. More specifically, an exhaustive literature review revealed no published studies that examine the relationship between COVID-19 related stress and self-care. This paper contributes to addressing these limitations in the current literature.

Aim and Research Queries

The overarching aim of this study was to investigate the predictive relationship of self-care to COVID-19 related peritraumatic distress (hereafter referred to as distress) among mental health social work clinicians (hereafter referred to as clinicians). In pursuit of that aim, this study also assessed current rates of COVID-19 related distress and self-care practices among the sample. This is the first examination of this line of inquiry known to the researchers.

This research effort was guided by three distinct research queries:

1. How do mental health clinicians fare in terms of COVID-19 peritraumatic distress?
2. What is the relationship(s) (group differences) among demographic and professional characteristics and distress?
3. Is self-care a significant predictor of distress?

Conceptual Framework

This study was informed by several theoretical tenets associated with stress and self-care. Transactional theories and perspectives examine the interactions between individuals and their environments. Notably, Environmental Stress Theory asserts that environmental stressors include factors such as illness, pollution, and natural disasters. These factors, singularly or in combination, can bring about distress (e.g., Lazarus & Folkman, 1984). Research questions #1 and #2 assesses the distress associated with an environmental factor, namely COVID-19, and other factors (e.g., demographic characteristics, etc.) that may impact the experience of that stress. Research question #3 is rooted in general concepts of wellness, which suggest engaging in self-care practices can mitigate or assuage distress. This notion is foundational to Orem's Self-Care Deficit Nursing Theory (see Orem & Taylor, 2011).

Methods and Materials

Protocol and Sampling

To collect primary data for this study, researchers deployed an electronic survey administered via an online survey management program (e.g., Survey Monkey). Following institutional review board (IRB) approval and the obtainment of a waiver of documentation of informed consent, researchers sent an email invitation to professional groups and asked those individuals to forward the invitation to other potential participants. Because of this approach, it is not possible to calculate an accurate response rate. All participants self-identified as licensed clinical social workers providing mental health clinical services at the time of the survey.

All data were collected during Summer 2020. Mental health clinicians who took part in the survey were offered a chance to enter a \$500 incentive drawing for their participation. The survey employed features that disabled IP and email address tracking (See http://help.surveymonkey.com/articles/en_US/kb/How-do-I-make-surveys-anonymous) Survey Monkey Anonymous. The incentive link was disconnected from primary survey via a separate link. Thus, participant responses were anonymous. The protocols used in this study were approved by an Institutional Review Board.

Participants

The sample consisted of 1568 ($N = 1568$) clinicians. Key demographic and professional data are included in Table 1. The typical participant was aged 41.86 ($SD = 11.90$) years and had practiced as a mental health clinician for 13.69

Table 1 Demographic and professional characteristics of mental health clinicians

	N	%
Gender		
Male	160	10.2
Female	1408	89.8
Sexual orientation		
Heterosexual or straight	1360	87.2
Gay or lesbian	72	4.6
Bisexual	112	7.2
Race/ethnic background		
White non-Hispanic	1425	91.3
Black non-Hispanic	101	6.5
Hispanic	20	1.3
Asian	12	0.8
American Native	2	0.1
Current relationship status		
Married	1028	65.6
Partnered	140	8.9
Widowed	32	2.0
Divorced	148	9.4
Separated	36	2.3
Never married	184	11.7
Highest academic degree		
Master's	1536	96.4
Doctorate	24	1.5
First professional degree	8	0.5
Members of professional organization(s) ^a		
Yes	392	25.3
No	1160	74.7
Physical health status ^b		
Excellent	180	11.5
Very good	540	34.6
Good	624	40.0
Fair	216	13.8
Current financial situation		
I cannot make ends meet	428	27.5
I have just enough money to make ends meet	796	51.2
I have enough money, with a little left over	332	21.3
Mental health status ^b		
Excellent	92	5.9
Very good	568	36.4
Good	700	44.9
Fair	200	12.8
Work remotely after COVID ^c		
Yes	1288	82.1
No	280	17.9
Supervise ^d		
Yes	376	24.1
No	1184	75.9

^aParticipants were asked if they currently belong to a professional membership organization, such as National Association of Social Workers, Clinical Society, etc.

^bParticipants were asked to self-report their physical and mental health status, respectively

^cParticipants were asked if they worked PRIMARILY remotely after March 11, 2020

^dParticipants were asked if they supervised mental health clinicians

(SD = 10.25) years. The sample reported working an average of 39.36 (SD = 9.95) hours per week.

Instrumentation

The following instruments were used to collect/measure data.

Demographic/Professional Information

Researchers collected data related to general demographic and professional information. Variables of interest included Gender, Sexual Orientation, Race/Ethnic Background, and other variables necessary to adequately describe the sample.

Distress

To measure COVID-19 related distress, researchers utilized the COVID-19 Peritraumatic Distress Index (CPDI; Qiu et al., 2020). CPDI is a 24-item scale designed to examine COVID-19 specific peritraumatic distress. The questionnaire entails parameters associated with stress, as outlined in the International Classification of Diseases (11th Rev.). Items are anchored at 0 indicating *never* and 4 indicating *most of the time*. CPDI scores range from 0 to 100, with higher scores indicating more distress. Cut scores are as follows: 0–28 (normal distress); 29–52 (mild distress); and, 53–100 (severe distress). The Cronbach's alpha of CPDI for this study was 0.90.

Self-Care

To measure self-care, researchers deployed the Self-Care Practice Scale (SCPS; Lee et al., 2020). This 18-item instrument uses a five-point Likert scale ranging from 0 (*never*) to 4 (*very often*) and produces an overall score calculated as a sum across all items. Possible scores range from 0 to 72, with higher scores indicating more frequent self-care practices. The Cronbach's alpha of SCPS for this study was 0.86.

Data Analysis

To answer the research questions, researchers conducted descriptive, bivariate and multivariate inferential analyses. The descriptive analysis showed frequency and mean distribution of main variables. Bivariate analyses included robust one-way analyses of variances (Brown-Forsythe tests) or independent sample *t*-tests. Participants were divided into groups based on various categorical demographic variables (e.g., race, degree, etc.), and their average COVID-19 distress scores were compared across the groups for statistically significant differences. In the multivariate inferential analysis, hierarchical multiple ordinary least squares regression

Table 2 Distress and self-care scores

Descriptives	Mean	Std. Dev	Min	Max
Total COVID Distress Scores (0–100)	29.48	13.90	5	90
Total Self-Care Scores (0–72)	39.09	8.94	2	62

was performed to examine the unique effects of participants' self-care score on their COVID-19 distress scores, after controlling for the effects of their key demographic covariates.

Findings

CPDI and SCPS Scores

Respondents' average CPDI score was 29.48 (SD = 13.90), indicating that the sample was experiencing distress slightly outside of normal ranges. Analysis revealed a SCPS mean score of 39.09 (SD = 8.94). Table 2 presents scores, means, standard deviations, minimum and maximum scores.

Bivariate Analysis

Group Differences

Due to the exploratory nature of the study, robust one-way analyses of variances (Brown-Forsythe tests) or independent sample *t*-tests were conducted to investigate cross-group differences based on the key demographic and professional variables (independent variables) and CPDI scores (dependent variable). Significant differences in mean CPDI scores were detected by *Relationship Status*, *Sexual Orientation*, *Physical Health Status*, *Mental Health Status*, and *Financial Status*, respectively. Table 3 contains a summary of results for the cross-group comparison tests conducted.

Multivariate Analysis

Hierarchical multiple regression analysis was performed to explore the unique effect self-care practices (after controlling for the effects of other key demographic predictors) may have on distress scores. Since several significant correlations were detected between participants' background factors and CPDI scores as reported previously, collinearity statistics were examined for any multi-collinearity concerns prior to a hierarchical multiple regression analysis. Analysis showed collinearity statistics (i.e., Tolerance and VIF) were all within accepted limits (e.g., Coakes, 2005).

The following variables were entered into the model (Step 1): Age, Year of Practice in Social Work, Gender, Marital Status, Physical Health, Mental Health, Current Financial

Table 3 Group comparison results

Variables	Statistics				
	<i>df</i>	Effect size	<i>F</i>	<i>p</i>	<i>SE</i> CI 95%
Gender (male vs. female)	1, 1514	.45	3.15**	.002	1.02 [- 5.20, - 1.19]
Marital status (married vs. not married)	1, 1518	.13	2.47*	.014	.75 [- 3.30, - .38]
Financial status	2, 1513	.08	60.75***	<.001	1.02 [8.60, 13.38]
Physical health	3, 1516	.01	7.34***	<.001	1.19 [1.31, 7.44]
Mental health	3, 1516	.16	112.50***	<.001	1.31 [19.26, 26.06]
Sex orientation (heterosexual vs. others)	1, 1518	.74	5.90***	<.001	1.10 [- 8.62, - 4.30]

* $p < 0.05$; ** $p < .01$; *** $p < 0.001$

Situation, Supervision Status, and Sexual Orientation. Self-care scores were entered as the sole second-level predictor (Step 2).

The model was statistically significant for distress at both steps. For Step 1, results revealed that five variables significantly predicted total distress: *Age*, *Financial Status*, *Physical Health Status*, *Mental Health Status*, and *Sexual Orientation*. Identifying as “heterosexual or straight” predicted lower distress scores by 5.390. Compared to those who reported “*excellent*” physical health, participants who were in “*very good*”, “*good*”, or “*fair/poor*” physical health had lower distress scores by 4.097, 3.655, and 9.109 points, respectively.

Likewise, mental health clinicians who reported “*excellent*” mental health, when compared to those who claimed *very good*, *good*, or *fair/poor* mental health were inclined to score higher on the total COVID distress scale by 2.894, 6.064, and 14.558 points, respectively. Financial stability also influenced distress. Mental health clinicians who reported “*I cannot make ends meet*,” or “*I have just enough to make ends meet*,” tended to have increased distress scores by 6.889 and 3.746 points respectively, after controlling for all other variables. In terms of age, a one year increase yielded a 0.161 decrease in distress; while the same increase in professional experience yielded a 0.999 decrease in distress.

For Step 2, self-care explained an additional 7% (approx.) of the variance in distress scores, above the demographic and professional information variables, $F(1, 1330) = 139.449$, $p < 0.001$, R^2 change = 0.070. A one point increase in self-care tended to lower distress by 0.472 points, after controlling for the effects of all other predictors. Please see Table 4.

Discussion

This study examined COVID-19 related distress among mental health clinicians, and the impact that self-care has on that distress. Given the impact of the pandemic on mental health professionals, this paper offers foundational insight on potential strategies for mitigating distress. The following

paragraphs outline salient points derived from study findings. For clarity, this section is organized so as to explicitly address the previously posed research queries.

How Do Mental Health Clinicians Fare in Terms of COVID-19 Peritraumatic Distress?

Overall, this study affirms suppositions that mental health clinicians are experiencing distress associated with COVID-19. The mean participant CPDI score was 29.48, which indicates participants were experiencing mild distress associated with the pandemic. Approximately 46% of social work practitioners in this study were experiencing mild or severe distress associated with COVID-19. These data indicate the need to address distress among social work practitioners.

Findings from this study are consistent with a handful of studies that have documented distress among other populations. In a national study that examined the emotional wellbeing of the general public, Pallson and Ballou (2020) concluded that over half of their sample reported having higher stress levels as a result of COVID-19. Similarly, in a study that examined the impact of the pandemic on health care workers in China, Lai et al. (2020) concluded that participants reported significant psychological burden related to treating patients with COVID-19.

What is the Relationship(s) (e.g., Groups Differences) Between Demographic and Professional Characteristics and Distress?

Analyses revealed group differences in distress by several demographical and general information variables. For example, participants who identified as married were in significantly less distress than those who were not married. This finding may be interpreted several ways.

Though a number of outlets have discussed the strain that COVID-19 has put on relationships, romantic and otherwise, this companionship may provide much-needed relief and support during the pandemic. Additionally, factors associated with marriage may include financial stability and shared homemaking tasks and responsibilities, among others. These

Table 4 Hierarchical multiple regression of self-care predicting mental health workers' COVID distress

Model	<i>B</i>	η^2	<i>SE</i>	<i>F</i> change	<i>R</i> ² change
Model 1				30.097***	.266
Age	-.133**	.007	.044		
Year of practice in social work	-.083	.002	.052		
Gender					
Male	-1.732	.002	1.123		
Female	Reference				
Marital status					
Married	-2.080**	.006	.744		
Not married	Reference				
Physical health					
Fair or poor	8.148***	.023	1.474		
Good	3.272**	.005	1.221		
Very good	3.865**	.008	1.182		
Excellent	Reference				
Mental health					
Fair or poor	20.573***	.080	1.914		
Good	9.674***	.025	1.663		
Very good	4.634**	.006	1.607		
Excellent	Reference				
Current financial situation					
I cannot make ends meet	8.515***	.050	1.019		
I have just enough money to make ends meet	4.234***	.017	.878		
I have enough money, with a little left over	Reference				
Supervise other social workers					
Yes	-.140	<.001	.820		
No	Reference				
Sex orientation					
Heterosexual or straight	-4.841***	.019	.958		
Others (gay or lesbian; bisexual; or prefer not to answer)	Reference				
Model 2				139.449***	.070
Age	-.161***	.011	.042		
Year of practice in social work	-.099*	.003	.049		
Gender					
Male	-1.395	.001	1.089		
Female	Reference				
Marital status					
Married	-1.198	.002	.713		
Not married	Reference				
Physical health					
Fair or poor	9.109***	.031	1.405		
Good	3.655**	.008	1.162		
Very good	4.097***	.010	1.125		
Excellent	Reference				
Mental health					
Fair or Poor	14.558***	.043	1.892		
Good	6.064***	.011	1.612		
Very good	2.894	.003	1.537		
Excellent	Reference				
Current financial situation					
I cannot make ends meet	6.889***	.036	.979		

Table 4 (continued)

Model	<i>B</i>	η^2	<i>SE</i>	<i>F</i> change	<i>R</i> ² change
I have just enough money to make ends meet	3.746***	.015	.836		
I have enough money, with a little left over	Reference				
Supervise other social workers					
Yes	– .818	.001	.783		
No	Reference				
Sex orientation					
Heterosexual or straight	– 5.390***	.024	.913		
Others (gay or lesbian; bisexual; or prefer not to answer)	Reference				
Self-Care Scores	– .472***	.094	.040		

* $p < 0.05$; ** $p < .01$; *** $p < 0.001$

factors may impact how participants experience distress, thus elucidating the group difference.

Findings also indicate that heterosexual participants experienced less distress than did those who identified as LGBTQ*. Perhaps these findings are not surprising. Several authors have suggested that LGBTQ* practitioners are faced with stress associated with professional disclosures related to sexual orientation (Carroll et al., 2011; Henretty et al., 2014), role encapsulation, tokenism (LaSala et al., 2008), homophobia, and heterosexism (Dentato et al., 2016), among others. Thus, it is possible that this practitioner group may have been at a higher level of distress prior to COVID or there are facets of COVID-19 that disproportionately impact these mental health clinicians.

Significant differences in CPDI scores were detected by perceptions of physical and mental health, respectively. In summary, the healthier one perceived themselves to be, the less distress they reported. In general, health has long been connected to lower stress levels. Both National Institute of Mental Health (see <https://www.nimh.nih.gov/health/publications/stress/index.shtml>) and the Mental Health Foundation (see <https://www.mentalhealth.org.uk/a-to-z/s/stress>) have linked health physical and mental health lifestyles to stress management and mitigation. Of course, this finding does bring about what Miller et al., (2019) described as the quintessential self-care chicken-and-egg scenario: Are individuals experiencing less distress because they perceived themselves as healthy, or are they healthier because they are experiencing less distress. Certainly more work is needed to critically examine this relationship.

Similarly, analyses revealed that those who were more financially secure experienced less distress. These findings may be expected. Veritably, financial stability, or lack thereof, can be a significant life stressor. The uncertainty of the labor and finance market brought about by COVID-19 may exacerbate that stress.

Is Self-Care a Significant Predictor of Distress?

In short, yes—analysis indicates that self-care significantly predicts decreases in distress among mental health clinicians. Self-care uniquely accounts for approximately 7% of the variance in participant distress. These findings, which are summarized in Table 4, shed new light on the explanatory relationship between self-care and COVID-19 related distress.

Though findings related to this predictive relationship are new, these results may be somewhat intuitive. As discussed in the literature review, several authors have discussed the potential impact of self-care, more generally. Based on these, and other, assertions in the literature, one could surmise that self-care is an appropriate strategy to assuage and/or mitigate distress associated with COVID-19.

Limitations

As with any study, this research has several notable limitations. While appropriate for a study of this type, additional perspectives (e.g., a larger sample size) may have impacted the results. The sample was overly Female and White, which may not be reflective of the general population of mental health clinicians. The study did not take into account several variables, such as parenting status, illness or interaction with others diagnosed with COVID-19, etc. As well, self-care practices may have changed throughout the pandemic and these changes may not be explicitly linked to the pandemic. It is possible that these, and other, variables may have had mediating/moderating influence related to the study findings.

Implications

For the foreseeable future mental health clinicians will be grappling with challenges related to COVID-19. Against that backdrop, this study offers two unique insights: (1) mental

health clinicians are experiencing distress associated with COVID-19; and (2) self-care is linked to lower COVID-19 related distress. Findings from this work have the potential to shape adept responses to supporting mental health providers in coping with these challenges.

Perhaps most importantly, this study suggests that self-care can be imperative to assuaging COVID-19 distress. Said another way, this study affirms anecdotes about the importance of engaging in self-care during the pandemic. This means that mental health practitioners, employers, and professional membership groups (e.g., associations/organizations) must foster increased awareness about the importance of self-care. As well, practitioners should be supported in engaging in self-care. These aims can be achieved in several ways.

Practitioners should seek out education and training associated with self-care. Miller's (2020a, 2020b) Self-care Actualization Theory (SAT) posits that increased self-care competency is critical to the integration of actions that make sustained self-care more likely. SAT is rooted in the premise that self-care is a professional practice skill that can be developed and fostered. As such, access to training about self-care may increase the likelihood that mental health clinicians engage in practices that can address distress. This notion is consistent with other assertions about the benefits of self-care training and education (Posluns & Gall, 2020). Given the current landscape, it is imperative that those trainings be implemented virtually or permit remote participation.

Broader mental health organizational responses are also needed. Employers should engage in strategic initiatives aimed at improving the overall wellbeing of mental health providers. Kanter and Sherman (2016) discussed the benefits of organizational level wellness and self-care initiatives, which include more engaged employees and increased stress management capacity, among other positive benefits. That said, it is important that the conceptualization of these types of organizational-level programs include employees. Miller and colleagues (2016) detailed a participatory mixed-method approach to developing organizational wellness responses at social service and behavioral health agencies. It is important to note that these types of initiatives may impact practitioner groups differently. As such, organizations should be mindful of traditional "isms" (e.g., racism, ageism, ableism, sexism, etc.) and who these factors impact clinician wellbeing.

From a macro perspective, mental health professional membership groups, associations and allied organizations play an important role in addressing COVID-19 related distress. These groups can be instrumental in disseminating information and providing guidance to mental health clinicians about COVID-19. For instance, Mental Health America (see <https://mhanational.org/covid19/frontline-workers>) and the National Institute for Mental Health (see

<https://www.nimh.nih.gov/health/education-awareness/share-able-resources-on-coping-with-covid-19.shtml>) have curated resources for workers to deal with distress associated with the pandemic.

In addition, given the impact of systemic factors, it is important that self-care include broad-based advocacy efforts associated with improving practice conditions. This entails advocating for manageable caseloads, improved salaries/pay equity, adequate employee benefits, and public investment in resources, etc. In short, it is important that stakeholder take a wholistic approach to supporting practitioner self-care.

Research implications abound. Future research may look to replicate the current study, on a national level, which may address geographical nuances associated with the COVID-19 outbreak. As well, these studies could take into account other variables (e.g., exposure to COVID-19, workplace setting, parenting status, etc.) that may impact distress and/or self-care. Based on afore-discussed implications, self-care training and other approaches to addressing COVID-19 should be implemented and critically evaluated (e.g., pre/post methods, etc.). Other areas ripe for exploration are the impact of organizational wellness initiatives, dissemination practices, barriers to engaging in self-care (e.g., perceptions of privilege, etc.) and longitudinal impacts of COVID-19 on mental health clinicians.

Conclusion

The work of mental health social work clinicians in addressing the COVID-19 pandemic is laudable and essential. However, as indicated earlier in this paper, that work can have consequences. Supporting practitioner wellbeing is integral to not only mental health service providers, but for the efficacy of the services they provide. As such, mental health employers, organizations, and associations are compelled to foster workplace and practice cultures, virtually and otherwise, that support mental health clinicians dealing with the impacts of the pandemic. This study provides an initial understanding of one way to do just that.

Declarations

Ethical Approval This research study adhered to proper ethical standards and was reviewed by a university Institutional Review Board (IRB).

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