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COVID-19 PANDEMIC AND MENTAL HEALTH: PSYCHO-SOCIAL COUNSELLING INTERVENTIONS

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Abstract

The Study examines Covid-19 pandemic and mental health: Psycho-social counselling interventions. The outbreak indeed has created concern and worry among the general population of many nations of the world. The world has beginning to adapt to new ways of doing things social distancing currently dominating our daily lives, staying indoor, There are several difficulties for people psychotherapists and practitioners have in adjusting to this development. Counselling intervention should be based on a thorough assessment of possible risk factors that may have contributed to the problem, the client's prior state of health, the history of bereavement, the presence of a history of self-harm or suicidal behaviours in both the client and his/her family, the history of previous traumas, and the socio-economic context of the client. Under the present pandemic, it is important to recognise the likely profound impact of COVID-19 on economic, social, religion and political levels on the individual's environment and the larger society.

***Keywords*:** Covid-19 Pandemic, Mental Health, Psychosocial, Counselling, Interventions

Introduction

The outbreak of COVID-19 has created concern and worry among the general population of many nations of the world. Many citizens of such nations are anxious and afraid and those

directly affected in different ways by the virus may be in greater panic, fear and worry. COVID-19 (Corona Virus Disease 2019, also known as 2019-nCoV), is a cluster of acute respiratory illness with yet to be fully identified causes, occurred in Wuhan, Hubei Province, China in December 2019 (Wuhan Municipal Health Commission, 2020; Paules., Marston, and Fauci, 2020; Wang, Pan, Wan, Tan, Xu, Ho, and Ho, 2020). Between December, 2019 and February 15, 2020, a total of 66,580 COVID-19 cases in China have been confirmed and 1,524 Chinese died from the disease. Internationally, sporadic cases exported from Wuhan were reported in 25 countries (such as 334 cases in Japan, and 67 cases in Singapore), 5 continents, and international conveyance (218 cases in "Diamond Princess") (World Health Organization, 2020a). On January 23, Wuhan city closed all access routes to stop the spread of the disease. Seven days later, the World Health Organization (WHO) declared COVID-19 as a Public Health Emergency of International Concern (PHEIC) (World Health Organization, 2020b). In addition to causing physical damage, COVID-19 also has a serious psychological impact on the mental health of the individual and the immediate members of his/her family.

Earlier in January 21, 2020, China confirmed human-to-human transmission of COVID-19 and some medical staff in Wuhan were also reported to have been infected by the disease (XINHUANET, 2020). Since then, the general public and family members have shown anxiety-related behaviours, causing a significant shortage of medical masks and alcohol across the country. On the night of January 31, due to a news release that "Shuanghuanglian" oral liquid could suppress COVID-19 (People's daily of China, 2020), the public rushed to pharmacies overnight to buy the drug. In addition, many front-line medical staff works more than 16 hours a day on the average, thereby loosing several hours of sleep. The reported case of a 37-year-old Japanese government worker who was in charge of isolated returnees from Wuhan who was

found to have died from apparent suicide (Seager, Ilana, Kroll & Martinez, 2020) must not have been unconnected to such a situation.

Evidence indicated that COVID-19 is a distinct clade from the beta corona viruses related to human severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (Zhu, Zhang, Wang, Li, Yang, Song, Zhao, Huang, Shi, Lu, Niu, Zhan, Ma, Wang, Xu, Wu, Gao, & Tan, 2020). Just as several studies have showed that mental health problems could occur in both healthcare workers and SARS survivors during the SARS epidemic (Shultz, Baingana, & Neria, 2015; Silva, Resurrección, Antunes, Frasquilho, & Cardoso, 2018 ;Blanckenburg, & Leppin, 2018; Xiao, 2020). Post-traumatic stress disorder (PTSD) and depressive disorders were the most prevalent long-term psychological condition (McGinn, Roussev, Shearer, McCann, Rojas, & Felker, 2019). Similar results have been reported in the previous study of MERS (Lee, Kang, Cho, Kim & Park, 2018). Based on the above research evidence, we have reason to speculate that the psychological condition of specific members of some families may also be affected during COVID-19 epidemic.

According to Dr Hans Kluge "With the disruptive effects of COVID-19 – including social distancing – currently dominating our daily lives, it is important that we check on each other, call and video-chat, and are mindful of and sensitive to the unique mental health needs of those we care for. Our anxiety and fears should be acknowledged and not be ignored, but better understood and addressed by individuals, communities and governments," (Al-Rabiaah, Temsah, Al-Eyadhy, Hasan, Al-Zamil, Al-Subaie, & Somily, 2020).

The COVID-19 outbreak started in early December 2019 in Wuhan, Hubei province, in China. Since then the psychological distress of COVID-19 in the general Chinese population is that many of the populace where under great tension as well as the Frontline healthcare workers

(HCWs) in Wuhan have also been under tremendous pressure and risk of contracting COVID-19. As at February 12, 2020, 21,569 HCWs from other cities in China have been deployed to support emergency response efforts while 1,716 Chinese HCWs who have contracted COVID-19 have died. Also, report by (Brooks, Webster, Smith, Woodland, Wessely, Greenberg, & Rubin, 2020) show that some healthcare workers described the situation as "more difficult and extreme than [they] could ever have imagined and they may "suffer psychologically". Such psychological distress is not unconnected to report of 49,671 confirmed cases and 2,305 deaths that were attributed to COVID-19 in Wuhan, the acclaimed birth place of the virus. These experiences are consistent with the increased psychological symptoms and conditions in HCWs during and after the SARS epidemic. The psychosocial impact of COVID-19 and psycho-social counselling interventions on populace cannot therefore be over emphasize in COVID-19 pandemic outbreak.

Psychological Impact Encountered When Staying Indoors

Staying indoor during any crisis could be at time very difficult for a healthy person, (Wuhan Municipal Health Commission, 2020) reaffirm that spending time indoors can cause a different psychological impact depending on how a person reacts and responds to the situation. On a positive note, some can have a positive psychological impact such as improving social connectedness with family members staying in the same indoor environment. However, (Brooks, et.al., 2020) identified some, negative psychological impacts of when staying indoor as follows:

i. Increased stress due to not being able to perform outdoor routines and activities, not being able to see friends
ii. Worry and anxiety about not being able to be physically present eg; to help loved ones especially families members.
iii. Helplessness, boredom, loneliness, and depression can also set in.

Psycho-Social Counselling Interventions

Any psychosocial counselling intervention is normally based on a thorough assessment of possible risk factors that may have contributed to the problem, the client's prior state of health, the history of bereavement, the presence of a history of self-harm or suicidal behaviours in both the client and his/her family, the history of previous traumas, and the socio-economic context of the client. Under the present pandemic, it is also important to recognise the likely profound impact of COVID-19 on economic, social, religion and political levels on the individual's environment and the larger society. This may therefore requires the adoption of new ways of working with structural inequalities emerging from the aftermath of COVID-19 which should be consistent with social determinants of mental health model (Lund, Brooke-Sumner, Baingana, Baron, Breuer, Chandra, & Saxena, 2018).

It is noted by (Brooks et al., 2020; Qiu, Shen, Zhao, Wang, Xie & Xu, 2020) where health systems have sufficient flexibility, for those with existing mental health conditions should continue their psychological interventions by technology enabled means. This can include telephone consults, or increasingly via digital platforms such as Skype, Zoom or health provider developed platforms. This presents a number of specific challenges including familiarity with the technology (both therapist and client), adaptation of the therapeutic intervention, awareness of the additional parameters of delivering therapy in lockdown conditions, and the accompanying question of the purpose of therapy in such unusual circumstances.

There are thus several difficulties that psychotherapists and practitioners have in adjusting their practice to technology enhanced therapy, which can be delivered from the comfort of their homes, as opposed to familiar public facilities or private practices. The following suggestions of how to adapt psychotherapy to this unique condition have emerged from our everyday clinical

experiences over the adaption to lockdown in several countries, and they represent an attempt to systemizing clinical practice for the duration of the emergence and of social life restrictions. Therefore, we provide a number of key points to guide counsellors in adapting practice.

i. **Draft a new contract**. Many clients will have difficulties in accepting digital psychotherapy. Counsellors must be aware that this is pragmatically the only option available (if this is the case), which will enable them to acknowledge and self-regulate their own difficulties with changes such as worry for the client's challenges, irritation with the option of discontinuing face to face psychotherapy or guilt at the idea of not being available enough. In all of these cases the counsellor remains open for phone/video contact where the client experiences psychological challenge. However, but negotiation is required over whether sessions are for crisis-management only; or whether regular sessions are still possible (and/or desirable to both parties. This can help retain a balance between acceptance of difficulties and the maintenance of a robust treatment framework.

ii. **Raise the bar for what we consider psychopathology**. Reactions of distress, such as fear, rage, anxiety, obsessions, guilt, constriction, rebellion against authority, emotion and behavioural dysregulation, albeit transitory, are to a certain extent normal during a crisis. The counsellor must first and foremost help the clients understand that their suffering is human and mostly unavoidable; this is not to say that they should be ignored or minimised. When clients can note how their mind is overwhelmed by symptoms, affect or relational problems, this creates a basis for agreement to work on them. Counsellors can note how experiencing fears for their own and their loved ones health is understandable, that to be worried about the future of the economy is reasonable, how to

behave with a certain degree of obsessions is adaptive (e.g. hand hygiene) or that unexpected losses of temper are to be expected in confinement. Where sharing is appropriate, the counsellor may provide examples of witnessing the same experiences and noting this is part of what the humanity is experiencing now. This is aimed at reducing feelings of self-shaming, self-criticism stigma, or guilt for one's own weaknesses. Self-disclosure is unique in this aspect. Above all, it is one of the most powerful interventions (Seager, et al, 2020) and in this moment it has become even more necessary.

iii. **Moment of personal vulnerability.** Counsellors may need to strategically disclose moments of their own personal vulnerability during the outbreak. We contend that in this moment counsellors should mindfully and tactically not stick to one of the principles of good self-disclosures (Dimaggio, Montano, Popolo, & Salvatore, 2015). In other words counsellors should disclose well-regulated feelings and thoughts. In this moment, still having command over their own experiences, counsellors may disclose moments in which they experienced momentarily feelings of fear, even moving closer to panic, worry, anger, sadness, rebellion and irritation than one ordinarily would. This helps create a sense of human connection and reduces in session risk, on the client's side of self-blaming or setting unrealistic standards of good mental health for the self. This can be balanced in session with learning from these experiences of momentary dysregulation.

iv. **Create the therapeutic environment**. We are not working in our offices but often from our homes. The therapy space must therefore be created anew. For video-therapy the

counsellor should choose what part of their home they want to show beyond their shoulders and possibly consider the clients' personality. Equally, the therapists will be projecting a sense of their own identity in these choices. It is better with some clients to choose a more neutral/professional background, for example bookshelves or a working table. With other clients there is less this need, and they experience a sense of familiarity even when they see the kitchen or the windows of the therapists' home. In any case, asking clients for feedback about how they experience the therapist in this new environment is crucial. Another issue is how to present oneself in the camera. Absence of embodied inter subjectivity deprives the session of face-to-face aspects of the human connection. We consider that adjusting zoom of the webcam, which means placing oneself at some distance can be helpful. Showing only one's face is artificial and deprives the client of gestures and nonverbal markers from the therapist. Conversely, at least a half-length shot (example, breaking news conductors) is better and some background must be present, so the clients retains a sense of a human being in context. This way the counsellor can use arms and hands and chest and shoulders to convey nonverbal signals making communication more natural.

v. **Be mindful of clients' individual personality**. Alternatively, some clients may feel more comfortable without using a camera and the use of audio might suit them better. Coping with such anxiety disorders as social anxiety might lead clients to avoid video. As in any form of coping, if using video is too much an emotional burden to that client, the counsellor accepts phone consultation, but keeps exploring the possibility to switch to video, which would be a kind of behavioural exposure. A compromise would be using a web platform with video disabled. Simply accepting coping deprives the counsellor the

possibility to counteract psychopathology. Whereas, gently asking if the client feels ready to switch to video, and explore the cognitive-affective antecedents of the possible refusal gives precious information about residual maladaptive interpersonal schemas which are fundamental therapy target. (Goldmann, & Galea, 2014)

vi. **Help clients build their own environment**. Counsellors may offer suggestions on how their clients can create therapeutic safe spaces that are protected from interference. Of course, having a private, distraction-free room is best, but even in this case clients can be suggested to use headphones and a microphone, and maybe some background music, by so doing, the risk of eve dropping is reduced. Alternatively, sessions can be conducted over smart phone in the open, for example, a private garden, the parking lot or in a car. Trivial as these may sound, we have found that these suggestions help many clients to accept and practice therapy even after initial reluctance. – Therapeutic focus –only self-regulation and overcoming distress or exploration of opportunities for building healthy parts and pursuing autonomy, exploration and expanding the healthy self (Dimaggio et al., 2015)? We have noted that in majority of cases where we have adjusted delivery of psychotherapy to fit the pandemic restrictions, clients are seeking a balance between acceptance of the current condition, whilst still trying to challenge maladaptive schemas and develop an emergent healthy part of the self. Indeed, once issues relating to the present crisis have been dealt with, client and counsellor may explore how the current distressing conditions create suffering not only for their direct traumatic effects, but also because they may indirectly bring undermine existing personality, cognitive and emotional vulnerabilities to the fore. Thus, counsellors may help the clients connect their present experiences to lifelong vulnerabilities that may enable therapeutic work to

continue as they did before the emergency, albeit with specific adaptations (Mohammed, Sheikh, Poggensee, Nguku, Olayinka, Ohuabunwo, & Eaton, 2015).

vii. **Help clients to identify effective coping strategies**. Prior to lockdown clients with avoidant personality disorders may have started questioning schemas of themselves as inferior and others are judging and therefore, they coped with social avoidance (Inchausti, Prado-Abril, Sánchez-Reales, Vilagrà-Ruiz, & Fonseca-Pedrero, 2018). In this moment behavioural experiments aimed at increasing social contact and thus further challenging the schemas are more difficult to enact. Yet, the counsellor may still explore opportunities, and build more basic steps for future real-life exposures. Clients looking for employment may be able to access online courses or training for life after. Clients searching for romantic partner may use dating Apps or explore the feelings and thoughts they experience when chatting with some new acquaintance. Even the home may be a test ground for new experiments. (Verity, Okell, Dorigatti, Winskill, Whittaker, Imai, & Ferguson, 2020) One client related difficulty in showing personal vulnerabilities to significant persons because she had learned that if she revealed these emotions others either became unavailable or distressed; therefore, she had avoided disclosure, or felt guilty for burdening them. Lockdown and having to live with her partner 24:7 helped her realize that there was no point in her concealing her personal feelings, thus she burst into tears with her partner; relating afterwards in therapy that she felt relieved as she realized that that was possible. These enabled schema-driven difficulties in continuing with disclosure of feelings could be addressed as a current therapeutic issue.

viii. **Guided imagery exercises**. Finally, some practices like two-chairs, sensorimotor work, guided imagery exercises, can regularly be performed simply by adjusting the zoom in the client room. The therapists may ask the client to step back so that the whole body can be observed and then ask to close their eyes and engage in guided imagery, or use bodily oriented work like grounding (Gardner, & Moallef, 2015) to enhance self-regulation or connecting with feelings of strength and personal agency. That said, for some clients that are unwilling or do not want to use this platform for treatment. If they are content to postpone specific elements of treatment until restrictions are lifted, and therapist should be sensitive in recognizing distress but also respecting the decision-making process (Zhang, & Li, 2011). It is still possible to remain open to the client re-contacting the therapist to recommence therapy

Mental Health and COVID-19 Pandemic

COVID-19 pandemic and associated disruption to society poses major challenges to the provision of mental health services. These challenges include the need to identify and monitor possible risk groups, contain the reaction to fear and better adaptation, provide a database on the needs of people in quarantine in order to develop ad hoc interventions, preventively intercept relevant psychopathological symptoms and lower situational stress to the emergency, reduce obsessive/anxious manifestations (such as thoughts and behaviours). Other challenges are the need to limit health anxiety and stabilize mood, prevent of domestic violence crimes, reduce the post-traumatic impact of the emergency for psychological morbidity as well as explore new ways of providing services. As a heuristic, it is useful to consider three (potentially overlapping) groups that can benefit from psycho-counselling intervention frameworks for mental health,

and/or treatment approaches. These are healthcare workers engaged in frontline response to the pandemic and their patients; individuals who will experience the emergence of new mental health distress as a function of being diagnosed with COVID-19, or losing family and loved ones to the illness, or the psychological effects of prolonged social distancing; and individuals with existing mental health conditions who are either diagnosed with COVID-19 or whose experience of social distancing exacerbates existing vulnerabilities.

Definition of Mental Health and Psychosocial Support (MHPSS)

Mental health refers to cognitive, behavioural, and emotional well-being. It is all about how people think, feel, and behave. It also refers to as a person's conditions with regard to his or her psychological and emotional well- being. Mental health is important to members of a given family because it is a vital part of that life that impacts on their thought, behaviours and emotions. Mental health includes our emotional, psychological, and social well –being. It affects how we think, feel, and act. It also determines how we handle stress, relates to others, and makes choices. Being healthy emotionally promotes productivities and effectiveness in activities, such as work, school and care giving (World Health Organization, 2020a). Examples of mental health among others include anxiety, panic disorder, depression, eating disorder, substance abuse and addiction.

Psychosocial support refers to the actions that address both psychological and social needs of individuals and communities. It helps individuals and communities to heal the psycho-social wounds and rebuild social structure after emergency or critical events. It can help change people into active survivors rather than passive victims. Psycho-social support also helps individuals and communities to heal the psychological effect and rebuild social structures after a crisis or disaster.

The term psycho-social refers to the close relationship between the individual and the collective aspects of any social entity especially for the healthcare workers (HCW). Psycho-social programmes are care skills used in assisting individual to meet their psycho-social and emotional well-being, as well as their physical and mental development. Some persons within the society need additional, specific psycho-social support if they have experienced extreme trauma or adversity or were deprived necessary care from the onset.

The composite term ‘Mental Health and Psycho-social Support' (MHPSS) refers to any type of local or outside support that aims to protect or promote psycho-social well-being or prevent or treat mental disorders. Support may include interventions in health, education, or interventions that are community-based. The term ‘MHPSS Problems' covers social problems, emotional distress, common mental disorders (such as depression and post traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual disability. It is widely used to describe the range of activities that are used to improve the well-being of individuals and to treat mental disorders.

MHPSS in disasters includes any support that people receive to protect or promote their mental health and psycho-social wellbeing during disasters/ crises/ epidemics/ pandemics or outbreaks and to treat mental disorders. One of the components of MHPSS is prevention and treatment of psychiatric disorders such as depression, anxiety and Post-Traumatic Stress Disorder (PTSD).

Mental Health in a Crisis Situation

During crisis/disasters/outbreaks, any individual may be affected emotionally as is happening during the current COVID-19 pandemic. How people respond to the crisis/disasters /outbreaks is influenced by their individual background, and differences compared to others, and the

community they live in. It is common for individuals to feel stressed, worried and anxious amid threaten situations. Fear and anxiety about COVID-19 can be overwhelming and emotions could cause strong emotional reaction in an individual. Xiao, (2020) opined that common psychological response of people that may be affected by the current COVID-19 varies from one person to the other.

These include:

i. Worry of the possibility that their family members could be infected
ii. Fear of falling ill and dying and losing loved ones
iii. Feeling helpless – not able to protect loved ones
iv. Stress and anxiety especially due to separation (from loved ones and caregivers) because of being quarantined
v. Fear of being placed under home surveillance because of the disease
vi. Avoiding health facilities due to fear of becoming infected while in care
vii. Fear of not being able to work during isolation, and of being dismissed from work
viii. Feelings of helplessness, boredom, loneliness and depression if isolated

Signs that indicate that your mental health is affected and you need psychosocial support

Since mental health is part of an individual overall health, it is possible to keep track of it with adequate knowledge if what it is. The following signs as the indicators:

• Drastic changes in sleeping pattern eg- insomnia

• Changes in appetite

• Extreme mood changes - Easily angry, agitated or irritable

- Feeling extremely sad

• Severe tiredness and feeling easily fatigued

• Losing interest on the things you loved to do

• Withdrawal from family members and friends

• Difficulty in focusing or concentrating

• Losing interest in the things you love to do

• Withdrawal from family members and friends

• Desire to increase alcohol or tobacco use

(Brooks, et. al., 2020**)**

Psychological Impact Encountered When Staying Indoors

Staying indoor during any crisis could be at time very difficult for a healthy person. Wuhan Municipal Health Commission, (2020) reaffirm that spending time indoors can cause a different psychological impact depending on how a person reacts and responds to the situation. On a positive note, some can have a positive psychological impact such as improving social connectedness with family members staying in the same indoor environment. However, (Brooks, et. al., 2020) identified some, negative psychological impacts when staying indoors as follows:

iv. Increased stress due to not being able to perform outdoor routines and activities, not being able to see friends

v. Worry and anxiety about not being able to be physically present eg; to help loved ones especially families members.

vi. Helplessness, boredom, loneliness, and depression can also set in

Principles of Mental Health and Psychosocial Support during COVID-19

The delivery of MHPSS services to all levels of victims involved in disaster in general and specifically during this COVID-19 pandemic follows the principle that basic needs shall be

provided to all victims, followed by restoration of community and family support and followed by focused and specialized services to a smaller sub-group within those affected by disaster(s).

In organizing psychological psychosocial counseling intervention assistance within and across various stages of the pandemic, practitioners should be mindful of the following four major challenges:

i. Healthcare system deficits, both in terms of material and human resources (i.e., lack of adequate personal protective equipment (PPE), infrastructure for digital interventions, staffing) or in mental health professionals not specialized in the psychological approach of crises and emergencies (Shultz, et. al., 2015 and Shultz & Neria, 2013). In China, the scarcity of human resources led to individual professionals accumulating multiple responsibilities, reducing the effectiveness of their interventions (Duan & Zhu, 2020). For this reason, government, policy makers and health managers need to be aware of health systems strengthening for increasing the capacity of mental health professionals, facilitate training for emergency intervention, and monitor workload burdens, especially when sustained over time.

ii. Societal underestimation of the (short and long-term) psychological consequences of pandemics and, consequently, limited resources to cope with them (Bitanihirwe, 2016). There is evidence that individuals exposed to public health emergencies have increased psychopathological vulnerability both during and after the potentially traumatic event (Fan, Long, Zhou, Zheng & Liu, 2015). Although the international COVID-19 pandemic response has been unprecedented in terms of mobilization of resource and finance, there will also be long-term impacts in terms of treatment burden, including mental health, particularly in low resource and conflict settings (UN,

2020). In China, the progression of COVID-19 aggravated the mental health of infected patients, the general population and health professionals (Duan & Zhu, 2020). Therefore, it is important to evaluate and identify all risk groups and adapt interventions to their specific needs. Among the variables to consider are disease trajectory, severity of clinical symptoms, place of treatment (in-home or out-of-home isolation and Intensive Care Unit), history of previous trauma, and previous history of mental health problems. Having this information will help classify people at risk and enable specific preventive mental health measures to be put in place.

iii. Poor planning and coordination of psychological interventions, especially when they are applied at different levels and by different professionals (Zhang, Wu, Zhao, & Zhang, 2020). In China, at the start of the COVID-19 outbreak, the absence of adequate planning of psychological interventions led to fragmented or disorganized implementation, compromising effectiveness and efficacy, and hampering access to available health resources. Any psychological intervention should be planned and coordinated together with all the social-health stakeholders involved, particularly primary care services and specialized public mental health services.

iv. Finally, there is also a risk attached to early crisis responses, leading to a proliferation of interventions and frameworks associated with an oversupply of well-intentioned but potentially non-evidence based psychological assistance, often Non-Governmental Organizations (NGOs) and the third sector. This is not to say all NGO interventions are compromised, in fact wherever they are made available they are highly desirable. That said, delivery of preventive interventions must be balanced by

delivery and/or supervision applied by appropriately qualified professionals (Loewenstein, 2018 and Ogden, 2019).

Conclusion

Counsellors are introduced to counselling interventions that are beneficial to them in their practice of individual and group counselling for the purpose of improving their clients' well-being, alleviating their distress and enhancing their coping skills. Also the counselling interventions discussed focused on present thinking behaviours and communication rather than on past experiences.

The current crisis is the first global crisis in the age of mass internet supported communication therapies, and this offers opportunities and challenges for delivering high-quality psychological online. Practical and technical adjustments to therapy are made available in order to generate corpus of knowledge based on the effectiveness of technologically supported psychotherapy that is oriented towards problem solving such as depression, anxiety, panic, fear, eating disorders, addictions, personality disorders, sleep disorders, bipolar disorder, substance abuse, and personality problems during this COVID-19 pandemic.

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