The Impact of COVID-19 on Social Workers: An Assessment of Peritraumatic Distress

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Abstract
● **Summary:** There is broad consensus that COVID-19 has had a pernicious impact on social work, in general, and among social work practitioners, more specifically. However, at present, very few, if any, empirical examinations of this impact exist. This exploratory study examined peritraumatic distress among a sample of social workers (N = 3920) in one southeastern state in the United States.

● **Findings:** Analysis suggests that distress is impacted by several variables. In general, participants identifying as male, married, reporting good physical and mental health, working in microcontexts, and who were financially secure tended to experience less COVID-19 associated distress. In addition, social workers identifying as LGBTQ and who had been working mostly remotely experienced higher levels of distress.

● **Applications:** Overall, findings indicate the need to provide adept support to social workers practicing during the pandemic. Data suggest the need for targeted support initiatives, typically for those who are from underrepresented groups (e.g., LGBTQ) or experiencing financial or mental/physical health issues. Certainly, researchers should continue to examine the impact of COVID-19 on social work practitioners and service delivery.

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In December, 2019, authorities in China notified the World Health Organization (WHO) of an unknown pneumonia emerging from Wuhan City in Hubei province. The disease, which was initially referred to as 2019-nCoV, was the source of much speculation and debate. Since that time, the disease, now known as COVID-19, has had a serious impact on every facet of society. As of July 6, 2020, WHO reported over 11,000,000 confirmed cases of COVID-19 and approximately 532,000 deaths worldwide (see covid19.who.int). The pandemic, which was classified as so in March 2020, has crippled world financial markets, put inordinate strain on medical infrastructure, and reaped untold consequences on general social and mental health.

Though very few, if any, empirical studies exist, it is widely assumed that COVID-19 has had a pernicious impact on social services. Specifically, several authors have suggested that the pandemic has caused stress among the social work labor force (e.g., Berg-Weger & Morley, 2020; Cudjoe & Abdullah, 2020). This article seeks to examine this stress and, as such, uniquely contribute to a current dearth in the literature.

This exploratory study examined peritraumatic distress among a sample of social workers ($N = 3920$) in one southeastern state in the United States. To collect primary data, researchers deployed the COVID-19 Peritraumatic Distress Index (CPDI; Qiu et al., 2020). This self-report instrument is designed to measure distress associated with the COVID-19 pandemic. This is the first known empirical study to explicitly examine this line of inquiry. After a brief review of pertinent background information, this article will explicate results, discuss findings, and proffer salient practice, policy, and research implications.

Background
The aim of social work practitioners, according to National Association of Social Workers (NASW, 2017), is the betterment of society and human well-being. International Federation of Social Workers (IFSW) echoed similar sentiments and explained that social workers toil toward a collective aim of social change and the liberation of all people. Indeed, the core mission of social work, no matter the context, is essential to a just, well-functioning society.

Given the scope and magnitude, even under ideal circumstances, actualizing the professional mission can be taxing for social workers. Evidence suggests that social work practitioners may be at increased risk for a plethora of “conditions of professional depletion” (Greville, 2015, p. 14). Among these conditions are...
compassion fatigue, vicarious traumatization, secondary traumatic stress, and burnout, among other problematic professional phenomena (e.g., Adams et al., 2006; Dunkely & Whelan, 2006; Grise-Owens et al., 2016; Miller & Grise-Owens, 2020; Ting et al., 2011). These challenges occur within a context in which social workers may receive inadequate supervision and support (e.g., Calitz et al., 2014). In addition, social workers are disproportionately impacted by ever-changing political climates, reductions in social service resources, and cumbersome bureaucratic processes (e.g., Miller et al., 2018; Whitaker et al., 2006). These challenges may be compounded for individuals from underrepresented groups (e.g., Ayala et al., 2017).

COVID-19 and social work practice

To be clear, there are very few, if any, empirical examinations on the impact of COVID-19 on social work practice or practitioners. These limitations notwithstanding, there is wide-ranging consensus that this pandemic has profoundly impacted social workers. In describing this impact, Amadasun (2020) postulated that “the social work profession, more than any other, is most hurt by the rampaging coronavirus (aka, COVID-19) pandemic” (p. 1).

COVID-19 has impacted social workers in a number of ways. For starters, social workers are ethically mandated to serve the populations most vulnerable to inimical consequences associated with COVID-19 (Berg-Weger & Morley, 2020). Pragmatically, social workers are tasked with simultaneously actualizing this mandate while also attending to their own needs. As well, distancing guidelines have fundamentally changed the way practitioners are able to deliver services (Cudjoe & Abdullah, 2020). As a result of the pandemic, many social workers made abrupt transitions to virtual service delivery, which may have proved difficult for practitioners and service recipients, alike.

In addition to these assertions related to social work practice, the broader literature offers insight and implications about impact of COVID-19 on professional helping practitioners. For example, in separate studies that examined the impact of COVID-19 among frontline healthcare providers (e.g., physicians, nurses, etc.), Shechter et al. (2020), Lai et al. (2020), and Xiao et al. (2020) found that participants reported increased levels of acute stress and depressive disorder symptoms connected to COVID-19. Spoorthy et al. (2020) reviewed six publications that assessed the impact of COVID-19 on healthcare workers. These authors concluded that demographic and professional variables, such as gender and age, were linked to stress and depressive symptoms associated with COVID-19. In a separate review assessing literature about the impacts of COVID-19 on the general public, Torales et al. (2020) noted a host of problematic issues including denial, anger, and fear connected to the pandemic. These findings in mind, it is possible, if not probable, that social work practitioners have experienced similar outcomes.
Research rationale and foci

There is a clear need for research about COVID-19 and social workers. The WHO and the Global Research Collaboration for Infectious Disease Preparedness (GRCIDP) recently held a global forum that outlined a research agenda aimed at assuaging the impact of COVID-19. At this forum, Yazdan Yazdanpanah, Chair of GRCIDP, discussed an “urgent need to develop safe and effective countermeasures that can be available, accessible and suitable for use in populations most in need” (2020, p. 4). Yazdanpanah went on to explain that research is an integral aspect of that response.

Despite this clarion call, research related to the impact of COVID-19 on social workers is nominal, at best. Given surges in COVID-19 cases and death, particularly in the United States, it is imperative that researchers engage in works that help to better understand COVID-19 and how to effectively support practitioners in dealing with it. This study contributes to meeting this aim.

The overarching focus of this study was to examine peritraumatic distress among social workers (N = 3920) in one southeastern state in the United States. Peritraumatic distress refers to the physiological and/or emotional distress experienced by an individual during a traumatic event (Bunnell et al., 2018). Consistent with assertions made by WHO and GRCIDP, this type of research has the potential to inform responses to supporting social workers during this, and future, public health crises.

Specifically, this study was guided by three exploratory research questions (RQs). These questions were informed by the aforereferenced literature denoting possible differences in how individuals may experience distress associated with COVID-19.

RQ1: What is the current level of peritraumatic distress related to COVID-19 among social workers?

RQ2: Are there group differences in COVID-19-related peritraumatic distress by demographic (e.g., race, etc.) and professional variables (e.g., work level, etc.), respectively?

RQ3: What variables predict COVID-19 related peritraumatic distress?

Methodology

Sample recruitment

Participants for this cross-sectional study were recruited via a nonrandom convenience sampling approach. All participants self-selected into the study by responding to an online survey invitation that was sent to professional listservs related to social work practitioners. Individuals were asked to forward the survey to other
social workers. Because this study used this snowball technique, calculating a response rate is not possible.

A waiver of documentation for the informed consent was requested and granted by a University Institutional Review Board (IRB). Each participant was asked to read the consent before entering the survey. Inclusion criteria for this study was as follows: (1) Be 18 years of age, or older; (2) Identify as a social worker; and (3) Be practicing social work in Kentucky [at the time of the survey].

The survey and its associated responses were managed via an online survey management system. All data were collected during Spring/Summer 2020. In appreciation for their participation, participants were offered a chance to enter a $500 cash card drawing. The incentive survey was separate from the primary survey. This approach permitted participant responses to be anonymous. While a response rate could not be determined, the completion rate for the survey was 78%. This in an appropriate alternative to a response rate (e.g., Eysenbach, 2004).

Participants

A total of 3920 \((N = 3920)\) social workers participated in this study. Descriptive statistics for demographic variables are included in Table 1. The typical participant identified as female (88.6%), White, non-Hispanic (88.2%), aged 42.77 \((SD = 12.01)\) years, and reported 14.41 \((SD = 13.1)\) years of social work experience. Please note that there is no specific state-level report associated with social work practitioners in the state where this study conducted.

Professional characteristics of the sample are included in Table 2.

Materials

To collect primary data associated with answering the previously posited research queries, researchers utilized the CPDI (Qiu et al., 2020). CPDI is a 24-item scale designed to examine COVID-19 specific peritraumatic distress. The questionnaire is based on relevant diagnostic guidelines for distress as outlined in the International Classification of Diseases (11th Revision, 2018). The instrument asked participants to designate the frequency of feelings and behaviors in the week prior to taking the questionnaire. Items are anchored at 0 indicating Never and 4 indicating Most of the Time. Example items include: Compared to usual, I feel more nervous and anxious and I feel insecure and bought a lot of masks, medications, sanitizer, gloves, and/or other home supplies. CPDI scores, which range from 0 to 100, are computed as a sum across all items. Scores as designated as follows: 0–28 indicates normal distress; 29–52 indicates mild distress; and 53–100 indicates severe distress. Because this survey is relatively new and not widely tested among social work populations in the United States, the survey was piloted for item clarity and structure among a pilot group of 31 \((n = 31)\) social work practitioners. These pilot data were not included in this analysis. The Cronbach’s alpha of CPDI for this study was .91 \((p < .001)\).
Table 1. Demographic characteristics of participants.

| Category                        | N    | %    |
|---------------------------------|------|------|
| Gender                          |      |      |
| Male                            | 424  | 10.9 |
| Female                          | 3436 | 88.6 |
| Other                           | 20   | 0.5  |
| Sexual orientation              |      |      |
| Heterosexual or straight        | 3404 | 89.5 |
| Gay or lesbian                  | 184  | 4.8  |
| Bisexual                        | 168  | 4.4  |
| Others                          | 48   | 1.3  |
| Race/Ethnic background          |      |      |
| White non-Hispanic              | 3456 | 88.2 |
| Black non-Hispanic              | 302  | 7.9  |
| Hispanic                        | 47   | 1.2  |
| Asian                           | 33   | 0.9  |
| American Native                 | 6    | 0.2  |
| Current relationship status     |      |      |
| Married                         | 2564 | 66.8 |
| Partnered                       | 276  | 7.2  |
| Widowed                         | 72   | 1.9  |
| Divorced                        | 356  | 9.3  |
| Separated                       | 60   | 1.6  |
| Never married                   | 512  | 13.3 |
| Educational level               |      |      |
| Bachelor’s                      | 176  | 4.5  |
| Master’s                        | 3608 | 93.1 |
| Doctorate                       | 80   | 2.1  |
| First professional degree       | 12   | 0.3  |
| Physical health status          |      |      |
| Excellent                       | 432  | 11.4 |
| Very good                       | 1496 | 39.3 |
| Good                            | 1420 | 37.3 |
| Fair                            | 400  | 10.5 |
| Poor                            | 56   | 1.5  |
| Current financial situation     |      |      |
| I cannot make ends meet         | 124  | 3.3  |
| I have just enough money to make ends meet | 892  | 23.5 |
| I have enough money, with a little left over | 1848 | 48.6 |
| I always have money left over   | 936  | 24.6 |
| Mental health status            |      |      |
| Excellent                       | 324  | 8.5  |
| Very good                       | 1392 | 36.6 |
| Good                            | 1632 | 42.9 |
| Fair                            | 420  | 11.0 |
| Poor                            | 36   | 0.9  |

aAnchored at 1 = Poor; 5 = Excellent.
In addition to the CPDI, researchers collected primary data associated with several personal (e.g., age, race, etc.) and professional variables (e.g., work level, professional group membership, etc.). Data associated with these variables are included in Tables 1 and 2.

**Table 2. Professional characteristics of participants.**

|                                    | N   | %   |
|------------------------------------|-----|-----|
| Members of professional organization<sup>a</sup> |     |     |
| Yes                                | 1108| 29.2|
| No                                 | 2692| 70.8|
| Practice level<sup>b</sup>         |     |     |
| Mostly microlevel work             | 2336| 64.0|
| Mostly mezzo-level work            | 432 | 11.8|
| Mostly macrolevel work             | 164 | 4.5 |
| Work spread out across levels      | 716 | 19.6|
| Currently not employed             | 4   | 0.1 |
| Work remotely after COVID<sup>c</sup> |     |     |
| Yes                                | 2856| 77.6|
| No                                 | 824 | 22.4|
| Supervision duties                 |     |     |
| Yes                                | 784 | 20.6|
| No                                 | 3020| 79.4|

<sup>a</sup>Participants were asked if they were a member of a professional organization.

<sup>b</sup>Indicates level of primary practice responsibility.

<sup>c</sup>Participants were asked if they worked PRIMARILY remotely after March 11, 2020.

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**Data analysis**

To answer RQs associated with this endeavor, descriptive, bivariate, and multivariate inferential analyses were conducted. The descriptive analysis showed frequency and mean distribution of main variables. One of the bivariate analyses (correlation analyses) looked at the relation between participants’ continuous demographic variables (i.e., age, years in social work practice, and weekly work hours) and their CPDI scores. For the last types of bivariate analyses (analyses of variances (ANOVA<sub>s</sub>)), participants were divided into groups based on various categorical demographic variables (e.g., race, degree, etc.), and their average COVID distress scores were compared across the groups. To assess the appropriateness of ANOVA, Levene’s test of homogeneity of variances was assessed. In one analyses related to differences by financial status, Levene’s test was not within an acceptable range, and a Brown–Forsythe analysis was initiated. For multivariate inferential analysis, multiple ordinary least squares regression was performed to examine the effects of each of the participants’ key demographic variables on their CPDI scores while controlling for the effects of all other covariates. Please note that given the appropriateness
of the sample size in relation to the statistical analyses, missing data were excluded from testing. Less than 2% of overall data were missing, at random.

Findings

**CPDI scores**

Mean CPDI scores were 28.76 ($SD = 13.68$). Breakdown by score category is as follows: 53.6% were experiencing normal distress; 40.5% were experiencing mild distress; and 5.9% were experiencing severe distress.

**Bivariate analysis**

Correlation analyses between the total distress scores and various continuous demographic variables produced significant relations with $Age$ ($r = -0.136, p < .01$) and $Years in Social Work Practice$ ($r = -0.151, p < .01$). These significant correlations indicate that the older and more experienced social workers tend to have lower CPDI scores.

Due to the exploratory nature of the study, one-way ANOVAs were conducted to investigate differences between key variables with appropriate sample sizes at each level on the dependent variable total COVID distress scores. Significant differences in mean total distress scores were detected for the following variables: gender, sexual orientation, physical health, mental health, supervision status, current financial status, current remote-work status, current relationship status, and work levels, respectively. Table 3 contains a summary of statistics for the ANOVAs conducted; score means and standard deviations are included in the following paragraphs.

| Variables                                      | Total COVID distress scores | Effect size | $F$  | $p$   | SE  | 95% CI               |
|------------------------------------------------|----------------------------|-------------|------|-------|-----|-----------------------|
| Gender (male vs. female)                       | .300                       | 5.57**      | .001 | 0.74  | [-3.59, -0.81]        |
| Degrees (masters vs. others)                   | .085                       | 2.12*       | .010 | 0.90  | [-4.09, -0.57]        |
| Marital status (married vs. not married)       | .227                       | 2.08*       | <.001| 0.48  | [-4.22, -2.35]        |
| Work levels (microlevel vs. others)            | .109                       | 7.22**      | .003 | 0.47  | [-2.29, -0.46]        |
| Financial status                               | .055                       | 105.45***   | <.001| 0.62  | [7.43, 10.38]         |
| Physical health                                | .029                       | 35.97***    | <.001| 0.92  | [5.19, 10.06]         |
| Mental health                                  | .189                       | 299.63***   | <.001| 0.86  | [19.77, 24.31]        |
| Sex orientation (heterosexual vs. others)      | .352                       | 0.26*       | <.001| 0.73  | [-9.23, -6.37]        |
| Remote work after COVID (Yes vs. No)           | .097                       | 0.16*       | .004 | 0.55  | [0.51, 2.67]          |
| Supervise other social workers                 | .124                       | 1.91***     | <.001| 0.56  | [-3.19, -1.01]        |

CI: confidence interval.
* $p < .05$. ** $p < .01$. *** $p < .001$. 

Table 3. Group comparison results for social workers’ CPDI scores.
Gender. Analysis revealed significant effect by gender, $F(1, 3658) = 5.57$, $p = .001$, Cohen’s $d = .30$. Mean CPDI scores for female social workers ($M = 28.87$, $SD = 13.72$) were significantly higher than their male counterparts ($M = 26.62$, $SD = 12.38$).

Sexual orientation. Mean comparison across groups was conducted based on self-reported sex orientation: heterosexual or straight versus not heterosexual or straight (e.g., Gay or Lesbian, Bisexual, & Prefer not to answer); significant effects were detected, $F(1, 3678) = .26$, $p < .001$, Cohen’s $d = .352$. Those who described themselves as heterosexual or straight ($M = 27.96$, $SD = 13.45$) scored significantly lower on CPDI than those who identified as not heterosexual or straight ($M = 35.76$, $SD = 13.62$).

Marital status. Significant cross-group differences in CPDI scores were found by marital status, $F(1, 3678) = 2.08$, $p < .001$, Cohen’s $d = .227$. Participants who were married ($M = 27.68$, $SD = 13.42$) reported significantly lower distress scores those who were not married ($M = 30.96$, $SD = 13.93$).

Primary work level. For work levels, analysis compared mean CPDI scores for those employed in mostly microlevel work with those from all other categories. Significant effects were detected, $F(1, 3678) = 7.22$, $p = .003$, Cohen’s $d = .109$. Social workers who engaged in mostly microlevel work scored significantly higher ($M = 29.60$, $SD = 14.08$) than those who worked at all other levels ($M = 28.23$, $SD = 13.39$).

Supervision status. Analysis showed that social workers in supervisory roles ($M = 27.96$, $SD = 13.45$) had significantly lower CPDI scores than those with no supervisory responsibilities, $M = 35.76$, $SD = 13.62$; $F(1, 3678) = 1.91$, $p < .001$, Cohen’s $d = .124$.

Remote work. CPDI scores were compared by social workers who worked remotely after COVID-19 was declared a pandemic. Significant differences in mean CPDI scores were found, $F(1, 3546) = .16$, $p = .004$, Cohen’s $d = .097$. Analysis showed that CPDI scores for those who were working mostly remotely ($M = 29.05$, $SD = 13.60$) were significantly higher than those who were not ($M = 27.46$, $SD = 13.68$).

Physical health status. For analyses, those who reported fair or poor health were combined into one category. A significant difference was detected, $F(3, 3676) = 35.97$, $p < .001$, $\eta^2 = .029$. Post hoc analysis (Tukey HSD test) revealed that the mean total distress scores for those who reported excellent physical health ($M = 24.97$, $SD = 13.08$) were significantly lower than the mean scores of those who reported Very Good ($M = 27.14$, $SD = 13.34$), Good ($M = 30.33$, $SD = 13.53$), or Fair or Poor physical health conditions ($M = 32.60$, $SD = 14.15$), respectively.
**Mental health status.** Again, due to low response in certain categories, *Fair* and *Poor* were combined into one level. A significant difference was found, $F(3, 3676) = 299.63, p < .001, \eta^2 = .189$. Post hoc analysis (Tukey HSD test) revealed that mean CPDI scores for those who reported excellent mental health ($M = 17.75$, $SD = 9.29$) were significantly lower than the mean scores of those who claimed *Very Good* ($M = 24.26$, $SD = 11.52$), *Good* ($M = 31.57$, $SD = 12.91$), or *Fair or Poor* mental health conditions ($M = 39.78$, $SD = 14.17$), respectively.

**Financial situation.** As a part of the survey, respondents were asked to select the response that best described their current financial situation: *I cannot make ends meet*, *I have just enough money to make ends meet*, *I have enough money, with a little left over*, or *I always have enough money left over*. The responses *I cannot make ends meet* and *I have just enough money to make ends meet* were combined into one level. A one-way robust ANOVA (Brown–Forsythe test) was used to compare CPDI scores by financial status; statistically significant differences were detected, $F(2, 3669) = 105.45, p < .001, \eta^2 = .055$. A Games-Howell test revealed a significantly lower mean total distress score for those who indicated: *I always have money left over* ($M = 23.86$, $SD = 11.90$) than those who noted *I cannot make ends meet* or *I have just enough money to make ends meet* ($M = 32.76$, $SD = 14.75$), or *I have enough money, with a little left over* ($M = 29.12$, $SD = 13.11$), respectively.

**Multivariate analysis**

To explore the effects key predictor variables may have on CPDI scores, a multiple regression analysis (ordinary least squares) was conducted. The following variables were entered into the model: *Age*, *years of practice experience*, *physical health status*, *mental health status*, *gender*, *sex orientation*, *highest academic degree*, *marital status*, *remote-work status*, *work levels*, *supervise other social workers*, and *current financial situation*. The model was statistically significant for CPDI scores, $F(18, 3208) = 49.792, p < .001, R^2 = .228$, adjusted $R^2 = .223$.

Results revealed that the following variables significantly predicted total distress: *gender* ($p < .01$), *work level* ($p < .001$), *finance status* ($p < .001$), *physical health* ($p < .001$), *mental health* ($p < .001$), *remote-work status* ($p < .01$), and *sex orientation* ($p < .001$). Table 4 identifies significant predictors of CPDI scores.

**Discussion and implications**

On March 26, 2020, International Federation of Social Workers Secretary-General Dr. Rory Truell made comments about social work and the COVID-19 pandemic. Of the profession, Dr. Truell remarked:

“Social work is responding extremely well to the Covid-19 crisis despite many countries reporting a lack of protective equipment, support and resources” (see https://
Table 4. Multiple regression predicting social workers’ COVID distress.

| Model                                      | B     | $\eta^2$ | SE   | p     |
|--------------------------------------------|-------|----------|------|-------|
| Age                                        | -0.014| <.001    | 0.030| .644  |
| Years of practice experience               | -0.024| <.001    | 0.034| .492  |
| Gender                                     |       |          |      |       |
| Male                                       | -1.841***| .002| 0.684| .007  |
| Female Reference                           |       |          |      |       |
| Marital status                             |       |          |      |       |
| Married                                    | -0.149| <.001    | 0.477| .754  |
| Not married                                |       |          |      |       |
| Degree                                     |       |          |      |       |
| Master’s                                   | -.922 | <.001    | 0.897| .304  |
| Others (high school, associate’s, bachelor’s, doctorate, & first professional) Reference | | | | |
| Work level                                 |       |          |      |       |
| Others (mostly mezzo-level, mostly macrolevel, work spread out, not employed) | 1.651***| .004| 0.450| <.001 |
| Mostly microlevel work Reference           |       |          |      |       |
| Physical health                            |       |          |      |       |
| Fair or Poor                               | 3.870***| .005| 0.995| <.001 |
| Good                                       | 3.261***| .005| 0.823| <.001 |
| Very Good                                  | 2.526** | .003| 0.783| .001  |
| Excellent                                  |       |          |      |       |
| Mental health                              |       |          |      |       |
| Fair or Poor                               | 19.668***| .089| 1.109| <.001 |
| Good                                       | 11.857***| .048| 0.939| <.001 |
| Very Good                                  | 5.171***| .010| 0.897| <.001 |
| Excellent                                  |       |          |      |       |
| Current financial situation                 |       |          |      |       |
| I cannot make ends meet, or just enough money to make ends meet | 4.644***| .016| 0.652| <.001 |
| I have enough money, with a little left over | 3.094***| .010| 0.553| <.001 |
| I always have money left over              |       |          |      |       |
| Reference                                  |       |          |      |       |
| Work remotely due to COVID-19              |       |          |      |       |
| Yes                                        | 1.444** | .003| 0.506| .004  |
| No                                         |       |          |      |       |
| Supervision status                         |       |          |      |       |
| Yes                                        | -0.364 | <.001    | 0.546| .505  |
| No                                         |       |          |      |       |
| Sexual orientation                         |       |          |      |       |
| Heterosexual or straight                   | -5.052***| .016| 0.694| <.001 |
| Others (gay or lesbian, bisexual, or prefer not to answer) Reference | | | | |

**p < .01. ***p < .001.
Whilst the impact of the services provided by social workers during the COVID-19 pandemic cannot be overstated, the comments by Secretary-General Truell seem to be mostly focused on external facing services—not the practitioners themselves. This study suggests that while social workers may be responding well to delivering services, the impact on those proffering the service is everything but well.

Findings from the current study suggest that proffering social work services may come at a cost for social workers. Mean CPDI scores for this study were 28.76, which fall just outside the normal range. In terms of categorical breakout, 53.6% of participants were experiencing normal distress; 40.5% were experiencing mild distress; and 5.9% were experiencing severe distress.

While somewhat concerning, these findings may not be surprising. As indicated in the aforereferenced background literature, several authors have discussed the stress facing professional service providers during the pandemic. And, in a recent national study of U.S. participants, Palsson et al. (2020) found that over half of their participants reported higher stress levels as a result of COVID-19. All told, data from the current study indicate that, like other populations, social workers are experiencing distress.

There are several ways that social workers may be supported in assuaging personal and professional consequences associated with COVID-19 distress. Notably, self-care can assuage personal and professional stressors among social work practitioners (e.g., Miller & Grise-Owens, 2020). Guidelines jointly explicated by the United Nations International Children’s Fund (UNICEF), IFSW, The Alliance for Child Protection in Humanitarian Action, and The Global Social Service Workforce Alliance have discussed the importance of self-care during COVID-19 (see https://www.ifsw.org/social-service-workforce-safety-and-wellbeing-during-the-covid-19-response-recommendation-actions/). These guidelines went so far as to suggest that social service practitioners develop and implement self-care plans. Grise-Owens et al. (2016) offered a template for such plans.

Data suggest that there are several demographic/professional dynamics that may compound COVID-19 distress. For example, findings suggest that social workers who identified as female experienced significantly higher COVID-19 related distress than did males. In fact, identifying as male explained significant decreases in distress (see Table 4). Given the stereotypical gender roles ascribed to females, perhaps this finding is not surprising. Females may take on inordinate amounts of homemaking, to include caring for minor children, etc. As well, research suggests that females are at increased risk for stress due to these experiences (e.g., Sareen et al., 2013). Thus, it is not surprising that COVID-19 may impact gender roles differently.

Individuals who reported being married also experienced lower distress. This finding may be connected to several factors. For example, Bush (2015) discussed the importance of relationships to well-being. Others have made similar assertions.
As such, being married may include social and romantic supports, which are particularly important given distancing mandates stemming from COVID-19. Additionally, it is possible that marriage is a proxy for other factors, such as financial stability, which can also lead to lower distress. Given the importance of relationships, social, romantic, or otherwise, agencies and organizations may look to more intentionally cultivate supportive structures and networks. Support groups, accountability groups, and the like can be an integral way to foster collective experiences and normalize stressful situations. Because previous research indicates that those from historically marginalized groups may disproportionately experience distress due to bias and prejudice (e.g., Ayala et al., 2017) and the current study indicates the same, particularly as it applies to lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ*) populations, specialized support groups or initiatives may be warranted.

To assuage distress to social workers associated with COVID-19, to include fostering strong support networks, it will take a broad coalition of social work stakeholders. Professional membership organizations are a key element to this coalition and are integral to conceptualizing, implementing, and assessing COVID-19 responses. Data from the current study suggest that these organizations may strategically engage in endeavors like training, professional check-ins and consultation, and information dissemination. Certainly, many already have. Entities like IFSW (see https://www.ifsw.org/updated-information-on-ifsw-and-the-covid-19-virus/), British Association of Social Workers (see https://www.basw.co.uk/coronavirus-covid-19-basw-updates), the NASW (see https://www.socialworkers.org/Practice/Infectious-Diseases/Coronavirus), and others have promulgated resources to assist practitioners in dealing with the pandemic. Membership groups, singularly and collectively, can be invaluable to a sustained response to addressing distress related to COVID-19.

In addition to membership organizations, social work education programs have a role to play in preparing practitioners for the realities of practice during public health emergencies (Cooper & Briggs, 2014). Like other social service agencies, education programs have scrambled to adapt to an ever-changing landscape due to COVID-19 (Tedam, 2020). Given the unknown future of this, and other pandemics, educators should integrate practice approaches congruent to meeting the needs of service recipients, and providers, during times of need. This may include being more intentional about integrating self-care, telehealth, and virtual counseling modalities into educational and training opportunities.

Participants in the sample who primarily practiced at the microlevel were experiencing significantly more distress than those who worked in other areas. This finding is particularly interesting given previous studies about wellness concepts. For example, Miller et al. (2020) found that social workers engaged in microwork engaged in significantly more self-care than those in other areas. This may suggest that COVID-19 has been particularly impactful for those in microcontexts. Perhaps, because many of these individuals may be employed in
private clinical settings, practitioners are more isolated and lack structures associated with other areas of social work practice. Additionally, COVID-19 has led to a number of regulatory changes, which has disproportionately impacted those in microcontexts (e.g., Miller, 2020). Other stressors for micropractitioners include ensuring adequate billing infrastructures, confidentiality, and technical requirements, which may be exacerbated by COVID-19.

Interestingly, findings indicate those who worked mostly remotely after the pandemic declaration by WHO experienced significantly more distress than those who did not transition to remote-work arrangements. On first thought, this finding may seem somewhat counterintuitive. In many professional spaces, remote work is often viewed as a “benefit” for employees. However, there are several plausible reasons that those working remotely may experience more distress. A recent report by the Society for Human Resource Management (2020) found that while employees typically like the option to work remotely, many worry about additional stress and ability to concentrate on work tasks. This stress may have actualized, specifically for those responsible for child-rearing and other caregiving activities. As well, it is possible that, particularly during COVID-19, participants were already experiencing higher levels of distress, which necessitated the need for remote work.

Or, the very transition to remote work may have been stressful. Many employers, particularly those in social services, may not have the requisite technological infrastructure, expertise, and/or support mechanisms to support a virtual transition to virtual service delivery. Several authors have discussed the lack of investment in the development of virtual technologies within social services (e.g., Miller et al., 2016). As such, workers may have felt ill-prepared or ill-equipped for this transition, thus leading to additional distress.

Perhaps not surprisingly, this study found that both physical health status and mental health status were linked to COVID-19 distress, respectively. In essence, for both physical health and mental health, the healthier the participant was, the less COVID-19 distress they experienced. These notions are similar to previous works that have linked physical and mental health to overall wellness concepts (e.g., Grise-Owens et al., 2016).

Given many restrictions associated with COVID-19, both physical and mental health plans may be disrupted, which may ultimately lead to distress. For example, many health facilities (e.g., gyms) were closed and mental health providers operated on limited/restricted schedules. The increased stressors associated with the pandemic, coupled with disruptions to regular or normal wellness routines, may negatively impact individuals seeking to cope with COVID-19 related distress.

Strengths and limitations

This study has several strengths. Notably, this appears to be the first study to examine COVID-19 related distress among social work practitioners. As Yazdanpanah (2020) suggested, this type of research is necessary for crafting
appropriate responses for supporting practitioners. Though this is an exploratory study, the sample size is more than adequate to examine group-specific factors that impact distress.

And, as with any study, this research also has limitations. All participants self-selected into the study and identified as a social worker. Though somewhat reflective of the social work practitioner population, more generally, the sample was overwhelmingly White and Female. Thus, assertions made based on this sample may not be generalizable. It is important to note that primary data for this study were collected via a tool not designed specifically for social workers, but for a broader public. Ongoing psychometric testing may be warranted. For these reasons, and others, assertions made based on the findings should be made cautiously.

Conclusion

Now, more than ever, it is imperative to have a prepared, safe, and well social work profession. Long after the medical issues associated with COVID-19 subside, the inimical social problems will persist. Social workers do, and will, play a vital role in addressing these problems. In order to understand how to support these workers, research, such as the current study, must be conducted, documented, and disseminated. This work can serve as the foundation on which to base this exploration.

Ethics

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