FAMILY PROCESS

The Witness to Witness Program: Helping the Helpers in the Context of the COVID-19 Pandemic

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The Witness to Witness Program (W2W), based on Weingarten's witnessing model (2000, 2003, 2004), began in July 2018 and originally was established to support healthcare workers and attorneys (our partners) who were experiencing empathic distress working with people involved in various stages of the detention process. The W2W program evolved to offer four primary components: clinician listening sessions geared to deep understanding of the person's story of their work and its challenges; an inventory of the person's current internal and external resources both in the present and in the past; help with removal of barriers to those resources; and development of a personal toolkit to handle stress. Additional services available to partners and their organizations included psycho-educational webinars, facilitated peer support groups, and organizational consultations to foster trauma-sensitive and resilience-hardy work environments. In March, after lockdowns due to the coronavirus pandemic, W2W pivoted to focus on handouts and webinars addressing how to cope with distress and moral injury, maintaining resilience, coping with grief, and dealing with multiple losses caused by the pandemic. Disaster sparked collaboration and innovation. A train the trainer model was developed to reach more community health workers providing services to the Latinx community dealing with losses similar to those experienced by the clients they serve. W2W continues to create virtual communities of support. In doing so we practice doing reasonable hope together (Weingarten, Family Process*, 2010, 49, 5).*

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On Sunday, May 24, 2020 *The New York Times* printed its first front page in the modern era with no graphics. Instead, there was one stark headline: "U.S. Deaths near 100,000, An Incalculable loss." Three days later, the actual boundary of 100,000 deaths was crossed, a figure so daunting that in newspapers all over the country, journalists were

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writing about the impact of the number itself in such a short period of time, barely four months. Thomas Curwen, writing in the *LATimes*, wrote: “The numbers consume us. Captured on dashboards, bar charts, straight lines and curves, they record and document the virus’ reach and force us to ask whether we value one life more than thousands of lives. Can we grieve for strangers as we grieve for those we know?” (Curwen, 2020).

This is the backdrop for understanding the Witness to Witness Program’s evolution 21 months after its inception in July 2018. The program began as a response to the urgent need for support experienced by those working at the border supporting clients in all stages of the immigration process. Within months, the program expanded in a variety of ways: numbers of volunteers, types of services offered, occupations of the partners we served, and their geographic locations. Then in March 2020, with the onset of shelter-in-place orders in most parts of the country, W2W morphed again. Many of our partners were furloughed or lost their jobs. Others were working from home with three generations or more living in one household. Most feared for their safety or the safety of their loved ones. To understand what we do now, it is necessary to understand what we did before.

HISTORY OF THE WITNESS TO WITNESS PROGRAM

The Witness to Witness Program (W2W) developed in response to the need articulated by Deliana Garcia, MA of Migrant Clinicians Network (MCN) during a workshop organized by Ruben Parra-Cardona, Ph.D., in connection with the American Family Therapy Academy (AFTA), in Austin, Texas, in June 2018. The workshop focused on work at the Southern border by community health workers and attorneys with asylum seekers, detainees, and undocumented individuals (Weiling et al., 2020).

The origin of W2W, however, goes back decades. W2W is based on the witnessing model (Weingarten, 2000, 2003, 2004), which formed the core concept of The Witnessing Project, which the first author ran from 1999 to 2017. The Witnessing Project worked with individual, families, and communities to transform the passive witnessing of violence and violation to effective action in a variety of contexts—from medical illness to postwar societies to violence in the home. One component offered was one-to-one virtual support for healthcare and community workers in different parts of the world, such as Kosovo and South Africa. Hearing the speakers’ stories at AFTA’s workshop, Weingarten thought the witnessing model would apply: The helpers needed help. Healthcare workers, community advocates, and attorneys were experiencing distress hearing the stories of hardship and trauma of their clients, patients, and community members. In addition, they were distressed by new policy regulations that had significant negative effects on the work they had been doing. They were demoralized and angry about these changes. Later, W2W added journalists to its roster of occupational groups served. W2W “partners” were primarily from these occupational groups.

From July 2018 to June 2019, the W2W grew from a pilot project of the American Family Therapy Academy (AFTA) to a full-fledged program supported by AFTA with 38 volunteers, six of whom were bilingual.[1] Celia Falicov, Ph.D., joined W2W as a volunteer in 2019 and became the Coordinator of Spanish Language Programming in 2020 (Falicov, 2014). All W2W volunteers are Members of the American Family therapy Academy (AFTA) and are trained systemic therapists who have experience doing clinical work with clients with histories of trauma. Volunteers read the same training materials. There is a

[1]The W2W was shepherded in its growth by then AFTA President, Victoria Dickerson, Ph.D. and Sarah Berland, LCSW, Chair of the Family Policy and Human Rights Committee. Claudine Lucena, MA, LMFT, an AFTA member, and Kate Wotanowicz, an AFTA program manager, provided administrative support. Sharon Starobin, MS is the outside rater. Jennifer Slack, MS, MA, LMFT and Karen Skerrett, Ph.D were original peer support group facilitators.

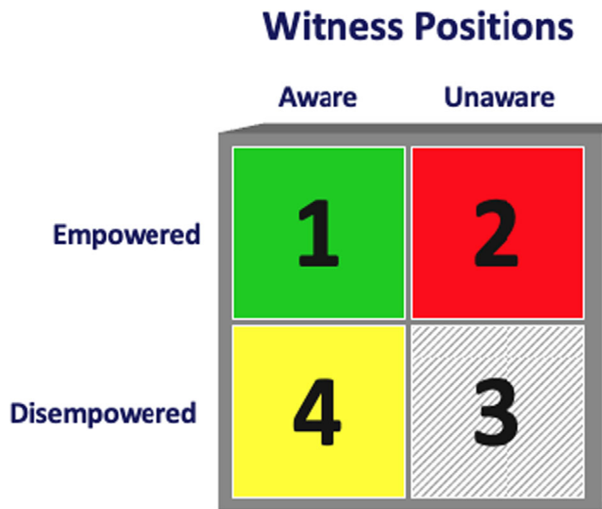

FIGURE 1. The four witness positions of Weingarten's witnessing model [Color figure can be viewed at wileyonlinelibrary.com]

clear protocol for how to make the initial contact, how to organize the sessions, and what concepts to emphasize. We call this a "uniquely applied standardized approach." Before being assigned their first partner, volunteers attend a conference call to meet each other and discuss the material and then have a final discussion with Weingarten. Volunteers send a note about each conversation with their partners. The notes are reviewed by Weingarten, de-identified, and independently rated by an outside rater. The average rating on a 1- to 5-point scale of helpfulness to the partner on the hundreds of notes W2W has received is 4.8.

W2W PROGRAM TRAINING MATERIALS, STRUCTURE OF THE CONVERSATION, AND PROGRAM DEVELOPMENTS

A number of resources have been developed that provide the conceptual basis and the action applications of W2W. Chief among them is the witnessing model (Weingarten, 2000, 2003, 2004). The model asserts that there are four witnessing positions, not one (Figure 1). Our positions vary depending on the situations we witness.

Position 1 occurs when one is an aware and empowered witness to violence, violation, or distress. Taking action, and clarity about what actions to take, goes along with the experience of this witness position. A person is likely to feel competent and effective in Position 1. Position 2 may be the position that is most dangerous to others. People, who witness violence, violation, or distress but do not understand what they are witnessing and nonetheless respond as if they know what they are doing, will be ineffective at best and harmful at worst. The negative impact of witnessing from this position may be far-reaching, particularly if the person witnessing occupies a position of power or is perceived as having power. In Position 3, a person cannot register what is truly happening and therefore takes no action to make things better. A witness who is unaware of and thus ignores someone's urgent need has abandoned that person and the effects may be as harmful as actions taken from Position 2.

Position 4 may be the most common for helpers and others. In this position, a person is aware of what is going on but is either uncertain what to do or lacks the internal or external resources to act exactly as he or she knows is necessary to do. This position saps

energy, enthusiasm, and resolve. Once aware of our witness position, we have a chance to change positions. Sometimes, when we are overwhelmed, we mistakenly believe that relief can come by moving into unawareness, using any number of tuning out strategies, like alcohol, devices, or excessive sleep. However, the only true relief and benefit to the person comes from moving into the aware and empowered position, that is, moving up to position 1 from position 4 not over to position 3.

In addition to the witnessing model, W2W volunteers use conceptual materials related to stress reduction, resilience, moral injury, coping with trauma responses, and developing vicarious resilience (Hernández et al., 2007) to assist partners to recover, maintain, and develop resources to help them move into the aware and empowered witness position.

The W2W Program operates with a clear structure. There is a psycho-educational component that is made available to each partner via an archived webinar, and then, AFTA volunteers provide 3–4 phone sessions that are geared to deep listening of the person's story of their work and its challenges; an inventory of the person's current internal and external resources as defined by the partner both in the present and in the past; help with removal of barriers to those resources; and development of a personal toolkit to handle stress. We believe that this sequence helps people move from the aware and disempowered witness position (4) to the aware and empowered position (1). While the conversations may be therapeutic, we do not offer therapy.

By October 2019, W2W had developed two additional service components besides the webinars and the clinician listening sessions, both of which were responsive to the distress that partners were communicating to their W2W volunteers: Facilitated open enrollment peer support groups and organizational consultations to foster a trauma-sensitive and resilience-hardy work environment. The latter was particularly focused on supervisors who were often caught between the mental health needs of their staff and the productivity demands of the administrators to whom they report.

In December, W2W was approached by Migrant Clinicians Network (MCN) to consider them as a host organization and fiscal sponsor given the alignment of their shared vision and mission. W2W had offered three webinars to MCN that were viewed by nearly 1,000 of their constituents, primarily healthcare workers in community healthcare settings working with underserved communities. An agreement between MCN and W2W was signed in February 2020.

W2W PIVOTS AFTER THE CORONAVIRUS PANDEMIC HITS

By the end of February, the first author had generated a 98-item project plan for W2W. By mid-March, with many states having shelter-in-place orders with the exception of essential workers, that project plan was moot. The first author, who had been directing W2W solo, began attending MCN staff meetings in March, lockdown having coincided with her joining forces with MCN. This set the ground for what became a critical part of W2W's evolution: Collaboration with MCN staff to bring W2W's perspective and expertise to communities MCN serves in a culturally respectful and linguistically appropriate way.

We recognized that while no one is an expert on the coronavirus pandemic per se, there has been sufficient experience with disasters to anticipate approaches that might be beneficial to support healthcare workers during this time (Baron, Jensen, & de Jong, 2002; Bonanno, Galea, Bucciarelli & Vlahov, 2007). A decade ago, researchers noted that the majority of research on adverse mental health reactions in first responders following disasters had focused on pre-existing risk factors that predisposed them to poorer outcomes, whereas it was becoming clear that interpersonal, organizational, and systemic factors were as likely to play as large a role in mental health sequelae (Kleim & Westphal, 2011). The Inter-Agency Standing Committee (IASC) guidelines for mental health in emergency

settings explicitly make psychosocial support a key element in its recommendations. (IASC, 2007). Systemic family therapists have long been proponents of a contextual, familial, organizational, and community-based approach to bolstering resilience following disasters (Landau & Saul, 2004; Saul, 2014; Ungar, 2018; Walsh, 2007). As the pandemic was unfolding in the United States in March, it became clear that there would likely be a mismatch between the number of W2W volunteers who would be able to commit time to one-to-one conversations with partners and the number of people who might want that support. This was true due to altered responsibilities of W2W volunteers related to working at home and caring for dependent children and parents. This pragmatic reality was congruent with W2W's belief in the value of social support for helpers and in alignment with what W2W already offered, interactive webinars and peer support groups. With the support of the leadership team of MCN, these became the focus of W2W's work. The goal of the work was the same: to give people resources that would allow them to feel better equipped to meet their personal, familial, and job responsibilities; to feel aware and empowered; and to feel competent to face the demands and uncertainties of life in COVID-19 time.

What we could not have predicted during the early days of the pandemic was how swiftly the key issues related to living through the pandemic would change, sometimes week by week. Because MCN staff are in continuous contact with the communities they serve, and because staff circulate information to each other on a daily basis, it was possible for W2W to respond nimbly to changing conditions and concerns. This presentation of W2W's work follows a timeline in order to highlight the contexts and issues to which W2W responded month by month.

APPLICATION OF W2W TO THE CONTEXT OF COVID-19

March 2020: Coping with Lockdowns

When lockdown began, MCN staff meetings included time not only for discussion of staff projects but also how staff were coping with shelter-in-place orders. In response to what she learned in these meetings and through other networks, Weingarten created a handout in March and disseminated it through a number of LISTSERVs as well as to all current and former W2W partners. The handout is based on several core concepts that derive from systemic family therapy but is worded in the colloquial language idiom of the W2W program. The underlying premises of the handout are as follows: (1) We are embodied creatures; effectiveness requires a calm body; (2) whether you are alone or not, you can create a relational world by creating a buddy system and checking in with your buddy daily as well as by dedicating routines, like handwashing, to people you care about; and (3) lower your expectations of yourself and others. People do not change during crises. (All handouts mentioned in this article can be accessed at the W2W web pages: https://www.migrantclinician.org/witness-to-witness).

The first COVID-19-related peer support group was offered March 20, 2020, and was attended by both attorneys and healthcare workers. There was an initial presentation followed by a lively discussion. Most attendees had only been sheltering-in-place for a week or so, but already household dynamics were coming into focus. Several core concepts were presented, each emphasizing the role of interpersonal factors. For example, after discussing the interplay between stress sensations in the body and concurrent or subsequent psychological experiences, Weingarten presented the likely scenario that people's biopsychological organizations during the crisis might not be compatible. She gave a vivid example within her extended family of one child's coping pattern diverging from his other family members' ways of coping. The general point was that this can produce

misunderstandings, conflict, difficulty meeting each other's needs, and fewer resources to interact with the community. Another core concept that was introduced had to do with understanding one's zone of resilience and how to address times one is either stuck higher than or lower than one's optimal zone. In line with the interpersonal approach to individual needs, the suggestion was made when considering self-care to, "Ask yourself: 'What would I tell my best friend to do right now?' and do it yourself."

Early April 2020: Moral Injury

Preliminary research findings about the impact of COVID-19 began circulating in March. At a staff meeting, MCN's Chief Medical Officer, Laszlo Madaras, MD, MPH, SFHM, shared the dilemmas surrounding the creation of criteria for triaging COVID-19 patients. The first author felt an urgent need to develop practices that might moderate the suffering she believed healthcare workers might experience from shouldering decision-making around the allocation of resources to some COVID-19 patients and not others. Weingarten was struck that in a "Sounding Board" article in the *NEJM* (Emanuel et al., 2020), the authors identify six recommendations to assist physicians making triage decisions about scarce resources, like ventilators, but mention only once the psychological impact on those same physicians of making the decisions. The authors wrote in their conclusion: "Such guidelines can ensure that individual doctors are never tasked with deciding unaided which patients receive life-saving care and which do not. Instead, we believe guidelines should be provided at a higher level of authority, both to alleviate physician burden and to ensure equal treatment (p. 6)."

Weingarten's concern for triage teams centered around the idea of moral injury, a concept that developed in the context of understanding an aspect of returning veterans' experiences in war. However, in recent years, this concept began circulating in relation to healthcare workers, in particular redefining the high rate of what is understood to be, and termed, "burnout" as "moral injury" instead (Dean, Talbot and Dean, 2019). Burnout tends to focus on the individual's response to conditions, whereas "moral injury" directs attention to the conditions themselves. This is much more in alignment with W2W's perspective.

Moral distress was introduced in the nursing literature by Andrew Jameton (1984). He defined it as the psychological distress of being in a situation in which one is constrained from acting on what one knows to be right. The definition does not posit acting or being coerced to act in a manner that one believes to be wrong. By contrast, moral injury includes acting against one's moral values. There is also a clear distinction between two versions of the moral injury construct. In the original version defined by Shay (1994) in his seminal book, *Achilles in Vietnam*, there are three components: betrayal of what's right, by someone in authority, and in a high stakes situation (Shay, 2012). In the Litz et al. (2009) version, there is a violation of what's right but by the self; there is no betrayal by an authority. Of course, both versions exist on and off the battlefield and in other contexts as well, as we are vividly learning in the context of COVID-19.

Shay's version of moral injury is represented in the politicization of the CDC's recommendations regarding face masks, a form of personal protective equipment (PPE). On March 10, the CDC downgraded its February recommendations regarding PPE from N95 masks to surgical masks for healthcare workers treating patients confirmed or suspected of having COVID-19. This guidance, it was later revealed, was issued at the behest of several members of Congress and several large hospital systems and health departments across a number of states despite warnings by occupational health and aerosol experts that this would jeopardize healthcare workers' safety. Given the supply chain difficulties of sourcing appropriate PPE, those urging relaxation of the guidelines were concerned not

for the survival of their employees but with the potential for lawsuits from workers, their families and labor unions should hospitals and health centers be unable to supply adequate PPE (Gollan & Shogren, 2020). In fact, according to CDC incomplete data, by the end of May, there were an estimated 67,113 COVID-19 cases among healthcare workers and approximately 300 healthcare workers had died (CDC, 2020). Numerous articles and blogs have been written by healthcare workers decrying their treatment by administrations more concerned with the financial bottom line than their workers' health (Dunleavey, 2020; O'Halloran, 2020). On June 1, an article appearing in the *Lancet* confirmed what had been thought to be the case weeks earlier: N95 or equivalent respirator masks provide significantly more protection from infection than disposable paper surgical masks or 12–16 layer cotton masks (Chu et al., 2020). In early June, the World Health Organization also issued face mask guidance that many considered dangerous (Cherrie, Loh & Aitken, 2020). The political context of this decision is not known yet.

Healthcare workers who were on hospital triage teams were also at risk for moral injury from taking an action that violated their own sense of what was right, namely ensuring that each patient had access to every possible means of life-saving equipment. This represents the moral injury perspective described by Litz et al. Weingarten was concerned about the psychological and spiritual toll that this would take and so created two handouts, one for coping with moral injury and one for a team debrief to help with workplace stress and moral injury. In addition to content from previous handouts, an explicit distinction is made between circumstances that may produce harm and the intention to harm. There is the suggestion that a debrief at the end of each shift is helpful and might include shared physiologic attunement through synchronous breathing; comments of appreciation and acknowledgment of team members; and a commitment to practice self-care as an expression of team solidarity. Weingarten has written about practices of acknowledgment where she describes making explicit an observation of another person that might not be noticed by that person. When the acknowledgment occurs, the person acknowledged feels appreciated. This circulates feelings of well-being and initiates virtuous cycles of caring (Weingarten & Worthen, 2009).

Mid- and Late April: Collaboration with Spanish-speaking Clinicians

In April, W2W presented three webinar versions of "Managing Stress in Uncertain Times." MCN Chief Medical Officer, Laszlo Madaras, and Weingarten presented a version in English for clinicians that emphasized the collective actions healthcare workers can take to sustain each other during the pandemic. There was also a section on sources of anxiety for clinicians (Shanafelt, Ripp, & Trockel, 2020).

The other two webinars were presented in Spanish after collaboration between Weingarten and four Spanish-speaking clinicians.[2] This collaboration proved to be seminal in W2W developing ways of being responsive to emerging issues for community health workers and other essential workers. The material presented was culturally respectful and linguistically appropriate for the Mexican and Puerto Rican audience. The presenters encouraged participation on the Chat, which happened, serving an important function in developing the content for subsequent webinars as well as providing peer support during the webinar.

The first Spanish-language W2W webinar was presented to the *Ventanillas de Salud*—Health Windows—(VDS). "The VDS is located throughout the Mexican Consular network and aim to increase access to health care and health literacy, provide health screenings, and promote healthy lifestyle choices among low-income and immigrant Mexican

[2]The clinicians are Sol D'Urso, MA, LMFT, a W2W volunteer, Alma R. Galvan, MCH, from MCN, Vanessa Ibarmea, MA, and Lorena Torres, PsyD. Celia Falicov, Ph.D. was a consultant.

populations in the U.S." (Rangel Gomez et al., 2017, P. 151). People of Mexican descent are the largest immigrant group in the United States and also the greatest number of uninsured. Many factors contribute to this disparity, among them racism, stigma, low English proficiency, and anti-immigration policies. To better serve this community, the Mexican government has developed partnerships with governmental and nongovernmental organizations of which MCN is one.

Vanessa Ibarmea MA and Lorena Torres PsyD presented the second Spanish version titled, "Stress Management During Uncertain Times: 'Reasonable hope' for health providers and essential workers in Puerto Rico during public health emergencies." The content of both webinars included material on the impact of incompatible responses to the pandemic on family members and housemates and an introduction to the witnessing model with attention to the risks of moving into the unaware and disempowered position by, for example, numbing out, abusing drugs or alcohol, or obsessive use of digital devices. Further topics included how to distinguish demoralization from depression (Griffith & Gaby, 2005) and identifying one's resilience pattern and how to utilize resources to stay in one's resilient zone more of the time. There was a section on ways to ward off PTSD, based on Bessel van der Kolk's work in relation to COVID-19 (van der Kolk, 2020). The webinar concluded with material on how to maintain reasonable hope (Weingarten, 2010).

There were only a few slides on grief. It says something about the speed with which the situation was morphing that a week after this webinar was constructed, it seemed essential to focus on grief with both a handout and a dedicated webinar in both Spanish and English.

May: Loss, Grief, and the Demography of Race and Class

Witness to Witness Program uses an intersectional lens to understand multiple overlapping forms of systemic oppression (Crenshaw, 1989). Death by COVID-19 presents a vivid example of the need to use an intersectional lens to understand the differential and devastating impact of the illness on people of color. From mid-April on, deaths from COVID-19 were escalating at alarming rates. By the beginning of June 2020, it is clear that the final story about the demography of infection and death is not fully known. Only about 75% of jurisdictions have reported data by race. However, some trends were beginning to emerge as early as April. At the time of this writing, it seems clear that mortality rates for people of color—African Americans, Latinx, Native Americans and Pacific Islanders—are indeed in excess of their populations in specific communities where records by race are being kept (Lin II, 2020).

When race is obscured, so too is racism. As Ibram X. Kendi (2020) writes, "I suspect that some Americans believe that racial data will worsen racism. But without racial data, we can't see whether there are disparities between the races in coronavirus testing, infection, and death rates. If we can't see racial disparities, then we can't see the racist policies behind any disparities and deaths. If we can't see racist policies, we can't eliminate racist policies, or replace them with antiracist policies that protect equity and life. Without racial data, we can't see racism, and racism becomes like asymptomatic carriers—spreading the virus, and no one knows it."

The phrases "systemic racism" and "legacies of structural violence" are terms that are useful to account for the disproportionate rates of death to the extent that these terms also point to the cumulative and chronic stressors that are part of the lived experience of people subjected to these forms of oppression. Chronic stressors are known to correlate with biomarkers of disease, early disease onset, and mortality (Epel et al., 2018). The factors that describe the harmful conditions within which people of color live, such as indoor and outdoor air pollution, cause excessive stress.

The VDS serves a largely undocumented Latinx, low-income population. They are overrepresented in frontline work as essential workers: grocery store clerks, nurses, cleaners, warehouse workers, and bus drivers, among others. At all times, they are undervalued, underprotected, and underpaid. This demographic—Latinx, poor, and frontline workers (64.4% are women) —was known by April to be disproportionately overexposed to COVID-19 infection and suffering excess mortality (Rho, Brown & Fremstad, 2020). Additionally, we had heard from the Chat from the first webinar that the VDS constituents were not just suffering losses and death, but suffering from the belief, or fact, that their loved ones had not been treated as well as white people had been.

In order to turn the grief handout into a webinar for the VDS, we gathered a group of five bilingual clinicians from Mexico, Argentina, and Puerto Rico who discussed each point and arrived at a consensus about the most culturally respectful ways to render the ideas in a mutually understood Spanish. An intersectional perspective on systemic oppression was foundational. We also incorporated insights from *Grief Therapy with Latinos: Integrating Culture for Clinicians* by Vazquez and Rosa (2011).

Some topics covered in the Grief webinar included: There is no right way to grieve; there are many ways to maintain a meaningful connection to the person who has died, including eating their favorite foods or listening to their favorite music; under conditions of COVID-19, it is likely that our expectations around dying, death, and mourning will not be met yet it is important to find culturally meaningful forms of respect that can be enacted; and immigration status may well have a negative impact on your ability to navigate illness and even death for your loved ones. The last slide pertaining to children and death was: "It's important to remember that even the most heartbroken child can grow up to live a good life, full of love and meaningful connections."

By the time of the grief webinar in English on May 20, our understanding of issues related to living and dying with COVID-19 had developed further and the webinar reflected these emergent ideas. We now understood better the timeline of the disaster: By late May, the phase had shifted from the "heroic" to that of "disillusionment" (DeWolfe, 2000). All of the insights gained in the Spanish-language webinar informed the English-language webinar. The frame offered was that "death reminds us of the incredible privilege that life is." Individual and family responses to the multiple crises of this time—crises stemming from losses of food and housing security; jobs; connections with neighbors; deaths of family members and friends; health problems; and diminished faith in leadership to keep people safe—were placed in a frame of phases of the pandemic.

June: Peer Support Groups in Spanish for VDS

In the beginning of April, we began a pilot project with staff of the VDS to do more intensive work, the better to assist them with the difficult tasks they face with families who are suffering food and housing insecurity, job losses, illness, deaths, and disruptions of mourning traditions and rituals. The objective of the project is that the participants obtain tools to manage their own stress and grief and can utilize these tools while working with the families they serve. Galvan proposed bringing on bilingual clinicians who have experience with VDS to learn the W2W model and we used a train the trainer model to do so.

The process of designing and implementing this pilot project demonstrates elements that have made W2W's response to the COVID-19 pandemic effective. VDS leadership was present at the two webinars and observed the distress their staff members were experiencing by following the Chat. They requested MCN/W2W to provide more intensive psychosocial support; the project had administrative "buy in." Multiple tiers of people mutually influence each other during the project: the VDS leadership team, the project

planning team, the curriculum development team, the Spanish-speaking facilitators, the VDS staff participants, and their clientele and the project evaluator.[3] Our model allows for a de-monopolizing of knowledge (Arora, Thornton, Komaromy, Kalishman, Katzman, & Duhigg, 2014).

As is always the case with work within the W2W model, the volunteers' and presenters' lives exist in a shared socio-historical-political moment with our partners and webinar participants. While W2W has always been clear that we do not do therapy in any of our program components, it is still possible that elements of our partners' stories may produce empathic distress (Weingarten, 2003). Many situations over time have occurred where clinicians have experienced a shared traumatic situation and written about that experience, for instance, the London Blitz, September 11 attacks on the United States, and terrorist attacks in Israel (Tosone, Nuttman-Shwartz & Stephens, 2012). Weingarten has written about navigating "intersecting losses" when she, as a therapist, has experienced traumatic losses similar to that of her clients (Weingarten, 2010a). Neither of these frameworks is exactly relevant to the positioning we assume in W2W since the management of boundaries need not be as strict. Rather, we work from a position of shared humanity, assume a commonality of experience, and share personal anecdotes in order to advance our educational objectives. With the onset of the COVID-19 pandemic and the subsequent civil protest related to the murder of Black people by police, this positioning has been essential to our creating connection and maintaining our own resilience.

Bringing the rage and grief into the training for facilitators and encouraging them to integrate it into the sessions themselves has made the sessions intense, meaningful, and bonding experiences for all involved. Participants in all four groups stated that they had never felt so comfortable in a group before and that they felt able to share challenges with ease.

Three sessions with the VDS are planned, each one followed by a debrief with the W2W trainer, D'Urso, and with Galvan and Weingarten. Each session has pre- and postevaluation measurement in the hopes that we can demonstrate that the model produces perceived benefits for the VDS participants in their sense of well-being and improvement in their skills. If the pilot project is successful, we will offer it to more people in more settings.

June: How to Support Someone Who is Suffering in the Context of the Pandemic

The theme of this webinar was "How to Support a Friend, Family Member or Colleague Who is Suffering in the Context of the Pandemic," and the likely forms of suffering were many. Again, the socio-historical political time in which we live was changing so rapidly that the slides prepared a week prior no longer seemed adequate to address the present moment. The witnessing model was centered as a way of creating a visual short-hand for the kinds of support that are helpful (see Figure 2). The webinar addressed how empathy can backfire, leading to withdrawal rather than compassion. We emphasized that empathy may fatigue but compassion does not. Grief and rage regarding the death of George Floyd and other people of color were addressed and placed within the context of COVID-19.

Distress due to unemployment was also discussed in this webinar. The Economic Policy Institute Report in June used an intersectional approach to present its data. Black women now have the highest unemployment rate among white men and white women, Black men and Black women. When Latinx women are added to the mix, they have the highest

[3]Project members include the four authors plus Celia Falicov, Ph.D., Vanessa Ibarmea, MA, Danna Carter, Ph.D., LMFT, Juan Jose Robles Gil LMHC MT-BC, Carmen R. Valdez, Ph.D., Patricia Navarro, MA, P.P.S., LMFT, and Jessica Calderón.

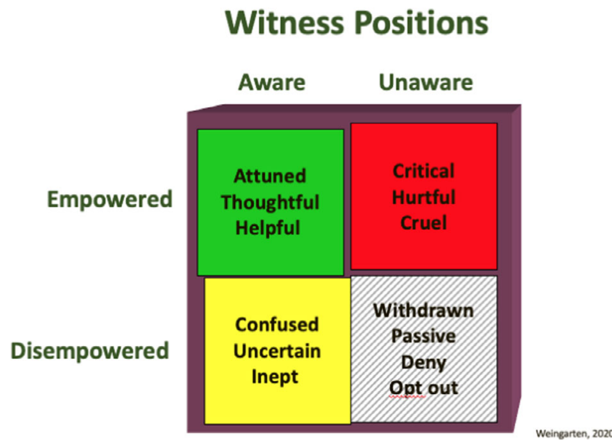

FIGURE 2. Application of the witnessing model positions to supporting another person [Color figure can be viewed at wileyonlinelibrary.com]

unemployment rate as of April 2020—about one in five Latina workers are unemployed. Latina are a large proportion of the population that MCN and W2W serve. Unemployment is a risk factor for suicide, called a "death from despair" (Case & Deaton, 2020a). Some researchers have suggested that there could be as many as 154,037 additional deaths attributed to drugs, alcohol, and unemployment in a slow recovery (Petterson, Westfall & Miller, 2020). However, Case, and Deaton, who originated the term "death from despair," state, "But a wave of deaths of despair is highly unlikely. Recessions are immensely costly because they disrupt people's lives, deprive them of work and income, and inhibit many of the activities that make life worth living. We need to find safe ways of getting back to work. But we should not scare ourselves with nightmares about tens of thousands of additional suicides or drug overdoses" (Case & Deaton, 2020b).

People of color have additional burdens, including being overrepresented in frontline work (as noted above), being more likely than white women to be single parents who have children at home, having underlying health conditions that predispose them to poor outcomes from COVID-19, more likely to be uninsured and to have few mental health resources available in Spanish (Gould & Wilson, 2020).

A number of supportive strategies were provided, including the distinction between small and trivial gestures, the pragmatics of "reasonable hope," and how to think about and respond to suicide risk. Again the Chat was used throughout the webinar and the comments from it will inform new webinars and handouts.

DISCUSSION

While the COVID-19 pandemic is a unique, challenging, and multifaceted disaster, W2W in collaboration with MCN has been able to serve over 2,700 people with a high degree of success as measured by the evaluations we have received. Many factors account for our being able to do so. W2W and MCN had worked together in the Fall of 2019 and so when the pandemic hit and W2W formally joined with MCN, they were known entities. MCN has multiple national offices for its staff of 35 and has been working remotely for about a decade. They have sophisticated interfaces for collaborating on their work, and they included W2W into these work platforms and their staff meetings. MCN is skillful at brainstorming and collaboration, and W2W has been welcoming of ideas.

Our joint emphasis on nonhierarchical knowledge circulation led to innovative ways of using the Chat to create virtual communities of support. This was made explicit in our marketing materials. During the English-language webinar on grief, there were over 350 unique comments, some of which were internally cross-talking among webinar participants, not directed to the presenter. Due to skillful moderation of the Chat, it was possible to integrate feelings, comments, and questions directly into the flow of the webinar. The content of each successive webinar was influenced by what we learned in the Chat, ensuring relevance.

The work with the VDS brought together a diverse group of clinicians eager to both learn the W2W approach and also contribute to it. The process of collaboration has been fruitful; we are continuously coevolving ways of learning from each other. While Anglo perspectives have often dominated programming offered to Spanish speakers in the United States, the MCN/W2W process has been robustly bidirectional. This has made for positive engagement and energized participation at every level. Our future holds continued collaboration.

CONCLUSION

A great deal has already been written about the likely negative mental health outcomes that are occurring and will likely occur as a consequence of the COVID-19 pandemic. Extrapolating from prior disasters, Galea, Merchant, and Lurie (2020) cite anxiety, depression, PTSD, domestic violence, child abuse, substance use disorder, and other mental and behavioral disorders as probable outcomes of the physical distancing required by COVID-19. Other researchers have found negative mental health impacts now (Xing, Sun, Xu, Geng & Li, 2020).

The Witness to Witness Program, in alignment with MCN's long-standing commitment to health justice, is working to ameliorate the pain and suffering in the present moment. MCN and W2W share a clear vision and moral foundation for our work, allowing us to recognize and take advantage of emergent design elements that advance our goals of providing meaningful support to healthcare and community workers serving vulnerable populations. When the pandemic hit, MCN staff collaborated with W2W to design innovative ways of supporting healthcare and community workers within the constraints of the social distancing required. Working with bicultural Spanish-speaking clinicians, W2W was able to create culturally rich materials that were relevant to both Spanish- and English-speaking audiences.

Migrant Clinicians Network staff have provided many kinds of support, including maintaining a W2W Facebook page as part of circulating perspectives that are congruent with W2W aims. As of June 15, in the last 15 weeks, W2W has reached more than 2,700 people with its webinars, presentations, and peer support groups. W2W volunteers and supporters of W2W receive the bimonthly program Update that provides an annotated compendium of relevant news and academic articles relevant to the W2W work.

There are significant mental health and public health risks at the intersection of the COVID-19 pandemic and race, some of which have been explored in this paper. There is yet another on which we wish to end this paper. Shay (2012) wrote: "I say that three things protect the mind and spirit of persons sent into mortal danger: (1) positive qualities of community of the face-to-face unit that create 'cohesion'; (2) expert, ethical, and properly supported *leadership*; and (3) prolonged, cumulative, realistic *training* for what they actually have to do and face (P. 57)." The mortal danger to which Shay is referring is battle but the conditions pertain for many essential workers in the context of the COVID-19 pandemic. We want to underscore Shay's use of the phrase "positive qualities of community" because we are painfully aware that negative qualities of community that create cohesion

at the cost of silencing dissent are harmful. The solidarity of police, for example, in the murder of George Floyd is an example of cohesion turned toxic. Leadership and training are also difficult to get right when we move from abstraction to pragmatics. Openness to dissent is essential to keep people safe.

A positive example of this comes from thousands of public health professionals, infectious disease professionals, and community stakeholders in an Open Letter "advocating for an antiracist public health response to demonstrations against systemic injustice occurring during the COVID-19 pandemic" published June 3 (Simon, 2020). The letter recognizes that White Supremacy is a lethal public health issue that contributes to the vulnerability of Black people just as police brutality does. They support protest as an effective means of resisting injustices and then make recommendations to do so as safely as possible, for protesters and allies.

Each one of us has a social location from which we can contribute to a more equitable and safer world. W2W's location calls us to create virtual communities of support that promote antiracist, ethical care. As dire and negative as the COVID-19 pandemic is as it plays out across the globe, it is at the same time showing ever more clearly the pervasive injustices and inequities that exist everywhere. All of us can mobilize to face what is so and work for the many changes necessary to create a healthier, safer world for all. We can do this as a work of hope and love together.

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