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Psychosocial Impact of the COVID-19 Crisis on Frontline Social Care Workers in Romania: Preliminary Findings

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ABSTRACT:
The pandemic exposed systemic vulnerabilities and intensified indirect trauma among social care workers, a group often marginalised in disaster planning. This article reports the preparatory stage of a doctoral study on Bucharest frontline workers, using a sequential mixed-methods design. For instrument adaptation and validation, it leverages the Erasmus+ CARES national dataset (n=296) to calibrate a culturally adapted Romanian ProQOL v5 with sensitivity to masked burnout. Preliminary findings indicate elevated secondary traumatic stress and high compassion satisfaction, with burnout near the normative mean yet suggestive of masking where organisational support is weak. The forthcoming qualitative phase (pending ethics approval) will explore coping, peer/institutional support, and organisational resilience. Framed within a hazard–vulnerability perspective, the study addresses an evidence gap and informs crisis-sensitive policy on trauma-aware training, reflective supervision, and digital competence.

Keywords: social care, COVID-19, psychosocial resilience, burnout, disaster response, ProQOL, Romania, secondary trauma

1. Introduction

This article presents the preparatory phase of a doctoral project at the University of Bucharest (Faculty of Sociology). It uses a sequential explanatory mixed-methods design: a national survey with a culturally adapted, post-pandemic ProQOL (Erasmus+ CARES, n=296; trauma-aware wording to minimise retraumatisation and detect masked burnout), followed by semi-structured interviews (pending ethics approval). The doctoral data collection itself is restricted to Bucharest frontline social care workers. ProQOL results are reported as T-scores (M=50, SD=10); preliminary patterns show high compassion satisfaction alongside elevated secondary traumatic stress and indications of masked burnout where organisational support is weak. The research is urgent because Romania's social care workforce is small and vulnerable (≈75,000 remain; ≈14,000 left post-pandemic; 87% women; >50% aged over 46). Treating COVID-19 as a disaster, the study examines professional quality of life, coping, perceived institutional support, and cumulative crisis exposure to inform trauma-aware, sustainable policy.

2. Theoretical framework and state of the art

Using the hazard–vulnerability lens from disaster sociology (Perry, 2007; Stallings, 2007; UNDRR, 2020), the analysis treats COVID-19 as a global disaster in which

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emergency mobilization and service reorganization intensified social workers' indirect trauma exposure. Occupational well-being is assessed through interlinked ProQOL constructs: compassion satisfaction (Stamm, 2010); compassion fatigue (Figley, 1995; Adams, Boscarino, & Figley, 2006; Bride, Radey, & Figley, 2007; Naturale, 2007); burnout (Stamm, 2010; Maslach & Leiter, 2016; Martínez-López, Lázaro-Pérez, & Gómez-Galán, 2021b; Holmes et al., 2021; Carvalho et al., 2023); secondary traumatic stress (Bride, Radey, & Figley, 2007; Sagit et al., 2021; Stamm, 2010); death anxiety (Martínez-López, Lázaro-Pérez, & Gómez-Galán, 2021a); resilience (Rutter, 1987; Bonanno, 2004); perceived social support (Cohen & Wills, 1985); and coping (Lazarus & Folkman, 1984). These dimensions covary—burnout and compassion fatigue co-occur where coping and institutional supports are weak, while STS signals deeper, identity-relevant distress.

3. Romanian context and preliminary results

Romania's social workers have engaged successive collective crises—COVID-19, the Ukrainian refugee influx, and regional floods—without standardized protocols, specialized training, or institutional psycho-emotional support. Despite their centrality to response and post-disaster social cohesion, social services were weakly embedded in contingency plans; under-regulation and absent support policies elevated burnout risk and sustained systemic strain. Within this context, the present study—undertaken under Erasmus+ CARES —empirically documents post-pandemic psychosocial vulnerabilities among frontline social workers and provides an evidence base for support and intervention policy. Other recent data indicate substantial workload pressure (≈46%), intensified by preventive isolation and resource shortages, driving exhaustion and attrition (Şoitu et al., 2023; Niţă & Petrescu, 2023). Preparedness remains limited: continuous training is scarce, and only 29.8% report prior work with disaster-affected populations, mostly learned in practice (Lazăr et al., 2023). Institutional responses in Bucharest (DGASPC) were predominantly reactive (PPE, exposure-limiting shifts, testing; 14-day workplace isolation in Sector 5), with minimal psychological support. Nationally, Military Ordinance No. 8/2020 imposed 14/14 shifts, while day-centre closures and PPE shortages curtailed services (UNICEF Romania, 2020). Although robust for routine provision, Law 292/2011, Law 197/2012, and sectoral standards do not require disaster-specific training (Petrescu, Negruţ & Goraş, 2025).

3.1 Best practices in professional education

Despite absent disaster-specific mandates, transferable models (**Tables 1–3**) delineate three domains; (A) Preparedness: MHF programs, crisis decision-making simulations, CBT-based resilience workshops, and supervision-led training for non-clinical staff.

Table 1: Strategies for Crisis/Disaster Preparedness Training in Helping Professions

No.	Subthemes	Explanation	Source
A1	Crisis-preparedness ecosystem: MHF/	Integrates basic psychological support (MHF), scenario-based simulations, structured pre-crisis	Wagener et al., 2019;

	simulations/pre-event training and role-play/supervision	training, and ongoing supervision/role-play to build decision-making, cut performance anxiety, and is associated with lower burnout/PTSD in real incidents.	Kourgiantakis et al., 2020; Brooks et al., 2020; Barnett et al., 2023
A2	Participatory, CBT-anchored development of cognitive & relational skills	Interactive workshops (cognitive restructuring, social/communication skills) strengthen coping and resilience; can be embedded within the A1 training package to mitigate burnout.	Barranco Expósito, 2007; Wagener et al., 2019
A3	Digital competence as a pillar of organisational preparedness	Training for responsible, effective use of digital tools sustains service continuity, enables remote delivery of simulations/MHF, and supports decision-making during crises.	Hilty et al., 2023; Kourgiantakis et al., 2020

(B) Self-care and burnout prevention: formal curricular integration of self-care, structured mindfulness programmes, and the Resiliency-Focused Supervision Model.

Tabel 2: Self-Care and Burnout

No.	Subthemes	Explanation	Source
B1	Curriculum-embedded self-care & professional formation	Make well-being a core learning outcome: integrate compassion fatigue, reflective self-assessment (motivation/ vulnerability), applied ethics (cases/role-play/group discussion), advocacy, and organisational change; use individual self-care plans as graded artefacts.	Engstrom & Powers, 2019; Newell & Nelson-Gardell, 2014; Zellmer, 2003
B2	Structured mindfulness programs (8–16 weeks) as a replicable resilience module	Evidence-based courses with defined dosage/methods reduce stress and build resilience for students and practitioners; portable to crisis contexts and linkable to B1.	Trowbridge & Mische Lawson, 2016
B3	Supervision-centred resilience (RFSM)	Embed self-care within supervisory relationships—ongoing check-ins, reflective practice, modelling/feedback—to build resilience and sustain long-term professional balance.	Mack, 2021

(C) Digital competencies and telehealth training to strengthen technological readiness, ensuring continuity of care and equitable delivery in remote/crisis settings.

Tabel 3: Digital Training / Telehealth

No.	Subthemes	Explanation	Source
C1	Core digital competence framework for social work practice	Make basic digital literacy, online communication, information/content management, e-transactions, and virtual problem-solving explicit learning outcomes; include actionable, field-ready examples..	Labrague, 2021; Morrison & Rooney, 2017
C2	Tech readiness as a resilience and continuity enabler	Digital skills underpin organisational preparedness, ensure continuity of care in crises, and expand	Hilty et al., 2023; Morrison

		access—especially in underserved areas; supports hybrid/remote delivery.	& Rooney, 2017
C3	Safety-centred, clarity-first practice models (e.g., Signs of Safety) in digital/hybrid contexts	Emphasise safety, transparent communication, and collaborative family work; align digital workflows with structured decision-making and training.	FitzSimons & McCracken, 2020

These best-practice categories offer feasible, context-sensitive training templates for Romania, enhancing workforce resilience and emergency response.

3.2 Recommendations for Public Policy Based on Literature Review

Given the lack of national psycho-emotional support policies, **the article proposes** Romania-adaptable macro/meso/micro recommendations for immediate practitioner support and long-term institutional resilience; **Table 4** summarises interventions, objectives, and international exemples.

Tabel 4: Public, Organizational, and Educational Policies for Preventing Burnout and Enhancing Professional Resilience in Social Work

Level	Indicative Objectives	Summarized Examples	Source
Macro	Recognise burnout as a public health issue and embed self-care in national/professional standards.	ICD/DSM recognition; national mental-health policies referencing burnout; professional guidelines (e.g., NASW) that formalise self-care/supervision expectations.	(Barranco Expósito, 2007; Mack, 2021)
	Secure dedicated funding and strengthen regulatory oversight to prevent and treat burnout.	Budget lines for prevention/treatment; investments in psychosocial infrastructure; enhanced inspections/audits and quality indicators across providers.	(Johnson & Long, 2020; Barranco Expósito, 2007)
	Institutionalise digital competence to sustain equitable services during crises.	Workforce training in responsible/effective digital tools; flexible hybrid/remote service standards; protected time/routines for digital self-care.	(Hilty et al., 2023)
Meso	Optimization of the work environment	Reducing workload; clarifying job descriptions and role Ambiguity; training supervisors in supportive leadership; increasing autonomy and participation in decisions; promoting a collaborative climate	(Morse et al., 2012)
	Positive supervision and emotional support		
	Normalization and support of self-care in the workplace	Fostering an institutional culture that validates and encourages self-care	(Engstrom & Powers, 2019)

	Unstable leadership, organizational memory, and crisis support	The role of leadership in building resilience and supporting staff during crises	(FitzSimons & McCracken, 2020)
Micro	Integration of self-care into professional training	University programs that teach workplace self-care, modeled by mentors	(Engstrom & Powers, 2019)
	Development of reflection and advocacy skills	Training in professional ethics, awareness of personal vulnerability, and advocacy	(Zellmer, 2003)
	Training in coping strategies and mental health	Training in mindfulness, cognitive-behavioral therapy, narrative reflection, etc.	
	Active supervision and support during practical training	Supervisor instruction	(Morse et al., 2012)

4. Conceptual Analysis of Coping Mechanisms: Criteria and Dimensions of Interpretation

Pending qualitative results, the article provides a seven-criterion conceptual analysis of coping mechanisms in the international literature.

4.1 Criterion: Level of Application

Coping mechanisms (**Table 5**) are **predominantly individual-level**; employer-contingent organisational supports and absent/misclassified system-level policies leave well-being underaddressed and access uneven.

Table 5: Level of Application of Coping Mechanisms

Level	Identified Mechanisms	Sources
Individual	Meditation, yoga, physical exercise; psychotherapy; mindfulness interventions; prayer; shamanic practices; recreational activities (drawing, sports, music, journaling); informal social support	(Benavides-Gil et al., 2024; Brooks et al., 2020; Engstrom & Powers, 2019; Labrague, 2021; Meuche, 2015; Zellmer, 2003)
Organizational	Support networks; institutionalized breaks; internal training programs; job rotation; collective reflection; professional supervision; case reduction policies; use of technology (digital platforms, telemedicine); moral support and advocacy; resilience therapy; staff training	(Anva Ratzon et al., 2022; Barranco Expósito, 2007; Brooks et al., 2020; FitzSimons & McCracken, 2020; Hilty et al., 2023; Mack, 2021; Zellmer, 2003)
Systemic	No coping mechanisms identified in the analyzed tables are explicitly defined as systemic measures implemented at the national level (e.g., government policies with broad applicability)	-

4.2 Criterion: Coping Strategies

Coping types (**Table 6**): Active—dominant/diverse (personal action, collective reflection, radical self-care, informal support); Passive—rare (time-out); Preventive—prominent (training, rotation, supervision, safety, self-care ed.); Intervention—post-onset therapy/support (resource-intensive, limited access); Adaptive—tech-mediated (telemedicine/platforms) sustaining practice.

Table 6: Type of Strategy

Type of Strategy	Included Mechanisms	Sources
Active	Meditation, yoga, physical exercise; social support; collective reflection; eco-social activism; recreational activities (drawing, sports, cooking); prayer; mindfulness; use of technology	(Barranco Expósito, 2007; Benavides-Gil et al., 2024; Brooks et al., 2020; Engstrom & Powers, 2019; Hilty et al., 2023; Labrague, 2021; Meuche, 2015; Newell & Nelson-Gardell, 2014; Zellmer, 2003)
Passive	Institutionalized breaks ("time-outs")	(Zellmer, 2003)
Preventive	Training programs, job rotation, professional supervision, experience/education, COVID-related guidelines, case reduction policies, self-care education	(Brooks et al., 2020; Johnson & Long, 2020; Labrague, 2021; Mack, 2021; Zellmer, 2003)
Intervention-Based	Psychotherapy; resilience therapy; moral-instrumental support	(Anva Ratzon et al., 2022; Labrague, 2021; Newell & Nelson-Gardell, 2014; Zellmer, 2003)
Adaptive	Use of technology during the pandemic (telework, digital platforms)	(Hilty et al., 2023)

4.3 Criterion: Purpose

The third criterion (**Table 7)** classifies coping by primary objective—stress reduction, burnout prevention, resilience enhancement—and by activation timing (pre-/peri-/post-exposure). Examples: stress reduction (individual techniques, psychotherapy, public-health protocols); burnout prevention (in-house training, job rotation, professional supervision, recreation/social support, psychotherapy); resilience (resilience-focused therapies, eco-social activism, supervision, continuing education, spiritual practice). Many strategies are multifunctional.

Table 7: Primary Purpose of Coping Mechanisms

Primary Purpose	Associated Mechanisms	Sources
Stress Reduction	Meditation, yoga, mindfulness, recreational activities, social support, prayer, shamanic practices, psychotherapy, COVID-19 guidelines	(Benavides-Gil et al., 2024; Labrague, 2021; Meuche, 2015; Newell & Nelson-Gardell, 2014; Zellmer, 2003)

Burnout Prevention	Training programs, job rotation, professional supervision, distraction activities, social support, psychotherapy	(Brooks et al., 2020; Johnson & Long, 2020; Labrague, 2021; Newell & Nelson-Gardell, 2014; Zellmer, 2003)
Resilience Building	Resilience therapy, eco-social activism, professional supervision, work experience, prayer	(Anva Ratzon et al., 2022; Brooks et al., 2020; Engstrom & Powers, 2019; Labrague, 2021; Mack, 2021; Meuche, 2015)

4.4 Criterion: Scientific Foundations

Fourth criterion (**Table 8**): evidence base—empirical, theoretical, institutional. Only mindfulness shows measured stress reductions ($p<0.01/p<0.05$); other strategies rely on theory/consensus or anecdote, highlighting a need for applied, context-sensitive evaluations.

Table 8: Scientific Foundations of Coping Mechanisms

Type of Scientific Basis	Mechanisms	Sources
Empirical	Mindfulness-based interventions	(Benavides-Gil et al., 2024)
Theoretical	Psychotherapy, eco-social activism, professional supervision, social support, prayer, training programs, experience, technology, journaling, COVID-19 guidelines	(Anva Ratzon et al., 2022; Brooks et al., 2020; Engstrom & Powers, 2019; Hilty et al., 2023; Labrague, 2021; Mack, 2021; Newell & Nelson-Gardell, 2014; Zellmer, 2003)
Best Practices	Collective reflection; case volume reduction policies	(Barranco Expósito, 2007; FitzSimons & McCracken, 2020)

4.5 Criterion: Accessibility and Feasibility

Fifth criterion (**Table 9**): accessibility/feasibility—minimal-resource vs high-support. Low-cost, self-initiated options are viable (social support, prayer, recreation, journaling, meditation); COVID-19 rules are uniquely easy. High-support strategies (psychotherapy, supervision, training, advocacy, caseload reduction, digital tech) require institutional capacity often lacking.

Table 9: Accessibility and Feasibility

Category	Identified Mechanisms	Sources
Low Cost	Social support, prayer, recreational activities, journaling, meditation, shamanic practices	(Labrague, 2021; Meuche, 2015)
Easy to Implement	Compliance with COVID-19 guidelines	(Labrague, 2021)

Requires Institutional Support	Psychotherapy, advocacy, professional supervision, training programs, technology, case volume reduction policies	(Anva Ratzon et al., 2022; Barranco Expósito, 2007; Brooks et al., 2020; FitzSimons & McCracken, 2020; Hilty et al., 2023; Labrague, 2021; Mack, 2021; Newell & Nelson-Gardell, 2014; Zellmer, 2003)

4.6 Criterion: Degree of Personalization

Criterion 6 (**Table 10**): generic vs. personalized. Generalizable—social support, training, public-health guidelines; most others require tailoring (spiritual practices, therapy/supervision, job rotation, advocacy, digital tools) to context; one-size-fits-all is rejected

Table 10: Degree of Personalization

Degree of Personalization	Identified Mechanisms	Sources
Generally Applicable	Social support, training programs, education, compliance with COVID-19 guidelines	(Anva Ratzon et al., 2022; Brooks et al., 2020; Johnson & Long, 2020)
Requires Individual Adaptation	Trauma-informed psychotherapy, radical self-care, religion, journaling, mindfulness, professional supervision, job rotation, technology, policies, advocacy, meditation, physical exercise	(Barranco Expósito, 2007; Benavides-Gil et al., 2024; Engstrom & Powers, 2019; FitzSimons & McCracken, 2020; Hilty et al., 2023; Labrague, 2021; Mack, 2021; Meuche, 2015; Newell & Nelson-Gardell, 2014; Zellmer, 2003)

4.7 Criterion: Perceived Impact of Coping Strategies

Criterion 7 (**Table 11**): impact horizon—short-term (breaks, mindfulness), long-term (rotation, supervision, workload reduction, education, psychotherapy, cumulative mindfulness), transformative (eco-social activism). Evidence mostly implicit; clearly supported: mindfulness (acute and sustained) and eco-social activism (transformative).

Table 11: Expected Impact of Each Mechanism

Type of Impact	Associated Mechanisms	Sources
Short-Term	Institutionalized breaks, mindfulness	(Benavides-Gil et al., 2024; Zellmer, 2003)
Long-Term	Job rotation, professional supervision, policies, education, mindfulness, psychotherapy	(Barranco Expósito, 2007; Benavides-Gil et al., 2024; FitzSimons & McCracken, 2020; Johnson & Long, 2020; Zellmer, 2003)
Transformative	Eco-social activism	(Engstrom & Powers, 2019)

5. Methodology

Sequential explanatory mixed methods: Stage 1—adapted ProQOL survey; Stage 2—semi-structured interviews.

5.1 Data collection tools and process

a. ProQOL - version adapted for COVID-19

ProQOL v5, culturally adapted for Romania/COVID-19 (pandemic-referenced item rephrasing, expert validation, Erasmus+ CARES pilot), measures Compassion Satisfaction, Burnout, and Secondary Traumatic Stress on a 5-point Likert scale. The validated version shows high reliability ($\alpha>0.84$), supports large-sample use, and includes semantic/emotional tailoring to better detect masked exhaustion in frontline roles.

b. Semi-structured interview

Qualitative component: a semi-structured, empathically worded interview guide probing coping and perceived institutional support, with modules on peer/organizational support, training, procedures/policies, gender equity, and improvement needs; it elicits accounts of Bucharest's COVID-19 experience and post-pandemic shifts. Methodologically finalized and awaiting Faculty Ethics approval; no results are reported. Interviews (individual, 60–90 minutes) will be face-to-face or online. Bucharest is purposively selected given the highest national incidence/longest restrictions, a dense institutional ecosystem, and feasibility within doctoral constraints.

5.2 Participants

Target population: Bucharest social care workers with direct beneficiary contact during COVID-19 (public and NGO sectors). Planned samples: $n\approx200$ (quantitative survey) and $n\approx20–25$ (qualitative interviews).

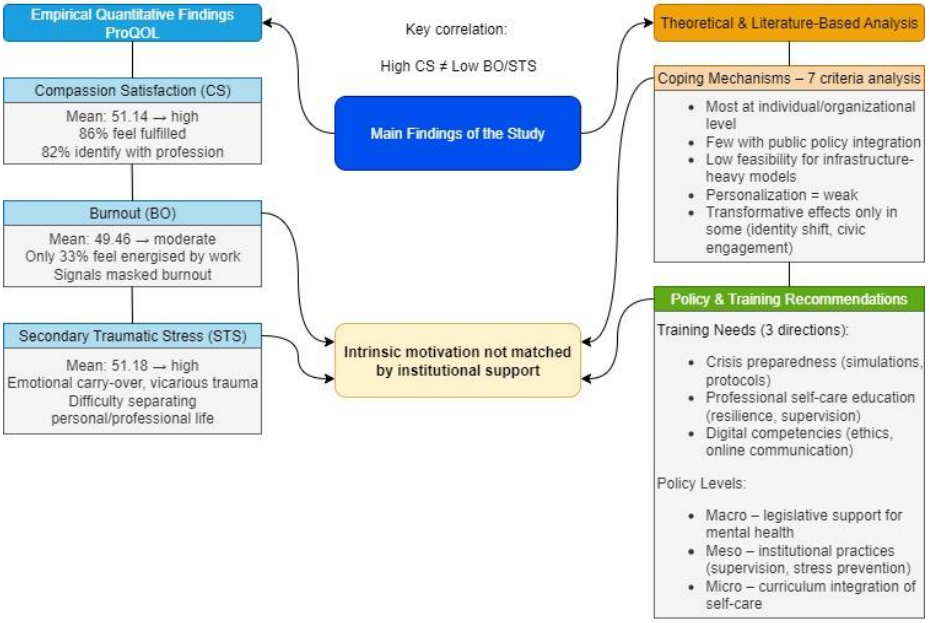
5.3 Ethics and Confidentiality

Informed consent (purpose, voluntariness, withdrawal, data protection); academic-only data use. Ethics are integral, with Faculty Ethics Committee approval safeguarding participants; procedures align with international standards.

6. Preliminary research results in Romania

This integrated process is visually summarized in **Figure 1**, which synthesizes the main empirical findings, theoretical insights, and resulting policy recommendations.

Figure 1: Integrated Synthesis of Main Results



6.1 Main quantitative results

Quantitative results show associations between emotional exhaustion, perceived institutional support, and adaptive coping among Romanian frontline social workers in post-pandemic/disaster contexts. ProQOL means: Compassion Satisfaction (CS)=51.14 (above threshold; 86% report frequent fulfilment; 82% pride/positive role identity); Burnout (BO)=49.46 (near critical; moderate exhaustion; ≈1/3 feel revitalised), suggesting masked burnout (high engagement without recovery supports); Secondary Traumatic Stress (STS)=51.18 (high), with difficulty separating work/personal life and persistent preoccupation, indicating vicarious traumatisation and heightened crisis vulnerability.

6.2 Theoretical and Literature-Based Results

Complementing ProQOL, a seven-criterion review shows interventions cluster at individual/organizational levels (policy gap), favor active/preventive/adaptive strategies with limited evidence, and vary in feasibility (low-cost most accessible), with impacts from short-term to transformative. It recommends crisis-response training, self-care/reflective supervision, and digital literacy, plus a macro–meso–micro framework (legislative protections; institutional supervision/stress management; curricular self-care) to bolster workforce resilience.

7. General remarks

Strong professional identity and motivation coexist with weak organizational/psycho-emotional support; absent systemic protections, individual resilience becomes a risk factor, driving chronic burnout and degrading service quality.

8. Limitations

Limitations: Bucharest-only, quantitative, cross-sectional, exploratory; qualitative phase pending ethics; adapted ProQOL v5 measures only CS/BO/STS; no cross-national comparator—thus limited generalizability and no temporal/causal inference. Nevertheless, it provides a baseline for integrating qualitative data and widening the scope beyond Bucharest.

Contributions: Cultural adaptation and psychometric validation of ProQOL v5 for Romania (Erasmus+ CARES), with author-led linguistic/emotional/contextual refinement that increases sensitivity to masked burnout; delivers a context-sensitive tool for frontline assessment and strengthens the doctoral project's empirical foundation.

9. Future Research on Social Care Work in Crisis Contexts

This exploratory, preparatory stage of a doctoral project sets a research agenda for an applied sociology of resilience in Romania's social services. Priorities: longitudinal trajectories of well-being/burnout/identity under repeated crises; impacts of post-pandemic organizational changes (digitalisation, isolation policies, team restructuring) on well-being, climate, effectiveness, and protection; gendered stress in a predominantly female, aging workforce (87% women; majority 46+); and qualitative analysis of informal peer support that substitutes for absent institutional supports.

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