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Conceptualizing Traumatic Loss During and After COVID-19

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Due to the COVID-19 pandemic, several social modifications have been made in the United States to reduce the infection rate that resulted in changes to the workforce, education system, and general community interactions. This evolving new normal has caused distress in many individuals. The purpose of this article was to conceptualize these changes from a loss perspective and determine if any traumatic symptomology might emerge from the loss, thus producing traumatic loss due to the changing normal. Clinical recommendations are given to mental health professionals when working with individuals who report distress due to the changing normal.

Keywords: new normal, loss, trauma, traumatic loss

In 2020, the Coronavirus 2019 (COVID-19) pandemic profoundly impacted the world by altering everyday experiences and affecting the physical and psychological health of individuals (Campbell, 2020). As of August 2021, researchers from the World Health Organization (WHO; 2021) reported 209,876,613 confirmed cases of COVID-19 and 4,400,284 deaths worldwide. Over 37.5 million of these confirmed cases and 625,375

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deaths occurred in the United States (Center for Disease Control [CDC], 2021a), and COVID-19 is now being diagnosed in children, adults, and older adults (CDC, 2021a). Researchers predicted the virus will continue to surge across the United States with increased reported cases, hospitalizations, and death rates (Wan & Dupree, 2020), and in 2021 a fourth wave of COVID-19 Delta variant is moving through the United States (Weintraub, 2021).

The United States government declared a national emergency to decrease viral spread and provide healthcare for infected individuals (Proclamation No. 9994, 2020). Federal funding was provided to assist state and local authorities to modify the economic and educational practices to protect the health and safety of the public (Savage, 2020). These modifications created a new normal which were meant to reduce the spread of the virus (National Institutes on Aging, 2020). Governmental officials authorized stay-at-home orders for non-essential workers, and most states complied (Wu et al., 2020). Further, researchers at the CDC developed interventions such as social distancing, wearing masks, washing hands, sanitizing areas touched, and symptom monitoring, which significantly changed the nature of daily interactions (CDC, 2020a). Barroso (2020) reported that 51% of Americans believed these changes will remain to some extent.

During this time, these social modifications impacted the work force, education system, and the general nature of community interactions and gatherings in the United States, with 44% of individuals reporting substantial changes to their daily lives (Pew Research Center, 2020a). Individuals in the workforce reported the major causes of stress and anxiety are due to the risk of exposure to COVID-19 (CDC, 2020b), uncertainty of the national economy, employment instability, and housing expenses (American Psychological Association [APA], 2020). Healthcare workers reported increased levels of anxiety, depression, and sleeplessness due to the high levels of pressure, exhaustion, and traumatic stress they experience (Hoffman, 2020). Many individuals struggled with the transition to a remote status for their work, while others lost their jobs with an increase in unemployment rates from 3.8% in February 2020 to 14.4% in April 2020 (Dey et al., 2020). One-in-four individuals struggled financially to pay expenses, one-third relied on personal savings or retirement funds to pay bills, and one-in-six individuals depended on food pantries (Pew Research Center, 2020b).

School systems transitioned to a remote learning format that created challenges for students, teachers, and parents (Decker et al., 2020). Some students were unable to transition to remote learning in a timely manner creating an education gap. Teachers and students faced the task of adjusting to a remote style of learning, while many parents found themselves working from home and managing their children's remote schooling simultaneously. Ninety percent of parents worried their child would fall behind in their education and reported increased stress due to taking on the educational responsibilities of their child (The Educational Trust, 2020). In addition, parents reported a tremendous amount of distress due to not knowing what is to come regarding their child's education and overall future (APA, 2020). Eighty percent of children reported increased stress levels (The Educational Trust, 2020) and school closures prevented them from receiving assistance related to mental healthcare, free lunch programs, and other social services (Hoffman & Miller, 2020).

The new and changing normal of 2020 and 2021 also impacted basic community contacts and daily routines. Depending on the local mandates, many cities and states issued restrictions on social gatherings that ranged from stay-at-home orders to limiting the number of individuals in a group ("COVID-19 restrictions", 2021). Many religious services transitioned to an online platform or were cancelled altogether, while restaurants either closed or ran at a reduced capacity. Grocery shopping also became a solitary activity as CDC researchers recommended either opting for curbside pick-up or staying at least six feet away from others inside the store (CDC, 2020a). These changes resulted in increased feelings of loneliness, which was also linked to higher depression and suicidal ideation rates (Killgore et al., 2020).

Currently, researchers developed a vaccine for COVID-19 and it is being distributed to individuals in the United States, and as more people become vaccinated infection rates will decrease (CDC, 2021b). With a decrease in infection rates parts of the economy will reopen and transform the new normal into another new normal. However, approximately 30% of Americans are resistant to taking the vaccine resulting in the fourth wave of the pandemic, which is causing uncertain changes to the new normal (Catalini, 2021). These instabilities have caused individuals great distress and will continue to as the new normal continues to shift. So far mental health issues such as stress, anxiety,

depression, and substance use has increased dramatically in the last year (Czeisler et al., 2020; Panchal et al., 2021; Vahratian et al., 2021). Young adults reported the highest rates of stress and symptoms of depression due to facing an uncertain future (APA, 2020). All this combined with the mortality rates from COVID-19 have resulted in a national mental health crisis.

The COVID-19 pandemic is an unprecedented event in history, and the combined loss of life, loss of the old normal, and the new normal continually changing presents great challenges for mental health professionals working with clients who struggle. These challenges could force mental health professionals to reconsider how they understand constructs like loss and trauma, as individuals might face death and/or nondeath losses. In addition, many of these losses can be traumatizing to individuals in ways unique to the changing normal. Our intention here is to re-examine the constructs of loss and trauma from the changing normal perspective, broaden the definition of traumatic loss, and provide strategies for mental health professionals as they work with clients.

Loss Related to COVID-19

Loss is defined as "the real or perceived deprivation of something deemed meaningful" (Humphrey, 2009, p. 5). The two main types of loss in the literature are death and non-death losses; typically, death loss is the most recognized type of loss and non-death loss is a more difficult concept to identify. Non-death loss is a loss of something tangible or intangible such as the loss of an object or immaterial constructs, such as relationships, a sense of identity, security, hope, faith, trust, or respect (Harris, 2020). Non-death losses are often not recognized as actual losses and therefore could be overlooked. Next, we describe five types of loss that include death and non-death losses, focus specifically on how non-death losses are experienced during the COVID-19 pandemic, and describe how these losses relate.

Primary, Secondary, and Multiple Losses

Primary loss is “a significant loss event. ...Secondary losses are those losses that are the consequence of a primary loss and vary according to the individual and the contexts in which loss occurs” (Humphrey, 2009, p. 5). Primary and secondary losses can either be death or nondeath related. Many individuals have experienced primary and secondary losses due to the COVID-19 pandemic and will continue to post pandemic. For example, if a husband and father of three children dies from COVID-19 during the pandemic, his death would be the primary loss. The secondary losses would be the loss of income and potential financial security, the widow’s loss of the identity of being a wife, and the loss of other roles and responsibilities the husband fulfilled.

Individuals have experienced many primary non-death losses due to the COVID-19 pandemic, one being the loss of employment. This loss results in multiple secondary losses, such as the loss of income, financial security, and the ability to pay bills. In addition, individuals might experience a loss of professional identity and overall purpose related to their vocation. Another non-death primary loss precipitated by the new normal is the loss of routine. This loss encompasses multiple experiences, including individuals working remotely, children attending school remotely, reduced family visits, limited travel, restaurant closure or decreased capacity, the inability to meet in person for religious services, and limited holiday celebrations. Secondary losses that result might include an individual’s loss of locus of control and/or loss of community connectedness. For parents who work from home, their secondary loss is time taken from work to help their children with their schooling.

As more people become vaccinated and COVID-19 restrictions are lifted, this will once again shift the new normal routine and produce further primary and secondary non-death losses. For example, individuals who work remotely during the pandemic might now prefer such a routine but may be mandated to return to the office post pandemic. An individual forced to work remotely during the pandemic, adjusting to the change, and learning it is their preferred format, only to be forced to return to the office after the pandemic can result in multiple losses.

The many primary and secondary losses individuals have endured during the COVID-19 pandemic are also examples of multiple loss. While Humphrey (2009) defined multiple loss as more than one primary loss occurring in a short time period, we propose

to expand the definition to include secondary loss as part of multiple loss. The secondary losses individuals experienced from the changing normal during COVID-19 have been detrimental and must be given the same consideration as primary losses. Some non-death secondary losses may be equally as impactful, if not more so, than the primary loss and therefore may require more clinical attention. In addition, multiple nondeath losses can be more difficult to recognize compared to a death loss. Individuals who experience a nondeath loss might not interpret it as a loss, and no formal rituals exist to identify and support the grieving for a nondeath loss.

Ambiguous and Disenfranchised Losses

Primary and secondary nondeath losses could be difficult to identity and thus qualify as an ambiguous loss. Boss (2016) defined ambiguous loss as "a situation of unclear loss that remains unverified and thus without resolution" (p. 270). She (2016) identified two types of ambiguous loss, one being a physical presence with a psychological absence and the other being a physical absence with a psychological presence. The changing new normal has caused a physical separation of loved ones with a continued psychological presence. For instance, nursing homes went on lockdown and prohibited visitors. Many health care workers chose to quarantine themselves from their family in order to minimize risk of transmission. In addition, the new normal has created psychological separation in the face of physical presence. For instance, a local restaurant is still present but the usual vibe of the Friday night crowd is absent. Worship services may still be running, but at decreased capacity and without elements of the service, like singing out loud or sharing food, that were hallmarks of attending religious services. In addition, individuals who adjusted to and might prefer this new normal will have to readjust to another new normal as the restrictions change or are lifted, making the loss more complex. Thus, the pandemic has created new ways to conceptualize ambiguous loss.

Disenfranchised loss is a loss that is not "openly acknowledged, socially sanctioned, or publicly shared" (Doka, 2016, p. 315). Traditionally, this type of loss concerns individuals who are not allowed to grieve due to stigma or societal expectations (Doka, 2016; Humphrey, 2009). However, disenfranchised loss can also be internalized as

individuals will either consciously or unconsciously prohibit themselves to acknowledge their losses (Kauffman, 2002). This self-disenfranchisement can occur over several contexts. For instance, individuals might evaluate their loss as less important compared to others' losses. Also, no rituals exist for certain nondeath losses that people are experiencing during the COVID-19 pandemic, such as the loss of routine, loss of social interaction, and loss of financial security. The lack of rituals could make it easier for individuals to disenfranchise their losses.

Complexity in Loss

The types of loss described above are interrelated. An individual who experienced a primary loss of employment might experience secondary losses of career identity and financial security with no clear way to grieve these secondary losses. Even if they recognize these losses, they may self-disenfranchise their grief and consider themself fortunate compared to their neighbor who lost their spouse to COVID-19. Another individual might now have to work remotely while also schooling their children from home. The family's primary loss of routine has resulted in a secondary loss of social connection, which may be too ambiguous to recognize as actual loss. These kinds of losses can result in anxiety, depression, substance abuse, and traumatic responses. Next, we describe how trauma can relate to loss during the COVID-19 pandemic and introduce how traumatic loss might be experienced during this time.

Trauma Related to COVID-19

The losses individuals experienced from the new normal can manifest into trauma symptomology with a range of effects. The Substance Abuse and Mental Health Services Administration (2014) defined trauma as:

> an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (p. 7)

In relation to loss, the threat or experience of physical and emotional losses during COVID-19 can possess a traumatizing effect and result in cognitive, emotional, and/or physical dysregulation when triggered (Corrigan et. al., 2011; Ogden & Fisher, 2015). Dysregulation can resemble both hyperarousal and hypoarousal symptomology (Ogden et al., 2006). For example, cognitive dysregulation could range from symptoms of excessive worry and racing thoughts to problems concentrating and mind going blank, emotional dysregulation could range from strong emotions to dissociation, and physical dysregulation could range from panic symptoms to body dissociation. Researchers traditionally described traumatic loss as events related to the witnessing or learning about the death of a family member, friend, or military unit member and these events may be perceived to be without warning, untimely, violent, unjust, and that their loved one suffered (Barlé et al., 2017; Stein et al., 2012). Here we propose to extend these events to any type of death or nondeath loss that leads to a traumatic reaction that results in cognitive, emotional, and/or physical dysregulation when triggered.

Shapiro (2018) described traumatic events on a spectrum from small *t* trauma that is non-life threatening to big *T* trauma that is life threatening. Traumatic loss can result from any traumatic event on this spectrum. Loss can be a combination of small and big T traumas that might be nondeath related but have serious implications for the future. For example, an individual who loses their job would classify this event as a nondeath loss, however, this loss may directly affect how they will cover the costs of living expenses regarding housing and food. While these types of losses are not always traumatic, when they are, mental health professionals must identify and treat them accordingly. Next, we provide examples of how traumatic loss has affected individuals during the COVID-19 pandemic and provide clinical recommendations.

Traumatic Non-Death Loss During and After COVID-19

Loss of employment. One possible intersection of loss and trauma is loss of employment. As described above, the unemployment rate has risen dramatically during the COVID-19 pandemic (Dey et al., 2020). The primary loss of employment could be seen as a small t trauma with big T implications if it affects an individual’s livelihood, thus

resulting in possible trauma symptomology. Traumatic secondary losses could include the loss of medical benefits and the ability to pay bills that could lead to eviction and the inability to purchase needed items to survive. These are clearly primary and secondary nondeath losses with possible serious implications, but the ambiguity of the loss prevents an individual from grieving in a similar way as a death loss. Even when the pandemic ends and an individual finds other employment, they may still struggle with the traumatic reactions they experienced during their unemployment.

Loss of routines. Another possible intersection of loss and trauma is the loss of daily routine. Many types of routines were lost during the pandemic, here we provide an example of employees who are parents of school-age children. Many employees lost their work routine and were mandated to work remotely during the pandemic. Individuals worked from home while assisting their children as they attended school remotely. A parent who lost their old work routine had to adjust to a new routine that combined the responsibilities of meeting work obligations and overseeing their child's online learning. This new routine could have resulted in increased stress for the parent, as they also had less resources to rely upon, such as daycare or family support. Parents may be forced to neglect their work to support their child, and as work deadlines and responsibilities piled up so too would the parents' overwhelming traumatic anxiety.

Even when the pandemic ends and work routines return to a new normal, parents may still experience traumatic reactions to these experiences. Parents who have been working remotely and supervising their child's online learning who can now return to work might still experience burnout and have trauma reactions when thinking about getting behind at work. In addition, after several months of working remotely, some individuals might now prefer this new work format only to be mandated to return to their place of work and thus experiencing another loss.

Clinical Recommendations

Based upon the content of this article, we provide three recommendations for mental health professionals who are working with clients struggling with transitioning through the changes related to the new normal. While these recommendations can apply to

many types of scenarios clients present, we used the above examples of individuals who experienced a loss of employment and loss of routine.

Using a Lens of Loss

When clients report struggling with adjusting to the changing normal, we recommend mental health professionals conceptualize these struggles from a loss perspective. First, if clients report being unemployed due to the pandemic, counselors can reframe this loss of employment as a nondeath primary loss that must be recognized and grieved. In addition, the mental health professional and client can uncover what secondary losses resulted from the primary loss and find ways to grieve them as losses. These secondary losses can be either tangible or nontangible in nature; for example, a tangible loss might be a client's ability to pay bills or shop for food, while an intangible loss might be the loss of financial security or the loss of a vocational identity. Regardless of the nature of the loss, counselors can define, validate, and normalize it as a legitimate loss.

Second, clients may have grappled with several losses related to their old routine, adjusted to some extent, and now may be faced with several additional losses due to a new routine based on the new normal. Mental health professionals can explore how these changes have affected their clients and reframe these changes as losses that must be grieved. This reframing can transition the client's ambiguous and possibly undefinable experience of dealing with their changing routines to the more familiar concept of loss and grief, which can validate and normalize their experience.

Once these changes are defined as losses, mental health professionals can then work with their clients to determine how these losses have affected them, educate about grieving styles, and explore which grieving style fits their personality (Humphrey, 2009). Identifying a client's grieving style can be the first step in the therapeutic process as they determine whether they are an intuitive griever, instrumental griever, or a combination of the two (Martin & Doka, 2000). Once a client's grieving style has been discovered, the mental health professional and client can create cognitive, behavioral, emotional, and spiritual grieving activities appropriate for their style (Humphrey, 2009). Clients can then

identify their struggle to the changing normal as a loss or series of losses and utilize effective grief strategies to adapt to these losses.

Using a Lens of Trauma

In addition to conceptualizing clients from a loss perspective, we recommend that mental health professionals assess for trauma reactions as clients present with adjustment problems due to the changing normal. For the example of the unemployed client during the pandemic, reframing the experience as a loss and mapping out primary and secondary losses is the first step. For the second step, the mental health professional would assess for trauma reactions connected to these losses. Trauma reactions can be any combination of emotional, somatic, and/or cognitive dysregulation (Ogden et al., 2006; Shapiro, 2018), and if the client experiences any of these symptoms while describing the losses this would qualify as a traumatic loss.

If a traumatic loss is present, we recommend the mental health professional treat the loss and the trauma reactions concurrently. Focusing on only the loss or the trauma does not holistically address the problem. For instance, engaging a client in grief work might help to grieve the loss of their employment during the pandemic but would not resolve the trauma reactions they experience when they think about the threat of losing their home. Also, mental health professionals who provide only trauma therapy to resolve the trauma related to the threat of losing their home might leave their client with unresolved grief related to the primary loss of employment and other related secondary losses. It is vital to conceptualize the grief and trauma together to understand how they relate to provide effective grief work and trauma therapy.

We also recommend that in addition to educating the client about loss and grieving styles, the mental health professional should educate the client about how traumatic reactions can present with emotional, somatic, and cognitive symptoms. Doing so can validate and normalize the client's experience with these reactions (Ogden & Fisher, 2015). The same recommendation applies to the second example of a client who struggles with the loss of routine, specifically parents who worked remotely and homeschooled their children. Mental health professionals working with these parents can help them identify

the primary and secondary losses due to working remotely and homeschooling their children while assessing for trauma reactions that stemmed from these losses.

Several evidence-based trauma interventions exist that can help clients who struggle with trauma, such as trauma-focused cognitive behavioral therapy (McMackin et al., 2012), eye movement desensitization reprocessing (Shapiro, 2018), sensorimotor psychotherapy (Ogden & Fisher, 2015), and cognitive processing therapy (Resick et al., 2016). A description of these trauma therapies is beyond the scope of this article, please refer to the above references for a more detailed review. We do not endorse any specific trauma therapy listed here but do recommend mental health professionals work with their clients to determine which type of trauma therapy might best meet their needs. If the mental health professional is not trained in a specific trauma therapy but trained in grief work, they could either work in tandem with a trauma therapist or refer the client to work exclusively with someone skilled in both grief and trauma therapy.

Self-Awareness of the Mental Health Professional

Mental health professionals must be self-aware of their own loss and potential traumatic reactions to the changing normal caused by the pandemic. Countertransference occurs when a mental health professional's own problems are intermingled into the therapeutic relationship or with a client's experiences (Corey, 2017). If the mental health professional is not self-aware, countertransference can lead to overidentifying with their own experience rather than focusing on the client's. This could cause the mental health professional to suggest ideas that worked for them instead of helping the client discover their own solutions.

Mental health professionals can increase their self-awareness through several strategies. First, self-led activities such as journaling and practicing mindfulness can help them become more self-aware of their own losses and trauma in relation to the pandemic (Richards et al., 2010). Second, mental health professionals can seek peer consultation to determine if any countertransference or other issues, such as burnout, might be impeding their effectiveness with clients (Carney & Jefferson, 2014). Last, we recommend mental health professionals seek out counseling session during the pandemic to work through their

own grief and trauma. Attending counseling sessions as a client can improve their personal well-being and professional efficacy (Gold & Hilsenroth, 2009; Macran et al., 1999; Pope & Tabachnick, 1994).

Conclusion

The COVID-19 pandemic resulted in several social modifications that created a changing normal that affected everyone directly and/or indirectly. Individuals have endured significant losses and possibly traumatic losses that may persist after the pandemic. It is important that mental health professionals remain aware of the potential types of loss their clients face and that this loss can have traumatic effects. In addition, mental health professionals must be aware of their own loss and trauma due to the changing normal. The idea of a stable normal continues to shift and may shift for a substantial amount of time as COVID-19 outbreaks occur, restrictions change, vaccination rates increase, and routines evolve. No clear timeframe exists for reaching a stable normal, and individuals may not begin recognizing their loss and trauma at the present time. The mental and emotional effects of loss and traumatic loss experienced during the pandemic may persist for years afterward and should be taken into consideration. Those working in community mental health should remain cognizant and empathetic of the experiences of their clients and self-aware of their own experiences to prevent burnout.

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