
RISK AND PROTECTIVE FACTORS FOR DEPRESSION AND ANXIETY IN PROFESSIONALS SUPPORTING VICTIMS OF CHILD ABUSE DURING THE COVID-19 CRISIS

FACTORES DE RIESGO Y DE PROTECCIÓN PARA LA DEPRESIÓN Y LA ANSIEDAD ENTRE LOS PROFESIONALES QUE APOYAN A VÍCTIMAS DE MALTRATO INFANTIL DURANTE LA CRISIS POR LA COVID-19

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Abstract: The COVID-19 crisis has challenged the well-being of professionals supporting abused children. The effects of some risk (i.e., number of nearby infected people and telecommuting and housework hours per day) and protective (i.e., social support, self-efficacy, and self-care) factors on depression and anxiety symptoms were tested in professionals supporting child-abuse victims in Chile during the COVID-19 crisis. Professionals ($N = 175$) answered self-reports. Having infected people nearby and social support predicted depression. The effect of social support on depression was partially mediated by self-efficacy and self-care. The effect of social support on anxiety was completely mediated by self-care. Results show that social and psychological variables are relevant to understand depression and anxiety symptoms in professionals even during the COVID-19 crisis.

Keywords: welfare, stress, child-protection workers, pandemic, South America.

Resumen: La crisis por la COVID-19 ha desafiado el bienestar de los profesionales que apoyan a niños que han sufrido abusos. Se examinó el efecto de algunos factores de riesgo (a saber, número de personas contagiadas alrededor y horas de teletrabajo y de trabajo hogareño por día) y de protección (a saber, apoyo social, autoeficacia y autocuidado) sobre los síntomas de depresión y ansiedad de profesionales de apoyo a víctimas de maltrato infantil en Chile durante la crisis por la COVID-19. Los profesionales ($N = 175$) respondieron autoinformes. El tener personas contagiadas alrededor y el apoyo social predijeron la depresión. La autoeficacia y el autocuidado mediaron parte del efecto del apoyo social sobre la depresión. El autocuidado medió totalmente el efecto del apoyo social sobre la ansiedad. Los resultados muestran que las variables sociales y psicológicas son relevantes para comprender los síntomas de depresión y de ansiedad de los profesionales, incluso durante la crisis por la COVID-19.

Palabras clave: felicidad, estrés, trabajadores de la protección infantil, pandemia, Sudamérica.

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The concept of psychosocial risks at work includes all the factors presented in the occupational field that could negatively affect the worker's well-being and health (physical, psychological, or social; Departamento de Salud Ocupacional, 2013). Despite its relevance, this concept has only been recently considered in labor regulations, due to the rise of concepts such as subjective well-being, quality of work life, and occupational health (Moreno Jiménez, 2011). It is believed that the current health crisis due to COVID-19 produced the challenge of supporting the health of workers and preventing psychosocial risks. The focus of this study was the mental health of Chilean professionals who support victims of child abuse during the pandemic.

Although in Chile the regulatory framework for this matter was constituted by *Ley 16744* (1968) and its subsequent amendments, it was not until 2013 when a national protocol for the surveillance of psychosocial risks at work was developed (Departamento de Salud Ocupacional, 2013). This protocol emphasizes different sources of occupational risk, especially relevant for the work of professional teams linked to childhood (e.g., the psychological demands associated with working with traumatized people) and especially relevant in the context of the current health crisis (e.g., the double task faced by professionals who are working from home).

There are precursory factors before the COVID-19 crisis that allow to argue that support professionals for children and adolescents who were victims of abuse constitute a group at high risk of suffering occupational diseases. These professionals face the exposure to various sources of stress from the task of containing highly traumatized people and complying with the demands of their institutions and the state agencies that regulate this work (Bilbao et al., 2018; Wooten et al., 2011). Multiple studies have found that these professionals have a higher risk of suffering burnout syndrome, compassion fatigue, vicarious trauma, depression, and anxiety (Boyas & Wind, 2010; Guerra & Pereda, 2015; Guerra Vio & Lira Mendiguren, 2007).

Different studies have analyzed the role of various factors concerning stress and job satisfaction. Among the risk factors described in the literature, the conflict generated between family life and work stands out, considering that child protection professionals often continue to work from home beyond their working hours. Alternatively, given the difficult situations they must deal with, they remain emotionally connected to their work, neglecting their own family. Those situations would be particularly relevant in cases where the professional has a heavy workload or has

lived similar traumatic experiences to those of the children to care (Baugerud et al., 2018; Kim, 2011; LeBlanc et al., 2012; Lizano & Mor Barak, 2012).

By contrast, among the protective factors the positive challenges at work, a sense of mastery or self-efficacy about the work, as well as a commitment to their organization and social support stand out (McFadden et al., 2015). There is also evidence that having self-care activities help these professionals to prevent and treat work stress (Alkema et al., 2008). In particular, Chilean studies have found that professionals who performed self-care activities more frequently (e.g., doing sports, eating healthy, having social activities outside of work, or maintaining an active spiritual life) had lower scores of depression and anxiety (Betta Olivares et al., 2007; Guerra Vio et al., 2011).

The new context given by the COVID-19 pandemic has brought changes in working conditions and new stressors that deserve to be studied because they may be affecting the mental health of these professionals.

WORK IN SUPPORT OF CHILDREN IN CHILE, COVID-19, AND CHANGE IN WORKING CONDITIONS

In Chile, child abuse has been considered a serious social problem, due to both its magnitude and its consequences. The Consejo Nacional de la Infancia (2018) conducted a prevalence study in which they surveyed 19,684 adolescents from all over the country. The results showed that 52% reported having experienced at least one exposure to caregiver abuse in their lifetime, 26% reported having suffered some type of sexual abuse, and 19% reported at least one situation of exposure to violence within their family.

Nevertheless, since 1997, Chile has developed specialized intervention programs dependent on the Servicio Nacional de Menores (SENAME) and supervised by the family courts. As a reference, SENAME (2019a) reported having provided specialized care to 299,932 children and adolescents during 2018, most of whom were supported by specialized centers while they remained living with their families. Only the most severe cases—in which there is no support from parents or other family members—are sent to live in residential homes or with foster families due to the Chilean tendency to privilege for the children to continue living with their parents, instead of sending them to residential or foster care. However, in all cases of maltreatment and abuse, children are sent to specialized treatment in outpatient support centers for victims of interpersonal trauma, under the close supervision of family courts.

SENAME (2019b) currently funds 158 specialized centers to support child and adolescent victims of abuse (including sexual abuse and sexual exploitation). In these centers, social workers, psychologists, lawyers, social work technicians, educators, and administrative personnel work to help victims overcome the consequences of traumatic events (Saavedra Inostroza, 2010). Professional teams must ensure the well-being of the children and adolescents they support and respond to the demands of the family courts that supervise this care. Each case is handled by at least two responsible full-time professionals (working 40 hr/week), who comprise a team known as *psychosocial team*. Each team looks after a maximum of 25 cases simultaneously, given the complexity of the tasks. Each case is cared for a variable period of time that ranges between 1 and 2 years. Interdisciplinary work within the team and work with other public and private institutions (e.g., schools, health system, drug use unit, or foster homes) is considered essential for the success of interventions.

To face the COVID-19 pandemic context, the teams modified their work format in a substantial manner, which generated additional stressors to a job that was already demanding before the pandemic. In Chile, the crisis caused by COVID-19 began to take shape on March 3, 2020, with the detection of the first case. Since then until the end of July 2020, date in which this paper was written, more than 350,000 cases and 9,000 deaths had been identified. As in the rest of the world, this forced the government to take measures to try to curb infections, among which social isolation, lockdown, closure of educational establishments, and paralysis of some economic activities stand out. Concerning the workplace, telecommuting emerged as a viable alternative to continue with the country's economic activities.

Regarding the specific work of centers for victims of child abuse in Chile, on March 18, 2020, when the Chilean government decreed a state of emergency, SENAME (Departamento de Protección de Derechos, 2020) issued instructions to the suspension of the face-to-face interventions, privileging remote attention (i.e., telecommuting). In this context, remote interventions (by telephone or internet) were a viable alternative to continue supporting victims of child abuse in the context of a pandemic. Furthermore, a recent study showed 85% of the families supported by these centers in Chile said they were available to be contacted via cell phone during the pandemic, 77% indicated they had access to the internet by their cell phone, and 40% via home computer (ONG Paicabí, 2020). According to that, from March 2020 all the specialized centers started

doing telecommuting. In this new scenario, the professionals began working from home.

However, in addition to the personal stressors of the pandemic (e.g., risk of contagion; illness of a relative or significant other; or demands for multitasking within the home, such as caring for one's children while telecommuting), the multiple changes in working conditions generated new stressors for the professional teams, such as the challenge to get familiarized with the different electronic and digital remote communication alternatives and the adaptation of the intervention objectives to the possibilities and limitations of this modality (Guerra, 2020). Besides, legal protection and institutional networks also began to operate remotely, making the intersectoral work more difficult.

Likewise, the context of lockdown, school closings, family economic crisis, and telecommuting by the children's parents generated new tensions within the families, which became an additional pressure for professionals who must contain these situations (Brooks et al., 2020; Pinto-Cortés et al., 2020). In this sense, although children and adolescents are not at high risk of COVID-19 infection, it has been found that they do suffer the psychosocial effects of the pandemic, such as increased interpersonal violence in homes, displacement, interruption of educational processes (with risk of exclusion), and restriction of spaces for fun and play (Moore et al., 2020), all of which generate additional challenges for the professional teams.

THE PRESENT RESEARCH

It was considered that the context of COVID-19 implies a strong additional labor stressor for the professional teams who support victims of child abuse. To the stressors of the pandemic (e.g., infection risk, quarantine, lockdown, and change in family dynamics), were added the change in working conditions (e.g., telecommuting, coordination difficulties with the team itself and with external support networks, etc.) and the potential increase in the complexity of the cases given that there were more stressors in the families, greater risk of abuse, and fewer tools to investigate and intervene.

International research during the pandemic has shown that these stressors affect the mental health of the teams, leading to the development of posttraumatic stress disorder and depression (Chew et al., 2020; Greenberg et al., 2020). However, so far, the Chilean government has focused almost exclusively on promoting the physical health

of people in the context of COVID-19, neglecting aspects related to mental health of both the general population and the teams that deliver services to the general population.

For this reason, the objective of this study was to evaluate the symptoms of depression and anxiety of professionals in professional care teams for children who have suffered abuse. In addition, the study sought to know the effect of some risk factors (i.e., number of nearby infected people, telecommuting hours per day, and housework hours per day) and protective factors (i.e., social support, self-efficacy, and self-care behaviors) on those symptoms. It was decided to include three possible protective factors—social, cognitive, and behavioral in nature—due to their potential usefulness in combating job burnout and mental health problems in aid professionals.

Social support in the prevention of depressive and anxious symptoms in support teams for child victims of abuse is an influential factor (Arredondo et al., 2020; Arredondo Ossandón, 2007). Similarly, self-efficacy—understood as the individual's belief about their ability to cope with excessive demands caused by highly stressful events (Benight & Bandura, 2004)—has shown negative relationships with work stress and positive relationships with job satisfaction in professionals who work with people who have suffered traumatic experiences (Law & Guo, 2016). Finally, self-care has shown to be a significant factor that prevents depression, anxiety, burnout, and secondary traumatic stress symptoms in aid professionals (Gelister, 2020)—understanding self-care as the professional's behavioral efforts to maintain a balance between their work and personal life and to carry out activities that allow them to contain work stress (Guerra et al., 2008).

Three hypotheses were posed: (1) The three risk factors (i.e., nearby infected people, telecommuting hours per day, and housework hours per day) would be positively associated with symptom levels, such that higher levels of depression and anxiety symptoms would arise with higher numbers of nearby infected people and the increased number of working hours per day (telecommuting and housework); (2) the three protective factors (i.e., social support, self-efficacy, and self-care behaviors) would be negatively associated with symptom levels, such that lower levels of depression and anxiety symptoms would arise with higher levels of social support, self-efficacy, and self-care behaviors; and (3) the protective factors would have a preventive effect on the symptoms through a path where social support would be positively associated with self-efficacy and with the practice of self-care (Benight & Bandura, 2004; Lazarus & Folkman, 1984).

METHOD

Participants

Participants consisted of 175 professionals from a nongovernmental organization financed by SENAME. The nongovernmental organization, located at the central zone of Chile, managed 17 outpatient psychosocial support centers for children under 18 years old who had suffered violations of their rights. Most of the participants self-identified with the female gender (80.00%), less frequently with the male gender (17.10%); the remaining percentage referred that they were not identified with any binary gender category (2.90%). Their ages ranged from 23 to 60 years ($M = 36.23$, $SD = 7.11$). Among participants, the distribution of jobs was as follows: social workers (37.70%), psychologists (28.00%), managers (9.10%), administrative staff (8.00%), technical advisors (6.90%), educators or tutors (4.00%), and technicians in the social area (2.30%); the remaining percentage grouped lawyers, occupational therapists, and planning managers.

Participants were complying with the sanitary regulations of the government of Chile to stop the spread of COVID-19, which were lockdown (i.e., avoiding leaving home), telecommuting (i.e., working from their homes), and doing their administrative tasks and interventions with children or adolescents via online or telephone for 10 to 11 weeks. Telecommuting began on March 18, 2020, and the administration of the instruments took place between May 26 and June 5, 2020.

Instruments

Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), Spanish version (Cabrera et al., 2015). It is a self-administered questionnaire of 14 items divided into two subscales of seven items each, Depression and Anxiety. The scale is in Likert format, ranging from 0 = *nada* [not at all] to 3 = *mucho* [much so]. The total score for Depression and Anxiety is obtained from the sum of their respective items, ranging between 0 and 21; the higher the score, the greater the symptoms. Cabrera et al. (2015) proposed a cutoff point of 10 for Depression and 12 for Anxiety. The Spanish version has factorial validity and good reliability. In this study, the alpha was .73 for Depression and .88 for Anxiety.

Sociodemographic instruments and questions related to COVID-19. A sociodemographic and labor instrument

was developed where (1) gender, (2) age, (3) role in the workplace, (4) the number of people infected by COVID-19 in their nearby nucleus (i.e., family, friends, neighbors, or themselves), (5) telecommuting hours per day, and (6) hours of work in household chores (e.g., cleaning, cooking, supporting other family members, etc.) per day were asked.

Significant Other subscale extracted from the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988), validated to Chile (Arechabala Mantuliz & Miranda Castillo, 2002). This scale is a self-report instrument that assesses the perception of support from a significant person (four items). The response options range from 1 = *muy en desacuerdo* [strongly disagree] to 4 = *muy de acuerdo* [strongly agree]. The total score is obtained from the sum of answers, ranging between 4 and 16; higher scores indicate greater perceived support. The Chilean adaptation of the scale showed factor validity and adequate internal consistency (Arechabala Mantuliz & Miranda Castillo, 2002). The Cronbach's alpha obtained in the present study was .89.

Generalized Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), Spanish translated version (Cid et al., 2010). This scale is a self-report instrument with 10 items about how capable the respondent feels to cope with adversity. The response options range from 1 = *incorrecto* [incorrect] to 4 = *cierto* [true]. The total score is obtained from the sum of all answers, ranging between 10 and 40; higher scores indicate greater perceived self-efficacy. Cid et al. (2010) reported good internal consistency, as well as factorial and convergent validity (as relationships with self-esteem and well-being) of the scale in a Chilean sample. Cronbach's alpha obtained in the present study was .85.

Self-Care Behavior Scale for Clinical Psychologists and Aid Professionals (Guerra et al., 2008), reduced version. It is a self-report scale created in Chile that in its original version assesses the frequency in which clinical psychologists and professionals in the psychosocial area execute potentially effective self-care behaviors to prevent job burnout. The scale has factorial and convergent validity (as negative relationships with secondary traumatic stress and depression) and good reliability. In this investigation, only the six items that were appropriate to the lockdown condition in the context of COVID-19 were used. The six items adapted to the current situation were (1) “¿Mantiene contacto online con sus compañeros de trabajo?” [Do you keep online contact with your coworkers?], (2) “¿Mantiene contacto online con su familia extensa o con sus amigos?” [Do you keep online contact with your extended family

or friends?], (3) “¿Realiza ejercicios físicos en casa?” [Do you do physical exercises at home?], (4) “¿Participa en actividades de crecimiento espiritual (religión, meditación, etc.)?” [Do you participate in activities of spiritual growth (religion, meditation, etc.)?], (5) “¿Mantiene una sana alimentación?” [Do you follow a healthy diet?], and (6) “¿El espacio físico donde usted realiza teletrabajo es apropiado (cómodo, calmado y privado)?” [Is the physical space where you telecommute appropriate (comfortable, calm, and private)?]. Response options ranged from 0 = *nunca* [never] to 4 = *muy frecuentemente* [very frequently]. The sum of the six items allowed to obtain a total score between 0 and 24; the higher the score, there was a more frequent practice of self-care. The Cronbach's alpha was .62.

Procedure

The implementation of the study was done within a Chilean nongovernmental organization that managed 17 specialized centers in support of victims of child abuse in Chile, during the state of constitutional emergency and catastrophe given by COVID-19 (Decreto número 104, 2020). The project was previously evaluated by the research ethics committee of the Centro de Estudios en Infancia, Adolescencia y Familia of the ONG Paicabí, Chile.

For the study, administrative, technical, and professional staff of the child and adolescent care centers of the nongovernmental organization ONG Paicabí received an invitation to participate by email ($N = 390$). To avoid pressures of any kind, it was explicitly explained the voluntary and anonymous nature of the invitation and access. A link to the Google Forms platform provided information about the scope of the study; the professionals gave their informed consent and answered the instruments. The response rate reached 44.87% ($N = 175$). Therefore, professionals interested in participating did so directly and anonymously on the online platform. Furthermore, the data from the 175 participants who answered the instruments were transferred into a database for further analysis. All the participants answered all the questions; thus, there were no missing data.

Data Analysis

Using the IBM SPSS Statistics (Version 25) software, descriptive statistics (i.e., mean, standard deviation, and range) were calculated for each variable of interest. The Shapiro-

Wilk test was also used to evaluate the scores distribution in the study variables. After that, the proposed model of relationships was tested using a path analysis. Even though the cross-sectional design was not the best option to analyze the causality of relationships, it was decided to do it due to the urgency of knowing risk and protective factors associated with the well-being of professionals in times of pandemic. This was a limitation of the study that must be considered; however, it allowed to have a better understanding of how some risk and protective factors were associated with symptoms in the context of the COVID-19 crisis. This was relevant for the prevention of depression and anxiety during the crisis, which was lasting longer than expected.

Considering the small sample size and the non-normal distribution of the variables, the maximum likelihood estimation method with bootstrapping of 10,000 iterations was used, which allowed to have confidence intervals for each of the parameters estimated. To do it, the Mplus (Version 7; Muthén & Muthén, 2012) statistical program was used. The model fit was evaluated based on $p_{\chi^2} > .05$, RMSEA $\leq .08$, and CFI $\geq .90$ (Schumacker & Lomax, 2004). According to Dominguez-Lara (2018), effect sizes were interpreted as follows: $\beta < 0.20$, weak; β between 0.20 and 0.50, moderate; and $\beta > 0.50$, strong.

RESULTS

Firstly, the results showed that professionals reported moderate levels of depression and anxiety (8.13 and 10.56,

respectively, of a possible maximum of 21); although, in both cases the scores were close to the instrument cutoff points. Additionally, there were no significant differences in the depression, $F(5, 169) = 0.86$, $p = .51$, $\eta^2 = .02$, or anxiety scores, $F(5, 169) = 0.95$, $p = .45$, $\eta^2 = .03$, between the different professions (i.e., social workers, psychologists, managers, administrative staff, technical advisors, and others). For this reason, all analyses were carried out with the total sample of participants and not differentiated by profession or role. Secondly, regarding the risk factors, the results showed that the participants telecommuted on average 8.43 hr/day, which is equivalent to a full working day under Chilean law. Moreover, an average of 4.31 hr/day of housework (e.g., cleaning, feeding, caring for the elderly or children, etc.) was added. Thirdly, regarding exposure to infection, the participants had a low level of infection in their immediate social environment: The average was less than 1 person infected per participant, and only 15.40% reported that a relative or close person had been infected with COVID-19 at the time of this study. Finally, regarding the potential protective factors to prevent symptoms, the participants reported moderate to high social support (13.43 points out of a possible maximum of 16), moderate to high self-efficacy (31.88 points out of a possible maximum of 40), and a moderate practice of self-care behaviors (14.53 points out of a possible maximum of 24). Table 1 shows the detail of the descriptive statistics. As can be seen, the only variable that fit the normal distribution was depression.

Regarding the hypothesized relationship model, Table 2 shows the regression coefficients and the confidence in-

Table 1. *Descriptive Statistics for Study Variables (N = 175)*

Variable	M	SD	Minimum	Maximum	Skewness	Kurtosis	W
Depression symptoms	8.13	3.50	0	19	0.16	-0.22	.99
Anxiety symptoms	10.56	4.82	0	21	0.08	-0.87	.97**
Nearby infected people	0.32	0.97	0	7	4.31	21.93	.38**
Telecommuting hours per day	8.43	1.98	3	14	-0.10	-0.01	.96**
Housework hours per day	4.31	2.29	1	14	1.43	2.57	.87**
Social support	13.43	2.73	4	16	-0.81	-0.37	.85**
Self-efficacy	31.88	4.03	22	40	-0.02	-0.78	.97**
Self-care behaviors	14.53	3.76	4	24	0.10	-0.17	.98*

Note. W = Shapiro–Wilk test statistic.

* $p < .05$. ** $p < .01$.

tervals for each of the parameters entered in the multiple regression equations. Although most of the significant relationships had a small effect size, the model had a good fit, $\chi^2(6) = 2.18$, $p = .90$, $RMSEA = .04$, $CFI = .99$, and explained 41.00% of the variance in depression, and 23.00% of the variance in anxiety.

Contrary to hypothesized, telecommuting hours per day and housework hours per day were not associated with depression or anxiety symptoms. The only risk factor that was positively associated with depression symptoms was the number of people infected in the nearby social environment; the greater the number of infected people, the greater the depression symptoms.

Furthermore, social support, self-efficacy, and self-care behaviors were negatively associated with depression. When these three factors appeared with greater intensity or frequency, the depression symptoms were lower. Additionally, it was noted that part of the effect of social support over depression was mediated by self-efficacy, indirect effect $\beta = -0.06$, $p < .05$, 95% CI [-0.14, -0.01], and another portion was mediated by self-care behaviors, indirect effect $\beta = -0.16$, $p < .01$, 95% CI [-0.30, -0.11]. In other words, the greater the social support, the self-efficacy, and the practice of self-care, the lower the depression symptoms.

Table 2. Regression Coefficients Tested in Path Analysis (N =175)

Effect	b	β	95% CI	
			LL	UL
Depression symptoms				
Nearby infected people	0.41*	0.11	0.04	0.78
Telecommuting hours per day	0.08	0.04	-0.12	0.27
Housework hours per day	0.04	0.03	-0.13	0.21
Social support	-0.13*	-0.15	-0.25	-0.02
Self-efficacy	-0.28**	-0.22	-0.46	-0.11
Self-care behaviors	-0.41**	-0.44	-0.54	-0.28
R^2	.41			
Anxiety symptoms				
Nearby infected people	0.18	0.04	-0.69	1.05
Telecommuting hours per day	0.24	0.10	-0.11	0.58
Housework hours per day	0.26	0.12	-0.03	0.55
Social support	-0.04	-0.03	-0.21	0.14
Self-efficacy	-0.24	-0.14	-0.52	0.04
Self-care behaviors	-0.47**	-0.37	-0.67	-0.28
R^2	.23			
Self-efficacy				
Social support	0.54**	0.36	0.33	0.75
R^2	.13			
Self-care behaviors				
Social support	0.49**	0.36	0.32	0.67
Self-efficacy	0.12	0.13	-0.02	0.27
R^2	.17			

Note. CI = confidence interval; LL = lower limit; UL = upper limit.

* $p < .05$. ** $p < .01$.

Regarding anxiety, only self-care behaviors had a direct effect on this type of symptoms: The more self-care behaviors, the lower the anxiety. However, once again an indirect effect of social support was appreciated, in this case, totally mediated by self-care behaviors: The greater the social support, the greater self-care behaviors and, in this way, less anxiety, indirect effect $\beta = -0.13$, $p < .01$, 95% CI [-0.37, -0.10]. Figure 1 shows in a didactical way the statistically significant regression coefficients.

DISCUSSION

The main objective of this study was to evaluate the symptoms of depression and anxiety in the members of care teams for victims of child maltreatment in Chile who have faced additional stressors—both in the personal and work environment—due to the COVID-19 crisis. The central hypothesis was that these personal (i.e., number of nearby infected people) and work stressors (i.e., telecommuting hours per day and housework hours per day) would be related to high levels of symptoms.

However, only the number of infected people in the professional's nearby network was positively associated with levels of depression. Therefore, professionals who had the highest number of people infected by COVID-19 in their immediate environment were those who presented the greatest depression symptoms. The results were according with the hypotheses because professionals, like the rest of the population, tended to become depressed due to the hopelessness caused by the situation of COVID-19, the an-

guish and fear of being infected themselves or their families, and the fear of losing a loved one (Chew et al., 2020; Greenberg et al., 2020).

Contrary to the hypothesis of this study, the work stressors associated with the pandemic (i.e., telecommuting hours per day and housework hours per day) were not associated with either of the two types of symptoms studied. The results were not according to the hypotheses considering a previous qualitative study with workers with similar characteristics (Guerra, 2020). That study reported that the elements most associated with work difficulties in the context of COVID-19 were the difficulty of establishing limits between telecommuting and personal life, as well as a tendency to a constant multitasking between housework (e.g., support in family tasks, support for children or older adults in the family, etc.) and professional work in the intervention of child victims of abuse.

However, in that previous study, the participants were only consulted for the difficulties associated with working in the context of the pandemic, without considering relevant protective factors that could broaden the coping framework of the participants. The classical theory of stress and coping (Lazarus & Folkman, 1984) states that much of the symptoms associated with stressful events do not depend on the event itself, but rather on cognitive factors (i.e., appraisal of the stressful situation and the resources of self-efficacy to face them) and coping strategies that the individual use to deal with adversity. In the present study, these variables were included, which may explain the absence of a relationship between COVID-19-related job stressors and symptoms. Furthermore, self-efficacy presented a negative relationship with

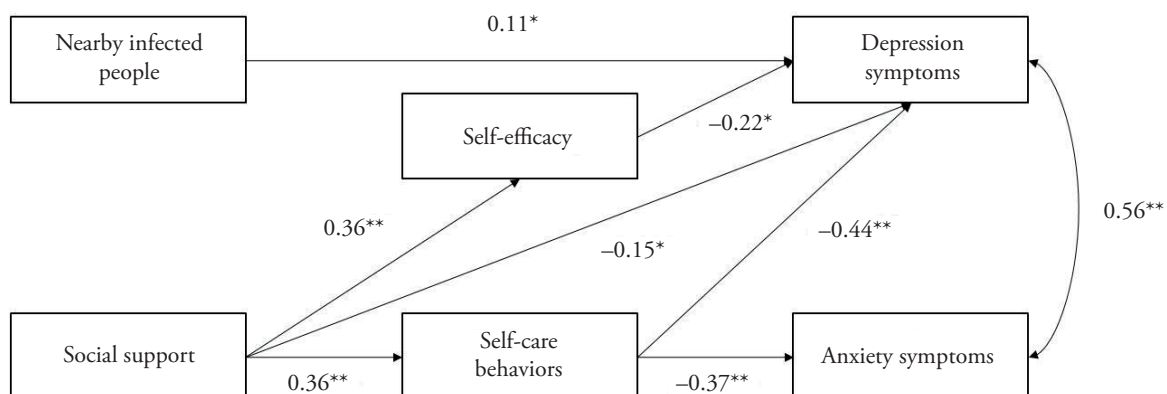


Figure 1. Path Diagram ($N = 175$). This figure does not include the nonsignificant effects of telecommuting hours per day and housework hours per day.

* $p < .05$. ** $p < .01$.

depression, and self-care behaviors were negatively related to the two types of symptoms, which is consistent with other previous studies (Gelister, 2020; Law & Guo, 2016).

Additionally, it was evident that social support was an important factor to prevent the symptoms of professionals in the context of COVID-19, either through a direct effect (negative relationship with depression) or through an effect mediated by self-efficacy and self-care behaviors: The greater the social support, the self-efficacy, and the self-care behaviors, the lower the symptoms. This is according with the evidence prior to COVID-19 (Arredondo et al., 2020; Arredondo Ossandón, 2007) and consistent with the classical authors (Benight & Bandura, 2004; Lazarus & Folkman, 1984).

The results of this study showed no relationship between work stressors associated with COVID-19 and symptoms of depression and anxiety. It could be that the protective factors included in this study explained that the stress associated with COVID-19 did not lead to more severe pathologies, such as depression and anxiety, and allowed professionals to experience stress within adaptive levels, which allowed them to cope with the task in a good way (Suri & Vaidya, 2015). Despite this, the results of this study should not lead to underestimating the effect of the new work stressors associated to COVID-19 crisis because they may have an effect on symptoms not included in the present study (e.g., neurobiological stress, irritability, self-medication, or consumption of substances). Future studies should consider this possibility and assess both adaptive stress responses and symptoms not included in this research.

Another element to consider regarding the lack of relationship between work stressors and symptoms was the time that professionals had been exposed to both the new work demands and the double task that involves working from home. In this study, professionals had only been exposed to these stressors for 10 to 11 weeks, which could be a very short time to develop the symptoms studied. Various authors have described that aid professionals, such as those who participated in this study, have a high motivation and dedication to service, so they often use all their resilience resources to carry out work for the benefit of their users. Only after these resilience resources are exhausted, professionals would begin to show symptoms of job burnout, among which depression and anxiety could be found (Figley, 1995; Moreno-Jiménez et al., 2004). Again, this study has the limitation of having included only a cross-sectional measurement. It would be relevant for future studies to assess the mental health of professionals exposed to the additional stressors associated with the pandemic for a longer time. In addition, a longitudinal

study would provide more conclusive evidence on the causality of the relationships tested in this study. Even though the cross-sectional design does not allow to ensure the causality of the relationships, it does allow to get an idea of how these variables behave in times of pandemic, which may be relevant to the welfare of patients and work teams and the prevention of mental health problems in them.

Another limitation of the study refers to having used a sample integrated by professionals from a single nongovernmental organization. It is known that different nongovernmental organizations have different dynamics, resources, or even work environments, so the results may not be representative of what happens in other work contexts.

In any case, this study highlights important factors associated with depression and anxiety in professionals in the context of COVID-19. Despite the novelty of the situation, this study offers evidence that social (i.e., social support), cognitive (i.e., self-efficacy), and behavioral (i.e., self-care behaviors) factors are important elements that may prevent mental health problems in professionals in the context of COVID-19. These factors had already been shown to be useful in self-care programs before the health crisis (Guerra Vio et al., 2009), but they were unprecedented in the context of telecommuting and may be useful to prevent mental health problems in the teams, especially if the COVID-19 crisis continues in time.

Prevention of mental health problems in professionals who support victims of child abuse brought benefits for the professionals themselves and for the children and adolescents they care for, also exposed to COVID-19 stressors in addition to their trauma history. Different authors argued that burned out or overstressed professionals display a poorer job and tend to present depersonalized behaviors towards their clients (Arón & Llanos, 2001; Vargas Pizarro, 2010). For this reason, it is crucial to evaluate the incidence of protective and risk factors of professionals' symptoms and to generate plans to support their mental health.

The knowledge emerged from this study, although preliminary given the small sample size, can serve to generate useful strategies in the current context of COVID-19. Furthermore, the study could contribute to design strategies for the mental health care of professionals in other situations of general crisis, such as, in the case of Chile, natural disasters or political crises that often put the professionals in a stressing situation similar to that experienced in the current health crisis. Among these strategies, it is relevant to consider programs oriented to care for the mental health in professional teams. These programs could promote self-care practices aimed at balancing the tasks associated with

telecommuting and housework. Finally, it is essential to promote collaborative work to improve the sources of social support in the context of pandemic.

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