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Kenta Asakura
Smith College, kasakura@smith.edu

Ruxandra M. Gheorghe
Carleton University

Danielle Rieger
Carleton University

Sarah Tarshis
Carleton University

Stephanie Borgen
Registered Social Worker

See next page for additional authors

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Authors

Kenta Asakura, Ruxandra M. Gheorghe, Danielle Rieger, Sarah Tarshis, Stephanie Borgen, and Amedeo
D'Angiulli

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Exploring Shared Trauma in the Time of COVID: A Simulation-Based Survey Study of Mental Health Clinicians

Kenta Asakura[1] · Ruxandra M. Gheorghe[2] · Danielle Rieger[3] · Sarah Tarshis[2] · Stephanie Borgen[4] · Amedeo D'Angiulli[5]

Abstract

From fear of contracting the virus, isolation from physical distancing, to navigating lifework balance, the COVID-19 pandemic is expected to leave long-lasting psychosocial impacts on many. Shared trauma refers to similar psychological reactions to an extraordinary community event when experienced by both the clinicians and clients. We examined the experiences mong mental health clinicians in Canada and the United States (n = 196) in this online survey study during the second phase of the pandemic (Spring 2021). In addition to using traditional survey items (e.g., demographics, scales, and short answers), we also used video-recorded Simulated Clients (SC; i.e., professional actors) as a novel method to elicit the participants' assessment of the SCs and the psychosocial impacts of the COVID-19 pandemic. Using shared trauma as a theoretical framework, we analyzed both quantitative and qualitative data. Quantitative results suggested that although these mental health clinicians certainly reported experiencing psychosocial impacts of the pandemic themselves, these shared experiences with client and general populations did not greatly impact how they understood the SCs. Qualitative results helped further contextualize the clinicians' own personal and professional lives. Implications for clinical practice and further research related to shared trauma are discussed.

Keywords Shared trauma · Clinical social workers · COVID-19 · Pandemic · Simulation · Mixed-methods · Online survey

Introduction

There is rising concern that the COVID-19 global pandemic will generate long-lasting impacts on collective wellness. A mounting threat of social upheaval, economic decline, psychological hardship, and largescale health repercussions has imposed global turmoil of stress, grief, loss, and uncertainty—particularly for marginalized groups, namely Black, Indigenous, and People of Color (BIPOC) (Gianfrancesco et al., 2021; Lund, 2020; Sze et al., 2020), women (Cabarkapa et al., 2020; Danet Danet, 2021; Volk et al., 2021), parents and caregivers (Magruder et al., 2021; Volk et al., 2021), people with disabilities (Cieza et al., 2021; Shakespeare et al., 2021), and queer and trans people (Kamal et al., 2021; Ruprecht et al., 2020).

At the forefront of the pandemic are health and social service workers. Since the onset of the pandemic, these workers have been in a unique position where they experience "the stress of [the] COVID-19 pandemic in their professional lives by providing services to clients who are often in states of crisis or adversity, while simultaneously experiencing the same trauma in their personal lives" (Holmes et al., 2021, p. 495). Various systematic reviews (Cabarkapa et al., 2020; Danet Danet et al., 2021; Lai et al., 2020) have found that frontline workers are more prone to various psychological impacts from COVID-19 than non-frontline workers, including vicarious trauma, stress-related disorders, depression, anxiety, sleep disturbances and burnout. To further contribute to relevant professional literature, the purpose of this

✉ Kenta Asakura
kasakura@smith.edu

1 Smith College School for Social Work, Northampton, MA, USA

2 Carleton University School of Social Work, Ottawa, ON, Canada

3 Department of Psychology, Carleton University, Ottawa, ON, Canada

4 Registered Social Worker, Ottawa, Canada

5 Department of Neuroscience, Carleton University, Ottawa, ON, Canada

mixed methods survey was to explore the experiences of traumatic stress among clinicians.

Literature Review

Shared Trauma

According to trauma theory (Herman, 2015), traumatic stress is defined as *common* and *normal* reactions to extraordinary situations like the COVID-19 pandemic as well as natural disasters, terror attacks, violence, war and poverty (Ali et al., 2021; Holmes et al., 2021; Tosone et al., 2003, 2012). While *primary trauma* implies the direct exposure of trauma experienced by an individual (Finklestein et al., 2015), *secondary trauma* describes the potential of psychological distress experienced by clinicians when exposed to clients' traumatic stories (Stamm, 1995). *Shared trauma* consists of both primary and secondary trauma when both clinicians and clients are exposed to the same traumatic event, which can have transformative or lasting impacts (Saakvitne, 2002; Tosone et al., 2003). In other words, shared trauma dually reflects a clinician's personal and professional lives in their role as both a victim and a helper.

Literature on shared trauma has been gaining prominence in social work over the last few decades. The term first emerged shortly after 9/11 to describe the joint distress of clinicians and clients after witnessing the attacks on the World Trade Center (Altman & Davies, 2002; Saakvitne, 2002; Tosone et al., 2003). Relevant literature documents clinicians' heightened anxiety and fear for their own safety and their clients' wellbeing during a crisis (Nuttman-Shwartz & Dekel, 2009; Saakvitne, 2002; Tosone et al., 2014). These scholars also highlighted clinicians' capacity for empathy, compassion, connectedness, and professional growth as they experience shared trauma (Ali et al., 2021; Bauwens & Tosone, 2010; Tosone et al., 2021).

Shared trauma has been since explored following events such as Hurricane Katrina (Tosone et al., 2014), conflict zones including the West Bank (Blome & Safadi, 2016), and the Gaza Strip (Dekel and Baum, 2010). Shared trauma is also now being discussed in the context of COVID-19 (Ali et al., 2021; Dempsey et al., 2021; Tosone et al., 2021). Tosone and colleagues (2021) reflected on the realities of social work students during the pandemic, highlighting the inevitability of interconnectedness with their clients as they experience similar emotions, struggles, fears, and resilience. Dempsey and colleagues (2021) also used a shared trauma lens to explore the impact of the pandemic on field education, student anxiety, and contingency plans to establish ways to better support students in a global crisis.

Health and Wellbeing Among Mental Health Clinicians During COVID-19

The pandemic has exacerbated occupational challenges of mental health clinicians on a global level, including increased job demands, inadequate equipment, training or resources, and insufficient time to complete their work (Ashcroft et al., 2021; Ben-Ezra & Hamama-Raz, 2020). Recent pandemic-related studies on social workers in the United States and the United Kingdom (Greene et al., 2021; Holmes et al., 2021; Miller et al., 2021) found that social workers (n range = 181–1568) met the diagnostic criteria for peritraumatic distress (46%), posttraumatic stress disorder (PTSD) (range: 22–26.21%), depression (46.90%), and anxiety (47.28%). Researchers have also documented a considerable decline in self-care practices among social workers in the pandemic context (Miller & Reddin Cassar, 2021). Others, however, reported that greater engagement with self-care practices predicted a decrease in pandemic-related distress among social workers (Miller et al., 2021).

Other scholars have argued that there might exist a relationship between social locations (i.e., privileges, marginalities) and the exacerbation of psychosocial impacts, especially for individuals who are BIPOC (Gianfrancesco et al., 2021; Lund, 2020; Sze et al., 2020), women (Cabarkapa et al., 2020; Danet Danet, 2021; Volk et al., 2021), parents and caregivers (Magruder et al., 2021; Volk et al., 2021), people with disabilities (Cieza et al., 2021; Shakespeare et al., 2021), and queer and trans people (Kamal et al., 2021; Ruprecht et al., 2020). One study empirically confirmed that social workers (n = 1568) who were married, heterosexual, physically healthier and more financially secure generally reported less distress than other clinicians (Miller et al., 2021).

Qualitative studies on social workers and other health and social service providers have revealed more nuanced understandings of these pandemic-related experiences. The study of frontline healthcare workers (n = 103) conducted by Bender et al. (2021) explicated that while interpersonal connection was increasingly difficult due to quarantine and isolation protocols, emotional connectedness was nonetheless a supportive coping strategy that strengthened practitioners' resilience during COVID-19. Exploring the ecological impacts of COVID-19 on health and human service workers (n = 531), Magruder and colleagues (2021) found that practitioners experienced impacts across various proximal and distal domains, including (1) interpersonal impacts, such as fear of infecting loved ones; (2)

intrapersonal impacts, such as facing infection or hospitalization themselves; (3) organizational impacts, such as increased caseloads at work; (4) community impacts, such as isolation from community; and, (5) public policy impacts, such as uncertainty or frustration with governmental policy responses to COVID-19. To add, in the qualitative portion of a recent large-scale Canadian survey, social workers ($n = 2470$) reported experiencing the following nine themes:

increased work-load; loss of employment; redeployment to new settings; early retirement; concern for personal health and safety; social workers in private practice seeing fewer clients; personal caregiving responsibilities; limiting recent graduates' employment potential and social workers experiencing new opportunities. (Ashcroft et al., 2021, p. 1)

For BIPOC social workers, these pandemic-related themes are often contextualized in relation to racial identity, social location, and professional experiences. Describing their experiences as Black American clinicians, Lipscomb and Ashley (2020) highlighted that they are navigating a "dual pandemic" (p. 221) defined not only by the COVID-19 pandemic, but also by repeated incidents of anti-Black racism. Alongside psychological distress, fear and emotional fatigue, they also identified difficulty sharing pain with other Black clients and discomfort working with white clients who offered their sentiments regarding race relations (Lipscomb & Ashley, 2020).

The Current Study

In this study, we explored whether and how mental health clinicians experienced shared trauma during the COVID-19 pandemic. While a considerable amount of research has been done on the pandemic and its impacts on frontline healthcare providers (e.g., Danet Danet et al., 2021), there is little known about social workers and other mental health clinicians from a shared trauma perspective in the context of COVID-19. While some have conceptually explored COVID-19-specific shared trauma about social work students in a higher education context (Dempsey et al., 2021; Tosone et al., 2021), there remains a dearth of work focused on shared trauma among practicing social workers and other mental health clinicians in the times of COVID. Empirical research on COVID-related shared trauma among frontline clinicians can contribute to social workers' knowledge on whether and how shared trauma might impact clinicians' response to client work, their own wellness, and clinical performance (Tosone et al., 2003). Furthermore, the nature of this global pandemic and its impact is ever changing and ongoing. By Spring 2021, mental health clinicians had

already been living and working in the midst of the global pandemic for a year. This was also the time when vaccines were starting to be made available to mental health clinicians. While much of the relevant literature has focused on the experiences of healthcare workers in general (e.g., Perraud et al., 2022; Serrão et al., 2022), we are unaware of studies that explored mental health clinicians' experiences during this particular time and context of the COVID, which is often known as the third wave (see Wu et al., 2021 for the Government of Canada classification). Given that the context of the pandemic and its impacts on clinicians are constantly developing, there remains a need for research that examines clinicians' experiences at different waves and contexts of this pandemic.

To address these existing gaps and needs identified in the current social work literature, we designed and conducted the current study in Spring 2021. Using both quantitative and qualitative data, the literature on shared trauma informed the following research questions (RQ): RQ1: What are the characteristics of clinician's psychosocial functioning and coping during the pandemic?; RQ2: What are the relationships between clinician characteristics and their psychosocial coping and functioning?; RQ3: What are the relationships between clinician characteristics and their assessment of Simulated Clients (SCs)?; and, RQ4: How do clinicians experience pandemic impacts on their personal and professional lives?

Method

We conducted an online survey using *Qualtrics* from March 2021 to April 2021, which was during the third wave of the pandemic when vaccines were recently made available to healthcare workers. We recruited and surveyed mental health clinicians practicing in Canada and the United States about the psychosocial impacts of the pandemic on them. Participants were then asked to watch two separate video-recorded simulated case scenarios, in which two professional actors were trained to portray realistic SCs and provide a monologue about their situations for several minutes. We then asked participants to assess the SCs' psychosocial functioning. This simulation method, a novel approach in social work research, is designed for participants to feel immersed in the scenario as if they are attending an actual session (Asakura et al. 2021). All research materials were approved by the university Institutional Review Board.

Sampling

Recruitment took place via professional listservs and social media groups subscribed by clinicians. A total of 196 clinicians completed all questions of the survey.

Survey Measures

Quantitative

We surveyed participants' demographic information, including age, gender, race, the country/state/province, years of practice, practice settings, and the highest education associated with the participant's clinical license. To examine pandemic impacts, we adapted the questions from the *COVID-19 Pandemic Mental Health Questionnaire* (Rek et al., 2020, 2021) to be more reflective of the third wave of the pandemic when the study took place (e.g., adding a question about COVID-19 vaccine status; removing a question about stocking up on household supplies since it was no longer happening). Participants were asked the following questions (1) Have you or someone close to you tested positive for COVID-19? (yes/no); (2) Has a person close to you died due to COVID? (yes/no); and (3) current employment status (e.g., full-time, laid off due to COVID) and mode of practice (e.g., remote, in-person, hybrid). We also asked about anxiety, depression, sleep disturbance, and irritability or anger experienced in the past 14 days of survey responses. The average score produced excellent internal consistency, $\alpha = 0.83$. Responses reflect an average endorsement of pandemic stress within the last 14 days, ranging from *1 = Not at all* to *5 = Very much*.

Video-Recorded Simulations Traumatic stress manifests in many different ways across people's emotional (e.g., shock, anger, irritability, helplessness), cognitive (e.g., impaired concentration), physical (e.g., fatigue, insomnia), and interpersonal (e.g., increased relational conflict) domains (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Using the definitions and examples of typical trauma responses provided by SAMHSA (2014) and our practice experiences in the field, we drafted two simulation scenarios. The scenarios were then revised multiple times upon consultation with clinicians working in relevant fields (e.g., addiction, intimate partner violence, trauma therapy). We hired and worked with professional actors to enact the following scenarios: SC 1, *Sophie*: A 43-year-old white single woman, who presents emotional distress while raising three children, one of whom is currently in cancer treatment; and SC 2, *Reggie*: A 32-year-old Black man, who presents relationship distress with his white male partner. An approximately three-minute monologue was video-recorded using *Zoom* platform for each simulated scenario.

Psychosocial Assessment Checklist Using SAMHSA's (2014) trauma framework, we created a checklist for par-

ticipants to identify the SCs' psychosocial functioning in the following domains: emotional, cognitive, physical, and interpersonal. Responses reflect an average rating of the SCs' functioning in the vignettes in the emotional, physical, cognitive, behavioral, and social domains, ranging from *1 = Least functioning* to *5 = Most functioning*. Scores were created for each psychosocial domain by averaging items within that domain. A rating of the SCs' overall functioning was created by averaging the domain scores. For both vignettes, overall functioning scores produced excellent internal consistency, $\alpha = 0.77–0.78$.

Qualitative

We asked a few qualitative questions in the survey. For the purpose of this article, we reviewed participants' responses to the following question: "Please describe the ways in which your personal and professional life has been impacted by the COVID-19 pandemic."

Data Analysis

Quantitative data analyses and assumption checks were analyzed using IBM SPSS v.27 software. All assumptions for each analysis were met and each analysis conducted is outlined in the results portion of this article. Qualitative data were analyzed using qualitative content analysis methods (Bengtsson, 2016; Elo & Kyngas, 2007; Hsieh & Shannon, 2005). Qualitative content analysis allows researchers to inductively summarize text data and identify categories (i.e., themes) on a descriptive level (Vaismoradi et al., 2013) and is appropriate for this study given the limited nature of online responses. Data were analyzed at two stages. We first coded the data independently by two research assistants. We regularly met as a team to review preliminary codes, while any coding disagreements were resolved at research team meetings. As a team, we then grouped these codes into categories. In making the reporting of results (i.e., impacts of COVID-19 onto the clinicians' lives) accessible to readers, we grouped the categories relevant to either positive or negative impacts. Since the purpose of qualitative research is not to reveal a single 'reality' and is rather to interpret the data reflexively, we chose to take on an iterative, team-based process to coding and did not calculate intercoder reliability (i.e., Cohen's kappa) (O'Connor & Joffe, 2020). To enhance trustworthiness of qualitative data analysis, we maintained individual field notes and reviewed them as a team, discussed preliminary codes as a team from multiple perspectives, took a team consensus on results, and provided sample quotes from participants to illustrate each category in writing up the results (Levitt et al., 2018).

Results

Quantitative

Participant Characteristics

The majority of participants were clinicians in Canada (80.1%). Participant age ranged from 24 to 71 years old with a mean of 39. Most were cisgender female (84.2%) and identified as white (72.5%). Due to the small proportion of minorities in this sample, ethnicity was examined as BIPOC or non-white (29.6%) or white (70.4%), wherein those who identified as mixed with white were categorized as BIPOC. Years of experience ranged from one to 20 years with a mean of nine. Sample characteristics are summarized in Table 1.

Psychosocial Impacts

To answer RQ 1 (*What are the characteristics of clinicians' psychosocial functioning and coping during the pandemic?*), we analyzed participants' answers to a series of questions relating to the psychosocial impacts of the COVID-19 pandemic. Responses were endorsed on a scale of *0 = Not at all* to *4 = Very much*. First, participants were asked to report recent psychosocial impacts relating to the pandemic that have occurred in the past 14 days. Most participants reported no or only slight effects relating to anxiety (73.5%), sleep disturbance (52.6%), or irritability (57.1%). Only 28% of participants endorsed recent feelings of depression. In fact, most participants (51.5%) reported being able to cope effectively with the stress caused by the pandemic. Most participants (63.3%) reported no urges or attempts to cope with substances. Most participants (61.7%) also reported no excessive urges to clean or disinfect to avoid contamination.

Participants were asked about specific stressors over the course of the pandemic. While some participants reported worries about health (32.7%) and the future (33.7%), most of this sample had little or no financial (64.3%), job (69.9%), childcare (77.6%), housing (58.2%), or interpersonal conflicts (68.4%). When asked about recent stressors, participants generally reported moderate confidence in their government and healthcare system.

To answer RQ2 (*What are the relationships between clinician characteristics and their psychosocial coping and functioning?*), a multiple linear regression was conducted to examine whether provider demographic factors of race, location, years of experience, and institutional setting affect participants' psychosocial impacts of the pandemic. A nonsignificant model was found (see Table 2, Model 1). An ordinal logistic regression was conducted to examine whether participant demographic factors of race, location, years of experience and institutional setting affect participants'

Table 1 Participant demographics

	n	%
Gender		
Cisgender woman	165	84.2
Cisgender man	26	13.3
Missing/Other	5	2.6
Ethnicity		
White/Caucasian	144	73.5
Black Canadian/African American	19	9.7
Asian	10	5.1
South Asian	12	6.1
Indigenous	9	4.6
Middle Eastern/North African	5	2.6
LatinX	1	0.5
Mixed race	1	1.5
Other	2	1.0
Location		
Canada	157	80.1
United States	39	19.9
Education		
MSW	138	70.4
Other Masters (e.g., Counseling, Nursing)	30	15.3
Doctorate (e.g., PhD, PsyD)	19	9.7
MD	9	4.6
Scope of practice		
Counseling	86	43.9
Healthcare	57	29.1
University and higher education	11	5.6
School	10	5.1
Children's mental health	6	3.1
Government	3	1.5
Child welfare	3	1.5
More than 1 area of practice	6	3.1
Other	14	7.1
Setting type		
Agency	122	62.2
Private practice	57	29.1
Both	6	3.1
Unspecified	11	5.6
Someone close to them tested positive for COVID-19	120	61.2
Someone close to them died of COVID-19	20	10.2
Vaccinated at time of study	107	54.6

ability to cope with stress during the pandemic. While a significant model was found (see Table 2, Model 2), no individual predictors significantly predicted the participants' ability to cope with stress.

A linear regression was conducted to examine whether the participant's vaccine status and whether the participant or someone close to them has tested positive with COVID-19 affects the provider's psychosocial functioning. A significant

Table 2 Regressions examining effects of clinician characteristics on clinician psychosocial functioning and assessment of SC overall functioning

	b	SE		R²
Model 1: clinician behavior			$F(5, 180) = 1.62$	0.04
Intercept	8.47	1.35		
White race	1.26	0.39		
Canadian	− 0.89	0.79		
Years of practice	− 0.03	0.05		
Agency setting	1.5	1.18		
Private practice setting	0.4	1.24		
Model 2: clinician stress coping			$\chi^2(5) = 9.00$	0.05
[Stress = 1]	− 2.95*	0.7		
[Stress = 2]	− 1.45	0.64		
[Stress = 3]	0.19	0.62		
[Stress = 4]	1.85*	0.64		
White race	− 0.11	0.32		
Canadian	0.12	0.36		
Years of practice	0.02	0.02		
Agency setting	− 0.25	0.54		
Private practice setting	0.6	0.57		
Model 3: clinician behavior			$F(2, 193) = 3.16*$	0.03
Intercept	12.07	1.27		
Positive COVID test	− 1.50*	0.6		
Vaccinated	− 0.02	0.59		
Model 4: clinician stress coping			$F(2, 193) = 0.01$	0
Intercept	3.54	0.34		
Positive COVID test	− 0.01	0.16		
Vaccinated	− 0.02	0.16		
Model 5: overall functioning—Sophie			$F(2, 188) = 0.18$	0
Intercept	2.84	0.09		
Gender male	− 0.02	0.13		
White race	− 0.06	0.1		
Model 6: overall functioning—Reggie			$F(5, 187) = 1.09$	0.01
Intercept	3.03	0.1		
Gender male	− 0.2	0.15		
White race	− 0.09	0.12		

The reference group for race is non-white, for Canadian is United States, for gender male is gender female

effect was found (see Table 2, Model 3). Individuals who have themselves or someone close to them test positive for COVID-19 saw a decrease in their psychosocial functioning by 1.5 points ($M = 9.62$, $min = 4$, $max = 20$). While this difference was significant, it was a small effect. A linear regression was conducted to examine whether vaccine status and whether the participant or someone close to them has tested positive affected the provider's recent ability to cope with stress. No significant effect was found (See Table 5, Model 4).

To answer RQ3 (*What are the relationships between clinician characteristics and their assessment of SCs?*), a multiple linear regression was conducted to examine whether participants' gender (male/female) and race (BIPOC/white) affected their perceptions of the overall functioning of Sophia and Reggie. For both vignettes, nonsignificant models were found (See Table 2, Models 5 and 6). For this sample, participants' race and gender did not significantly impact their assessments of the SCs overall functioning.

Chi-Square Tests of Independence were conducted to see whether differences in participants' gender, race, and highest educational training affected their assessment of SCs on individual items. A Bonferroni adjustment was used to adjust for multiple tests; using a significance threshold of 0.001, there were only four significant differences found in this sample. In assessing Sophie, a greater proportion of men than women reported symptoms of difficulty connecting, $\chi^2(1, N = 196) = 10.14$, $p = 0.001$, $V = 0.23$, and anxiety, $\chi^2(1, N = 196) = 11.64$, $p = 0.001$, $V = 0.25$. In assessing Reggie, a greater proportion of white participants endorsed

substance use issues, $\chi^2(1, N = 196) = 13.98$, $p < 0.001$, $V = 0.27$. No other significant differences were found.

Qualitative

Qualitative data were analyzed asking *RQ4: How do clinicians experience pandemic impacts on their personal and professional lives?* Examples of participant responses for each result (i.e., categories) is shown in Table 3. As shown in previous research (e.g., Danet Danet, 2021; Holmes et al., 2021; Miller et al., 2021), participant responses suggested mostly negative impacts. These negative impacts were as follows: (1) Exacerbated health risks and mental health vulnerabilities; (2) experiences of loss and grief; (3) increased dissonant responsibilities at work and home; (4) difficulties with personal-professional boundary management; and (5) distress over racial injustice in society. First, the pandemic seems to have exacerbated the participants' risks and vulnerabilities related to health and mental health, such as contracting COVID-19, anxiety, depression, substance abuse. Next, these qualitative data suggested that the pandemic brought a variety of types of losses and grief. For example, participants reported losing loved ones, financial security, employment to a sense of connection with others, as well as associated feelings of grief. Furthermore, participants reported increased dissonant responsibilities in their personal and professional lives due to increased caseload, childcare and caregiving responsibilities at home. This was marked by the participants' uneasy feelings of having to choose between equally important but sometimes conflicting priorities in their personal and professional lives. Additionally, participants in this survey reported difficulties managing boundaries between their personal and the professional lives. Specifically, the participants reported having to navigate similar experiences shared with clients during the pandemic, especially given that the sessions were taking place remotely from home. Finally, racial injustice exposed by the pandemic, such as state sanctioned violence against Black people, anti-Chinese/Asian sentiment, and reports of racial disparities of health outcomes, appeared to cause much distress in participants.

Participants also shared several, perhaps inadvertently positive impacts on their personal and professional lives during the pandemic. These positive impacts were as follows: (1) Benefits of online support for clients; (2) greater access to self-care and personal or professional development; and (3) greater awareness of structural inequality and privilege. First, the shift to online therapy, triggered by the pandemic, allowed greater access to therapeutic services among clients with whom the participants could not have worked otherwise, such as those who live in rural areas or do not have accessible transportation. Second, the pandemic afforded the participants more time with their families and for their own self-care activities. Similarly, the pandemic offered them a greater accessibility to online resources for professional development (e.g., continuing education courses). Finally, the pandemic especially exposed various structural inequalities and provided participants with a learning opportunity about social problems (e.g., racial inequality) as well as their own personal and/or professional privileges.

Discussion

This mixed-methods survey explored experiences of shared trauma among mental health clinicians during the COVID-19 pandemic. This study offered a methodological innovation. We employed two video-recorded SC monologues as a way to elicit the participants' clinical response. The use of SCs offered a novel, methodological advantage (Asakura et al. 2021) that allowed participants to share their immediate clinical assessment without ethical concerns of involving real clients during such a vulnerable time. Rather than inquiring retrospectively about their practice, this allowed us to survey clinicians about their practice while they too lived in the midst of the pandemic. This is a unique contribution of this study to the literature.

Our quantitative results showed that clinicians might experience psychosocial impacts of the pandemic (e.g., sleep difficulties) similarly to client and general populations, as supported by previous research (e.g., Miller et al., 2021). While these experiences might not be necessarily *traumatic* (i.e., deeply distressing and impactful) for all clinicians, this certainly suggests that there is a shared experience between clinicians and general populations during the times of COVID-19. On the other hand, the majority of our participants reported coping relatively well with the pandemic. This is corroborated by previous literature that suggests that experienced and highly-trained clinicians may effectively utilize necessary coping skills even during times of distress (Bauwens & Tosone, 2010; Holmes et al., 2021; Tosone et al., 2014).

Our results also showed little relationship between clinicians' personal characteristics and the psychosocial impacts of the pandemic on them. Additionally, there was little relationship between clinicians' experiences with the pandemic, their personal characteristics (e.g., race, location) and their clinical assessment of the two SCs. This suggests that the clinicians' own experience during the pandemic might not necessarily act as a barrier in their professional ability to understand clients. This is certainly encouraging and might point to the professionalism that allows these clinicians to uphold their practice skills despite their shared experience of the pandemic. This might also be explained by the timing of data collection. Given that these clinicians already had a full year (since the onset of pandemic in Spring 2020) of involvement with clients while navigating the pandemic themselves, they might have had sufficient time and practice

Table 3 Sample qualitative responses

Theme	Sample quotes
Negative impacts	
(1) Exacerbated health risks and mental health vulnerabilities	*"It feels like life is 'all work and no play' right now. I have noticed an increase in my alcohol consumption and I experience anxiety or low mood/irritability several days a week (prior to the pandemic, this was not the case)."* *"Feeling emotionally and mentally burnt out because I feel more helpless and it's hard for me to navigate this without my go to coping (gym, friends, family) and trying to help others navigate on top of that. Having a way harder time detaching and disconnecting. Have barely slept. Became very anxious when I haven't struggled with anxiety before."*
(2) Experiences of loss and grief	*"Personally, due to the death of my husband, I have had to grieve in isolation which has been very difficult. I ache to have my family and friends around me, but it is not possible."* *"Continued isolation from friends and family. Working from home (90% of time). Started an additional job due to financial struggles. Death of a family member. Increase work load that results in poor work life balance. Cancelled vacations and celebrations. A delay in starting our journey to family planning."*
(3) Increased dissonant responsibilities at work and home	*"It has felt incredibly overwhelming and stressful to have to be a support for clients while I am struggling to even support myself and my family. It is a time when there has been widespread struggles with mental health and therefore we have been needed more than ever but we too are negatively impacted by the same things impacting others. And because of the pandemic, the number of clients had increased, as has the severity of people's symptoms. Oh and we are also trying to do home school or attend to our own family's mental health struggles and it is just too much!"* *"It has been a difficult decision to send my other child back to school due to concerns about covid and some health issues that she has. The hardest part is questioning every decision and feeling like there is no decision that is the 'right' one. Always second guessing"*
(4) Difficulties with personal-professional boundary management	*"I have shifted from working at the office everyday to working fulltime in my tiny apartment. There is no healthy separation between my work life balance. I am finding it increasingly difficult to maintain a boundary between the two."* *"I also feel that lack of separation from home and work and engaging in emotional work while in the sacred space of home has impacted burnout and stress as well. Holding space for clients, hearing stories of trauma and walking out of my 'office' into my home, into a room with my children (during times of online learning) was extremely difficult."*
(5) Distress over racial injustice in society	*"I think that I have been more emotionally impacted by the Black Lives Matter movement and recent gun violence than be COVID-19."* *"I have been concerned about the BLM movement, as I have seen how it has significantly impacted our working conditions and what my colleagues have had to endure for so many years. I also have been effected, being a South Asian female, as racism has been a part of my life as well."*
Positive impacts	
(1) Benefits of online support for client	*"Due to my work moving online I am now working with a broader population in the state. This now includes those who are typically in more insular and rural areas. In many ways, the shift to telework has increased access to mental health and substance use services. I am seeing people who might not have had access to these services otherwise. Further, I have heard reports from many of my patients that these services being online made it easier to reach out."*
(2) Greater access to self-care and personal or professional development	*"Quite a few clients who have anxiety or agoraphobia find it easier to be present in sessions with me because they are in their home/ safe place; they have increased communication with their other health care providers as well on account of this so the health care that they are able to receive is more fitted to their situation (this is accessibility related). It will be important to continue having services available remotely."*

Table 3 (continued)

Theme	Sample quotes
(3) Greater awareness of structural inequality and privilege	*"I have been able to spend more time with my friends getting together outside for walks which I haven't been able to do in many years due to being far too focused on my work."* *"Something that helped me so much was attending psychotherapy training and conferences online. Meeting and interacting with other professionals who did not know me was so great. I have a clinical supervisor and a clinical supervision group and all that helped but the trainings at least once a week and on occasion 3 times a week kept me sane."* *"I have experienced much of the pandemic in a very privileged position. I am able to work from home, my partner is able to do the same and we live well together. I have been able to keep my job, and am financially stable. I recognize my privileged position daily."* *"I am privileged to have maintained employment throughout this pandemic. Finances have been tight, however my work was able to move online. I also do not have children, so childcare was not an issue. I was also privileged enough to support the BLM protests and movement in my city while protecting my personal health."*

to foster a work-life balance by the time of this survey. Another possible explanation could be the sampling bias of our study. Given that white, cisgender individuals typically fare better during the pandemic than marginalized populations (Gianfrancesco et al., 2021; Kamal et al., 2021; Lund, 2020; Ruprecht et al., 2020; Sze et al., 2020), our sample—predominantly white and cisgender—could explain the results of minimal psychosocial impacts of the pandemic. To add, the majority of participants resided in Central Canada and their experiences might be context-specific to the political, social and economic climate of this location. Finally, it is also plausible that highly overwhelmed clinicians could not afford to participate in this time-consuming study in the first place due to their own personal time and capacity constraints.

Interestingly, our quantitative data revealed that testing positive for COVID-19 or knowing someone who has tested positive for COVID-19 may elicit a decrease in clinician psychosocial functioning compared to those who were vaccinated, did not test positive, and did not know anyone who tested positive. Since the study was conducted in the midst of the pandemic and there was still so much unknown about the long-term effects of COVID, these participants may have felt more stressed as a result of this uncertainty.

Despite the quantitative results, qualitative results showed a more nuanced understanding of the clinicians' pandemic-related experiences, corroborated by previous empirical studies highlighting clinicians' experiences with anxiety (Ashcroft et al., 2021; Greene et al., 2021), depression (Greene et al., 2021), and grief and loss (Holmes et al., 2021). Our qualitative results also revealed the impacts of the larger sociopolitical climate at the time of this study, including the Black Lives Matter Movement and anti-Asian sentiments, on clinician wellbeing. As corroborated in others' work (Chae et al., 2021; Lipscomb & Ashley, 2020), the emotional distress and feelings of helplessness of clinicians exposed to anti-Black and anti-Asian racism were also revealed in the qualitative portion of our study. The strength of qualitative research lies in its ability to elicit participants' complex thoughts and feelings that often cannot be captured in a quantitative survey alone. Without the qualitative aspect of this study, our results likely failed to fully understand these socio-political contexts of the pandemic and their psychosocial impacts on those working at the frontline.

Our qualitative results add nuances to the existing relevant literature. The pandemic has generated feelings of increased dissonant responsibilities in clinicians' personal and professional lives, marked by feelings of having to choose between equally important, but often conflicting, priorities (e.g., pressures to support clients while having to support themselves and their families). Clinicians also reported difficulties building and maintaining relationships with colleagues or accessing peer support in the remote working condition. Although our quantitative results showed that the majority of participants were relatively "doing well," our qualitative results certainly suggest that clinicians' own pandemic-related experiences remain a concern. From living and working in the same space, helping clients who share similar situations, to managing increased personal and professional responsibilities, these results suggest the importance of managing isolation and navigating a work-life balance during the pandemic. Especially given that self-care has been now added to the *NASW Code of Ethics* (Murray, 2021), to support clinicians in enhancing their self-care practices is a vital responsibility for those engage in clinical education, supervision, and clinical practice with helping professionals.

As suggested by previous literature on shared trauma (Holmes et al., 2021), our results suggested that extraordinary events like the pandemic could provide constructive opportunities for clinicians. Our findings showed that remote working conditions afforded clinicians with new opportunities, such as having more time for continuing education, enhancing service access for hard-to-reach clients, and engaging in racial and social justice work. Despite the struggles participants reported, the pandemic also created an opportunity for further learning, enhanced empathy, compassion and connectedness in clients during this distressing time, which has also been echoed by others who study shared trauma (e.g., Bauwens & Tosone, 2010; Nuttman-Shwartz & Dekel, 2009). Clinicians are encouraged to keep these promising results in mind while supporting clients during distressing times.

Limitations

Several limitations must be taken into account when readers interpret the study results. While the online survey allowed us to recruit clinicians from various disciplines from two countries, there was no way to verify that respondents were licensed clinicians who met all of the study criteria. As well, despite our concerted efforts to recruit diverse participants, our sample was predominantly white, cis-women from Canada. Given how differently the pandemic impacted and was handled across states/provinces and countries, readers are cautioned to interpret our study results when discussing clinicians in other geographical and social contexts. This biased sampling occurred likely because initial recruitment reached potential participants through the research team's local professional networks in our predominantly white mid-sized Canadian city, and we closed the survey when the first 200 responses were recorded. This was certainly a missed opportunity given the well-documented health disparities among marginalized groups during COVID-19 (Gianfrancesco et al., 2021; Lund, 2020; Sze et al., 2020). Additional target recruitment efforts (e.g., recruiting BIPOC clinicians first) are warranted in future research to better capture the experiences of those from marginalized communities. Given the urgent and constantly changing nature of the pandemic and its impacts, we were unable to locate a scale that fit perfectly for the purpose of this study. We used a newly developed scale on the pandemic impacts on mental health (Rek et al., 2020, 2021) by adapting some questions to better suit the pandemic context in which this study was conducted (i.e., the public was better informed of the virus by this point). These modifications were necessary for us to accurately capture participant response in this particular pandemic wave and context. The reliability of the modified scale ($\alpha = 0.83$) aligned with that of the original instrument (Rek et al., 2020, 2021). While face validity of the modified scale was ensured by those in the research team that worked in the field as frontline social workers, these modifications likely changed the construct validity of the scale. This is certainly a study limitation. Once more researchers have used this scale to conduct similar studies on mental health clinicians, a validation study can and should be conducted to further strengthen the scale. Doing so will contribute greatly to advancing research in this area. Another limitation of the study is the fixed nature of qualitative data collected in an online survey format. Unlike interview or focus group data, participant response could not be elaborated, which limited our ability to contextualize the data during analysis. We also were unable to engage in member-checks or participant feedback on results (Levitt et al., 2018). Finally, the survey did not include several important variables, such as parenting status, caregiving responsibilities, and ages of children—all of which could have impacted participants' experiences with pandemic. At the time of this article, the COVID-19 pandemic is not yet behind us, and global crises will continue to impact the lives of clients and clinicians. Taking these limitations into account, further research on clinicians is needed to further advance our knowledge base of shared trauma.

Conclusion

This mixed-methods study surveyed 196 clinicians in Canada and the U.S. on their pandemic-related experiences during the third wave of the pandemic (Spring 2021). In addition to using traditional survey items (e.g., demographics, scales, and short answers), we also used video-recorded monologues of two SCs in order to elicit the clinicians' assessment of SCs. Clinicians reported similar psychosocial impacts of the pandemic to client and general populations, though more than half of them reported coping well with the pandemic. Our study results on the participants' assessment of SCs also suggests that clinicians' pandemic-related experiences might not necessarily negatively impact clinical practice, and clinicians are relatively well-equipped to support clients well even in times of global distress. As we continue to live and work in the times of COVID-19, our study supports the importance of assisting clinicians in navigating a work-life balance and further developing empirically-grounded knowledge about shared trauma and its positive and negative impacts on clinicians.

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Kenta Asakura, MSW, LICSW, RSW, Ph.D., is an Associate Professor and Chair of the Practice Sequence at Smith College School for Social Work. He engages in a robust program of simulation-based research on clinical social work education and practice.