



Coping with Covid 19: The Challenges Ahead

From the President's Desk

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Keith Dobson

So much has changed in the past few months, and yet so much remains the same. As social animals, humans still want and need interpersonal contact. So even while the current pandemic compels us to maintain physical distance, limit our travel, and to self-isolate if we are exposed or develop symptoms, we yet need to retain our communication and build collective resiliency. I have been extremely impressed in the recent past by the manner and degree to which people in the field of mental health and CBT in particular have leapt into the crisis of COVID-19 to promote best practices. Dr. Sarah Egan from Perth, Australia has worked with others to lead the development of a great list of international resources ([see https://www.wccbt.org/Downloads/CBT_to_improve_mental_health_during_the_COVID-19_pandemic.pdf](https://www.wccbt.org/Downloads/CBT_to_improve_mental_health_during_the_COVID-19_pandemic.pdf)) related to strategies to maintain mental health during this time. Many CBT associations and groups around the world have offered free webinars and information about the psychological effects of pandemics and how to mitigate these effects.

One of the particular developments during the past few months is how much distance technologies have been harnessed to deliver telehealth services, including CBT. It has been written that "It is an ill wind that blows no good". Distance therapy does have the potential to deliver health services in previously underserved geographical regions or to populations who might otherwise not get care, and so it is my sense is that one of the "goods" that will come from this pandemic is a productive discussion of the blend of live and distance delivery of evidence-based therapies such as CBT.

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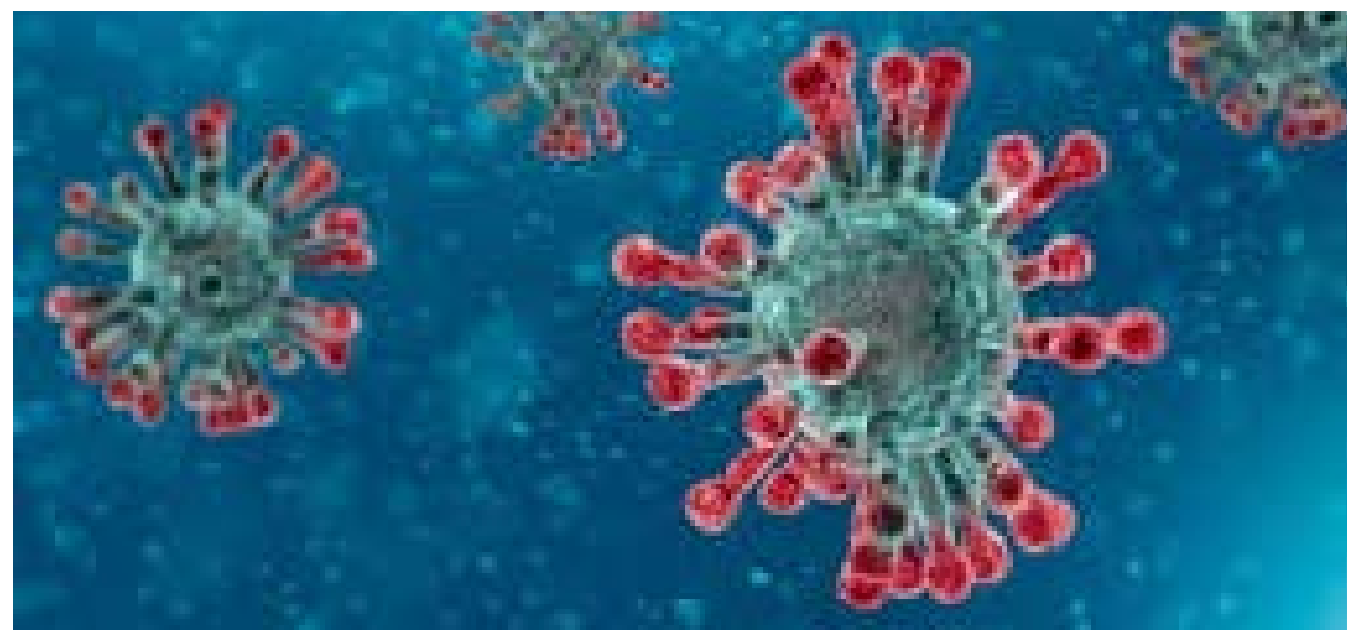
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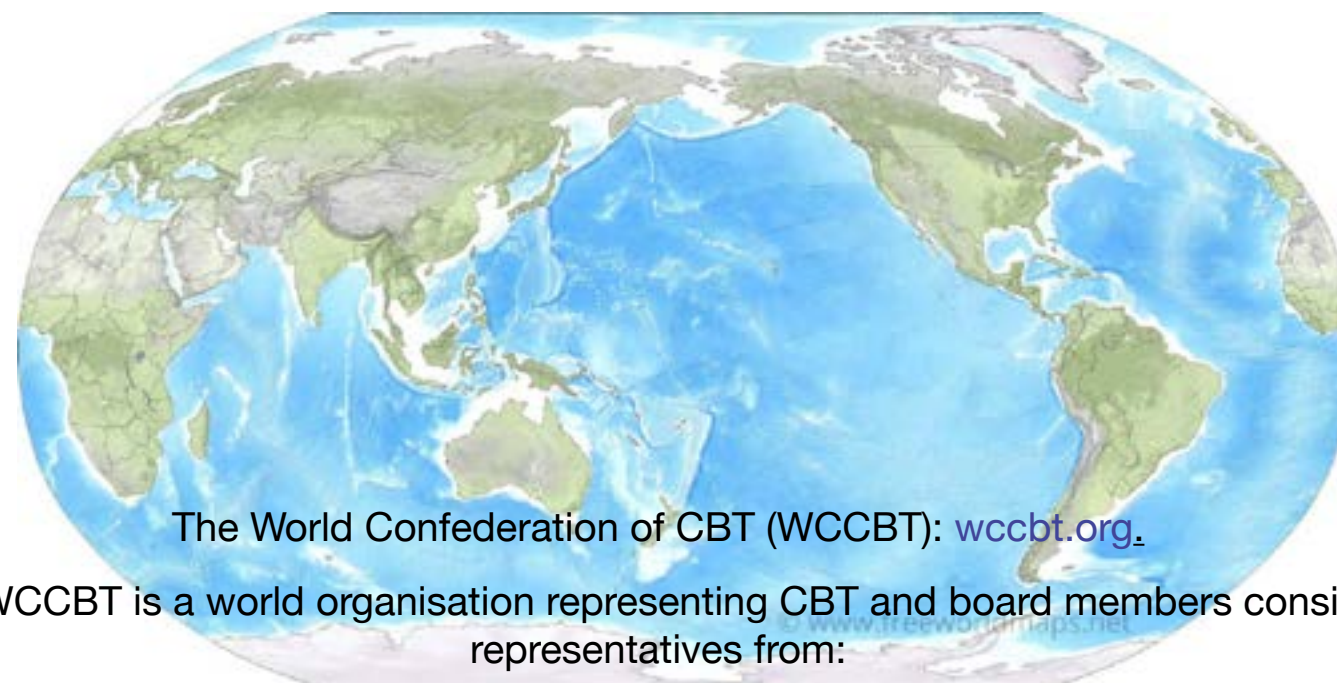
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This issue of our e- newsletter includes important summaries of CBT for a number of diverse clinical problems and populations, including grief, anxiety, self- injury couple relationships and economic worries. The articles, written by world leaders, reflect the wide applicability of the CBT approach to human suffering, and how we can also enhance human performance and functioning. We all owe a debt of gratitude to the authors for taking the time to write what are in essence short articles about their work and the work of others in their respective areas. The articles, as well as other works by these authors, are recommended to the reader.

In closing, let me note that unfortunately it appears that the COVID- 19 pandemic will remain with the world for the foreseeable future. Since the beginning of the pandemic I have been saying that we all need to follow best advice from our public health agencies (e.g., physical distancing, wearing masks in public, frequent hand-washing), but we also need to adopt and promote the best advice for mental health (e.g. regular sleep and wake cycles, exercise, eating well, engaging in meaningful work, doing enjoyable activities, maintaining social contacts, supporting others and causes that are “larger” than us). I know a number of people who have taken this time as an opportunity to appreciate what they already have, to reflect on what is important in their life and to make some decisions that will be the long-term heritage of this pandemic experience. I wish everyone who reads this message the best possible health.

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Australian Association for Cognitive and Behaviour Therapy (AACBT): aacbt.org

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Changing the way we deliver psychological therapies: a COVID silver lining

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Traditionally CBT therapists and their clients meet together for a treatment session in a clinic room or in another venue that is more appropriate for in vivo work (such as a crowded shopping mall for a client with agoraphobia). Other methods of delivering therapy such as telephone or video conference sessions and therapist supported internet programmes have also been developed and have shown their value. However, in most countries take up of these remote modes of treatment delivery has been modest.

That was before COVID. In recent months, many countries have implemented strict lockdowns and social distancing in order to reduce transmission of the virus and it has been impossible for therapists and clients to be together in the same place for a treatment session. In order to continue treatment, many therapists have switched to working from home using video conferencing or the telephone to connect with clients who are also in their own homes. In England the Improving Access to Psychological Therapies (IAPT) programme delivers evidence-based treatments for depression and the anxiety disorders to around 610,000 people each year. In a period of only a few weeks the 8,000 or so IAPT therapists shifted to remote therapy delivery. The shift was so efficient that there was no reduction in the number of treatment sessions provided by the service. A few months on, it is clear that remote delivery of therapy is much more viable than previously thought. This is one of the



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silver linings of the COVID tragedy. While we all hope that we will be able to return to delivering therapy in clinics in the future, it seems unlikely that things will return to exactly the way they were before COVID. Remote delivery of therapy is likely to play a much more prominent role as it clearly has advantages for some

clients and therapists. It also has limitations that need to be considered alongside the advantages.

For clients, obvious advantages include saved travel time, greater anonymity, and possibly more choice of therapist and appointment times. Potential downsides include difficulty (and sometimes impossibility) of having a secure, private and uninterrupted place for therapy sessions at home and, for some, a less satisfying relationship with one's therapist. For therapists, advantages also include less travel as well as more flexible working conditions. Potential downsides may include initial difficulty in arranging supervision, loss of informal time with colleagues, not having suitable space at home, and difficulty separating work from home life.

Another silver lining of COVID has been the way in which numerous members of the psychological therapy community have worked together to provide free online resources to support therapists throughout the world as we adapt to new ways of working. In the UK, the BABCP website (www.babcp.com) has open access webinars on treating OCD and Health Anxiety in the context of COVID, plus many other useful therapist resources. Our research group has developed an extensive free therapist resources website (www.oxcadatresources.com) with manuals and numerous short videos on how to deliver aspects of empirically

supported CBT interventions for PTSD, Social anxiety and panic disorder. A new [COVID-19 page](#) brings together written guides, webinars and video clips specifically focusing on remote delivery and COVID related issues (such as PTSD following a stay in an intensive care unit). Exeter University's CEDAR website also has an open access [webinar](#) on how to deliver behavioural activation for depression. It is heartening to see the wide interest in these resources (currently 13,000 therapists in 138 countries have registered with the [oxcadatresources](#) website, for example). Of course, UK clinical researchers are not unique in providing free practical resources for therapists. Similar websites exist, or are being developed, in the USA, other European Countries and Australia and elsewhere. Hopefully, this trend will continue. Free resources are urgently needed if evidence-based CBT interventions are to be made widely available throughout the world. National and international CBT organizations will also need to consider how they can help guide the public to resources that have an evidence-base, so the risks of disseminating poor practice are minimized.

Not all of our new ways of working have been rigorously evaluated. There is clearly a need for randomized controlled trials (RCTs) and other formal evaluations. In England, IAPT services use a session-by-session outcome monitoring system to collect outcome data on essentially everyone (99%) who has a course of treatment. This data is being closely monitored to see whether the change to remote delivery of treatment during COVID affects outcomes. Similar services in [Norway](#), [Ontario](#) and elsewhere are also using this type of outcome monitoring system. It is hoped that session by session outcome monitoring will be adopted more widely in the future as it allows rapid detection of changes in outcomes within our therapy services as new models of delivery are tried out. Such routine data collection supplements, but does not replace, traditional RCTs.

Couples' Relationships in the Age of COVID-19

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Across cultures, the majority of adults live in committed romantic relationships. Thus, as we experience COVID-19 as individuals, communities, societies, and a broader world, many of us also experience this devastating crisis and unique set of experiences as couples. While research has shown that if individual partners are struggling, the couple is likely to be impacted by these complications (Whisman, 2019), current comments will focus on how the conditions created by the virus have the potential to impact the couple's functioning.

In addressing the impact on the couple, it is meaningful to differentiate between issues (a) focal to getting the virus per se and (b) changes in the couples' lives resulting from the virus (e.g., restricted interactions, financial implications). First, almost all couples have to deal with the concern that that one or both partners or family members might contract the virus. As partners attempt to discuss these concerns with each other, their success in doing so likely relates to their overall ability to communicate, one of the best long-term predictors of relationship success (Karney & Bradbury, 1995). Thus, couples who have difficulty communicating in general might struggle when discussing the pandemic and each person's worries. Furthermore, partners might differ in how they cope individually with stressors such as the virus. One partner might need to talk about the virus frequently while the other person prefers to minimize such discussions and "get on with life and focus on the positives." Such differences can pose notable challenges for couples as each person attempts to influence the other person to conform to their individual coping style.

In addition, the pandemic has created dramatic changes in how partners interact with each other and other family members as they shelter in place or reduce their interactions with the outside world. First, whereas many partners typically count on a number of persons to meet their social needs through family, friendships, and colleagues, being at home places much greater responsibility on the couple's relationship to meet each person's face-to-face social needs. Whereas this might provide positive opportunities to get to know one's partner better, it can put undue pressure on the relationship to be "all things" for an extended period of time. Similarly, many couples have children at home, and having additional time with them can be valuable. However, helping to entertain and educate children, along with increases in home childcare can be stressful for couples, particularly if they have to negotiate how both partners try to work from home while attending to children. Meanwhile, couples who are separated or divorced while continuing to co-parent might experience challenges as they negotiate whether and how to have children move from one family environment to the other. Furthermore, some couples need to attend to aging parents who might be at higher risk for serious consequences from the virus. While wanting to be responsive to family members, couples might be reluctant to be in direct contact with high-risk family members due to concern about spreading the virus, thus, feeling helpless in how to respond. Thus, couples must address multiple family members' needs in this unique context.

On a daily pragmatic level, many couples have to renegotiate household tasks and responsibilities,

often with one or both partner being asked to assume increased responsibilities. This can be particularly complex if the couple experiences additional complications deciding whether one partner should continue to work outside the home for financial reasons. As they negotiate household and employment roles, many couples are dealing with notable if not devastating financial complications such as job loss, resulting from restricting various countries' economies.

In many instances, the above needs for adaptation have gradual negative impacts on the couple or family, yet at other times this can lead to major negative events such as physical violence directed at the partner or children. These smaller and more major negative impacts can be seen, for example, in Australia which has a free call Family Relationships Advice Line (FRAL)¹ to address relationship concerns. As stay-at-home restrictions were implemented, call rates doubled immediately, focusing on couples' relationship stress, difficulties in managing working from home, managing child care, disputes between separated parents about child care arrangements disrupted by COVID-19 restrictions, and concerns about domestic violence. Despite total calls declining as restrictions were eased, the continuing effects of COVID-19 restrictions remained a common concern raised by callers.

The above discussion points out that many couples are likely to struggle to some extent with stressors caused by the pandemic. Yet, other couples appear to be adapting well, and not surprisingly, this is influenced by a variety of risk factors such as other health complications, age, racial status, and employment complications (Weber, Wojda, Carrino, & Baucom, 2020). In fact, many of these U.S. couples report notable post-traumatic growth or renewed meaning as they confront these challenges.

From a clinical perspective, approaches such as cognitive-behavioral couple therapy (CBCT, Baucom, Fischer, Corrie, Worrell, & Boeding, 2020) and integrative behavioral couple therapy (IBCT, Christensen, Doss,



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& Jacobson, 2020) have been developed to address a wide range of substantive concerns within a broad behavioral framework; likely, clinicians can adapt such approaches with a focus on pandemic-specific concerns. In addition, COVID-19 in some instances appears to have long-term medical impacts, and CBCT and other approaches have been adapted to address both medical (ref) and individual psychological difficulties within a couple context (Baucom, Porter, Kirby, & Hudepohl, 2012). Thus, we have much to offer as many couples, both during the pandemic and as the pandemic eases, come forward to address important relationship and associated individual concerns related to the virus.

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Footnote

We thank Relationships Australia Queensland for providing the data on the rate and content of enquiries to the national Australian Family Relationships Advice



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Rod Holland, eNews editor



Meeting the mental health needs of children and youth during covid-19

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Preliminary evidence suggests that children are particularly vulnerable to the mental health effects of the COVID-19 pandemic (Pearcey, Shum, Waite, Patalay & Creswell, 2020). The impact of lockdown policies (e.g., school closures, isolation), COVID messaging and media consumption as well as parental job loss, financial stress, and health concerns provide the perfect storm to negatively impact young people's mental health and wellbeing. Over the coming months and years, familial financial stress and job loss as a result of COVID-19 are likely to have a sustained and profoundly negative impact on the mental health of many children and youth. According to the UN Policy Brief, the impact of COVID-19 on children has been uneven. Existing evidence points to the emergence of significant inequities, with some young people expected to experience disproportionate distress and be unable to access services. Such inequalities are likely to become even more entrenched over time.

Although the transitions and uncertainty over the coming months may continue to be challenging for many children and teens, as a community of CBT therapists we have an array of evidence-based strategies that can help children and families during and beyond this crisis. The first line of treatment recommended for the management of excessive anxiety in youth is CBT. In line with this, there have been several evidence-based COVID-19 specific resources developed for parents, carers and educators that rely on cognitive behavioural principles such as: "COVID-19: We've got this covered!" and www.emergingminds.co.uk. There are also a number



of online treatment programs for anxiety that are available to young people and their families such as Brave Online, Cool Kids Online and Coping Cat. Yet very few children who receive formal help for anxiety receive CBT. In a study conducted in the UK, less than 3% of children with an anxiety disorder reported receiving evidence-based therapy for anxiety. Ensuring that children and their families have access to evidence-based care, particularly at this time of crisis, should be a priority.

With forced isolation and reduced social contact, children with pre-existing mental health difficulties have been able to avoid or withdraw from situations that might typically make them feel anxious (like presentations at school, interacting with others, public transport). As a result, going back to school and other activities might cause increased anxiety, given the key role avoidance plays in maintaining anxiety. Some children and teens may also experience increased health-related anxiety due to the virus, like worrying about catching or spreading the virus, or concern about the safety of loved ones, making a return to activities difficult. Anxiety can be reduced by gradually approaching the situations the child or young person finds challenging. By doing this, the child is provided with more accurate evidence about the threat. Doing this in a gradual way is recommended to slowly build mastery. For those children who are finding the return to school too challenging, it is recommended that parents discuss with the school staff possible options to allow the child to gradually return to school. The manner of this gradual transition will depend on the content of the child's worries. For example, if the child is refusing to return to school because they are overly worried about upcoming school assessments, then consider discussing with the school a gradual transition back

to assessment tasks, for a limited period of time. To help the child feel more confident facing these challenging situations, provide a series of strategies such as cognitive restructuring or relaxation that the child can practice before and during the situation. To some extent, increased anxiety at this time is to be expected. Anxiety is a natural response to a threat. Part of our role as therapists is to normalise the experience of anxiety and provide strategies to support the child and family so that the anxiety does not prevent the child from being able to get the most out of life.

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Grief in the context of COVID-19

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Of the numerous social, economic and medical impacts of the Coronavirus pandemic, the fatalities resulting from its global spread are the starkest. As this article is posted, the world exceeds 18 million documented infections, and has suffered nearly 700,000 deaths from COVID-19 (World Health Organisation, 2020). Precisely as predicted by demographic microsimulation forecasts in the earliest weeks of the pandemic in the West, this tsunami of loss raises the spectre of “the collateral damage that this level of mortality would exact,” making it “important that the burden of bereavement, and its potential mental and physical health consequences, is factored into discussion of the public health challenge facing all nations” (Verdery & Smith Greenway, 2020, p. 2). For psychologists, awareness of the distinctive risks for complicated grief associated with such losses is a compelling necessity.

On the one hand, grief following the death of a significant attachment figure is a normal human response, that should not be considered a psychiatric disorder. However, an enormous body of research in many countries has led the World Health Organization (2019) to recognize Prolonged Grief Disorder in its most recent edition of the International Classification of Disease (the ICD-11) as a stress-related condition distinguishable not only from adaptive grieving, but also from depression, anxiety, and posttraumatic stress disorders (see Table 1). In this form of life-vitiating, protracted and anguishing response to loss, mourners struggle with turbulent emotions of longing, guilt, loneliness and desolation which tangibly impair their ability to function in the contexts of family, work and the



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social world for many months beyond the death, and not uncommonly, years. Moreover, ongoing ruminative preoccupation with the lost relationship or the circumstances of the death carries real health risks for a variety of stress-related disorders, cardiac problems, addictions, immune system dysfunction, impaired quality of life and even suicide (Maerker, Neimeyer & Simiola, 2016). And worrisomely, the COVID context of dying presents a perfect storm of converging forces that greatly exacerbate the likelihood of prolonged and complicating grief in its aftermath.

In the past 20 years, a great deal has been learned about risk factors for bereavement complications, which include social isolation, unexpectedness of the death, lower education or socioeconomic disadvantage in the mourner, insecure and anxious attachment, spiritual struggle in bereavement, inability to make sense of the loss, and lack of institutional and informational support in the care facility in which the death takes place (Neimeyer & Burke, 2017). Significantly,

Table 1. WHO ICD-11 Criteria for Prolonged Grief Disorder

- Death of a close person
- Persistent and pervasive grief response accompanied by longing for or preoccupation with deceased
- Intense emotional pain (sadness, guilt, anger, denial, blame, lost sense of self, absence of positive mood, numbness, avoidance of social and other activities)
- Minimum of 6 months after death, exceeding social, cultural and religious norms
- Significant impairment in personal, family, social, occupational or other functioning

every one of these factors characterizes deaths that occur in the context of the current pandemic—whether or not they result from COVID-19 or other causes. Thus, family and close friends of patients are characteristically isolated from their loved ones at the end of life in an effort to mitigate contagion. This reverses decades of progressive policies that, as recently as last year, generously supported family caregiving. Social distancing and shelter at home protocols combined with travel bans further isolate mourners from one another, even during funerals and memorial services. Such services are commonly either minimally performed online, postponed indefinitely, or foregone altogether. Especially for the vulnerable elderly or those with compromised health conditions, COVID deaths commonly come suddenly, within mere days or weeks of diagnosis, even with respiratory support. In many nations, coronavirus fatalities disproportionately affect the urban poor, whose living conditions and more limited access to health care place them at far greater risk of contagion and death. Inability to perform traditional caregiving and offer creaturely comfort and touch at the bedside of the dying challenges attachment imperatives to draw close to loved ones at points of need, leaving in their wake a heavy burden of helplessness, shame and guilt. Religiously oriented mourners may question the beneficence, power, or intentions of a God they once trusted to care for them and their loved ones, while struggling with estrangement from spiritual communities shuttered during the pandemic. Core elements of people’s assumptive worlds and the sense that life is predictable, controllable, just and meaningful are commonly undermined by the pandemic in general, and the context of dying in particular. Further, overwhelmed and hermetically sealed medical facilities and elder care homes rarely have the luxury to attend compassionately to family needs, as they guard their perimeters and bend all efforts toward urgent care of severely ill patients, while attempting to protect the health of their anxious, exhausted and beleaguered staff. The



consequences are entirely predictable: As the present health crisis recedes and the months roll forward, the incidence of prolonged and debilitating grief among those bereaved by any cause in the context of the corona crisis can be expected to skyrocket well above the incidence rate of 10% documented in pre-pandemic times (Lundorff et al., 2017).

Unfinished business in bereavement

Psychologically speaking, a common denominator of all of the above risk factors is their contribution to unfinished business in bereavement, those unresolved relational issues between the living and the dead that defy simple suasion, reassurance or well-meaning advice from friends, family and sometimes therapists to “move on” (Klingspon, Holland, Neimeyer & Lichtenthal, 2015). Programmatic research on these sources of complication have identified two thematic clusters of concern yielding psychometrically clear subscales on a carefully validated measure of the construct, the Unfinished Business in Bereavement Scale (UBBS; Holland, Klingspon, Lichtenthal & Neimeyer, 2018), entitled Unfulfilled Wishes (e.g., I wish I could have attended to ____’s needs more closely in his/her final days; I wish I had told ____ how much s/he meant to me) and Unresolved Conflict (e.g., I never got a chance to resolve a breach in our relationship; I wish I had had the chance to tell ____ that I forgive him/her). Taken together with the meaning made of the loss, UB accounts for 50-60% of the variance in complicated grief symptomatology (Holland et al., 2018), and is especially likely to arise in immediate family relationships (Klingspon et al. 2015).

One obvious injunction for practicing therapists would be to assess such potent predictors of prolonged grief as challenges to meaning or unresolved relational issues by using validated clinical scales (Holland et al. 2018) to assess the character and severity of such issues for the client and to introduce these themes into the work of therapy. Alternatively, open probes in the therapeutic session (e.g., What did you once

believe about life that you no longer are so sure of? Are there things that you would want to express or work out with your loved one if you had the chance?) can bring to light issues deserving attention, and open the door to the appropriate selection of any of a plenitude of therapeutic procedures (e.g., directed journaling; imaginal dialogues) for helping clients review and revise their assumptive worlds and address unfinished business with the deceased (Neimeyer, 2012; 2016). Unfortunately, however, developing competence in this existential work of rebuilding worlds of meaning shattered by loss, and restoring a sense of attachment security with the dead, are rarely given space in graduate curricula. Hence, there is a need for further professional development through ongoing professional continuing education¹. Given the predictably high demand for professional level grief therapy arising from the current and future pandemics, we hope that our cognitive behavioural colleagues will join us in embracing this challenge.

¹ Readers interested in pursuing such training might consider annual pre-conference workshops offered by the Association for Death Education and Counseling (www.adeconline.org), or the American Association for Suicidology (www.suicidology.org), as well as the extensive online and onsite training modules offered by the Portland Institute for Loss and Transition (www.portlandinstitute.org)

Further Reading

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Coping with Financial Anxiety During the Pandemic: Ten Steps to Handle Your Worries

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We are facing a worldwide economic downturn as a result of the impact of the coronavirus pandemic. Many countries are experiencing the highest rates of unemployment since the 1930s and national productivity has dramatically declined. Many businesses are facing bankruptcy. In a recent study of people in the United Kingdom, Israel and the United States, financial anxiety was as high as health anxiety. Given the uncertainty as to when effective treatments or vaccines will be available, many people worry that these economic difficulties may last indefinitely.

How can we handle our anxiety about finances during a real economic crisis? Let's consider ten steps to coping better with your financial worries.

1. Normalize anxiety about finances.

If you are worried, you can normalize and validate your feelings about money. You are not alone. We are not robots so we get anxious when we perceive a threat, lose our jobs, or find ourselves living with uncertainty. You have a right to your feelings, but you also have a right to do something about them.

2. Get the information.

When we worry about things we often focus on what we imagine could happen and ignore the information that might be helpful. For example, this is a time for you to review the information about your savings, financial assets, and sources of support. Many people will be able to take advantage of government relief programs such as unemployment benefits which may be extended for a longer period of time. In some cases, you may be able to negotiate delay or reduction of payments on rent or debt. Information can help you put things in perspective.



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3. Keep a budget.

Although it may be uncomfortable to keep track of your spending, it may help you understand where you can more easily cut back. For example, do you really need to buy that expensive latte or can you make your own coffee? In fact, during this period many people are spending less, since restaurants, travel, and shopping

have become more difficult to pursue. Being flexible is a great way to cope.

4. Consider your future earnings.

We often focus on the present threat and underestimate our future capabilities. For example, if you are 30 years old you might consider your future earnings. If you assume the present conditions for another year, but you have another 30 years of earnings, you might reframe the current time as a detour. What are your future earning possibilities?

5. Challenge your worries.

When we worry about finances we struggle with thoughts and images about catastrophes, chain reactions of negative events, and inability to find alternatives. You can challenge these worries by considering how having less money is not necessarily a catastrophe, focusing on what you can still do with less money, and imagining a range of possible ways of coping. For example, unemployment rates may currently be high, but the employment market is fluid, ever-changing, and in many countries the rates of unemployment are beginning to decrease.

6. Expand your life portfolio.

Rather than focus only on money, think about a range of valued areas in your life. Think about your life as a large pie with pieces of different sizes representing meaningful activities. Money is one piece of the pie, but how about the other parts of your life portfolio? This can include your role as a partner, parent, friend, member of the community, someone who learns, exercise, relaxation, health, and kindness. Expand your life portfolio to feel emotionally richer. Money cannot buy you the other parts of the pie.

7. What can you do for free?

We have been used to thinking we "need" certain things that we never had before we got them, such as technology, fashionable clothes, restaurants, travel, and other "manufactured needs". These are not real needs—they are simply preferences. So what can you do for free? For example, you can exercise, learn, go on-line, connect with friends and family, show kindness, meditate, and love yourself.

8. What did you enjoy doing when you had less money?

We often think that what we have "accumulated" is what we absolutely cannot live without. But many of us can remember a time in the past when we had less. How did you enjoy yourself back in the day when you had less?

9. What does money mean to you?

Money may have symbolic value for you—reflecting status, security, power, success. But money is really a means to an end. The question is what ends, purposes and values are important? For example, you can show love and kindness to others and to yourself without money. Security has more to do with what you think you need and what gives you meaning, rather than how much you have. The research shows that above a certain income level money is not related to greater happiness. And comparing ourselves with others is not going to make you feel better.

10. Practice gratitude.

It may seem strange to talk about gratitude when you are worried about finances. But gratitude is free and it immediately enriches your life. Think back about people in your life in the present and the past that you are grateful to. Maybe it was a parent, friend, teacher, or someone who was supportive to you. Consider writing a short statement—maybe even send it to them—expressing your gratitude. When you give the gift of thanks to others you may feel richer in your own life.



Supporting individuals who self-injure: The impact of the COVID-19 pandemic

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Non-suicidal self-injury (NSSI), the deliberate damage to body tissue in the absence of conscious suicidal intent (ISSS, 2020) has become a serious health concern. Most often emerging during adolescence, approximately 18% of adolescents, 13% of young adults (18-25 years) and 5% of adults (over 25 years) report having engaged in self-injury (Swannell et al., 2014). Individuals self-injure for many reasons, but the most common is to cope with intense or unwanted emotions (Taylor et al., 2018). Not surprisingly then, NSSI is associated with a range of mental health concerns (e.g., low self-esteem; anxiety; depression). Although not suicidal in nature, NSSI is the most reliable predictor of subsequent suicidal thoughts and behaviours; individuals who self-injure are 3-5 times more likely to report later suicidal ideation and attempts (Franklin et al., 2017). Importantly, NSSI typically emerges three years before the onset of suicidal behaviour, providing a critical window for early intervention (Kiekens et al., 2018).

The impact of COVID-19

Although the full extent of COVID-19's effect on people's mental health and wellbeing will not be known for some time, its impact is nonetheless unprecedented, ubiquitous, and significant. Globally, millions of people have been diagnosed with COVID-19 and hundreds of thousands have died (World Health Organization, 2020). This has resulted in experiences of loss, grief, and people worried for their own safety and that of loved ones. In addition, people worldwide have incurred substantial financial burdens, job losses, disruptions to education, and major upheavals in daily routines. Coupled with these major life changes are the necessary public-health measures (e.g., stay-at-home orders, physical distancing) implemented to curb disease spread, which have contributed to heightened



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stress and social isolation. Many individuals who self-injure experience difficulty coping and use NSSI to obtain relief from overwhelming and otherwise difficult emotions (Taylor et al., 2018). Further, loneliness, isolation, and low social support are well-documented factors involved in NSSI (e.g., Wolff et al., 2013). Understandably then, in the current pandemic context, stressors of this nature have potential to deplete coping efficacy and contribute to NSSI risk.

From a help-seeking perspective, there are also concerns that increased demands for medical services amid the COVID-19 pandemic will deter individuals from seeking medical aid for injuries. Notably, there is bound to be worry about risk of contracting COVID-19. This is in addition to the general reluctance individuals who engage in NSSI have to seek medical attention. Prior work has shown that health professionals can hold stigmatising and negative views toward NSSI (e.g., Karman et al., 2015). Aware of such stigma, many individuals who engage in NSSI are reluctant to seek help (e.g., Rosenrot & Lewis, 2018). When considering the heightened stress and demands on resources created by COVID-19, the same stigmatising attitudes that deter people from seeking help may be exacerbated. Because of this, it is critical that professionals are equipped with knowledge about effective responding when working with individuals who engage in NSSI.

What can clinicians do?

Over recent years, there have been concerted efforts to better understand NSSI recovery, with a focus on factors associated with cessation of the behaviour. However, an exclusive focus on cessation of NSSI neglects the many nuances the people with lived NSSI

experience describe (Lewis et al., 2019). Of note, individuals report ongoing thoughts and urges to self-injure, long after ceasing to engage in the behaviour (Kelada et al., 2014). Although the strength of these thoughts and urges will wane over time, the ongoing nature of such thoughts suggests it may be more realistic to accept ongoing thoughts as a natural part of the recovery process, rather than focus on eliminating them. Similarly, acceptance that setbacks do occur will minimise any sense of failure an individual may feel if they do self-injure.

An important part of recovery is finding alternatives to self-injure that serve the same purpose for the individual. However adopting new strategies can be difficult and take significant effort and practice. Development of self-efficacy, both to engage alternative strategies and to resist urges to self-injure is thus important. Another critical consideration is the impact of scarring which may result from NSSI. Scars can have different meanings for different people; they may be a source of shame, or may signify strength and resilience (Lewis & Mehrabkhani, 2016). Visible scarring can be a source of inadvertent disclosure of NSSI. Given the significant NSSI stigma (Staniland et al., in press), individuals should prepare for such disclosures, considering when, how, and to whom this may occur, and how inadvertent disclosures will be addressed. With an acceptance of ongoing NSSI thoughts, self-efficacy to resist urges and persist with alternative coping strategies, acceptance of scarring, and a plan for managing disclosures, an individual can move toward self-acceptance and resilience (Lewis & Hasking, 2019).

The provision of online resources represents an especially relevant means to reach individuals who engage in NSSI during challenging times. Yet although the Internet represents a salient and often preferred means to obtain support for and resources about NSSI, researchers have cautioned about some online material (Lewis & Seko, 2016). For example, some online content



presents hopeless messages about the prospect of recovery (Lewis et al., 2012), can be triggering (Baker & Lewis, 2013), and may not always provide evidence-based information (Lewis et al., 2014). With this in mind, Table 1 presents a brief overview of recommended resources that can be shared with individuals who self-injure.

Table 1.

Resources to share with individuals who engage in self-injury

Self-injury Resources

Self-injury Outreach & Support: www.sioutreach.org

- Provides general information and resources concerning self-injury
- Provides coping guides and recovery stories for individuals who self-injure
- Provides a series of guides for families, friends, romantic partners, and professionals

Shedding Light on Self-injury: www.self-injury.org.au

- Provides general information concerning self-injury
- Provides resources for professionals who work with individuals who self-injure

Self-injury & Recovery Research & Resources: www.selfinjury.bctr.cornell.edu

- Provides a wide range of general information and resources concerning self injury
- Provides information for people who self-injure and individuals in support role (e.g., families, schools, professionals)

In addition to informal means of obtaining support and NSSI resources via websites, tele-health and virtual platforms have inevitably become more commonplace since the onset of the pandemic. Although there are potential barriers to these means of service provision (e.g., learning to use new technologies, individuals finding a safe and private location to meet while others are home) their use is likely to remain given the lasting public health measures in many regions worldwide.

Above all, we recommend adopting a person-centred approach to working with individuals who self-injure, that considers the experience of the individual. This

person-centred approach avoids defining a person by their behaviour (e.g., self-injurer), and instead aims to understand the unique experience of each individual (Hasking & Boyes, 2018). Adopting a respectful curiosity, clinicians can ask 'What does self-injury do for you?' to better understand why someone may engage in self-injury. This will not only inform treatment provision, but serves to validate the individual, and foster rapport.

Conclusion

The various impacts of COVID-19 and the social distancing required to minimize disease spread mean mental health professionals need to be aware that some clients may engage in NSSI and be prepared to effectively respond. Employing some of the aforementioned techniques may prove useful in this regard. Moving forward, it will also be important to work toward developing novel, relevant, and research-informed online approaches to support people who self-injure.

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