URCSA CAPE REGIONAL SYNOD

Core Ministry for Congregational Ministry

THE TRAUMA OF COVID-19

Compiled by Aimee Jasson (Clinical Psychologist)

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PSYCHOLOGICAL TRAUMA AND COVID-19

- The diagnosis of what is traumatic is subjective and contextual. It is the individual's experience that determines if an event is traumatic or not.
- A traumatic response would be one in which the individual feels extreme stress that overwhelms their ability to cope, which increases the risk for negative mental health issues. It is also likely that existing mental health issues suffered by individuals will exacerbate during this time.
- COVID-19 is seen as a new type of trauma – 'mass trauma'. And as novel as the virus is, so also is robust research regarding the implications of this type of trauma globally.
- Currently, in mental health circles, the focus is on the individual's experience of stress, distress and anxiety in response to the pandemic. And although there is a general acceptance of an increase in Post-Traumatic Stress Disorder (PTSD) post the pandemic, this research is still emerging and evolving.
- The COVID-19 pandemic have inherent characteristics that could trigger strong feelings of worry and anxiety, i.e. it is ambiguous (open to different interpretations and opinions), it is novel and new (we don't have any experience to fall back on) and it is unpredictable (it is unclear how things will turn out).

NORMAL/ADAPTIVE STRESS RESPONSES IN A CRISIS:

- The following symptoms/ reactions/ behaviours are seen as normal when individuals are faced with a traumatic event:
    - Physical symptoms e.g. shaking, headaches, feeling very tired, loss of appetite, aches and pains, difficulty concentrating
    - Crying, sadness, depressed mood, grief
    - Anxiety, fear
    - Being 'on guard' or 'jumpy'
    - Worry that something really bad is going to happen
    - Insomnia and nightmares
    - Irritability and anger
    - Guilt, shame
    - Confused, emotionally numb, or feeling unreal or in a daze
    - Appearing withdrawn or very still (not moving)
    - Not responding to others, not speaking at all
    - Disorientation (not knowing their name, whey the are from and what happened)
    - Not being able to take care of themselves and their children (e.g. not eating or drinking, not being able to make simple decisions)
- During contact with clients, the above reactions are usually normalised, and Psychological First Aid is done.
- Time is allowed for a natural neurological process to happen to process the crisis. Clients are encouraged to seek professional assistance if the reactions continue and worsen over a period of 4-6 weeks.
- If symptoms worsen, it is recommended that the individual be referred to a mental health professional. At times medication might be indicated to treat some of these symptoms.
- Psychology uses the American Psychiatric Associations guide for best practice, which indicate that for any mood disorder, i.e. Anxiety disorders and Depression, both medication and psychological intervention has the best prognosis.
- It also important to assist individuals in recognising the difference between real problem anxieties and hypothetical / anticipatory anxiety.
- Real problem anxiety / worries are about actual problems that are affecting individuals in the present, e.g. only having enough food in the house to last a few days.
- Hypothetical/ Anticipatory anxiety: High levels of anticipatory anxiety might be present. This is when anxiety is focussed not on what happened in the past, but what might happen in the future, e.g. becoming infected with the virus, possibility of unemployment.

DEVELOPING POST TRAUMATIC STRESS DISORDER (PTSD)

- Although research around COVID-19 and PTSD are still emerging and developing, anecdotal reports indicate that there is a rise in the prevalence of diagnosed PTSD since the start of the pandemic.
- The symptoms for PTSD are as follow:
    - A hypervigilance stance
    - Constant avoidance behaviour (which is encouraged)
    - Negative mood and cognitions

- Fear about the ending of the world 'as we know it'
- Belief in a dark and/or foreshortened future
- For those infected or quarantined: intrusive thoughts related to health and even death might be a likely consequence

- The current aim for mental health services is to protect and reduce the incidence of COVID-19 related traumatic stress. To achieve this, early intervention and psychological first aid (PFA) is recommended.

PSYCHOLOGICAL FIRST AID (PFA)

- This is first-line psychological support for people affected by a crisis.
- At its core, PFA is humane, supportive and practical assistance to others who recently suffered a serious stressor.
- According to the World Health Organisation, the aim of PFA is:
  - Establish safety, calm and hope and the opportunity to connect to others
  - Have access to social, physical and emotional support
  - Regain a sense of control by being able to help themselves
- *These three factors are important to reduce immediate distress, improve adaptive functioning and aid in long-term recovery.*
- PFA is not debriefing and it is not psychotherapy or counselling.
- It is a way in which individuals are emotionally contained in order for them to continue near to normal functioning.
- It is also helpful to hand people a pamphlet describing symptoms they might experience in response to the pandemic and include telephone numbers of organisations or individuals they could access that could assist them.

PFA ACTION PRINCIPLES (WHO)

Prepare	Learn about the crisis event Learn about available services and supports Learn about safety and security concerns
Look	Observe for safety Observe for people with obvious urgent basic needs Observe for people with serious distress reactions
Listen	Make contact with people who might need support Ask about people's needs and concerns Listen to people and help them feel calm
Link	Help people address basis needs and access services Help people cope with problems Give information, e.g. psycho-education around stress reactions Connect people with loved ones and social support

Reflection:

- In 2014, SA Stress and Health (SASH) projected that one third of South Africans suffer from mental health issues. The number associated with this was 17 million individuals, excluding children and adolescents.
- The reality of services: Africa (including South Africa) have 1.4 mental health workers per 100 000 people of the population. The global mean is 9. This means that mental health services are already under tremendous strain, and that a part of the population that would need mental health assistance, would probably not get any in their lifetime. Training lay counsellors especially in a modality like PFA might alleviate some of the pressure on formal mental health services.
- Also, large part of South African communities live in poverty. This means that as much as mental health issues are addressed, so also should social and economic issues be addressed. In poor communities the trigger to mental health issues are intertwined with the social and economical status of that community.
- The challenge is for services to hear and respond to this because billions lack access to necessities that make good mental health possible.
- A response to support mental well-being should then also be linked to being able to inform people where to access social and economic support, e.g. accessing food parcels for those experiencing anxiety triggered by food scarcity due to poverty.

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