Psychosocial Support for Individuals Diagnosed with Covid-19: Experiences of Volunteer Counsellors from India

Report

By

National Disaster Management Authority, New Delhi

In collaboration with

Rahbar,

A Field Action Project of the School of Human Ecology

Tata Institute of Social Sciences, Mumbai

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FOREWORD

Any disaster- whether man made or natural, can threaten people's lives and be a significant burden on those affected. In the acute phase of a disaster response, treating physical health problems has often been prioritized; however, over the past two decades the psychological impact of disasters has come to be a major focus of disaster health management.

The ongoing Covid-19 pandemic is a major health crisis, that has affected millions of people worldwide since its outbreak. The disruption caused by the pandemic, like the enormity of living in isolation, changes in daily life, job loss, financial hardship and grief over the death of loved ones has the capacity to affect the mental health and well-being of many. Stigma and discrimination against person(s) who have tested positive for Covid-19 is another major source of distress, in addition to the already existing physical and mental health issues. In such a scenario, psychological assistance services, including telephone, internet and application-based counselling have played a huge role in easing the stress of the general population and providing timely interventions for people having acute emotional distress.

Keeping in mind the above need, The National Disaster Management Authority (NDMA) started a helpline initiative on 22nd April, 2020 to offer basic psychosocial support to the people who were diagnosed with Covid-19 through telephonic counselling to be carried out by qualified and experienced counsellors. This is a unique intervention as the people testing positive for Covid-19 do not call up the helpline but are instead called up for checking on their psychosocial state and providing some relief in the form of counselling. Another advantage is that these counselling services are conducted from a remote place. The tele counselling services, in the form of psychological first aid, helps the patient and family deal with the mental health concerns of the pandemic along with providing transparent, genuine and timely information to them. Till date, the counsellors have contacted over 1.5 lakh people diagnosed with Covid-19 in India. These volunteers working with NDMA comprise of trained mental health professionals - Clinical Psychologists, Counsellors and Psychiatric Social Workers who can speak a range of different languages apart from English and Hindi.

NDMA collaborated with Tata Institute of Social Sciences (TISS) to provide training and supervision for the counsellors delivering their service to people diagnosed with Covid-19. In addition, TISS has also supported NDMA with the research and documentation process. The present report provides a first-hand insight into the range of psychosocial concerns that people experienced during the pandemic, as conveyed to the counsellors. It aims to shed light on the reality of the immense emotional impact caused by the pandemic and the psychosocial interventions that have been implemented successfully. The outcomes of the report can generate a deep understanding about policy recommendations and strategies to tackle the mental health impact of disasters of this scale.

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RE-IMAGINING FUTURES
भविष्य की पुनर्कल्पना
TISS

PREFACE

The CoVid-19 pandemic, unprecedented in its nature and impact, has disrupted human life across the globe. In less than a year, there have been over 1.5 million deaths worldwide and new infections continue to rise unabated as several countries experience subsequent waves of the disease and a mutating virus. Even as nations are mobilizing public health resources to address the acute medical crisis at hand, the global community is also bracing itself for the psychosocial impact and its long-term reverberations on quality of life long after the pandemic has been contained.

India has a large treatment gap in mental health. Almost 80% of the population that requires mental health support lacks access to it. This gulf has been further widened with the psychosocial instability caused by CoVid-19 and social distancing regulations making mental health care even more difficult to access. Persons with pre-existing psychological concerns and persons diagnosed with CoVid-19 are among the most vulnerable during this time. In such a scenario, the need for developing approaches to accessible, affordable and timely psychosocial care for vulnerable populations is most critical.

Recognizing this urgency, the National Disaster Management Authority launched an innovative 'reverse helpline' in the early stages of the pandemic, armed by a volunteer force of mental health professionals from across the country. Acknowledging that volunteer counsellors on the frontlines require contextualized training and ongoing supervision, *Rahbar*, a field action project of the School of Human Ecology at the Tata Institute of Social Sciences, Mumbai, was invited to collaborate with the NDMA. Since June 2020 the *Rahbar* team has been supporting NDMA in its Psychosocial Care Helpline *by providing contextually sensitive and trauma informed training and supervision to counsellors*. Through its field action projects and courses, TISS has always been at the forefront of designing initiatives that are informed by principles of social justice. The collaboration between TISS and NDMA is an affirmation of our commitment to designing mental health initiatives that are responsive to intersecting political, social and economic vulnerabilities.

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The present report, a documentation of the insights from the Psychosocial Care Helpline, upholds the tradition of evidence informed practice that TISS stands for as an institution of academic excellence. Through this report, NDMA and TISS have attempted to capture the complex nature of psychosocial concerns experienced by people affected by the pandemic, through the voices of volunteer counsellors who are providing mental health support on the frontlines. These perspectives bring to light the 'on-ground realities' of Covid-19 in India, psychosocial interventions that are being implemented and directions for enhancing the competencies of mental health professionals during this time. The strength of this report lies in bringing together the unheard voices of people affected by the pandemic which will serve as valuable signposts in shaping recommendations for policy initiatives and mental health response strategies during the unfolding pandemic.

I thank the volunteer counsellors for their contribution and the Rahbar team led ably by Dr. Chetna Duggal, faculty in the School of Human Ecology, TISS for designing and completing the study. My sincere appreciation to the NDMA for supporting the initiative.

S. Bharat

Shalini Bharat

Acknowledgements

The authors would like to express their sincere gratitude to everyone who made this study possible and contributed towards the culmination of the report.

First and foremost, we thank Shri. G.V.V. Sarma, IAS, Member Secretary (ex), NDMA, Shri. Sandeep Poundrik, IAS, Additional Secretary (ex), Mitigation, NDMA and Shri. Vijay Singh Nemiwal, Joint Advisor (Mitigation), NDMA for thoughtfully initiating the unique 'reverse helpline' to offer psychosocial support to individuals in distress during the Covid-19 pandemic. This research study and report is the result of their foresight and vision in bringing mental health support to the forefront of disaster management services during the pandemic.

We also thank Shri. Sanjeeva Kumar, IAS, Member Secretary NDMA and Shri. Ramesh Kumar Ganta, IAS, Joint Secretary (Mitigation), NDMA for extending support to completion of this Report.

We are grateful to Prof. Shalini Bharat, Director, Tata Institute of Social Sciences, for extending her unwavering support for this collaboration between NDMA and *Rahbar*, a field action project of TISS. It was her vision for TISS to engage in Covid-19 response initiatives that made it possible for *Rahbar* to provide psychosocial training and supervision to counsellors across India during the pandemic.

We also acknowledge the role of the Institutional Review Board of TISS for undertaking a detailed review of the research proposal, providing valuable inputs and granting ethical clearance for the study.

We express our deepest gratitude to all the volunteer counsellors associated with the NDMA Psychosocial Helpline who took the time to participate in the study and provided rich insights. Their commitment to fill out call details in feedback forms and their willingness to share their experiences with the initiative is greatly appreciated. Their effort helped in documenting the psychosocial concerns of people affected by Covid-19 and aided in bringing the meaningful work done through the helpline into the public domain through this report. We are grateful for their active participation in the study.

Our heartfelt acknowledgement for the team from Parahit Technologies led by Shri Hemanth Purohit for providing the technology platform for running the helpline. Their continuous technical support and handholding in this sphere has been invaluable.

The authors would also like to acknowledge the contribution of Ms. Arpitha Jacob, Ms. Durga V. Ashok and Ms. Sushmita Karmakar for supporting the independent audits of

the quantitative data for this study. Their generous inputs helped the team with auditing the data and presenting the analysis.

The culmination of this study represents the coordinated effort of multiple individuals and organizations working remotely across diverse parts of the country to provide psychosocial care to people during the pandemic. We sincerely hope that learnings from this study will aid in formulating strategies for future psychosocial interventions during disasters.

Executive Summary

Background

With its high infectivity and concerns about fatality, the novel coronavirus disease (Covid-19) has caused a far-reaching psychosocial impact. Existing literature has highlighted the role of psychological interventions, in particular psychological first aid, in responding to the unique stressors posed by the pandemic.

Taking into consideration the need for psychosocial support and counselling to address the mental health concerns of individuals diagnosed with Covid-19 in the country, the National Disaster Management Authority of India (NDMA) started a national level psychosocial care initiative in April 2020. The initiative was conceptualized as a 'reverse helpline' whereby mental health professionals like psychologists, counsellors and psychiatric social workers provided brief counselling support to individuals diagnosed with Covid-19. By the end of January 2021, 120 volunteer counsellors had reached out to more than 80,000 individuals diagnosed with Covid-19.

In May 2020, NDMA collaborated with *Rahbar*, Tata Institute of Social Sciences (TISS), Mumbai to provide training and supervision to volunteer counsellors, as well as to carry out a research study to document the process and insights generated from the initiative.

Research Methods

The objective of the study was to develop an understanding of the nature of psychosocial concerns faced by individuals diagnosed with Covid-19 and document the counselling support provided by volunteer counsellors. The study also aimed to explore the experiences of counsellors working with the helpline and ways in which receiving training and supervision for the work impacted their personal and professional growth. To meet the objectives, a qualitative dominant, concurrent triangulation mixed methods study was designed, and ethical clearance was sought from the Institute Review Board, TISS. Quantitative data was obtained from about 500 call feedback forms [1] of twenty counsellors across the months of April to September 2020, which was further content analysed. In-depth interviews were conducted with eleven counsellors and thematic analysis was used to analyse

[1] Feedback forms were a uniform tabular format provided to each counsellor where they were required to fill in demographic details of clients they called and the nature of psychosocial concern(s) brought up during the conversation, along with additional comments (if any). These forms had to be filled up by the end of each day that the counsellor made calls and submitted to NDMA.

the qualitative data. Both strands of data were triangulated to get a richer understanding of the research objectives.

Findings

As per the data obtained from the call feedback forms, the range of psychosocial concerns experienced by individuals diagnosed with Covid-19 were related to health and medical concerns, appetite and sleep related disturbances, financial and logistical concerns, experienced stigma, and relational concerns. These concerns impacted the emotional well-being of individuals, leading to a range of responses like stress, loneliness, boredom, anxiety, fear, helplessness, sadness, frustration and hopelessness. Psychosocial interventions like the establishment of a therapeutic framework, holding and containing distress, using supportive techniques to enhance coping, generating alternative perspectives and referring to specialized services were found to be effective by volunteer counsellors in alleviating the distress of individuals.

Women were found to share more relational concerns as compared to men. Individuals in the age group of 21 to 40 years reported a higher susceptibility than others to be impacted emotionally by the stressors posed. Additionally, individuals in the first phase of calling (in the months of April, May and June) shared more medical concerns pertaining to unsatisfactory treatment facilities and services as compared to the individuals contacted in the second phase between the months of July, August and September.

The research also captured the experiences of counsellors while working with the initiative, in terms of their motivation to join the helpline, challenges of their role and the impact on their personal and professional development. Counsellors shared that they were motivated to join the initiative by their desire to reach out to individuals in distress and contribute through their professional training.

Handling limitations in the medium of tele-counselling, addressing practical needs and finance related concerns that clients presented, supporting clients with recent bereavement and navigating ethical dilemmas during the calls were some of the challenges experienced by counsellors in the current work. According to counsellors, working on this initiative increased their understanding towards ground realities and enhanced their counselling skills.

Training and supervision helped build knowledge, learn practical skills, engage in reflective practice, access peer learning and support, and further increased professional competence. The counsellors also benefitted from the facilitators' approach in the sessions.

Implications and Recommendations

Findings from this study have implications for psychosocial initiatives during biological disasters, training and supervision for counsellors and future research on psychosocial care.

Recommendations were made related to the incorporation of psychosocial support initiatives in the acute and long term response to disasters. Tele counselling services were identified as an effective tool to address the mental health concerns of individuals in distress during large-scale disasters like the current pandemic. Additionally, provisions for specialized helplines for vulnerable groups and post-recovery follow-up care were proposed to be included as a part of Covid-19 response.

The need to address and mitigate the stigma associated with Covid-19 was also identified as a priority, and regulation of information about the pandemic was recommended to curb discriminatory behaviours towards individuals diagnosed with the disease. A recommendation was also made for the provision of referral services and structured follow-up mechanisms for high-risk populations.

The need for specialized training for counsellors in the areas of psychological first aid and trauma informed care to meet the unique requirement of crisis situations was recognized. Additionally, the inclusion of supportive supervision to aid counsellors in processing the impact of prolonged exposure to trauma was suggested.

Structure of the Report

Chapter 1 provides a detailed background of biological disasters, in particular the Covid-19 pandemic and its psychosocial impact on people around the world and in India. The disaster management cycle has been discussed along with the role of psychosocial care in disaster risk reduction. Institutional frameworks for psychosocial care in disaster management have also been highlighted in addition to psychological support and counselling in response to the psychological impact of Covid-19.

Chapter 2 entails an overview of the NDMA Psychosocial Care (PSC) Helpline Initiative, that includes information about its inception, recruitment of volunteer counsellors, technical support for the work, protocols, orientation and the general working of the helpline. Details about interventions with Delhi Police personnel have been highlighted in **Chapter 3**.

Chapter 4 covers the information regarding NDMA's collaboration with *Rahbar*, TISS Mumbai for capacity building of helpline counsellors and outlines details of the content and process of sessions.

The research methods incorporated for the study have been discussed in **Chapter 5**. **Chapter 6 and Chapter 7** present the findings from the study. The nature of psychosocial concerns and intervention approaches are presented in Chapter 6 while counsellors' experiences of the PSC Helpline, training and supervision are outlined in Chapter 7. This is followed by the Conclusions section.

Psychosocial Support in Disaster Contexts:

Understanding and Addressing the Psychosocial Impact of Covid-19

Disasters are large scale events that are often unexpected and cause death and trauma, combined with damage to property and livelihoods (Neria et al., 2008). While there is no consistent definition of disasters to be found in literature, researchers have agreed that disasters share three key characteristics of a large-scale traumatic event. Firstly, disasters threaten harm or death to a large group of people, irrespective of the actual extent of lives lost. Second, they affect social processes, causing disruption of services and social networks and communal loss of resources, and lastly, they involve secondary consequences like identifiable mental and physical health outcomes amongst those affected (Goldmann & Galea, 2014).

The Disaster Risk Reduction (DRR) and Disaster Management Cycle

The disaster risk reduction (DRR) and disaster management cycle illustrates the ongoing process by which governments, businesses and civil society plan for and reduce the impact of disasters, react during and immediately following a disaster, and take steps to recover after a disaster has occurred (World Health Organization, 2002). Appropriate actions at all points in the cycle lead to greater preparedness, better warnings, reduced vulnerability or the prevention of disasters during the next iteration of the cycle. The complete disaster management cycle includes the shaping of public policies and plans that either modify the causes of disasters or mitigate their effects on people, property, and infrastructure (World Health Organization, 2002). Several variations of the DM cycle have been used effectively in the past for health management during emergencies and disasters (Carter, 1991; Natural Disasters Organization, 1992; United Nations Office of the Disaster Relief Coordinator, 1991; World Health Organization, 1999a). The 4 steps of a disaster management cycle are as follows.

Prevention and Mitigation

Disaster prevention refers to a situation where people's susceptibility to hazards is eliminated by moving people from hazardous zones, providing complete protection from hazards or preventing the hazard altogether. Disaster mitigation, on the other hand talks about actions aimed at reducing the impact of future hazardous events, where the goal is also to reduce the susceptibility of high-risk groups towards the disaster.

Preparedness

The aim of preparedness is to "achieve an adequate level of readiness to respond to any emergency situation through programmes that strengthen the technical and managerial capacity of governments, organizations, institutions and communities" (Environmental Health in Emergencies and Disasters, 2003; pg. 21). Vulnerability assessment also enables one to anticipate concerns that specific groups might come across in the event of a disaster and during the period of recovery. Such initiatives are associated with national legislature and policies for disaster management, strengthening of institutional and human resources, and public awareness, education and participation in disaster management.

Response

The goal of this step is to provide immediate assistance to maintain life, improve health and support the morale of the affected population. Such assistance may range from providing aid like transport, temporary shelter or food, to repairing the damaged infrastructure and providing psychosocial aid. The emphasis is to meet the basic needs of people until more sustainable and permanent solutions are found. Over time, this phase often merges with long-term recovery and development.

Recovery

This phase begins when the emergency is brought under control and the affected population is capable of undertaking activities that restore their lives and the infrastructure that supports them. There might be many opportunities during the recovery period to enhance prevention and increase preparedness, thus reducing vulnerability by increasing capacity to cope with and recover from future disasters.

Planning is required on all levels, right from the community level to national and international levels, to make sure that the programmes for disaster prevention and mitigation are carried out according to clear objectives with adequate resources and management arrangements, and to ensure that strategies, resources, management structures, roles and resources for emergency response and recovery are determined and understood by key actors. The complete disaster-management cycle includes the shaping of public policies and plans that either modify the causes of disasters or mitigate their effects on people, property, assets and infrastructure. Institutional capacity can also be increased through organizational innovation and training.

Role of Psychosocial Care in Disaster Risk Reduction (DRR)

With disasters increasing in frequency globally (Guha-Sapir et al., 2012), disaster awareness and efforts to mitigate the psychological effects of hazards and bolster resilience has become very essential (Galappatti & Richardson, 2016). The World Conference on Disaster Reduction (WCDR) convened in Kobe, Japan identified an action plan known as the Hyogo Framework to be implemented between 2005-2015. It acknowledged the need to address mental health and psychosocial consequences of disasters by calling for actions to "enhance recovery schemes including psycho-social training programmes in order to mitigate the psychological damage of vulnerable populations, particularly children, in the aftermath of disasters" (UNISDR, 2005, p. 11). The subsequent Sendai Framework (2015-2030) went on to specifically mention the need to "enhance recovery schemes to provide psychosocial support and mental health services for all people in need" (UNISDR, 2015, pg. 22). Mental health and Psychosocial Support (MHPPS) is viewed to be associated with the 'non- structural' measures in DRR terminology which essentially means any measure that doesn't involve physical construction and doesn't use knowledge, practice or agreement to reduce risks and impacts. It rather includes measures through policies and laws, public awareness raising, training and education (UNISDR, 2009). Thus government entities and civil societies may aim to integrate MHPPS concepts and approaches into DRR plans and mechanisms across a wide range of settings with the intended outcome of promoting and protecting the well-being of people.

Institutional Frameworks for Psychosocial Care in Disaster Management

A review of Indian research on mental health and psychosocial aspects of disasters in terms of delivery of services, training and research activities carried out in the last two decades shows a paradigm shift from the medical model to the psychosocial model, with community based care and support forming the core of the disaster response (Satapathy & Bhadra, 2009). Various policy initiatives are visible at different levels, that cover both natural and man-made disaster situations. As a part of psychosocial care in disaster management, it is essential to shed light on the available policy documents addressing psychosocial issues at the national and international levels.

International Initiatives

The World Health Organization document on Mental Health in Emergencies has outlined the basic principles in responding to calamities that include,

> Preparation before emergencies, assessment based on the local cultural context, collaboration with different stakeholders, integration of interventions into primary health care, ensuring access to service to all, implementation of training and supervision, ensuring a long term perspective of interventions and monitoring indicator. (Mental Health in Emergencies, 2003, pg.3)

The Sphere Project (2004) is the humanitarian charter based on the principles and provisions of international humanitarian law, international human rights law, refugee law and Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief. The charter focuses on the core principles that govern humanitarian action and upholds the rights of populations affected by disasters to protection and assistance, along with reasserting their right to a dignified life in the aftermath of a disaster. The charter also points out to the legal responsibilities of states to guarantee the right to protection and assistance and in case they are unable or unwilling to fulfil their responsibilities, humanitarian organizations are to provide assistance and protection to the affected population.

The International Human Rights Standards on Post-Disaster Resettlement and Rehabilitation (2005) focuses on long-term post-disaster resettlement and rehabilitation. It was the first time that a comprehensive guide was compiled for widespread use that incorporated broad human rights standards. The goal of the charter is to help institutionalize international standards for all relief and rehabilitation work to follow. It is also the first step towards bringing applicable human rights standards to all those involved in reconstruction, most importantly, the survivors. The next steps focus on providing tools and training for the actual implementation of such standards through a collaborative process.

The key actions suggested by the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in emergency settings on Psychosocial Care and Human Rights (2007) are as follows:

- Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.
- Implement mental health and psychosocial supports that promote and protect human rights.
- Include a focus on human rights and protection in the training of all relevant workers.
- Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation.
- Advocate and provide specific advice to states in bringing relevant national

legislation, policies and programmes into line with international standards and on enhancing compliance with these standards by government bodies (institutions, police, army, etc.).

National Initiatives

The Disaster Management Act (2005) laid the guidelines for the establishment of Disaster Management Authorities at the national, state and district levels, whose role was to lay down the policies, plans and guidelines for disaster management to ensure timely and effective response to a disaster. Realizing the importance of mental health and psychosocial interventions in the aftermath of disasters, the National Disaster Management Authority (NDMA) formulated the guidelines on Psychosocial Support and Mental Health Services (PSSMHS). This was a landmark step to involve active participation and contribution of various stakeholders that included ministries, departments, institutions and experts from the field for promoting a culture of prevention, mitigation and preparedness for prompt response during emergencies. The guidelines outline the interventions aimed at addressing a wide range of mental health and psychosocial concerns, which include psychosocial first aid as the immediate response followed by psychosocial support. It aims at having in place a well-structured referral mechanism for continued support, that involves an active community participation along with participation from NGOs and government agencies. Specific attention is also given to vulnerable sections of the community. Under the umbrella of National Health Policy (NHP), National Mental Health Programme(NMHP) and District Mental Health Programme(DMHP), the PSSMHS is to be delivered through an integrated pathway as a part of general health care and general relief in disasters.

The NMHP programme was initiated in 1982 and the re-strategized NMHP's District Mental Health Programme (DMHP) was developed as an approach to deliver mental healthcare through the Primary Health Care system for all districts. Apart from continuing the existing programmes, it is envisaged that 500 more districts will be brought under the DMHP activities in the 11th Five-Year Plan. The availability of mental health teams in every district for a disaster situation is to be ensured, making it a major starting point for PSSMHS in disaster situations.

The National Health Policy (2002) reiterated the need for an adequately vigorous disaster management plan in place to effectively cope with situations arising from natural and man- made calamities. There have been plans to revise the Mental Health Care Act, National Guidelines on Psychosocial Support & Mental Health Services in Disasters and People with Disabilities Act to bring focus on psychosocial care and mental health in disasters. This has

already been included in the National Guidelines on Medical Preparedness and Mass Casualty Management by the National Disaster Management Authority, the apex authority in Disaster Management in India (Satapathy & Bhadra, 2009).

Thus, with the growing recognition about the significance of mental health in disaster management, the psychosocial components of disasters need to be addressed for the early recovery of the people affected and to build the psychological resilience of the community (Nagaraja & Murthy, 2008). Addressing the psychosocial and mental health consequences of disasters is particularly important in lower income countries like India, which face a higher burden of illness, lack of health infrastructure, greater socio-economic disparities and have limited access to mental healthcare.

Biological Disasters

Based on the definition given by the Disaster Management Act (2005), biological disasters may be described as scenarios involving disease, disability or death on a large scale among humans, animals and plants due to toxins or disease caused by live organisms or their products. Such disasters may be natural, in the form of epidemics or pandemics of existing, emerging or re-emerging diseases and pestilences, or man-made by the intentional use of disease causing agents in Biological Warfare (BW) operations or incidents of Bioterrorism (BT).

Covid-19 as a Biological Disaster

The novel coronavirus disease (Covid-19 as coined by World Health Organization), that had its origins in a cluster of unexplained cases of pneumonia in the city of Wuhan in China, was declared a pandemic on 11th March, 2020 by the WHO and has affected countries all over the world since then (Rajkumar, 2020). By January 2021, within a span of 12 months, there were over 100 million confirmed cases and 21,82,000 deaths attributed to the disease around the world. Given the population and socio-economic domains affected, Covid-19 could be regarded as a biological disaster (Hsieh et al.,2020). In the wake of this global health crisis, stringent safety measures like self-isolation and lockdowns were implemented to curtail the spread of the Covid-19 virus (Adhikari et al., 2020), that consequently had outcomes ranging from infringement of personal freedom to growing financial losses (Pfefferbaum & North, 2020).

Psychosocial Impact of Biological Disasters

During biological disasters, fear, uncertainty and stigmatization is seen to be present not only in patients and healthcare workers but also in the general population (Hsieh et al., 2020).

The impact of quarantine on mental health was studied in Taiwan using survey questionnaires for people who were quarantined during the SARS epidemic in the country. It was reported that while respondents agreed with the quarantine policies, most of them still experienced negative psychological effects and stigma (Peng et al., 2004). Those who had been quarantined or suspected to be infected reported to have higher levels of depression, poor neighborhood relationships, poor self-perceived health and a higher economic impact as compared to those not infected (Ko et al., 2006). An increase in substance use was also reported along with a significant rise in the rate of suicide in the general public during that time (Fan, 2005).

Drawing from the experiences of Taiwanese people with the SARS disease in 2003, it was noted that victims of infectious diseases experienced health and economic loss and were often discriminated against and avoided due to fear and anger. The response was different for victims of natural disasters on the other hand, who usually received empathy, support and care. Healthcare workers also faced additional mental health challenges during the SARS outbreak, where they reported conflicting feelings between their role as healthcare providers and parents as well as struggles between their professional responsibility and the fear of putting their families at risk to the infection (Maunder et al., 2003).

Disasters tend to have a large scale impact on social groups and produce human and material losses, resulting in insufficient resources of the community and difficulty in coping through social mechanisms (Lopez-Ibor, 2006). Thus biological disasters have a significant mental health impact on those affected (Bonanno et al., 2008) and studying mental health in the face of disasters is extremely important.

Psychosocial Impact of Covid- 19

The sudden and unexpected outbreak of the coronavirus disease (Covid-19 pandemic) raised several concerns regarding its mental health and psycho-social consequences. According to WHO, safety measures like self-isolation and quarantine affected usual activities, routines and livelihood of people which led to increased loneliness, anxiety, depression, insomnia, harmful alcohol or drug use, and self-harm or suicidal behaviour (World Health Organization, 2020). In addition to that, isolation may have been particularly detrimental for people already suffering from mental illnesses like depression and anxiety (Lange, 2020).

Widespread outbreaks of infectious diseases have been found to be associated with psychological distress and symptoms of mental illness (Bao et al., 2020). Inferring from studies conducted in the aftermath of epidemics and disasters like Hurricane Katrina (Wang &

Gruber, 2007), the terrorist attacks of September 2001 (Galea et al., 2002) or the SARS disease (Maunder, 2003), it was estimated that as much as 10% of the population could possibly meet the criteria for major depressive disorder following the Covid-19 pandemic and perhaps even a larger number might be prone to experience post-traumatic stress disorder symptoms (Swartz, 2020). Blumenstyk (2020) predicted that levels of anxiety were set to rise, both through direct causes like fear of contamination, grief, stress and depression triggered through exposure of the virus, and through influences from the consequences of the economic and social havoc occurring on a societal level.

An early nationwide survey conducted in China by Qiu et al. (2020) showed that rates of psychological distress, such as depression, panic disorders and anxiety had gone up in the general population since the beginning of the pandemic. A total of 52730 respondents filled in a self-report questionnaire to record their psychological state within a month of declaration of Covid-19 as a public health emergency in the country. Results indicated that about 30% of the participants showed mild to moderate rates of psychological distress while close to 5% respondents stated that they faced severe psychological distress.

Over the last eight months, there has been emerging evidence of the direct and indirect psychological impact of the pandemic. The direct impact refers to the physical and psychological distress associated with receiving a diagnosis of Covid-19 for oneself or loved ones, while the indirect impact can be understood as the effect of public policies and interventions to contain the disease (Pancani et al., 2020). Uncertainty in prognoses, shortage of resources for testing and treatment and for protecting responders and healthcare providers was also a pressing source of mental health concern for people in few countries, as reported by Pfefferbaum (2020) in April 2020. The effects of the pandemic on individuals (through stigma and social isolation) and the community (in the form of economic losses, work and school closures and poor distribution of necessities) led to varying levels of emotional distress and unhealthy means of coping in the general population (Pfefferbaum, 2020).

Groups Vulnerable to the Psychosocial Impact of Covid-19

Some groups might be more vulnerable to the psychosocial impact of the pandemic as compared to others, in particular those who were infected, those who were at high risk of infection (like the elderly population, children, healthcare workers or people with compromised immune functioning) and those with pre-existing psychiatric, medical, or substance use issues (Minihan et al., 2020). Risk factors like exposure to trauma, minority status, low social support and pre-existing psychiatric illness could have long lasting mental health consequences for the vulnerable populations (Goldmann & Galea, 2014).

Healthcare providers and other frontline workers were at a heightened risk to emotional distress during the pandemic, due to their direct contact with the virus, fear of infecting their family members and friends, longer working hours and shortage of personal protective equipment (Minihan et al., 2020). As experienced during earlier outbreaks of infectious diseases like SARS and Ebola (Barbisch et al., 2015), healthcare professionals in the frontline of duty treating Covid-19 patients also faced lack of motivation along with social stigma as they were distanced due to people's fear of getting the virus from them (UNICEF, 2020). An early study in China on frontline health professionals during the Covid- 19 outbreak by Zhang et al. (2020) revealed that medical health workers were more susceptible to psychosocial problems as compared to non-medical health workers. Medical health workers had a higher prevalence of insomnia, anxiety, depression, somatization and obsessive compulsive symptoms in an online survey conducted with 2182 individuals.

A longitudinal study by Wang et al. (2020) conducted in China with about 1732 participants showed that the younger members of a population (between the age group of 12-15 years), mostly comprising of students, were more likely to show symptoms of mental illness as a result of the pandemic. Child maltreatment, domestic abuse, lack of peer contact and parental mental illness were reported as sources of risk for children and adolescents (Fegert et al., 2020).

The elderly population has been considered to be at an increased risk for Covid-19 infection since the beginning of the pandemic due to their probable weakened immune system and association with chronic underlying diseases. A survey on the psychological status of the elderly in China revealed that within a sample size of 1556 participants in the age range of 60 years and above, about 37% of the population reportedly experienced depression and anxiety (Meng et al., 2020). Women were more likely to experience anxiety and depression as compared to men, according to the aforementioned study.

People with alcohol dependence who underwent an urgent detoxification before being quarantined could have probably experienced anxiety, fever and hallucinations among other concerns (Jayakumar, 2020).

Psychosocial Impact of Covid-19 in India

The Indian Psychiatry Society reported a 20% rise in mental illnesses in the country since the outbreak of Covid-19 (Loiwal, 2020). Healthcare inequalities and widening economic and social disparities harshly affected the poorest sections of the country.

Meanwhile, the nationwide lockdown resulted in economic losses especially for the population of daily-wage workers and migrant laborers, posing major psychosocial risks

(Goleccha, 2020). Even before the massive spread of the virus across the country, there were isolated reports of extreme responses like self-harm and suicide due to heightened fear of contagion, as early as February 2020 (Goyal et al., 2020). Two case studies in the Indian scenario as observed by Sahoo et al. (2020) indicated self-harm attempts that related to the anxiety of developing the virus and eventual death.

A longitudinal study conducted in the country with 159 participants over the first two months of lockdown found that anxiety, stress and depressive symptoms increased over time in the population (Gopal et al., 2020). The study also found that personal, professional and social disruption in the lives of individuals during the nationwide lockdown had an adverse impact on their psychological well-being. Further, the steep increase of Covid-19 cases in the country, and worldwide, elevated their levels of anxiety by prompting a perception of unpredictability. In the study, women were reported to have a greater prevalence of psychological concerns as compared to men.

The Covid-19 pandemic and the accompanying lockdown undoubtedly had an effect on every individual. The psychosocial concerns that emerged during the pandemic might evolve into long-lasting health problems. It could consequently result in stigma and discrimination against vulnerable populations as well. There is a critical requirement for the society at large to be sensitive towards the mental health impact of the long-drawn out disaster. Development and implementation of necessary disaster-response policies to address the psychosocial needs of citizens in the times of crisis is also the need of the hour.

Psychosocial Support and Counselling in Response to the Psychological Impact of Covid-19

Against the backdrop of an overburdened mental healthcare system in developing countries, the direct and indirect psychosocial effects of Covid-19 present an urgent challenge for mental health research, practice and policy (Holmes et al., 2020). In this context, increasing access to psychological support through technologically-informed approaches present an opportunity to adapt to the mental healthcare delivery challenges posed by the pandemic (Inchausti et al., 2020).

Counselling is seen as an essential component in the mental health response to Covid-19. According to the American Counselling Association, counselling can be defined as “a professional relationship that empowers diverse individuals, families and groups to accomplish mental health and wellness goals.” Mental health professionals like psychologists, psychiatric social workers and psychiatrists are trained to respond to a range of emotional concerns pertaining to the pandemic, like self-isolation, job loss, grief and fear of contacting

the disease among many others (Swartz, 2020). Psychological first aid (PFA) is a brief form of counselling adapted for crisis. PFA is defined as a "humane, supportive response to a fellow human being who is suffering and who may need support" (World Health Organization, War Trauma Foundation and World Vision International, 2011, p. 2). Not intended to be a long-term support, this means of care is an immediate and timely support for individuals who experience distress as a result of a crisis, like in the case of the Covid-19 pandemic (Minihan et al., 2020). PFA aims to address client concerns at the right time so that they do not snowball into more distressing mental health concerns later.

A study by Boscarino et al. (2011) on post-disaster mental health interventions based on the World Trade Centre disaster in the USA showed the effectiveness of brief counselling and psychosocial support following a large-scale traumatic event. The application of PFA during the past epidemics has also provided significant benefits in aiding people with emotional distress (Shah et al., 2020). Thus the role of PFA in the Covid-19 outbreak is crucial in managing the mental stress originating from enormous impacts of the infection in various facets of individual and societal life.

The Covid-19 pandemic has resulted in mental health implications for every individual, in varying degrees. Healthcare workers, individuals at risk of contracting the virus and those who are diagnosed with the infection are seen to be prone to psychosocial stressors more than others. The existing guidelines outline the importance and need for psychosocial interventions during disasters to provide timely support to individuals in distress. At present, there is little documentation of mental health initiatives during the pandemic from the country. The current study aims to document the psychosocial care initiative started by NDMA and outline the different kinds of psychosocial concerns being faced by individuals affected by the pandemic. The insights generated by counsellors would be applied to develop evidence based frameworks for future crisis work.

Responding to the Need of the Hour:
An Overview of the NDMA Psychosocial Care (PSC) Helpline Initiative

National Disaster Management Authority of India (NDMA), the apex body for disaster management in India, was created to establish an enabling environment for institutional mechanisms at the state and district levels as mandated by the Disaster Management (DM) Act, 2005. NDMA lays down the plans, policies and guidelines for disaster management in the country while maintaining an ethos of prevention, mitigation, preparedness and response.

The Covid-19 pandemic is an unprecedented biological disaster that has disrupted human life across the world. Establishment of accessible and affordable avenues to provide timely psychosocial support to individuals in distress has been critical during such a time.

Keeping in mind the need for psychosocial support and counselling to address the emotional concerns of individuals testing positive for Covid-19 in the country, the National Disaster Management Authority (NDMA) of India started a national level helpline to support these individuals. Details of the initiative have been outlined below.

Aim and Vision

The aim of the helpline was to provide brief psychosocial support to individuals diagnosed with Covid-19.

The helpline was developed with the vision to initiate a service which anonymously provided primary psychosocial assistance to Covid-19 patients in order to deal with their immediate stressors, and disseminated genuine and verified information surrounding the pandemic.

Objectives

The objectives of the initiative were as follows.

- To provide, emotional support and brief counselling interventions to people diagnosed with Covid-19.
- To provide accurate information surrounding the pandemic, in terms of treatment protocols in different states, precautions to be followed for prevention of the disease etc.
- To empower and support the patients and their families to reach out to services and resources available with them in case of continuing concerns.
- To provide basic resources of mental healthcare providers, NGOs and local helplines in cases of acute psychosocial distress.
- To provide structured training and supervision opportunities for volunteer

counsellors in order to improve client experience.

- To collate and organize the feedback obtained from volunteer counsellors to develop contextually sensitive policy recommendations for psychosocial interventions, training and supervision in the face of future crisis situations.

Overview

In response to the pandemic situation, in April 2020, NDMA started a helpline initiative to offer basic psychosocial support to the people who were diagnosed with Covid- 19 through telephonic counselling. The service was to be carried out by qualified and experienced counsellors. It was planned that such compassionate talking or counselling would entail specific components of Psychosocial First Aid (PFA) such as listening non- judgmentally, giving reassurance and general information and encouraging self-help and other support strategies. The intervention was unique and one of its kind in the country as it was a kind of a 'reverse' helpline whereby the people testing positive for Covid-19 did not call up the helpline but were instead called up for checking on their psychosocial state and providing some relief in the form of counselling. These counselling services were conducted remotely.

While other helplines did exist in the country during the pandemic, at times individuals testing positive for Covid-19 were not in a position to access the support needed. This could be due to a variety of reasons like lack of knowledge about the services, overwhelming physical, emotional or logistical situations, lack of telephonic connection, lack of cellular phone balance for prepaid phones and unavailability of mobile network connectivity among others. The uniqueness of the NDMA helpline lied in the fact that the volunteer counsellors proactively called up individuals diagnosed with Covid-19 and checked up on their physical and emotional health. In situations where individuals reported emotional concerns, brief psychosocial support was provided and resources were given to seek further help, if needed.

Inception

With the spread of the coronavirus infection in India, NDMA started receiving the details of people testing positive for Covid-19 in the country from ICMR (Indian Council of Medical Research) on a daily basis. This data was being used by NDMA for a variety of activities such as mobility analysis of patients, alerting people who came in contact with a person infected with Covid-19 to get themselves tested etc. It was during such exercises that officials of NDMA happened to talk to individuals diagnosed with Covid-19 and understood their need for emotional support, which ultimately led to the conceptualization of this initiative. NDMA initiated the psychosocial helpline on 22nd April 2020 after recognizing a need for psychological assistance services to help the people diagnosed with Covid-19 and the

larger community. The tele counselling services, in the form of psychological first aid, helped individuals and their families deal with the mental health concerns of the pandemic and provided transparent, genuine and timely information to them.

The helpline has currently been active for 10 months. Till the fourth week of January 2021, 120 volunteer counsellors had spoken to about 80,000 people diagnosed with Covid-19 in India.

Recruitment of Volunteer Counsellors

NDMA planned to recruit trained professionals from the field of mental health for the initiative. The volunteer counsellors working with NDMA comprised of clinical psychologists, counsellors and psychiatric social workers. In April, NDMA circulated a notice, inviting mental health professionals to be a part of this initiative through different social media platforms and asked them to send in their curriculum vitaes (CVs) for screening. After checking for relevant educational qualifications and professional experience in the field, NDMA recruited the first group of volunteer counsellors. A second batch of counsellors were recruited on 31st July 2020, followed by a third and fourth batch on 10th September 2020 and 9th October 2020 respectively, taking the total size of the group to around 120 volunteers. The volunteer counsellors were asked for their language preference during the time of recruitment, to be able to have a mixed group, speaking a range of vernacular languages.

Technical Support for the Work

For the purpose of the helpline, NDMA required a calling system to be developed where the numbers of the volunteer counsellors as well as the patient remained confidential to maintain the privacy of both parties involved. To fulfill this criteria, NDMA collaborated with Parahit Technologies, a technology provider company based in New Delhi, to develop a mobile application with the required features. The patient demographics and mobile numbers received by NDMA were segregated according to the language speaking preferences and sent to the service providers to upload the relevant data in individual counsellor accounts on the application. The first batch of counsellors were given basic training by NDMA to get them acquainted with the calling system and a WhatsApp group was also created where the counsellors could troubleshoot technical difficulties with the application, if need be.

It was observed within a few days that volunteer counsellors using an iOS operating software in their phones were unable to use the calling application. NDMA took this into account immediately and got the technology provider to develop a web based calling system

for such users within 15-20 days, after which the system was accessible by everyone in the group.

Whenever a new batch of counsellors were recruited, they were added to the WhatsApp group for the initial 7-10 days in order to get acquainted with the calling system and directly clarify their questions related to the navigation of the application. Post the initial handholding, the new counsellors continued to interact with the other volunteer counsellors in the Counsellor WhatsApp group and were asked to exit from the technical support group. Since the technical support group was a closed group wherein sensitive information was shared, it was preferred that newly recruited counsellors exited from the group once they were comfortable with the system. In case volunteer counsellors had technical glitches as they continued calling, they were asked to report their concerns to the programme coordinator, who then alerted the support team for resolution.

Protocols and Orientation

Post recruitment, the counsellors were provided necessary guidance on operational procedures, ethics and mental health advisories issued by NDMA as well as the Ministry of Health and Family Welfare, Government of India, which would need to be strictly adhered to while carrying out the service. They were also asked to sign a non-disclosure agreement, whereby the volunteer counsellors were required to maintain strict confidentiality regarding patient details and any other information shared with them.

Working of the Helpline

The tele counselling service was conducted through a specially designed mobile application which was installed in the volunteer counsellor's mobile phone. This mobile application ensured that neither the individual's number was visible to the counsellor nor the counsellor's number was visible to the individual. NDMA provided data of people testing positive for Covid-19 in India and fed it into the application installed in the counsellor's phone. When the counsellor called up an individual diagnosed with Covid-19 from the application, it only revealed the basic information required for counselling the person, while did not reveal the phone number to the counsellor. The volunteer counsellors then offered psychosocial support to individuals in the form of Covid-19 education, ways to cope with anxiety, fear and excessive thinking, bereavement counselling, enabling catharsis and inspiring hope and referrals to specialized services, as needed.

The volunteer counsellors were also required to fill in a feedback form with the details of their conversation with the assigned person(s) diagnosed with Covid-19 on a daily basis.

This form entailed demographic details of the individual like name, age, gender and location, a check-in on their sleep, mood and appetite, along with other psychological concerns faced by them and the response of the volunteer counsellor. These feedback responses were collected by NDMA and a daily and weekly report was generated with the summary of the issues emerging from feedback forms to be shared with state governments and relevant agencies.

Recruitment of the Research and Programme Associate

As the work expanded, a need was felt to involve a dedicated professional for supporting the coordination of the PSC Helpline as well as to carry out the research and documentation activities. Therefore, on 20th July 2020, NDMA appointed a Research Associate to provide support to the NDMA team in this aspect. This person was required to assist the volunteer counsellors by providing them with updated calling data, organizing training and supervision sessions for them, orienting the newly recruited counsellors with the protocols and responsibilities, and preparing daily and monthly reports about the findings to be handed to the Reporting Authority at NDMA. In cases of acute psychosocial distress reported by volunteer counsellors, the Research Associate had to escalate the information obtained to the higher authorities at NDMA for further action. The Research Associate was a point of contact for the volunteers, where she answered or forwarded their queries pertaining to the helpline to the relevant stakeholders and helped in its resolution.

In terms of the research and documentation, the Research Associate was required to conduct data collection by collating and organizing feedback forms received from volunteer counsellors along with conducting in-depth interviews with few purposively selected counsellors from the group, analyze the information obtained and prepare the final report. The Research Associate had to work closely with the Principal Investigator from the TISS-*Rahbar* team that was involved in supporting the training and research activities carried out by NDMA.

The NDMA Team

The NDMA team comprising of Shri. G.V.V. Sarma, IAS, Member Secretary (ex), NDMA, Shri. Sandeep Poundrik, IAS, Additional Secretary (ex), Mitigation, NDMA, Mr.Vijay Nemiwal, Joint Advisor, NDMA and Ms. Maitreyee Mukherjee, Senior Consultant, NDMA had been working on the PSC Helpline Initiative since its inception.

Furthering the Psychosocial Care Intervention with Delhi Police Personnel

Within a few weeks of commencement of the Psychosocial Care Helpline initiative, Delhi Police authorities approached the Member Secretary of the Mitigation Department at NDMA to extend the intervention for Delhi Police personnel who were testing positive for Covid-19. The effect of the Covid-19 pandemic and the resultant lockdown had a deep impact on the personnel, who were required to coordinate local shutdowns, encourage social distancing and enforce stay-at-home mandates all while completing the responsibilities for which they were already understaffed and underfunded. As first responders, they were also at the risk of experiencing increased stress due to the prolonged threat of virus exposure, hostility from other community members, shortage of resources and the concern of exposing their family members to the virus.

Calling Process and Technical Help

NDMA appointed two volunteer counsellors from the group exclusively to support the psychosocial needs of the personnel. Since the web based calling system was not developed by that time, one of the counsellors who had an iOS software, obliged by using her personal contact number to communicate with the police personnel to avoid any delay in beginning the counselling process. Meanwhile, the other counsellor used the mobile application in place for Android users. As the 'unlock phase' in the country started, one counsellor decided to terminate the work and go back to her private counselling practice, while the other counsellor continued to provide her services to the initiative. July onwards, a list of Covid-19 positive personnel was provided to the counsellor once a week and she was required to call them up. Follow up calls were also arranged with personnel who didn't answer the call or needed the counsellor to check on them again within a few days. Meanwhile, Delhi Police also collaborated with other organizations to provide support to their workforce who were diagnosed with Covid-19.

The numbers were received from the Delhi Police coordinator by the Senior Consultant at NDMA who then passed it on to the Research Associate. The Research Associate allotted these numbers to the service providers and they were required to upload it to the counsellor's accounts to ensure confidentiality of both parties. In case of any technical support, the counsellors could raise the issue with the Research Associate and she would then alert the technical team for resolution.

Additionally, the counsellors were part of the WhatsApp group where they could access support from other volunteer counsellors regarding the work and also discuss difficult

cases with each other without disclosing the identity of their clients. Direct communication linkages were established either by emails or WhatsApp messages between the counsellors and the NDMA Psychosocial Care team, comprising of the Senior Consultant and the Research Associate in case of any concerns that needed redressal.

Psychosocial Work with Delhi Police Personnel

In the initial months of the pandemic i.e. April, May and June, the work load was intense and both the counsellors were allotted numbers of Delhi police personnel who were diagnosed with Covid-19 on an everyday basis. They were required to dedicate 2-3 hours in a day to provide psychosocial support to them through different interventions based on their needs. On talking to the police personnel, several kinds of concerns came up which had an impact on their mental health, like the fear of infecting their families with the virus, distress due to the financial burden, stigma and health concerns among other logistical and social problems. Some of them also conveyed that the residents of their society had objections to them staying in the vicinity once they had contracted the virus, making the police personnel feel alienated and hurt. It was observed that out of the concern to protect their families, the personnel did not confide in their neighbours to share their feelings. At times, the hyper-masculine culture of policing also played a role in deterring them from expressing their vulnerability in front of anyone, including the counsellors.

Impact of Psychosocial Support on Police Personnel

The NDMA volunteer counsellors intervened with the police personnel by providing them a space to vent out their feelings and feel heard. The counsellors also educated them about various stressors that could have an impact on their mental health and tried to normalize the same. Supportive psychotherapy worked well with the personnel which was complimented with reassurance and building hope. Few instances of anxiety were navigated by helping them with grounding techniques, mindfulness and breathing exercises. Anger management was also used as an intervention in situations where personnel felt very frustrated with their situation. Most of the personnel were appreciative of the initiative and reported feeling understood and cared for. Being in a difficult profession like theirs where they had to constantly be present in the service of others, they felt acknowledged and rewarded that there was some to ask them how they were doing.

Reporting and Case Escalation

For the ease of coordination among the group, Delhi police members created a WhatsApp group that included the programme coordinator from Delhi Police, few authorities from the department and the counsellors from different organizations who were working with the initiative. Counsellors were alerted on the group when a list of numbers were allotted to them. At the end of the calls from a particular list, the counsellor from NDMA was supposed to prepare a report to be submitted to the Coordinator at Delhi Police and also to NDMA. This brief report included some demographic details of the personnel like name, age and gender, the nature of psychosocial concerns if any and the intervention used by the counsellor to support them.

In cases that needed immediate help, the counsellor was expected to contact the coordinator at Delhi Police on an urgent basis and report the issue to him. He would then take the case forward by escalating it to relevant authorities. The counsellor could also suggest long term mental health interventions and provide necessary resources to the personnel in case she assessed that they needed continued support for their concerns.

Webinars with Police Authorities

The Delhi Police officers also had regular webinars with the counsellors in order to gain feedback about the work and understand if anything more could be done from their side to support their taskforce. Experts in the field of mental health were invited to take up webinars on different topics related to psychosocial care during the pandemic. The counsellor from NDMA was also a part of few such webinars and gave her inputs on the topics covered.

Felicitation of the Work Done by NDMA

Following the continued success of the NDMA initiative in counselling Delhi police personnel diagnosed with Covid-19, the authorities at Delhi Police initiated a felicitation programme for all individuals and agencies who were involved in providing psychosocial support to their personnel. The programme was held on 18th August 2020. In this programme, Delhi Police felicitated NDMA functionaries for their contribution to the well-being of the Delhi Police personnel.

Training and Supervision of Helpline Counsellors: Collaboration with Rahbar, Tata Institute of Social Sciences

Tata Institute of Social Sciences

Tata Institute of Social Science, (TISS) was established in 1936 and since its inception has been a premier academic institution that has developed innovative teaching programmes and cutting edge research projects, all of which are rooted in socio-cultural realities. The vision of TISS is to be an institution of excellence in higher education that continually responds to changing social realities through the development and application of knowledge towards creating a people-centred, ecologically sustainable and just society that promotes and protects dignity, equality, social justice and human rights for all.

TISS has four campuses across India - Mumbai, Tuljapur, Hyderabad, Guwahati and extension work across the country. Currently, TISS has 21 schools, 45 centres and 8 independent centres dedicated towards quality education and research. Collectively, they offer a range of educational programmes at the bachelor's level, masters level and doctoral level, in addition to online, short-term and open distance learning programmes.

The School of Human Ecology

The School of Human Ecology (SHE) was established in 2015. However, 2009 onwards the School, in its earlier avatar as the Centre for Human Ecology successfully developed and anchored the MA in Counselling programme, which evolved into the M.A. in Applied Psychology programme (Clinical and Counselling practice) currently being offered by SHE. The School of Human Ecology now anchors an M.A. programme and an M.Phil. programme in Applied Psychology (Clinical and Counselling practice) and a Ph.D. in Applied Psychology. The programmes have been developed in response to the need to equip counsellors and clinicians with adequate skills to deal with the mental health crisis in the country. The School is uniquely positioned with expertise in the areas of Applied Psychology for the training and development of skilled professionals to work with individual adults, children, families and communities on aspects of well-being and quality of life. In addition, the SHE has been successfully running short term courses.

Rahbar

Rahbar ('guide' or 'companion' in Urdu) is a field action project of the School of Human Ecology, Tata Institute of Social Sciences, which aims to promote training, supervision and professional development for mental health practitioners in India, especially

those in resource constrained contexts, in order to ensure access to quality mental health care for all.

Rahbar was started in 2019 to help fill the gap in opportunities for lifelong professional development and specialized training and supervision for mental health professionals. The genesis of *Rahbar* was an outcome of a study conducted with psychotherapists across India, who articulated challenges in the field with respect to accessing high quality training and supervision (Duggal et al., 2020). Supervision involves a senior member of the field mentoring, supporting and monitoring a practitioner's work in order to ensure their ability to practice ethically and competently. This study found that unlike their counterparts in the West, upon the completion of basic training, mental health professionals in India had limited access to avenues for supervision. They were catering to extremely large case-loads and were at risk of experiencing burnout in the absence of adequate training or professional support. Mental health professionals in India strongly articulated the need for supervision but only a few are able to access it because of the dearth of supervisors and platforms. As a response to the findings of this study, *Rahbar* was established with the vision to provide accessible, affordable and high quality supervision to mental health professionals across India.

Rahbar's Covid-19 Initiative.

The Covid-19 pandemic and ensuing lockdown in April 2020 was a watershed moment for mental health professionals across the country. Not only did mental health professionals have to contend with navigating the abrupt transition to remote therapy in a resource-constrained nation, there was also an acute awareness of the mental health crisis that was brewing at our doorstep because of unmitigated infections, lockdown, migration, unemployment, and mass trauma. By April 2020, counsellors, psychologists, social workers across the country had begun to mobilize resources at local and national levels to launch helplines and pro bono mental health services. These early helplines and mental health initiatives formed the first layer of the country's spontaneous mental health response to the Covid-19 pandemic. It was during this time that *Rahbar* recognized the need for specialized training and supervision for counsellors involved in providing psychosocial services during the pandemic. Pre-existing frameworks of psychosocial first aid and crisis counselling developed in the West were not adequate to respond to the novel mental health challenges that an unprecedented pandemic and lockdown had created for the Indian population. In such a situation, mental health professionals would themselves have to create frameworks that were culturally relevant, trauma-informed, and responsive to the needs of the population

while simultaneously contending with higher caseloads, loss of income, loss of workspaces, greater exposure to trauma and the emotional impact of the pandemic in their personal lives. The need to support mental health professionals was therefore imminent and critical.

In April 2020, *Rahbar* launched its special Covid-19 initiative to support mental health professionals during the pandemic. Between April and November 2020 *Rahbar* has supported over 350 mental health professionals in India and Nepal through largely pro bono training and supervision, informed by the core values of promoting social justice, reflective practice and ethical care in mental health. *Rahbar's* approach has been one of 'supportive supervision' which recognizes that nurturing the emotional well-being and resilience of counsellors through the supervisory relationship is just as important as developing relevant knowledge, skills and competencies.

Rahbar's Collaboration with NDMA

In May 2020, the *Rahbar* team contacted the National Disaster Management Authority after learning of its Psychosocial Care Helpline for Covid-19. The *Rahbar* team proposed to support the helpline through training and supervision for counsellors. Training and supervision sessions by *Rahbar* commenced on May 28th, 2020 and since then *Rahbar* and NDMA's collaboration has continued to evolve through training, research & documentation, and manual development. The following table outlines key milestones of this collaboration

Table 1

Overview of Key Milestones in Rahbar and NDMA's Collaboration

Overview of Key Milestones in Rahbar and NDMA's Collaboration during the pandemic	
May 2020	● *Rahbar* team contacted NDMA to provide training and supervisory support to volunteer counsellors ● A 3 month Training and Supervision Plan was developed (June to August)
June 2020	● 4 Training Sessions were completed pro bono (weekly) ● 4 Supervision Sessions were completed pro bono (weekly)
July 2020	● Bi-monthly Supervision Sessions continued pro bono ● NDMA and *Rahbar* collaborated for Documentation and Research of Helpline initiative with ethical approval from TISS Ethics Review Board
August 2020	● Bi-monthly Supervision sessions for counsellors continued till end of August pro bono

	● NDMA offered to provide financial support for *Rahbar's* services and invited *Rahbar* to continue supervision for counsellors from September to December 2020
September 2020	● TISS and NDMA signed a Memorandum of Understanding (MoU) under which: ● *Rahbar* would provide 8 supervision sessions (bi-monthly) to NDMA's volunteer counsellors between September to December 2020 ● *Rahbar* would compile a training manual for psychosocial counselling during the pandemic in order to document the framework and learnings developed through the NDMA PSC Helpline. The manual would be published jointly by TISS and NDMA.
September to December 2020	● Bi- monthly Supervision Sessions continue ● Preparation of Training Manual underway ● Completion of Supervision sessions ● Submission of PSC Helpline Documentation Research & Report
February 2021	● Publication of Training Manual

Training and Supervision of Volunteer Counsellors

The aim of the collaboration between *Rahbar* and NDMA was to develop and deliver high quality training and supervision support for volunteer counsellors of the NDMA helpline. While the training sessions were aimed at enhancing counsellors' conceptual knowledge and theoretical background in psychosocial care interventions, the aim of supervision was to provide ongoing support for counsellor well-being, promote self-awareness and reflective practice and enhance skills.

Approach to Training and Supervision

Contextually Relevant. *Rahbar's* approach to training and supervision for NDMA counsellors was designed to be tailored to the cultural and contextual realities of India and the unique challenges experienced by counsellors in catering to diverse sections of the population. While developing training modules, care was taken not to draw exclusively from western concepts and frameworks of counselling without consideration of local realities and

the Indian cultural landscape. In creating training content, the facilitators drew upon evidence-based frameworks while striving to integrate these with learnings gained from their practice as clinicians in the field and experiences of training and supervision in India.

Informed by Social Justice. The *Rahbar* team was cognizant of the fact that in a country like India, mental health services needed to be grounded in the recognition of social, political and economic realities that reinforce structural oppression and give rise to vulnerabilities along the intersecting lines of gender, caste, class, religion, sexuality, (dis)ability and geographical location. Far from being an equalizer, the Covid-19 pandemic has only further cleaved these historical fault lines, revealing the inequality in society and further enhancing the need for mental health care approaches that are rooted in social justice.

Collaborative and Responsive. Training modules and supervision sessions were designed by *Rahbar* after conducting an in- depth needs assessment with the NDMA counsellors. This was done to ensure that the training content remained relevant, experience-near and collaborative for the counsellors. Prior to the start of training, counsellors were invited to fill out a comprehensive needs assessment form which consisted of open ended questions designed to elicit detailed responses on:

- Counsellors' professional background
- Nature of calls in PSC Helpline and needs articulated by persons diagnosed with Covid-19
- Gaps in skills and knowledge as perceived by the Counsellor in providing psychosocial care to people diagnosed with Covid-19
- Professional challenges in carrying out helpline work
- Suggestions for content to be covered in training and supervision sessions
- Suggestions for process of training and supervision (didactic/experiential/reflective/skill-based etc.)

Informed by Feedback. An attempt was made by the *Rahbar* team to consistently invite and utilize counsellors' feedback to reflect on the process of training and supervision. This was done by seeking detailed feedback from counsellors through online forms after each training session on aspects of the training such as:

1. Depth of Content covered
2. Style of facilitation
3. Pace of session
4. Safety of space

5. Methods used in session
6. Key learnings/outcomes
7. Limitations of the session
8. Suggestions for future sessions

Feedback was sought through a secure online platform which hosted a semi-structured feedback form. Feedback forms provided counsellors the option of entering data anonymously so as to protect their confidentiality and create a safe space for learning without the fear of trainer bias.

After each training session, feedback received from counsellors was analyzed and incorporated for the next session. Reflexivity was considered an important dimension of *Rahbar's* approach, therefore each session was followed by a detailed debrief between the facilitators to reflect on the process of the session, content discussed, facilitation style, facilitator assumptions and blind spots, and learnings from the session. Learnings from reflective debriefs and counsellor feedback were incorporated in subsequent sessions.

Overview of Training and Supervision Sessions

Training. A total of four training sessions were conducted by *Rahbar* for volunteer counsellors involved with NDMA's psychosocial support helpline. All the sessions were conducted weekly for a duration of two hours via a video based platform. Based on the needs and challenges articulated by the counsellors, and the emerging psychosocial challenges of people diagnosed with Covid-19, a training plan was designed and delivered. The following table outlines content and process of training sessions.

Table 2

Overview of Training Sessions for NDMA Counsellors by Rahbar (TISS)

Overview of Training Sessions for NDMA Counsellors by Rahbar (TISS)			
Session No.	**Module**	**Content**	**Process**
	Introductory Session	1. Introducing trainers and counsellors 2. Sharing overview of plan for training and supervision sessions with counsellors and seeking their feedback 3. Establishing a safe relational context for training 4. Reflective discussion on motivations to join the helpline	Ice breaker Introduction activity Reflective Activities
1.	**Psychosocial First Aid During the Pandemic**	1. Psychosocial Support and First Aid : Principles, Rationale and Models 2. Preparing to Start Psychosocial Support work 3. Skills in telephonic counselling 4. Basic counselling skills	Didactic Reflective Questions Case vignettes
2.	**Supporting Clients in Distress**	1. Assessing Needs 2. Linking Needs to Intervention 3. Supporting people with practical needs 4. Regulating high emotional distress (anxiety, anger and grief)	Didactic Skills Experiential Activities
3.	**Stigma**	1. Manifestations of stigma during the pandemic 2. Interventions for stigma at individual level 3. Interventions for stigma at a community level	Didactic Case Examples and Vignettes

4.	**Supporting Clients at High Risk and Ethical Practice**	1. Risk Management a. Understanding Risk b. Sources of Risk in the pandemic c. Assessment d. Interventions 2. Ethical Practice a. Ethical principles in counselling b. Ethical dilemmas in telephonic support c. Ethical decision making	Didactic (PPT) Case Examples Skills

Supervision Sessions. Supervision sessions conducted by *Rahbar* were aimed at enhancing the motivation and professional resilience of counsellors, building skills and promoting reflective practice. Supervision sessions were conducted in a group format and helped counsellors utilize the opportunity for peer learning through experiential activities, reflective dialogue and skill-building tasks. The focus of supervision sessions was modified as the needs and competencies of counsellors evolved. These were seen in three phases as outlined in the table below

Table 3

Overview of Supervision Sessions for NDMA Counsellors by Rahbar (TISS)

Overview of Supervision Sessions for NDMA Counsellors by *Rahbar* (TISS)		
Phase	**Description**	**Process**
Phase I Sessions 1 to 5	● In this phase, weekly supervision sessions were aimed at complementing the conceptual learning of weekly training sessions with an opportunity for reflective practice and skill building.	● Topics discussed in training were brought up for discussion in supervision through creative and experiential activities that invited counsellors to reflect on their own values, beliefs, biases and perspectives in order to promote counsellor self-awareness and reflexivity. Skill building activities were also incorporated.

Phase II Sessions 6 to 12	● Upon the completion of training modules, supervision sessions shifted to bi-monthly format. ● The focus of supervision shifted to case-based discussions where counsellors were invited to bring examples from helpline work for discussion to the group. ● The aim of case based discussion was to address common challenges faced by the counsellors group, create a space for group reflection, and develop skills in assessment and intervention for challenging problems.	● Case presentation by a maximum of two counsellors detailing nature of psychosocial concerns, challenges faced by counsellor. ● Reflections from the group were invited after the case presentation. Facilitated by the supervisors, the group reflected on counselling process and interventions used, and brainstormed alternate perspectives. ● Care was taken to ensure that demographic details and client identity were concealed and the Rahbar team reviewed the case a day before discussion.
Phase III Sessions 13 to 17	● In this phase the supervision sessions shifted to skill building activities and reflective practice	● Case vignettes were provided to the group and a list of counselling skills were presented under different categories like listening, support, exploration, perspective building, problem solving and limit setting ● Counsellors were invited to reflect on the vignette and phrase statements from different skill categories. ● Sessions on reflective practice focused on counsellors own journey with the helpline, their learnings, experiences and

		perceived growth. This was done through the medium of arts based activities.

The training and supervision sessions were anchored by the *Rahbar* Project Director and Project Co-ordinator.

Counsellors' Feedback on Training and Supervision

Counsellors provided feedback after each session, which helped the *Rahbar* team review the relevance of training content, reflect on the facilitators' approach and modify the process of training and supervision. Aspects of the sessions that were found helpful as well as those elements that needed to be changed were highlighted by counsellors in the feedback forms after every session.

Feedback from the counsellors indicated that the content of training was tailored to the knowledge and skills that they required to navigate specific challenges of providing psychosocial care to individuals diagnosed with Covid-19. Specifically, sessions that built knowledge on bereavement counselling, stigma mitigation and ethical decision making were rated as most helpful. In addition to developing conceptual knowledge, counsellors' feedback indicated that training was helpful when facilitators shared concrete techniques and tools that could be applied in the counselling sessions, e.g., what not to say to someone who is grieving, grounding techniques to reduce distress, etc. Counsellors also provided constructive suggestions on how the facilitators could improve their approach to training by pacing the sessions better and sharing reading material after the session.

In their feedback, counsellors indicated that supervision was a 'safe space' that promoted reflective practice and self-awareness. The personal and professional 'selves' of the counsellors were equally supported through the reflective activities of supervision, which gave counsellors an opportunity to feel validated, especially as they were navigating the challenges of Covid-19 in their own lives. Feedback indicated that activities used in supervision sparked counsellors' awareness of their own needs, values and biases and often helped them process the difficult emotions that routinely emerged while working with trauma. In terms of suggestions, counsellors suggested the inclusion of skill building practices in supervision which were duly incorporated.

Research and Documentation Support

In addition to providing training and supervision for volunteer counsellors, *Rahbar* also frontlined the process of conceptualizing the present research study to document the work of the PSC Helpline. NDMA invited Rahbar to assist in documenting the process and insights generated from the PSC helpline by utilizing data provided by counsellors. *Rahbar's* role involved conceptualizing the study and designing a research framework suitable for analysing all the relevant dimensions in the data entered by volunteer counsellors in their call feedback forms. The *Rahbar* team supported NDMA in recruiting a Research Associate for the purpose of the study and guided the research associate through the process of executing the study. The Research Associate prepared a research proposal which was then submitted by the Project Director of *Rahbar* to the Institute Review Board at TISS for Ethical Approval. Feedback from the Ethics Committee was received by *Rahbar* and recommendations were incorporated in the proposal. The *Rahbar* team oversaw the process of data collection and supported the Research Associate by auditing the data for analysis and designing the analysis framework. The Research Associate was guided by the Project Director and Project Coordinator of *Rahbar* in analysing the findings and compiling the present report. Senior Consultant, NDMA provided necessary support and programmatic insights to the Project Director and Coordinator of *Rahbar* as well as the Research Associate in carrying out this study.

Documentation and Insights from the PSC Helpline Initiative: Research Methods

Several studies have been conducted during the ongoing pandemic to understand its impact on the mental health of people infected as well as the general population. Based on the findings of existing research, brief psychological interventions have proved to be successful in alleviating the distress of individuals during large scale emergencies and disasters (Boscarino et al., 2011). However, there is very little documentation about the psychosocial initiatives carried out during the pandemic from India. The current research study was an endeavour to explore counsellor narratives in providing psychosocial support to individuals diagnosed with Covid-19 via the NDMA helpline. This chapter will present the methods that were employed to undertake the study.

Aim

The study aimed to explore the experiences of volunteer counsellors in providing psychosocial counselling via the NDMA helpline for persons diagnosed with Covid-19.

Objectives

- To explore what motivated the counsellors to volunteer for the psychosocial counselling helpline and provide support to persons diagnosed with Covid-19.
- To understand the range of psychosocial concerns experienced by persons diagnosed with Covid-19, as identified by the volunteer counsellors.
- To explore the nature of psychosocial counselling support provided to persons diagnosed with Covid-19 by the volunteer counsellors.
- To identify the challenges experienced by the volunteer counsellors in providing counselling to persons diagnosed with Covid-19
- To obtain the perspectives of volunteer counsellors on how the experience of working on the helpline impacted them personally and professionally.
- To explore the impact of training and supervision on the professional development of the volunteer counsellors as they provided psychosocial counselling support to persons diagnosed with Covid-19.

Rationale for the Study

At present, there is little documentation of mental health initiatives during the pandemic from India. By filling this gap in literature, this study was an attempt to highlight the critical but often overlooked mental health dimensions of the pandemic and advocate for the training and supervision of mental health professionals leading psychosocial support initiatives during crisis.

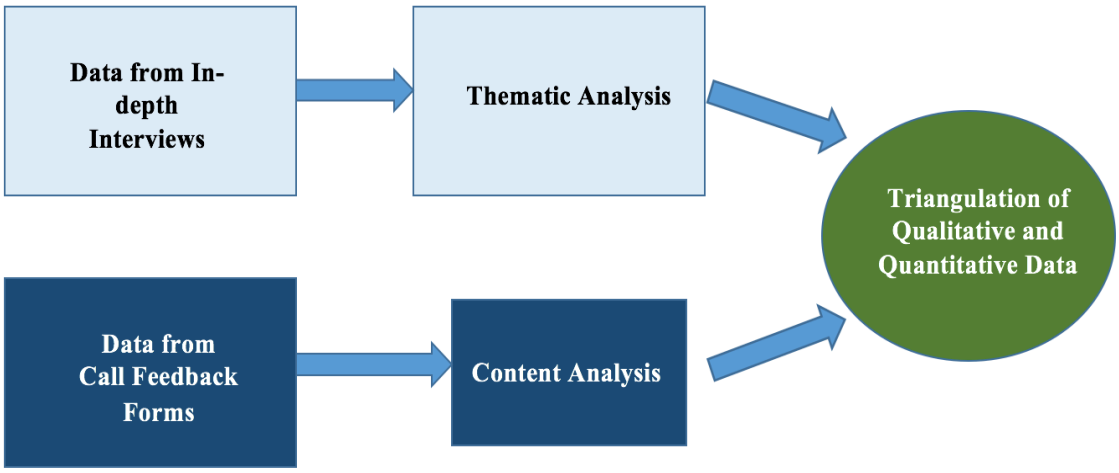
Approach to Inquiry

A qualitative dominant, concurrent triangulation mixed methods design was adopted for the current study. The intent of the concurrent design is to obtain different but complementary data on the same topic in order to best understand the research problem (Creswell & Clark, 2017). This method was ideally suited for the present research as it provided a means to analyze the quantitative data obtained from feedback forms and qualitative data from interviews with volunteer counsellors at the same time to understand the experiences of volunteer counsellors in providing psychosocial support to persons diagnosed with Covid-19. The feedback forms were content analyzed to transform the descriptive data to categorical and numerical data and thereafter, the quantitative analysis was done to understand the nature of psychosocial concerns identified by the volunteer counsellors as per age, gender and phase of calling. Through this process, the large data set of forms was made suitable for basic statistical analysis through frequencies, percentages and aided in establishing patterns in the data through cross-tabs.

Thematic analysis of interviews was carried out to identify and analyze patterns or themes within the data. Both, the qualitative and quantitative data were then integrated during the data interpretation stage and writing. The research design for the current study is depicted through Figure 1.

Figure 1

Research design for the current study



Tools

The following tools were used to obtain data for the study:

Call Feedback Form

This feedback form was filled out by volunteer counsellors each day that they completed calls. It was used to obtain data on the nature of psychosocial concern faced by the people and the interventions used by volunteer counsellors to respond to the same.

Intake Questionnaire

In order to obtain information about the professional context of the participants, an intake questionnaire was created which included questions about how the counsellors identified themselves professionally, their educational and training background, previous and current professional experience apart from working with the PSC initiative, therapeutic orientation and few questions about their association with the helpline.

In-depth Interview Guide

This guide consisted of open-ended questions developed keeping in mind the objectives of the study. The qualitative research interview is a place where knowledge is constructed from the direct interactions between the interviewer (researcher) and the interviewee (participant) (Polkinghorne, 2005), and in-depth interviews are one of the most widely used methods to collect data in a qualitative research study. Hence an in-depth interview guide was developed keeping in mind the objectives of the study. The domains of enquiry included in the interview were as follows-

- Introduction about their professional journey
- Motivation for joining the helpline
- Psychosocial concerns surrounding Covid-19
- Interventions and responses used by the counsellors
- Challenges faced by the counsellors
- Impact of working with the helpline on their personal and professional journeys and
- Role of training and supervision to improve their knowledge and skills.

Sample

The participants selected for this study included volunteer counsellors who had been working with the NDMA Psychosocial helpline initiative for people diagnosed with Covid-19. The inclusion criteria for the selection of participants were:

Inclusion Criteria

The sample included volunteer counsellors from the NDMA helpline with:

- A minimum qualification of Masters in Psychology or Social Work or specialized courses in disaster based psychosocial care.
- Volunteering for the NDMA Psychosocial helpline initiative for a minimum of 1 month
- Completed a minimum of 100 calls during their period of engagement.
- Had submitted completed feedback forms for the days that they had made calls.

Sampling Strategy

The participants were selected using purposeful sampling. In purposeful sampling, participants are deliberately selected by the researcher for their ability to provide rich insights that are relevant for the research questions at hand (Patton, 2014). Out of a total of 120 volunteer counsellors who were a part of the initiative at different points of time, 20 individuals meeting the inclusion criteria were approached to obtain consent to use their filled feedback forms. Within that group, consent was sought from counsellors for an in-depth interview. Eleven volunteer counsellors who were actively engaged with the volunteer work and gave consent to be a part of the study were further interviewed. The final sample size was determined based on saturation of data.

Sample Size

Call feedback forms of 20 volunteer counsellors were analyzed for obtaining quantitative data. Within this group, in-depth interviews were conducted with 11 participants.

Ethical Considerations

The research proposal for the present study was submitted to the Institute Review Board (IRB) of the Tata Institute of Social Sciences for Ethical Review. The IRB provided detailed feedback on various dimensions of the study in order to ensure the rights of participating counsellors and protect the data obtained from persons diagnosed with Covid-19. Based on the recommendations of the IRB, several changes were incorporated in the proposal which ensured greater sensitivity and rigour in data collection and clarity on the rights of participants.

The following ethical considerations were kept in mind during the study:

Ethical Considerations for Accessing Data from Counsellor Feedback Forms

- Identifying details about persons diagnosed with Covid-19 was not used in any way. The focus was to review and analyse the counsellor feedback forms on psychosocial concerns experienced. In the data shared by counsellors, anonymity and confidentiality was maintained by masking the identifying information of the patients and the counsellors. This data was only accessible to the NDMA team and was shared with the *Rahbar* team only for analysis after it was coded and entered into a master sheet.
- Written informed consent was obtained from counsellors prior to using their call feedback forms for any further analysis. They were informed about the details of the study and were also assured that their participation was completely voluntary. At any point during the study, they could decide to withdraw their participation without it having any implications on other aspects of their involvement with the initiative.

Ethical Considerations for Interviews with Counsellors

- A detailed participant information sheet, containing information about the research was provided in Hindi/English to all the counsellors approached to be a part of the study. This Participant Information Sheet was designed to be easy to understand and outlined clearly the purpose of the study, specific details regarding the process of data collection, risks and benefits of participation and an orientation to the rights of participants.

- Written informed consent for participation and audio recording was obtained from all counsellors. Each participant was given the opportunity to ask questions and address clarifications prior to data collections. During the process of seeking informed consent participants were assured that their participation was entirely voluntary and that they had the right to withdraw from the study at any point without it impacting their role in the helpline or training sessions.
- Participants were informed that the study would be carried out as a collaboration between NDMA and the TISS *Rahbar* team. Since the *Rahbar* team was involved in overseeing the data analysis and was also familiar with the counsellors through their interactions during training, steps were taken to mitigate an ethical breach of participant confidentiality. The Research Associate assigned a pseudonym to each participating counsellor and ensured that all identifying data was masked before data analysis with the *Rahbar* team. Before seeking informed consent, participants were told that no identifying information would be revealed during data analysis, or for reports and publications emerging from the study.
- The interviews were scheduled according to the convenience of the counsellors.
- The interviews were conducted by the Research Associate who was a trained psychologist and was oriented to the ethics of this research. The researcher was equipped to offer psychological support if any part of data collection created distress for the participants.
- Participants were informed that if any part of the interview process was distressing for them, they had the choice to pause, skip the question, or stop the interview altogether.
- After the interview the researcher conducted a debrief with the participants to ensure that the process was comfortable for them, as well as to seek their feedback on the process.
- Audio recordings of the interview were accessible only to the researcher. Safety and confidentiality was maintained by ensuring digital storage of data in encrypted formats.

Data Collection Process

Counsellors entered client data into feedback forms at the end of each day. The call feedback for the months of April to July was submitted to NDMA and made available to the Research Associate after she joined. Post her appointment, volunteer counsellors were asked

to submit their feedback forms on another Email ID that was jointly accessible by the Research Associate as well as the Reporting Authority at NDMA. A signed consent was sought from the potential participants before using their feedback forms. The Research Associate then collated the forms received and masked all the identifying information of the volunteer counsellors and patients to maintain anonymity, by developing a code book.

Development of a Code Book

Information available from each call feedback form was organised into domains like demographics, status of the person when contacted, nature of psychosocial concerns reported, interventions from the counsellor and positive feedback from the clients. Within each domain, sub-domains were identified based on what was available in the call feedback forms. For example, the sub-domains identified under the domain of interventions used by counsellors were disseminating accurate information, using supportive techniques, providing hope and positivity, providing a holding space for clients, giving reassurance, building insight and providing referral services/linkages to relevant resources.

The code book was a compilation of all domains and sub-domains that were identified, and codes were assigned for data entry. Age of the clients were entered as reported in the feedback forms while other data, like for instance current status of the client, were given codes like '1'- in hospital or quarantine centres, '2'- at home. Sub-domains within them were given codes like '2.1'- in home quarantine since the beginning, '2.2'- home quarantined after returning from the quarantine centre. The missing data was coded as '999' while data that was not applicable was entered as '99'.

The data from the feedback forms was entered on MS Excel using the codes to ensure that the code book was effective and comprehensive. Some initial analysis was done on MS Excel itself to ensure that the data obtained could be used for further analysis. Few additional codes were added after re-evaluating the codes and the code book was finalized.

Data Entry

Data was entered based on the code book created on all identified domains like sociodemographic data, status of the person when called, nature of psychosocial concerns, interventions used by counsellors and the positive feedback obtained. This provided a brief overview of the calls made by the participants to people diagnosed with Covid-19 and the feedback obtained from them. The data was entered on MS Excel using codes as developed in the code book.

Interview Process

The identified volunteer counsellors were asked to fill out the intake questionnaire and mail it to the researcher before the interview was conducted, to help the researcher get a fair knowledge about the participant before the interaction. They were then contacted by the researcher and the purpose of the study was described to them. Their queries, if any, were answered. The interviews were conducted on Zoom, a video calling application, and the invite to join the call was sent to the participants in advance for the slot decided by them. The process began with a detailed orientation to the ethics of the study and participants' rights such as establishment and maintenance of anonymity and confidentiality, right to withdraw consent and exclusion of any part of their narrative they were not comfortable with including in the final study. Following this, a signed informed consent was asked to be mailed from their side. After the participants were comfortable with the procedure, the interview process began, once permission was sought for recording the interviews.

Each interview lasted for 1.5 hours to 2 hours, depending on the participant's involvement with the research process. At the end of the interviews, the participants were duly thanked for their time and contribution, and the conversation was kept open for additional comments and concerns.

Analysis

Quantitative Data Analysis

The responses from feedback forms were content analysed to transform qualitative data to quantitative data using the code book. Once the data was entered on MS Excel, it was reviewed for accuracy and data cleaning was done, which involved removal or editing of incorrectly entered data. This data was then imported on Statistical Package for Social Sciences (SPSS) version 20, for secondary analysis for each of the domains on which data was entered. Both descriptive and initial statistics were used to analyze the data, using cross tabulation or contingency tables. Chi-square and Fisher's Exact tests were also conducted to assess whether there existed an association with categorical variables like age, gender or phase of calling with the nature of psychosocial concerns brought up in the calls. The following were the null and alternative hypothesis that were presumed in the Chi square test of association.

N1- There will be no significant association between the two groups.

A1- There will be a significant association between the two groups.

Qualitative Data Analysis

Interviews were audio-recorded and transcribed word-to-word. Thematic analysis was used to analyze the qualitative data obtained from the in-depth interviews. Thematic analysis is defined as a qualitative analytical method for "identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes the data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic." (Braun & Clark, 2006, p. 79). It offers an accessible and theoretically flexible approach to analysing qualitative data. Line-by-line coding was carried out and these codes were collected to form broader themes that made organizing the findings of the study much easier to understand.

Data pertaining specifically to the psychosocial concerns faced by persons diagnosed with Covid-19 and responses of counsellors to these concerns were triangulated from feedback forms and counsellors' interviews, to create an in-depth understanding of the mental health challenges associated with Covid-19. Client experiences related to their motivation to join the initiative, challenges faced and impact of the work on personal and professional development was also categorized and presented thematically.

Data Presentation

The responses for qualitative data in the following sections have been discussed according to a notation given by Pope-Davies et al. (2002). Since there were a total of 11 counsellors who were interviewed, the words like 'generally', 'most', 'many', 'often', 'majority', 'usually' and 'typically' were used to indicate the characteristic response of a majority (six or more) of the respondents. The words 'some' indicated responses from four to six respondents. 'A few' indicated responses from three or fewer participants.

For the quantitative data, the level of significance used for all the statistical tests was .05. Chi square tests were conducted for large sample sizes, specifically to test associations of psychosocial stressors with gender and phase of calling. Fisher's exact test, on the other hand, was used when one or more of the categories had a small-sized sample, like the association of age with psychosocial concerns.

Counsellor Call Metrics

The 20 counsellors made a total of 7186 successful calls between the months of April and September. Psychosocial concerns were brought up in 657 calls i.e., 9.14% of the total calls. The counsellors made between 107 to 649 calls each with an average of 359 calls recorded per counsellor. In their feedback forms, counsellors reported the brief interventions

used under the broad themes of enabling catharsis and inspiring hope. One hundred and seventy-eight counsellors (27.09%) mentioned that they used the former intervention while 68 used the latter. The call metrics have been presented in the table below.

Table 4

Counsellor call metrics

No of counsellors	Total no. of calls	Range of calls	Average calls per counsellor	Number of calls with psychosocial concerns	Brief Interventions used	
					Inspiring Hope	Catharsis
20	7186	107- 649	359	657 (9.14%)	68 (10.35%)	178 (27.09%)

Client Data

Call feedback forms received from volunteer counsellors reported that they provided psychosocial support to 657 clients and/or their family members from April to September, out of which 444 clients were men and 213 were women. The age of the clients ranged between 14-days to 93 years with an average client age of 40.52 years. At the time of the call by the counsellor, it was reported that 216 clients were currently in hospitals/quarantine centres, 217 in home quarantine and 143 clients had returned home after completing their quarantine period in hospitals or other quarantine centres. Data about their current state was not obtained from 81 clients. Out of the 657 clients counselled, 121 of them requested a call back from the counsellors after a few days to check on their emotional well-being as they believed that it would be beneficial for them. The information has been presented in the table below.

Table 5

Overview of Client Data

No. of clients who were provided psychosocial support	Gender wise break up		Age		Quarantine status of client				Callback %
	Male	Female	Age range	Average Age	In hospital/quarantine center	Home quarantined	Back home after quarantining elsewhere	Missing Data	
657	444(67.57%)	213(32.42%)	0.04 yrs. to 93 yrs.	40.52	216 (32.87%)	217(33.02%)	143(21.76%)	81(12.32%)	121 (18.41%)

Age and Gender Distribution

From the sample size of 657 clients who had reported psychosocial concerns, age details were available for 646 clients, as the age of nine men and two women were not mentioned in the respective feedback forms.

Of the 646 clients, for whom age details were available, the age range of the men was 14 days-84 years and of the women was 1-93 years. The mean age of men was 40.60 years while the mean age for women was 40.45 years. It can be seen that most men (43.2%) and women (45.5%) who faced psychosocial concerns, either reported by themselves or by their family members were in the age range of 21-40 years. Followed by that, 167 men (37.6%) and 65 women (30.5%) belonged to the age range of 41-60 years. The table indicates that ~9.7% men and ~17% women in the age range of 61 to 100 years mentioned the presence of psychosocial issues related to Covid-19 in their calls. In the age group of 0-20 years, there were 7.4% men and 6.1% women who reported psychosocial concerns.

Table 6

Age and gender distribution of clients (N=657)

Gender	**Men**	**Women**
Age	Frequency (%)	
0-20	33 (7.4)	13 (6.1)
21-40	192 (43.2)	97(45.5)
41-60	167 (37.6)	65 (30.5)
61-80	41 (9.2)	30(14.1)
81-100	2 (0.5)	6 (2.8)
Missing data	9 (2)	2 (0.9)
Total	444(100)	213(100)

Geographical Location

Of the 657 clients who reported psychosocial concerns, 16.2% were located in Delhi , followed by Maharashtra (13.54%), Andhra Pradesh (12.7%) and West Bengal (9.74%).

Table 7

Geographical location of clients (N=657)

State	No. of calls with psychosocial concerns	Percentage (%)
Delhi	107	16.2
Maharashtra	89	13.54
Andhra Pradesh	80	12.17
West Bengal	64	9.74
Assam	57	8.67
Uttar Pradesh	39	5.93
Kerala	39	5.93
Karnataka	36	5.47
Telangana	34	5.17
Gujarat	30	4.56
Rajasthan	28	4.26
Bihar	21	3.2
Tamil Nadu	17	2.58
Uttarakhand	12	1.82
Madhya Pradesh	3	0.45
Missing data	1	0.15
	657	100

Volunteer Counsellors' Profile

The twenty volunteer counsellors participating in the current study belonged to diverse professional backgrounds and had varied counselling experience. In the group, there were four men participants and sixteen women participants and their age ranged between 22 years to 65 years. Some of the participants had been a part of the initiative since the beginning and had completed six months of association with the PSC helpline by the end of September while some others had joined the helpline more recently. Their training and supervision attendance was also based on the time that they had been involved with the initiative. The socio-demographic details have been presented in the table given below.

Table 8

Socio-demographic details of the counsellors

Name (Pseudonyms)	Age	Gender	Educational background	Total no. of completed calls	Months of Engagement	No. of Training and supervision session attended
Rishabh	24	M	Masters in Clinical Psychology	346	2 months	3
Priyanka	44	F	Masters in Psychology	496	6 months	12
Meenal	25	F	Masters (MSc) in Psychology	502	6 months	10
Deepali	54	F	Masters in Social Work	373	6 months	12
Namrata	30	F	MPhil in Psychiatric Social work	544	6 months	11
Kriti	23	F	Masters in Clinical Psychology	227	6 months	9
Nivedita	30	F	Masters in Psychology	618	5 months	7
Roohi	50	F	Masters in Counselling Psychology	649	4 months	13
Shalini	22	F	Masters in Clinical Psychology	228	3 months	10
Keshav	45	M	Course on Disaster Psychosocial Intervention	308	5 months	11
Naresh	40	M	Masters in Behavioural management and cognitive therapy	302	4 months	6
Prachi	65	F	PhD in Sociology	107	3 months	12
Mrinalini	23	F	MSc in Clinical Psychology	148	4 months	12
Anushka	24	F	Masters in Psychology	496	6 months	4
Anjali	40	F	PhD in Clinical Psychology	368	6 months	7
Beena	36	F	Masters in Psychology	225	4 months	9
Neeraj	24	M	Masters in Clinical Psychology	347	2 months	4
Suman	24	F	Masters in Clinical Psychology	381	2 months	3
Akshita	23	F	Masters in Clinical Psychology	340	2 months	4
Aishwarya	23	F	Masters in Clinical Psychology	181	2 months	1

*A total of 14 training and supervision sessions were conducted by the TISS Rahbar Team till the end of September.

Further, the participants who were interviewed were also asked about the professional setting(s) where they had previously practiced or were currently practicing and the therapeutic orientation they identified with. The volunteer counsellors had varied experience of working in educational settings like schools and colleges, hospital outpatient facilities, government service agencies, NGOs and some also had a private practice of their own. Most of them viewed their orientation as being eclectic and integrative, where their therapeutic approach drew from supportive, interpersonal, humanistic, systemic, cognitive, behavioural and psychodynamic frameworks.

The chapter outlined the process by which the research study was conceptualised and carried out. It attempted to give the readers a detailed understanding about the research framework employed, insights into counsellor and client demographics, data collection process and analysis. The findings of the study would be described further in the following chapters.

Findings from the Study:

Nature of Psychosocial Concerns and Intervention Approaches

This chapter presents the nature of psychosocial concerns faced by individuals diagnosed with Covid-19 and the impact it had on their emotional well-being, as identified by the volunteer counsellors. Interventions used by counsellors to respond to client distress are also outlined. Narratives of resilience that emerged from conversations with individuals were highlighted. Information gathered from the in-depth interviews was triangulated with the data received from the call feedback forms of the counsellors to develop a deeper understanding of the concerns and interventions related to Covid-19. The major themes that emerged have been discussed below.

Nature of Psychosocial Concerns

Volunteer counsellors shared a range of psychosocial concerns that were noted in the feedback forms and were also shared during the in-depth interview that was conducted. The concerns reported were related to medical facilities and healthcare services, finances, logistics, stigma experienced, and relational issues. Each of these domains have been discussed below.

Health Concerns

This section covers concerns pertaining to the health of individuals after they were diagnosed with Covid-19. A total of 234 individuals (35.61%) out of the entire sample reported this concern. Sources of distress for clients included their experience of Covid symptoms, concerns related to testing, presence of comorbid health conditions, fear of recurrence of the infection and fear of death due to the disease.

Figure 2

Health Concerns Reported by Clients (N=234)

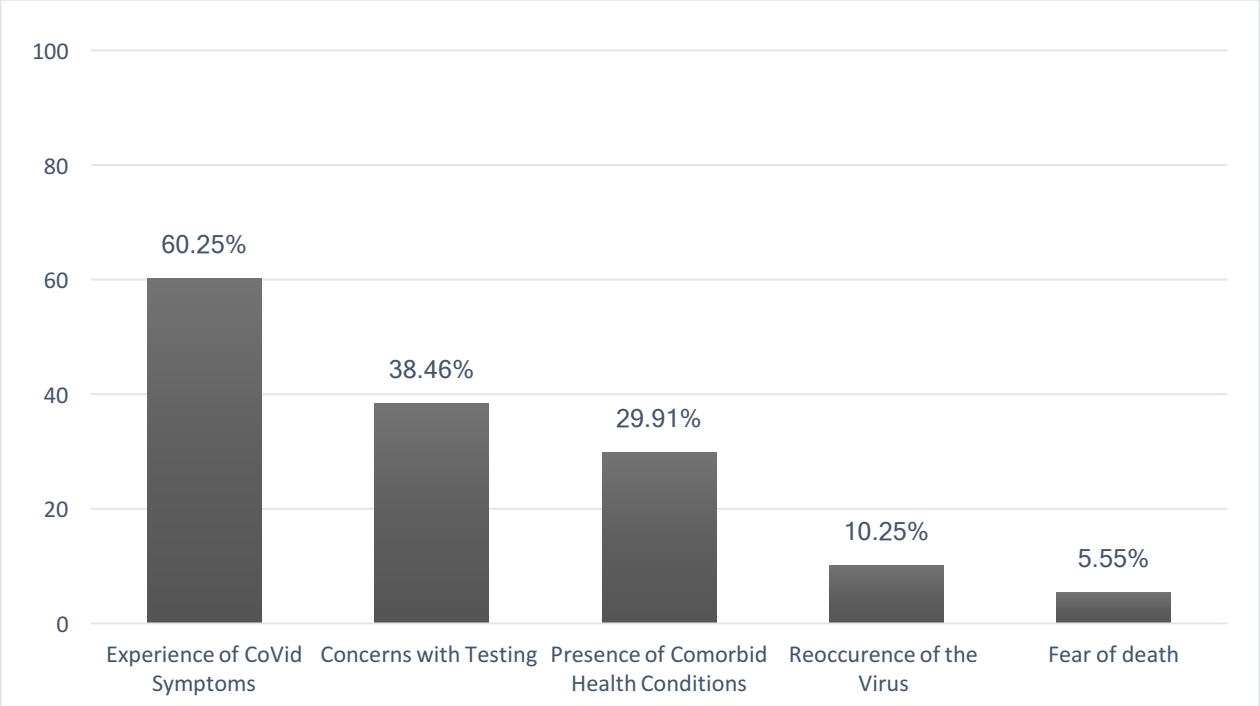


Figure 2 depicts the health concerns that were shared by individuals diagnosed with Covid-19 as per the entries on the feedback forms. The details of the nature of health concerns experienced as per the quantitative and qualitative data obtained will be discussed below.

Experience of Covid-19 Symptoms. During the calls, more than half individuals (60.25%) stated that they were concerned about the symptoms related to the virus that they were experiencing, such as breathlessness, body ache, loss of sense of taste and smell etc.

Concerns with Testing. As per call records, 38.46% individuals cited testing related concerns as a source of distress. Out of 90 people who reported this concern, 37.78% mentioned that a retest was not done after the completion of their quarantine period to confirm that they were free of the infection. 34.45% individuals also doubted the validity of the test in the absence of Covid symptoms. 27.78% mentioned that there was a delay in

testing while 18.89% individuals reported that they did not receive the physical copy of the test reports. Some individuals (18.89%) conveyed that there was a discrepancy between two Covid-19 test results.

One counsellor brought forward a situation where a family member reported receiving test results after their family member had passed away due to Covid-19. Meenal (F, 25 years) described,

> The man had died 45 days earlier and they got a call just 3 days ago telling that they took a test and it is positive. What's the point now? Apparently the family kept getting calls from volunteers asking how they were and she was very frustrated about the whole thing. (Meenal)

Presence of Comorbid Health Conditions. Approximately 30% individuals highlighted that the presence of comorbid medical conditions like diabetes, high blood pressure, cardiovascular issues, cancer etc. was a matter of concern for them due to their heightened vulnerability to the effects of the infection. According to Centres for Disease Control and Prevention, adults with pre-existing underlying medical conditions were at an increased risk for severe illness from the virus that caused Covid-19.

An additional theme brought up in one of the interviews with volunteer counsellors was the exacerbation of mental health concerns in individuals with pre-existing conditions. Shalini (F, 22 years) reported, "pre-existing mental health conditions…got further exacerbated during the pandemic due to the destruction of regular lifestyle." She also discussed how stressors related to the pandemic had worsened a client's symptoms of clinical depression and led to deterioration in his condition.

Recurrence of the Virus. For 10.25% individuals, the possibility of recurrence of the infection post-recovery was a stressor. Narratives of few volunteer counsellors revealed that clients feared going back to the same environment after recovery as they were afraid of reinfection from others who might have not got themselves tested. One of the counsellors, Priyanka (F, 44 years) shared a similar concern that came up during her conversation with a client. She said,

> The houses in slum areas are so close that people would fear going back home because most of them [sic] were not getting tested. Those who got themselves treated didn't want to go back. I could see anger and helplessness and hopelessness in them. (Priyanka)

Lack of information about the pandemic deepened the fear in individuals as they didn't know if a re-infection could occur.

Fear of Death. Some individuals (5.55%) also reported a fear that they might succumb to the virus, especially those with comorbid health conditions or those who belonged to the geriatric population. Another issue was the acute fear in the beginning of the pandemic that anyone who had contracted the virus would eventually die. This was anxiety-provoking and caused people to panic. In the words of Rishabh (M, 24 years), **"**one kind of fear was that if you contract the virus you are going to die."

Cross tabulations and chi-square tests were used to test the association of overall health concerns with age and gender of clients and the phase during which the call was made to them.

Table 9

Cross Tabulation and Chi-square Result for Gender and Health Concerns (N=657)

		Overall Clients		Clients Reporting Health Concerns		Chi square Test of Independence
		N	%	N	%	
Gender	Men	444	67	148	63	3.113
	Women	213	33	86	37	
Total		657	100	234	100	

There was no significant association between gender of clients and the health concerns reported, (χ^2 (1, N= 657) = 3.11, p = .078) with the concerns being relevant for both men and women.

Table 10

Cross Tabulation and Fisher's Exact Test Result for Age and Health Concerns (N=646)

		Overall Clients		Clients Reporting Health Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	15	6.6	5.372
	21-40 years	289	44.7	94	41	
	41-60 years	232	35.9	85	37.1	
	61-80 years	71	11	33	14.4	
	81-100 years	8	1.2	2	0.9	
Total		646	100	229	100	

Fisher's exact test results showed that there was no significant association between age of clients and health concerns reported. Individuals across age groups reported these concerns.

Table 11

Cross Tabulation and Chi-square Result for Phase of Calling and Health Concerns (N=657)

		Overall Clients		Clients Reporting Health Concerns		Chi-Square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	51	21.8	1.075
	Quarter 2 (July, August and September)	528	80.4	183	78.2	
Total		657	100	234	100	

As depicted in Table 11, no significant association was found between the phase of calling and health concerns presented, (χ^2 (1, N= 657) = 1.075, p = 0.300). Individuals reported health concerns across both phases of calling.

Medical Concerns

This section covers stressors related to unsatisfactory medical facilities and disappointment with authorities that was a source of distress for individuals diagnosed with Covid-19. These stressors were reported by 162 individuals i.e. 24.65% of the entire sample population. Concerns pertained to lack of medical care and treatment, unsatisfactory food and cleanliness in the hospital or quarantine centres, exorbitant treatment costs and patient information not being conveyed.

Figure 3

Medical Concerns Reported by Clients (N=162)

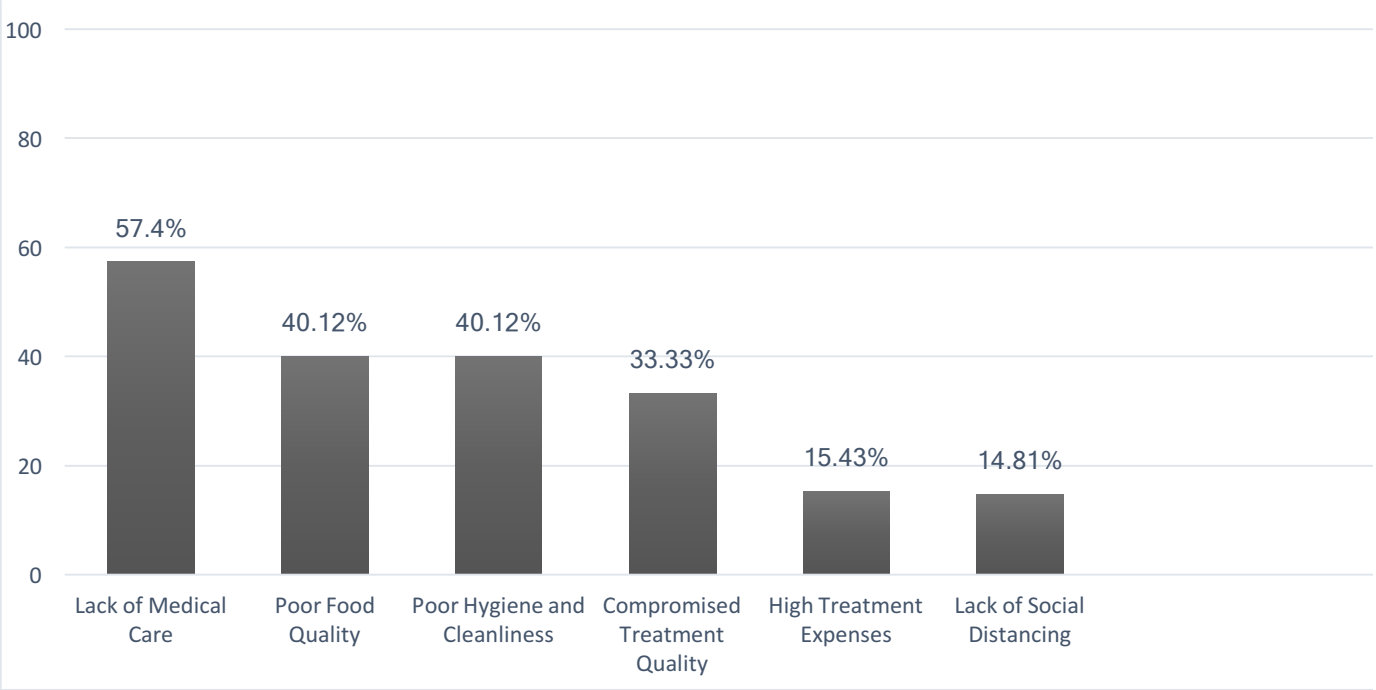


Figure 3 depicts the concerns related to medical facilities and response of authorities as brought forward by individuals diagnosed with Covid-19. The data obtained from the feedback forms and interviews with volunteer counsellors will be discussed further.

Lack of Medical Care. This concern was presented by more than half individuals (57.4%) who felt that they were not treated well by hospital authorities and staff. In the words of one of the volunteer counsellors, Deepali (F, 54 years),

> An aspect which was time and again reported (by clients) for specific centres and hospitals was the attitude of doctors where the patients said that they were treated very inhumanely.

> The staff would throw the packets of medicines and biscuits from the threshold of the room… (Deepali)

The same counsellor went on to outline a specific case where the unsatisfactory experience with the doctors that had a deep impact on the patient. She described,

> They had just come back paying 5 lakhs to the hospital for the services which were atrocious but also because of the treatment the doctors gave. So either he is in shock or a state of depression because of this. Otherwise because of being Covid positive he didn't have any suffering, but this attitude had snatched away his confidence and self-esteem. (Deepali)

Poor Food Quality. About 40% individuals mentioned that they were unsatisfied with the food provided in hospitals/quarantine centres where they were admitted for treatment. Data from the feedback forms were further coded and analysed to explore specific concerns related to food that emerged. Out of the total individuals who reported this concern, a large group (80%) thought that the food was unsuitable and not in sync with their needs. 50.76% revealed that the food provided was unhygienic while 35.38% people found the diet to be inadequate according to the needs of a recovering patient. Additionally, 20% individuals also reported that they were not given meals after regular intervals, which could have an effect on their recovery.

Poor Hygiene and Cleanliness. Similar to the previous concern, 40.12% individuals had concerns regarding the cleanliness of the hospitals/quarantine centres. 98.46% of the total individuals who spoke about this concern mentioned that washrooms/bathing areas were in unhygienic conditions while 83.07% stated that the wards were not clean. At times, patients were expected to share common toilets and bathing areas and wait in long queues for their turn, which added to their distress.

Compromised Treatment Quality. Some individuals (33.33%) shared that the medical treatment provided to them in hospitals/quarantine centres was not proper. Out of the individuals who mentioned this concern, 51.85% individuals stated that the protocols and guidelines with respect to Covid-19 treatment in hospitals were ambiguous while 40.74% were of the opinion that timely medical help was not provided, which led to a deterioration in the patient's health. 24.07% believed that treatment for other illnesses were not provided by the doctors during this time while 1.85% reported that medical authorities wrongly labelled them as being Covid-19 positive and started Covid-19 related medication when in reality they had visited the hospital for some other concern.

The concern about timely help not being provided by hospitals was also highlighted in an interview with a volunteer counsellor. Meenal (F, 25 years) described a situation where family members of a patient blamed the hospital authorities for the person's death. She said, "More than loss it was frustration and anger towards how the case was being handled by the authorities. Because they felt things were not done in a timely way and that's why the person had passed away." Another counsellor, Namrata (F, 30 years) spoke about the current state of hospitals where treatment for other illnesses was not being given. She said, "these days many people are being admitted or going to the hospital for their other needs… like if they have diabetes or asthma but those issues are not being taken care of and everywhere it's Covid-19"

The Covid-19 pandemic had only added to the already strained system and emphasized the critical need to expand public health services across the country.

High Treatment Expenses. Some individuals (15.43%) reported that hospitals/quarantine centres were charging them exorbitantly for the treatment. Narratives from interviews with volunteer counsellors also revealed that individuals felt exploited as they were charged hefty amounts for medications and treatment while there was little transparency regarding how the money was being used. According to Priyanka (F, 44 years), "their bills come up to 11 lakhs or 16 lakhs and the person doesn't survive. So the family is left with 2 burdens- one is loss of a loved one and also with the financial burden." Another counsellor, Deepali (F, 54 years) shed light on the possibility of private hospitals overcharging clients. She said, I know a lot of patients who felt very cheated ...they charge about 50000 a day… so a lot of anger towards private hospitals who were charging exorbitantly, minting money in the pretext of this."

Lack of Social Distancing. About 15% individuals described their hospital wards or quarantine centres to be overcrowded. They mentioned that the objective of quarantining patients was not fulfilled as social distancing was not possible in such an environment. At times, people also reported that recovering patients were kept in the same vicinity with patients who had just been diagnosed with Covid-19, which could increase the chances of reinfection. In the words of one of the participant counsellors, Namrata (F, 30 years), who had been counselling Delhi police personnel,

> There was this thing of police personnel having to share common toilets because many of them were put in quarantine centres and not everyone was provided with hospitals. So sharing of common toilets and questions like how the infection will increase were there… (Namrata)

Lack of Information. An additional theme that some counsellors brought forward in the interviews was the inability of family members to get updates about the patient's health once they had been hospitalized. Family members often conveyed anger and frustration as there was no transparency about the treatment being provided. Meenal (F, 25 years) stated,

> The nurses and doctors don't really answer patient questions when they need or they don't respond to the families when called. When called in the hospital they say "I don't know and there is another doctor who is going to come so maybe you can ask him." So it's a constant cycle that the family doesn't get answers… (Meenal)

Another counsellor, Shalini (F, 22 years) described a case wherein family members were not informed by the hospital authorities about how the person had passed away. She described,

> I had a call with somebody who had lost their father and he told me that the gentleman who had passed away was in his late 70s or early 80s…I think there was a lot of frustration about not having got any clarity of what happened and there was a delay in test results. (Shalini)

They reported a lack of clarity about the treatment protocols being followed in hospitals as they were not allowed to meet patients or get accurate information from any source in the hospital.

Cross tabulations and chi-square tests were done to test the association of all the concerns related to medical facilities and authorities with age and gender of clients and the phase during which the call was made to them. The results have been explained below.

Table 12

Cross Tabulation and Chi-square Result for Gender and Medical Concerns(N=657)

		Overall Clients		Clients Reporting Medical Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	114	70.4	0.764
	Women	213	32.4	48	29.6	
Total		657	100	162	100	

There was no significant association between gender of clients and the medical concerns reported, (χ^2 (1, N= 657) = 0.764, p = 0.382) with the concerns being relevant for both men and women.

Table 13

Cross Tabulation and Fisher's Test Result for Age and Medical Concerns(N=646)

		Overall Clients		Clients Reporting Medical Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	9	5.7	
	21-40 years	289	44.7	58	36.9	
	41-60 years	232	35.9	70	44.6	7.722
	61-80 years	71	11	18	11.5	
	81-100 years	8	1.2	2	1.3	
Total		646	100	157	100	

Fisher's exact test results showed that there was no significant association between age of clients and medical concerns reported. Individuals across age groups reported these concerns.

Table 14

Cross Tabulation and Chi-square Result for Phase of Calling and Medical Concerns(N=657)

		Overall Clients		Clients Reporting Medical Concerns		Chi-Square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	46	28.4	
	Quarter 2 (July, August and September)	528	80.4	116	71.6	10.457*
Total		657	100	162	100	

*_Note._ $p < .05$

A chi-square test of association showed that the relationship between phase of calling and medical concerns was significant, (χ^2 (1, N= 657) = 10.457, p = 0.001). 46 out of 129 individuals (35.65%) in Quarter 1 and 116 out of 528 individuals (21.96%) shared having this stressor. Thus it was more likely that disappointment with medical facilities and authorities were reported in the first phase of calling i.e., in the months of April, May and June.

This finding can be supported with narratives of few counsellors who also observed that there was a general lack of information in the initial days of the pandemic regarding the treatment to be given to individuals diagnosed with Covid and discharge and quarantine protocols. Hence clients expressed their disappointment in the healthcare system more often in the earlier days of the pandemic. In the words of Keshav (M, 45),

> These trends were there in the beginning where people were confused whom to contact for reports and who will tell them when they'll get discharged or who will give them the details about their illness. They didn't know anything. They were just told to be there and were given 1-2 tablets every day. They had been there since 4-5-6-10-15 days and just hoped they would get discharged soon. They were very unsatisfied with how everything was being handled.
>
> (Keshav)

Logistical Concerns

This segment highlights the logistical concerns that individuals faced in the duration of their illness. A total of 111 individuals (16.89%) shared these concerns with the counsellors during their interaction. Lack of clarity regarding treatment protocols, inaccessibility to necessities during home quarantine, issues related to contact tracing and home sanitization as well as concerns related to transportation and garbage disposal were shared by clients.

Figure 4

Logistical Concerns Reported by Clients (N=111)

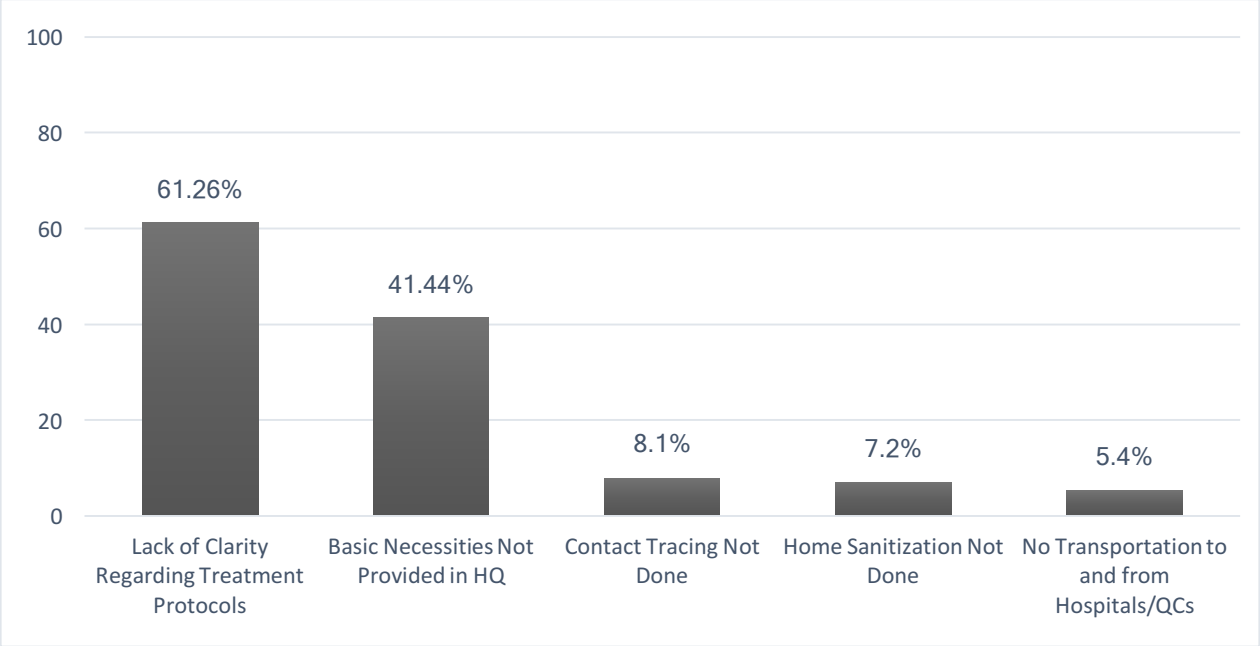


Figure 4 indicates the logistical concerns that were mentioned by volunteer counsellors in their call feedback forms after talking to individuals diagnosed with Covid-19. Each of the themes will be discussed below, along with narratives of counsellors which also brought forward similar concerns.

Lack of Clarity Regarding Treatment Protocols. More than half of the individuals (61.26%) reported facing this concern, as per call records. When asked about the psychosocial issues that were frequently talked about by clients, some counsellors mentioned that the lack of access to verified and reliable information about treatment protocols was a major source of worry. Especially during the beginning of the pandemic, there was inadequate information about the resources to be accessed for specific concerns, protocols

surrounding Covid-19 testing, discharge guidelines and provision of basic necessities. Frequent changes in the guidelines and protocols also added to the distress of clients. One of the counsellors, Deepali (F, 54 years) highlighted,

> In the month of June when they started with the rule that no second test was required, that was a phase when nobody was sure. The patients were not very clear whether it is needed or not. Also about how do they go about it…if they are not able to go out and if their quarantine period is over, how and when will somebody come and give them a discharge slip? So things were not clearly told to them so that left them with a lot of confusion about what exactly is to be done and how. (Deepali)

Another counsellor, Shalini (F, 22 years) described her challenge in addressing clients' questions about the relevant guidelines to be followed to ensure safety. She said,

> With the protocols changing frequently…especially in the beginning we did not necessarily have an updated answer and there wasn't a single place or single resource we could turn to in order to confirm what the protocol was. (Shalini)

Basic Necessities Not Provided in Home Quarantine. During the calls, 41.44% individuals reported that basic necessities like groceries and medicines were not provided to them in home quarantine. Similar to the data obtained from the feedback forms, few participant counsellors mentioned this in their interviews too. Individuals diagnosed with Covid-19 reportedly faced difficulties in obtaining daily necessity items like food, medicines, milk etc. while in home quarantine. Meenal (F, 25 years) shared,

> There was a woman whose 2 family members got tested positive so they couldn't go out to get their monthly ration that is required for the family. When asked, the neighbours also did not help them and when they asked the authorities and volunteers there, they said they'll get back to her but didn't. (Meenal)

Rishabh (M, 24 years) shared his views about how the non-availability of basic needs could have a negative impact on a person's mental health. In his words, "the basic needs have been compromised. So if you look at Maslow's hierarchy of needs, of course removing any two of them will affect your mental health adversely".

Contact Tracing Not Done. In the pandemic, contact tracing of people in contact with the individual diagnosed with Covid-19 was seen as a necessary protocol. However, according to 8.1% individuals, this protocol was not followed by authorities to alert people

who might have come in contact with them. This concerned individuals as they did not want others to spread the virus unknowingly.

Home Sanitization Not Done. According to call records, 7.2% individuals who faced logistical concerns shared that their houses had not been sanitized after their recovery. As per them, sanitization had to be carried out by local municipal authorities and in the absence of this practice, other family members were put at risk.

No Transportation to and from Hospitals/Quarantine Centres. This was a concern majorly reported by individuals during the lockdown when local transportation was not available for commutation and no one was willing to transport people possibly diagnosed with Covid-19. 5.4% individuals reported this concern as transportation was not arranged to and from hospitals and quarantine centres. When people did not have their own vehicle or could not arrange their travel, they were left with no other option than to walk from one place to another, which was a major stressor.

Issues with Garbage Disposal. An additional theme brought up in the interviews was the issue with garbage disposal as at times, municipal bodies refused to collect the garbage from homes where one or more individuals were diagnosed with Covid-19. Namrata (F, 30 years) outlined that sometimes neighbours' attitude towards persons diagnosed with Covid-19 also stopped them from coming out of their homes to dispose the waste. She described an incident where "the police person was admitted in the hospital and the family was just confined to their rooms and they couldn't go out to even keep the garbage."

Few other counsellors highlighted that the lack of information about the transmission of the virus was also a reason for which persons diagnosed with Covid-19 feared putting out the garbage. In such a state, they asked the counsellors if there was a way in which the situation could be tackled.

Cross tabulations and chi-square tests were conducted to derive association, if any, between the overall logistical concerns and age and gender of clients. The association with phase of calling was also checked to explore any relationship.

Table 15

Cross Tabulation and Chi-square Test Result for Gender and Logistical Concerns (N=657)

		Overall Clients		Clients Reporting Logistical Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	81	73	1.773
	Women	213	32.4	30	27	
Total		657	100	111	100	

There was no significant association between gender of clients and the logistical concerns reported, (χ^2 (1, N= 657) = 1.773, p = 0.183) with the concerns being relevant for both men and women.

Table 16

Cross Tabulation and Fisher's Exact Test Result for Age and Logistical Concerns (N=646)

		Overall Sample		Clients Reporting Logistical Concerns		Fisher's exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	10	9.1	3.992
	21-40 years	289	44.7	55	50	
	41-60 years	232	35.9	33	30	
	61-80 years	71	11	10	9.1	
	81-100 years	8	1.2	2	1.8	
Total		646	100	110	100	

Fisher's exact test results showed that there was no significant association between age of clients and logistical concerns reported. Individuals across age groups reported these concerns.

Table 17

Cross Tabulation and Chi-square Result for Phase of Calling and Logistical Concerns (N=657)

		Overall Clients		Clients Reporting Logistical Concerns		Chi-Square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	29	26.1	3.567
	Quarter 2 (July, August and September)	528	80.4	82	73.9	
	Total	657	100	111	100	

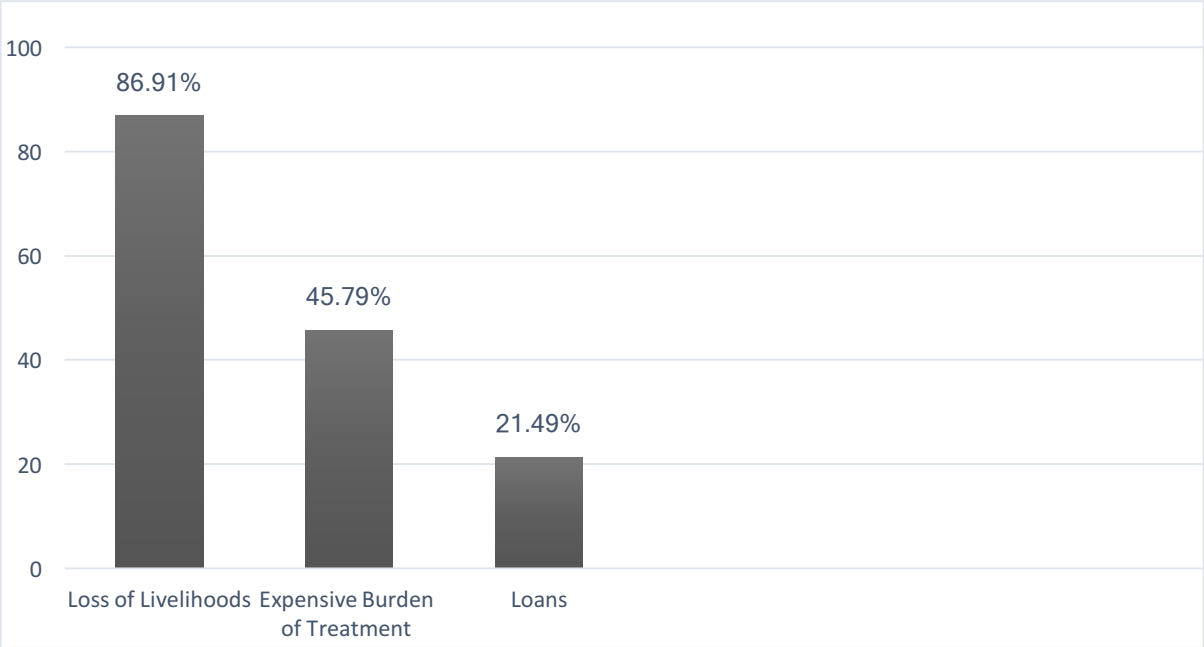
A chi-square test showed there was no significant association between phase of calling and logistical concerns, (χ^2 (1, N= 657) = 3.567, p = 0.067). Individuals reported these stressors in both the phases of calling.

Financial Concerns

The following section presents sources of financial distress in individuals diagnosed with Covid-19. This concern was identified in 107 individuals (16.28%) out of the total sample size. Concerns surrounded the loss of livelihood, expensive treatment and loans owing to the economic crisis as a result of the lockdown.

Figure 5

Financial Concerns Reported by Clients (N=107)



The concerns related to finances that were experienced by individuals diagnosed with Covid-19 are depicted in the Figure 5. Data obtained from feedback forms and interviews with counsellors will be discussed below.

Loss of Livelihoods. Of the individuals who reported financial concerns, a staggering 86.91% people conveyed that they had lost their source of livelihood amidst the pandemic. Narratives of volunteer counsellors also revealed this to be a major concern that caused severe distress to individuals. One of the counsellors, Roohi (F, 50 years) recounted,

> This has happened once or twice where the person told me that in their village they say "our family is not getting any work because we were Covid positive. All our money has run out." He said that the ration had gotten over and wanted help from my side. (Roohi)

Numerous individuals from economically poor sections of the society had been affected as they mostly survived on daily earnings. In the words of Prachi (F, 65 years),

> I frequently came across cases of people not having recourse to their earlier livelihood options, poorer sections in particular who have lost jobs for e.g. vegetable and fruit vendors, chowmein or idli/dosa sellers, all doing petty business on a pushcart, a tourist guide for Taj Mahal, a factory worker in Delhi who cannot go back to work because it costs too much to have a re-test done, and the employer won't take him back unless he furnishes a negative report… (Prachi)

Few other counsellors shared woeful narratives of individuals who were harshly affected by the economic repercussions of the pandemic and didn't have access to financial aid to get back on their feet. Some individuals also reported not having enough money to sustain themselves or their families for another meal.

Expensive Burden of Treatment. About 46% individuals who conveyed having financial troubles highlighted that the exorbitant cost of Covid-19 treatment was a source of distress for them. For people who did not have a steady income, it was extremely difficult to even get themselves tested. As recounted by Nivedita (F, 30 years),

> The charge for a Covid test in private hospitals is very high. For people who are rich it is fine but not for everyone. I remember a call where a person said that they had spent Rs. 3500-4000 for their tests and now that they had to get a re-test done for 5 members in the family, it was an economic problem… (Nivedita)

Loans. Another concern that was brought forward by individuals diagnosed with Covid-19 was the increasing loans they had to repay. The loan was either taken during the pandemic to fulfil their basic needs or had been taken earlier but the interest had been rising due to non-payment in the lockdown. Of the people who reported financial concerns, 21.49% individuals outlined distress related to debt.

Cross tabulations and chi-square tests were done to test the association of overall financial concerns with age and gender of clients and the phase during which the call was made to them.

Table 18

Cross Tabulation and Chi-square Result for Gender and Financial Concerns (N=657)

		Overall Clients		Clients Reporting Financial Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	80	74.8	3.013
	Women	213	32.4	27	25.2	
Total		657	100	107	100	

The results of the chi square test showed no significant association between gender and financial concerns, (χ^2 (1, N= 657) = 3.013, p = 0.083). This concern was relevant to individuals of both the genders.

Table 19

Cross Tabulation and Fisher's Exact Test Result for Age and Financial Concerns (N=646)

		Overall Clients		Clients Reporting Financial Concerns		Fisher's Exact Test
		N	%	N	%	
Age of clients	0-20 years	46	7.1	9	8.6	1.872
	21-40 years	289	44.7	44	41.9	
	41-60 years	232	35.9	40	38.1	
	61-80 years	71	11	10	9.5	
	81-100 years	8	1.2	2	1.9	
Total		646	100	105	100	

Fisher's Exact Test results showed no significant association between the age of clients and financial concerns presented during their conversation with counsellors. Individuals of all age groups reported this concern.

Table 20

Cross Tabulation and Chi-square Result of Phase for Calling and Financial Concerns (N=657)

		Overall Clients		Clients Reporting Financial Concerns		Chi-Square Test of Independence
		N	%	N	%	
Phase of calling	**Quarter 1** (April, May and June)	129	19.6	15	14	2.555
	Quarter 2 (July, August and September)	528	80.4	92	86	
Total		657	100	107	100	

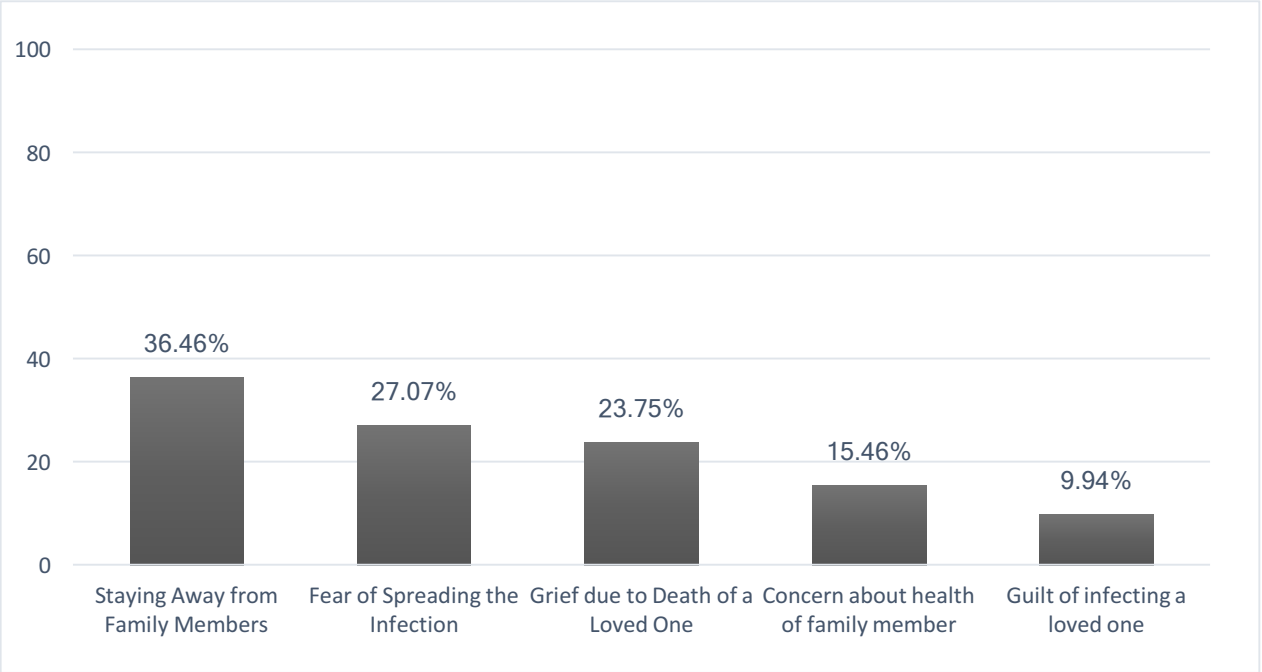
A chi-square test found no statistically significant association between the phase of calling and financial concerns, (χ^2 (1, N= 657) = 2.555, p = 0.110). Individuals were likely to report this concern in both the phases of calling.

Relational Concerns

This section highlights interpersonal factors that were a source of distress for clients. One hundred and eighty-one individuals (27.54%) within the total sample shared that they faced relational stressors pertaining to the health of their family members, fear or guilt of spreading the infection and grief owing to the loss of a loved one.

Figure 6

Relational Concerns Reported by Clients (N=181)



Relational stressors brought forward by individuals during the call with counsellors was represented in Fig 6. Each of the concerns will be discussed hereafter.

Staying Away from Family Members. Out of the people who conveyed relational concerns as a source of distress, the highest percentage of individuals (36.46%) spoke about their anxiety of staying away from family members who were dependent on them. This concern was largely seen in women who had caregiving roles. Interviews with few participant counsellors revealed that while they were in quarantine, managing childcare roles was a struggle for women. As described by Shalini (F, 22 years),

> There was a concern where parents of young children were quarantined. So in terms of childcare like "how am I going to take care of my child? My child is with my relatives and he/she is missing me and I am missing my child". The other day we discussed a case during supervision as well where the child would sit at the door and cry so you can't really explain it as there have been times where the child is an infant and what can you tell the child? (Shalini)

At times, even children were being taken to quarantine centres after testing positive for Covid-19 and the separation was distressing for the child as well as the parents.

Fear of Spreading the Infection. Approximately 27% individuals reported that they feared spreading the infection to vulnerable family members such as older people and children.

Grief Due to Loss of Loved Ones. The Covid-19 pandemic has posed an extreme threat to global health and is a leading cause of death worldwide. From the people who experienced relational concerns, 23.75% mentioned that they were grieving the loss of a loved one. The grieving process reflected a unique convergence of responses that were affective, cognitive, behavioural, physical and spiritual.

Narratives of volunteer counsellors also highlighted instances of grief that came up during their conversations and the different ways in which individuals handled the loss. In the words of a counsellor Meenal (F, 25 years),

> Loss came up quite a lot when I called somebody whose family member had passed away. But they seemed to be either not wanting to share the feeling because the call was made from the government's side or because it was an unknown person they were talking to. Sometimes they also didn't see the loss as unexpected. (Meenal)

Few counsellors highlighted the struggles of the family members who were dealing with the loss of the person who happened to be the sole breadwinner of the family. Kriti (F, 23 years) outlined a case where a woman felt overwhelmed after losing her husband to Covid-19. She said,

> Once this happened was that a (sic) woman lost her husband and she had a 5-year-old child. He was the sole earning member of the family so they didn't know what to do after his death. The woman was asking me if I could help her in any way. She had crying spells and was just not able to stop crying. (Kriti)

According to counsellors, addressing acute grief in their calls was a major challenge as they couldn't predict how the conversation could go. There were different ways in which individuals coped with their loss. While there were individuals who were in a state of high emotional trauma, some had already anticipated the loss and were more prepared to deal with it. Age and health condition of the person seemed to affect how family members responded to the loss.

Concern About the Health of Family Members. About 15% individuals mentioned that they were worried regarding the health of a family member. The worry was exacerbated when the family member diagnosed with Covid-19 had pre-existing health conditions or belonged to the older age group. It was seen that children of older parents reported increased anxiety as they feared that the infection could lead to serious complications.

Guilt of Infecting a Loved One. Some individuals (9.94%) also experienced guilt for infecting their loved one(s) with the virus. They held themselves liable for contraction and transmission of the virus, especially if there were vulnerable members at their home.

Cross tabulations and chi-square tests were conducted to check if there were any associations between overall relational concerns and age and gender of clients. The relationship between relational stressors and phase of calling was also tested for associations, if any.

Table 21

Cross Tabulation and Chi-square Result for Gender and Relational Concerns (N=657)

		Overall Clients		Clients Reporting Relational Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	104	57.5	11.681*
	Women	213	32.4	77	42.5	
Total		657	100	181	100	

**Note.* $p < .05$

A chi square test of association showed statistically significant difference between the gender of clients and the relational concerns conveyed, (χ^2 (1, N= 657) = 11.681, p = 0.001). As depicted in Table 21, 77 out of 213 women (36.15%) and 104 out of 444 men (23.42%) shared this concern. Thus women were more likely to report relational stressors as compared to men. This finding was supported by the narratives of volunteer counsellors where women

conveyed familial roles and responsibilities more than men. In the words of a counsellor, Rishabh (M, 24 years),

> It (psychosocial concerns) was very gender specific. If it was a woman client, then she had a lot of familial responsibilities on her shoulders and if it was a man then he spoke about the logistical and financial issues like the income and those kind of things… (Rishabh)

Women have also traditionally been involved in emotional labour, which involves tending to family relationships. Sociologist Heejung Chung (2020) describes the role as "ensuring the emotional wellbeing of not only children but also parents and other family members. In other words, they are in charge of the mental load of worrying about the family." (Power, 2020, pg. 67). This extra load that women might be carrying could aggravate the high levels of distress that they were already at risk of during the pandemic.

Table 22

Cross Tabulation and Fisher's Exact Test Result for Age and Relational Concerns (N=646)

		Overall Clients		Clients Reporting Relational Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	14	7.8	2.217
	21-40 years	289	44.7	83	46.1	
	41-60 years	232	35.9	58	32.2	
	61-80 years	71	11	22	12.2	
	81-100 years	8	1.2	3	1.7	
Total		646	100	180	100	

Fisher's Exact Test results showed no significant association between the age of clients and relational concerns presented during their conversation with counsellors. Individuals of all age groups reported this concern.

Table 23

Cross Tabulation and Chi-square Result for Phase of Calling and Relational Concerns (N=657)

		Overall Clients		Clients Reporting Relational Concerns		Chi-square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	42	23.2	2.017
	Quarter 2 (July, August and September)	528	80.4	139	76.8	
Total		657	100	181	100	

No significant association was found between the phase of calling and relational concerns conveyed by individuals diagnosed with Covid, (χ^2 (1, N= 657) = 2.017, p = 0.155). This concern was relevant to all individuals, irrespective of the phase in which they were contacted.

Stigma Related Concerns

This section outlines stigma related concerns that arose due to people's perception about individuals diagnosed with Covid as well as their own anticipation about reactions to their diagnosis. 18.72% of the sample i.e. 123 individuals reported this as a source of distress. This section was elaborated based on the facilitators for stigma, manifestations of stigma and its outcome on individuals.

Figure 7

Stigma Related Concerns Reported by Clients (N=123)

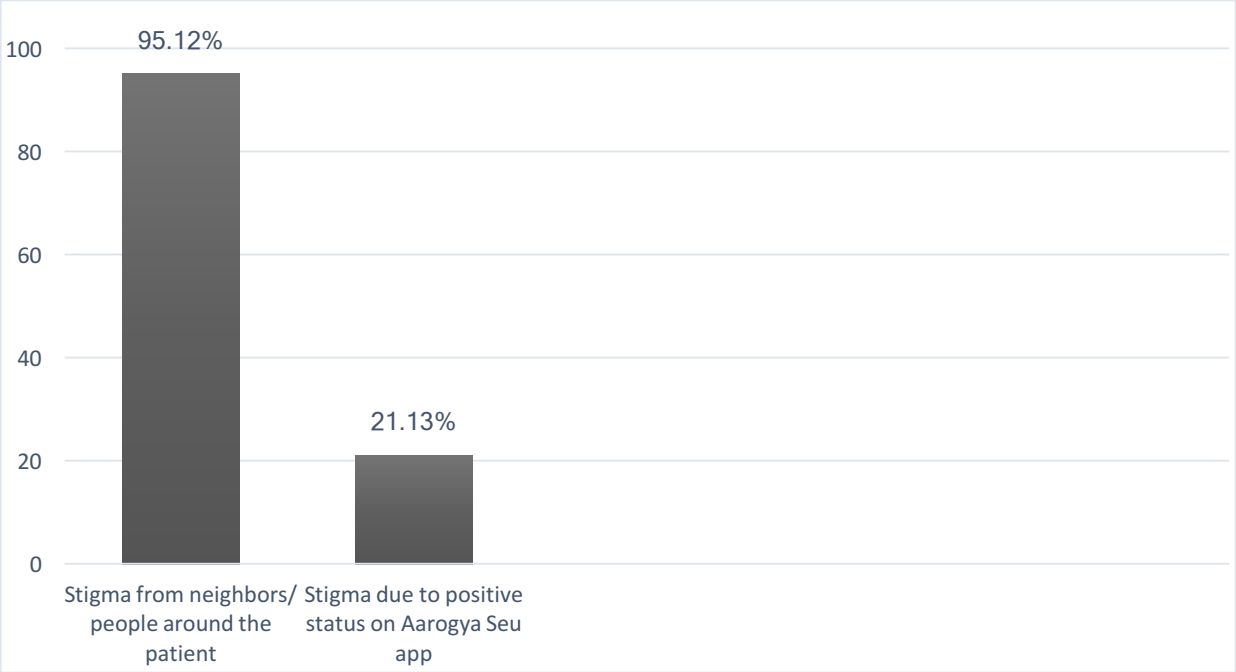


Figure 7 represents the stigma related concerns faced by individuals diagnosed with Covid-19, as obtained from call feedback forms. Each of the domains highlighted in the call feedback forms and interviews with participant counsellors will be discussed below.

Stigma from Neighbours/People Around the Patient. The current Covid-19 pandemic provoked social stigma and discriminatory behaviours against anyone who was perceived to have been in contact with the virus (World Health Organization, 2020). In the current study, out of the people reporting stigma related concerns, 95.12% said that they were being stigmatized by their neighbours and other people around them after they got to know the news of their diagnosis.

Facilitators of Stigma.

Stigma Attributed to Lack of Information. Some volunteer counsellors reported that individuals diagnosed with Covid-19 were stigmatized solely because people around them did not have accurate information about the transmission of the virus. While in home quarantine, individuals were asked to remain inside their homes with their doors and windows shut and even the family members who were not infected were withheld from stepping out of their house to get daily supplies. To add to that, their neighbours did not help them to procure necessary items out of the fear of contracting the virus. Meenal (F, 25 years) highlighted the extreme stigmatization that was faced by one of the client she spoke to,

> In one situation, the family who tested positive and was isolating themselves…they were not even allowed to open their windows and if they did they were asked to close it. That was something that was too much I'd say because right now we say that people who are infected should stay in a well-ventilated area. So if they close themselves in the house it's really not going to help them in any way. (Meenal)

Few counsellors noticed that individuals avoided communicating the news of their diagnosis to family members if they were living in a different city as it could lead to discriminatory behaviour against their family members. Namrata (F, 30 years) described a similar conversation with a police staff. She said, "one police person said that my family stays in a village in Rajasthan and if the village people would come to know that I am positive here, they would do something to my family there."

While it was understandable that there was confusion, anxiety and fear among the general public surrounding the pandemic due to lack of information, it could often lead to harmful effects on people who were subjected to the stereotypes.

Stigma due to Positive Status on the Aarogya Setu Application. About 21% individuals diagnosed with Covid-19 mentioned that one of the sources of stigma was their positive status on the Aarogya Setu mobile application. Aarogya Setu is an Indian Covid-19 contact tracing, syndromic mapping and self-assessment digital service, primarily a mobile application, developed by the National Informatics Centre under the Ministry of Electronics and Information Technology. If a person tests positive for the virus, their status is immediately updated as 'positive' on the application, after which medical intervention is arranged (Ministry of Electronics and Information Technology, Government of India). Individuals reported that their status continued to remain positive on the application for almost 2 months after their recovery. This played a discriminatory role as they were not

allowed to go out in public places that mandated the use of the application and were also wrongly reported as 'Covid positive' to people around them, resulting in stigma.

Manifestation of Stigma. Counsellors indicated different stigmatizing behaviours that people diagnosed with Covid-19 were subjected to.

Labelling. Few counsellors highlighted that individuals infected with the virus were being labelled by their neighbours and other people around them. The act of putting a poster outside the house of the individuals or a stamp on their arms stating that the person was 'Covid positive' invited discrimination and blame. Deepali (F, 54 years) recounted a similar concern that she came across. She said, "the frustration of their house being earmarked as a 'Covid positive' zone…they didn't like the idea of it. They felt as if they had been branded something"

Hostility. Alienation and hostility was reported by counsellors towards individuals suffering from Covid-19 as people distanced and segregated themselves from them. Some volunteer counsellors brought up this concern as individuals felt hurt and upset by the way they were being treated by people with whom they previously shared a cordial relationship. Many individuals were also asked to vacate their rented houses after being diagnosed with the infection. In the words of a counsellor, Roohi (F, 50 years),

> There was this young boy 20 something...he said he was in the hospital and when he came home, he got weird looks from everybody. He felt really bad as all the people whom he knew and lived around treated him that way. (Roohi)

Another counsellor, Rishabh (M, 24 years), described the effect of stigmatization on the emotional health of individuals. He said, "people who faced stigma experienced hopelessness, sadness, depression. When I talked to them, the tone of the voice itself said a lot about them. I spoke to them for 3-4 minutes and I realized that aspect." Narratives of other counsellors also revealed the plight of individuals in dealing with societal stigma and discrimination in addition to the consequences of the infection on their physical health.

Ill-treatment. In addition to the alienation and discrimination that individuals were subjected to, there were incidents of overt ill-treatment, according to counsellors. Some volunteers conveyed that individuals were made to feel like "untouchables" as no one wanted to talk to them or come near them. As described by a counsellor, Roohi (F, 50 years),

> There was one family where the man said that they were not well and their relatives were not even giving them food because they didn't want the dabbas (boxes) to be touched by them. So the relatives used to get food from restaurants and keep it in front of their house. (Roohi)

There were some isolated incidents where individuals were verbally abused and threatened if they came out of their houses even after the completion of their quarantine period. Priyanka (F, 44 years) highlighted one such instance and said,

> This person I spoke to expressed his grief that people had been hurling abuses at him because their area had been cordoned off because of his diagnosis. He somehow managed and after 14 days of his quarantine, he was reading the newspaper at the door of his house when people came and they were shouting and saying that "we will lodge a complaint that you are out and your quarantine hasn't ended still so you better get in or we will bring the police." (Priyanka)

Outcomes of Stigma. The outcomes of stigma on individuals diagnosed with Covid was divided into two aspects, namely anticipated prejudice and lack of support from people around them.

Anticipated Prejudice. Some individuals were concerned about whether they would ever be treated 'normally' even after they ceased to be Covid-19 positive. Shalini (F, 22 years) highlighted, "these days it's very common to find some of the people you call say "I am scared that once my quarantine is over and I go out, how are my neighbours going to react?" This concern was reiterated in the narrative of another counsellor. Meenal (F, 25 years) said,

> The most common thing that I came across was worry and anxiety about what would happen after they recovered and after the pandemic ended. Would they be accepted in the society or would people still people not talk to them or discriminate against them?" (Meenal)

Thus accounts of volunteer counsellors shed light on the fact that stigmatization was not a short term concern for individuals diagnosed with Covid-19 but it had repercussions that could last for a longer duration.

Lack of Support. Some counsellors recounted that individuals did not get the necessary support that they needed from neighbours due to stigma. People from rural areas also mentioned this concern as municipal bodies did not help them out when they relied on them for assistance. In the words of Keshav (M, 45 years),

> There is also no support from local panchayats, especially in rural areas. Many people complain that they don't know whom to tell. For them, the next level of people they can report to is the Panchayat...so the officials don't bother, they don't come, they don't call also
>
> (Keshav)

Additionally, it was difficult for the geriatric population to go through the ordeal of the illness without having help from others. Kriti (F, 23 years) mentioned that, "one elderly person shared that he lives alone and wondered how he would manage…even neighbours were behaving badly."

Thus, social stigma as well as the self-inflicted stigma associated with the pandemic can take a heavy toll on those recovering or those who have survived the virus. Experiencing isolation and stigma from social boycott and discrimination can also lead to an increased risk of loneliness and distress in vulnerable populations.

Cross tabulations and chi-square tests were done to test the association of all stigma related concerns with age and gender of clients and the phase during which the call was made to them. The results have been explained below.

Table 24

Cross Tabulation and Chi-square Result for Gender and Stigma Related Concerns(N=657)

		Overall Clients		Clients Reporting Stigma Related Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	91	74	2.833
	Women	213	32.4	32	26	
Total		657	100	123	100	

A chi square test of association indicated no significant relationship between gender and stigma related concerns in clients, (χ^2 (1, N= 657) = 2.833, p = 0.092). Individuals of both genders reported these concerns.

Table 25

Cross Tabulation and Fisher's Exact Test Result for Age and Stigma Related Concerns (N=646)

		Overall Clients		Clients Reporting Stigma Related Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	9	7.4	4.761
	21-40 years	289	44.7	64	52.5	
	41-60 years	232	35.9	37	30.3	
	61-80 years	71	11	12	9.8	
	81-100 years	8	1.2	0	0	
Total		646	100	122	100	

Fisher's Exact Test results showed no significant association between the age of clients and stigma related concerns presented during their conversation with counsellors. Individuals of all age groups reported this concern.

Table 26

Cross Tabulation and Chi-square Result for Phase of Calling and Stigma Related Concerns (N=657)

		Overall Clients		Clients Reporting Stigma Related Concerns		Chi-square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	24	19.5	0.001
	Quarter 2 (July, August and September)	528	80.4	99	80.5	
Total		657	100	123	100	

No statistically significant association was found between phase of calling and stigma related stressors of clients, (χ^2 (1, N= 657) = 0.001, p = 1.000). This was relevant for individuals in both the phases of calling.

Sleep and Appetite Concerns

This section covers the sleep and appetite related concerns reported by individuals post their diagnosis. In the sample, 94 individuals (14.3%) reported this concern.

Figure 8

Sleep and Appetite Concerns Reported by Clients (N=94)

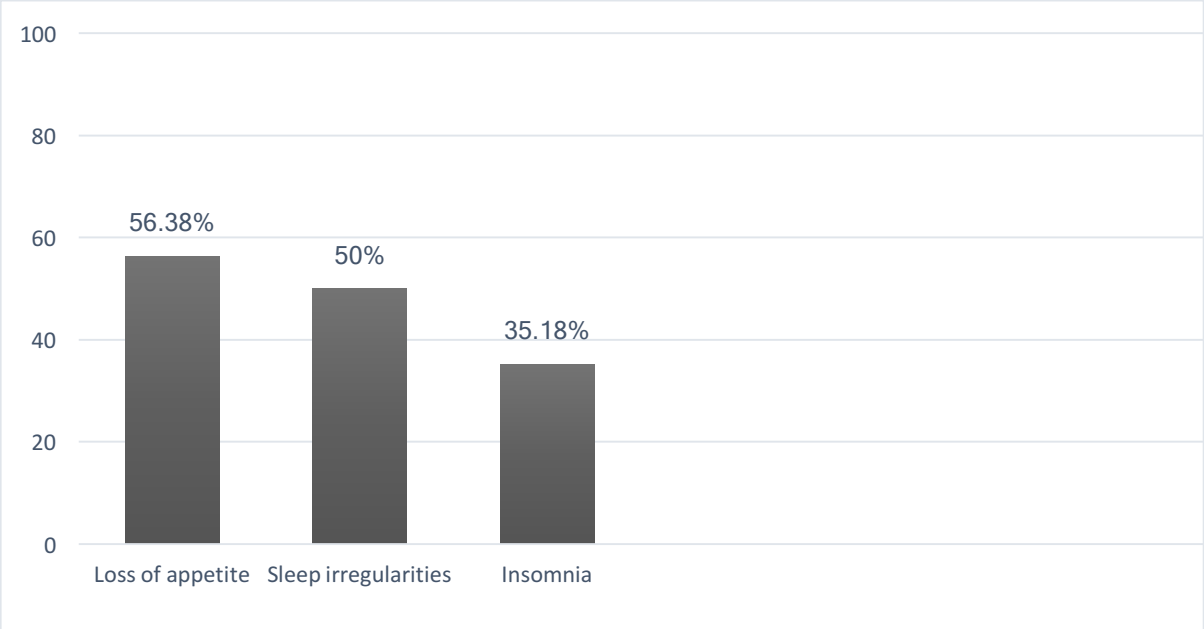


Figure 8 presents the sleep and appetite concerns that were highlighted by clients diagnosed with Covid-19. The themes have been elucidated below.

Loss of Appetite. This concern was brought up by a large group of individuals (56.38%) where they believed that their appetite had reduced after they tested positive for Covid-19. Individuals diagnosed with Covid-19 infection often reported symptoms related to the irregularities of the digestive tract like diarrhoea and loss of appetite. Psychological causes like sadness, grief, anxiety, boredom and stress were also linked to a decreased appetite in individuals during distressing situations.

Sleep Related Concerns. Out of the people who reported behavioural concerns, 50% had some sleep irregularity while 35.18% indicated having insomnia. Similar to loss of appetite, sleep and mental health were also seen to be closely related and those dealing with an emotional upheaval were more likely to have insomnia or other sleep problems.

Cross tabulations and chi-square tests were done to test the association of overall behavioural stressors with age and gender of clients and the phase during which the call was made to them.

Table 27

Cross Tabulation and Chi-square Result for Gender and Sleep and Appetite Concerns (N=657)

		Overall Clients		Clients Reporting Sleep and Appetite Concerns		Chi-Square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	56	59.6	3.209
	Women	213	32.4	38	40.4	
Total		657	100	94	100	

A chi-square test of association showed no significant relation between gender and sleep and appetite concerns, (χ^2 (1, N= 657) = 3.209, p = 0.073). Individuals of both genders reported this concern.

Table 28

Cross Tabulation and Fisher's Exact Test Result for Age and Sleep and Appetite Concerns (N=646)

		Overall Clients		Clients Reporting Sleep and Appetite Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	4	4.3	2.656
	21-40 years	289	44.7	44	47.8	
	41-60 years	232	35.9	30	32.6	
	61-80 years	71	11	13	14.1	
	81-100 years	8	1.2	1	1.1	
Total		646	100	92	100	

Fisher's exact test results showed that there was no significant association between age of the clients and the sleep and appetite concerns reported. Individuals of all age groups reported this concern.

Table 29

Cross Tabulation and Chi-square Result for Phase of Calling and Sleep and Appetite Concerns (N=657)

		Overall Clients		Clients Reporting Sleep and Appetite Concerns		Chi-square Test of Independence
		N	%	N	%	
Phase of Calling	**Quarter 1** (April, May and June)	129	19.6	12	12.8	
	Quarter 2 (July, August and September)	528	80.4	82	87.2	3.280
Total		657	100	94	100	

The results of the chi-square test of independence showed no significant relationship between sleep and appetite concerns and the phase of calling the clients, χ^2 (1, N= 657) = 3.280, p = 0.070. Individuals could report this concern irrespective of the phase in which they were contacted.

Up until now, this section focussed on various individual, relational and societal factors that were a source of distress for clients. Association of these stressors with gender and age of clients, and phase of calling was also tested to check for any significant relationship between the variables. Individuals conveyed that the aforementioned factors led to various effects on their emotional well-being and mental health, like feelings of anxiety, loneliness and fear among other reactions. These emotional concerns in individuals after they were diagnosed with Covid-19 have been explored henceforth.

Emotional Concerns

This segment covers the emotional concerns shared by individuals diagnosed with Covid-19. A staggering 548 individuals out of a sample of 657 (83.4%) shared different emotional responses that included anxiety, fear, stress, helplessness, depressed feelings, irritation, frustration, hopelessness, loneliness, feelings of disempowerment and boredom.

Figure 9

Emotional Concerns Reported by Clients (N=548)

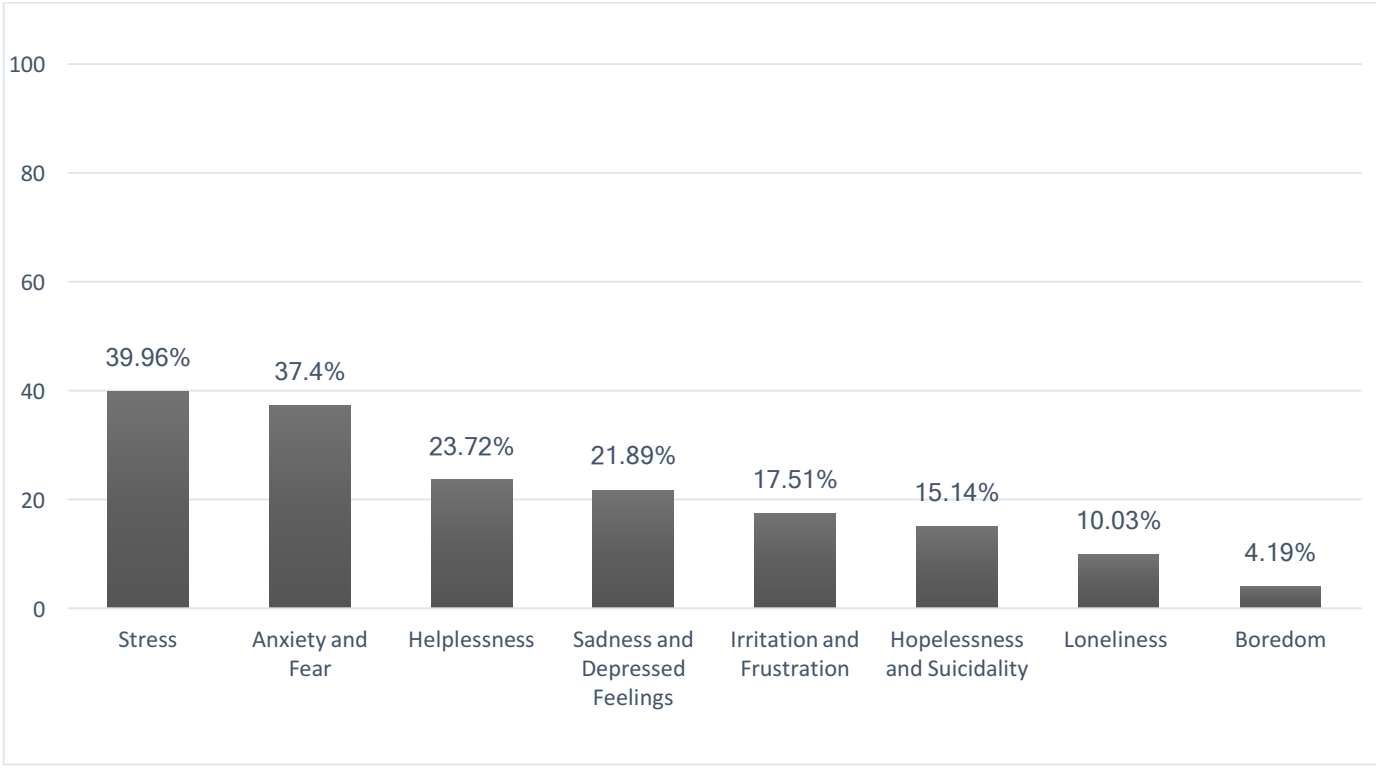


Figure 9 represents the different emotional responses that were shared by people as a result of testing positive for Covid-19. Each of the domains will be explained below.

Stress. Amongst those who reported emotional distress, 39.96% individuals shared with the counsellors that they felt stressed. They expressed experiencing stress about different aspects of the pandemic like fear of infecting their loved ones with the virus, financial concerns, health and isolation, among other things.

Anxiety and Fear. This response was shared by about 37.4% individuals reporting emotional distress. Nivedita (F, 30 years), one of the participant counsellors shared her experience of providing psychosocial support to someone who had a fear regarding the infection. In her words,

> There was news that when someone is diagnosed with Covid, they have breathing issues and high fever etc. Listening to all this, the patient felt that if he had extreme symptoms then where will he go and what will he do? When my call got connected the next day, he told me that he was living all alone and felt very anxious…(Nivedita)

The narrative of another counsellor, Kriti (F, 23 years) revealed how frequently she came across clients who expressed feeling anxious over the calls. She said, "If I made 100 calls for example, 65 people had anxiety." Few individuals also opined that idleness and boredom often led them to have anxious repetitive thoughts. Dependence on devices and gadgets was seen as a means to cope with the anxiety in some situations.

Helplessness. About 24% individuals conveyed helplessness due to the ill-treatment by authorities. Namrata (F, 30 years) outlined an example where the client felt helpless as she belonged to an economically poorer section of the society and believed that there was no one to support her. As described by her, "When I asked them why were they not filing a complaint against the authorities, she asked "who listens to the poor?" and that nothing will happen if they even do something and she was so confident of this belief." Another counsellor, Prachi (F, 65 years) highlighted a similar conversation with a client. She said,

> One particular set of very poor patients were absolutely convinced that they were not being attended to by the authorities because of their low class status and for the same reason the tests were not being conducted for them to declare them corona negative, and hence they were not being discharged from the ward. They felt strongly that not having the clout or ability to bribe, or having no way to approach those in authority was the reason for their neglect and extended stay in the government run facilities. (Prachi)

At times, individuals expressed their anger towards the government authorities as they felt that they were not provided with proper healthcare and were left to fend for themselves. On the other side, lack of trust in the establishment was also reported as some people believed that they were wrongly declared Covid positive and quarantined in hospitals for making money fraudulently.

Sadness and Depressed Feelings. It was found that out of the total individuals who reported emotional responses to stressors, 21.89% mentioned that they experienced sadness and low mood at different points during their illness. Narratives of few volunteer counsellors conveyed that individuals experienced low mood as a result of being idle and sometimes overthinking about the future. In the words of a counsellor, Shalini (F, 22 years), "when I

look back at calls I feel that low mood is often very commonly found with feelings of fatigue…**"** Another counsellor, Rishabh (M, 24 years) highlighted that people felt low after getting to know about their diagnosis. He said, "I wouldn't say depression but feeling low or sad about finding out that they had Covid and will have to go through the trouble."

Irritation and Frustration. From the feedback form responses, it was noted that out of the individuals who experienced emotional distress, 17.51% mentioned irritation and frustration as a key response. It could be gathered from the accounts of few counsellors that this issue was prevalent across different age groups and backgrounds. As outlined by Shalini (F, 22 years),

> Couple of people while having the conversation said that their moods were low and they seemed to be losing their temper quickly which was leading to a lot of fights with people in the family because all of them were sitting at home so fights were happening. There is a lot of arguments, everybody was tensed so tempers were up flying high… (Shalini)

Another source of frustration for individuals were the innumerable calls that they were getting from different government agencies after their diagnosis. According to the counsellors, a number of people expressed their frustration about the fact that there was a lack of communication among the different agencies and they were being asked the same information from different sources.

Hopelessness and Suicidality. A major concern observed in some individuals (15.14%) who experienced emotional trouble was the presence of hopelessness and suicidal thoughts. The pandemic was a stressful time for individuals and the feelings of fear and anxiety, loneliness, alienation and sadness became constant and overwhelming for some, as reported by volunteer counsellors. Counsellors mentioned various sources of distress that burdened individuals, like social isolation, stigma, loneliness and being in close quarters with unaccommodating family members over a long period of time. Uncertainty about their health or the future was a major stressor, more so for frontline workers who had been working tirelessly in the pandemic.

Loneliness and Boredom. Approximately 10% individuals reportedly experienced loneliness while 4.19% reported boredom as a result of being quarantined away from their families and loved ones. A volunteer counsellor, Shalini (F, 22 years) described the experience of a client who was quarantined in a hotel in a different city, away from his family. She said,

> When I made calls to [a particular state], they still hadn't started the home quarantine system so a lot of people were at the quarantine centre and because the state runs a lot on tourism they had started using small hotels as quarantine facilities. There was a lot of loneliness and boredom because they were in a hotel, a single building, nowhere to step out even for a breath of fresh air and they were stuck in a room, like a little room with really nothing to do.(Shalini)

Although some individuals might have experienced loneliness and boredom, counsellors did not find it to be widespread as people tended to keep in touch with friends and family over audio and video calls. Some individuals would interact with fellow people in quarantine and did not feel as though they were isolated.

Cross tabulations and chi-square tests were done to check for associations between emotional responses and age and gender of clients as well as with the phase in which the call was made.

Table 30

Cross Tabulation and Chi-square Results for Gender and Emotional Concerns (N=657)

		Overall Clients		Clients Reporting Emotional Concerns		Chi-square Test of Independence
		N	%	N	%	
Gender	Men	444	67.6	372	67.9	0.139
	Women	213	32.4	176	32.1	
Total		657	100	548	100	

No significant association was seen between gender and emotional concerns, (χ^2 (1, N= 657) = 0.139), conveying that both men and women reported these concerns.

Table 31

Cross Tabulation and Fisher's Test Result for Age and Emotional Concerns (N=646)

		Overall Clients		Clients Reporting Emotional Concerns		Fisher's Exact Test
		N	%	N	%	
Age of Clients	0-20 years	46	7.1	31	5.8	15.742*
	21-40 years	289	44.7	254	47.3	
	41-60 years	232	35.9	191	35.6	
	61-80 years	71	11	56	10.4	
	81-100 years	8	0.9	5	1.2	
Total		646	100	646	100	

**Note*. $p < .05$

The chi-square test of association was performed to examine the relationship between age and emotional concerns. The relation between the two variables was significant, $p = 0.003$. 254 individuals out of 289 in the age group of 21-40 years (87.88%) followed by 191 out of 232 individuals (82.32%) from the age group of 41-60 years expressed emotional concerns more than others.

Table 32

Cross Tabulation and Chi-square Values for Phase of Calling and Emotional Concerns(N=657)

		Overall Clients		Clients Reporting Emotional Concerns		Chi-square Test of Independence
		N	%	N	%	
Phase of calling	**Quarter 1** (April, May and June)	129	19.6	110	20.1	0.402
	Quarter 2 (July, August and September)	528	80.4	438	79.9	
	Total	657	100	548	100	

The results showed no significant association between phase of calling and emotional concerns expressed by individuals diagnosed with Covid-19, (χ^2 (1, N= 657) = 0.402, p = 0.526). Individuals from both the phases expressed these concerns.

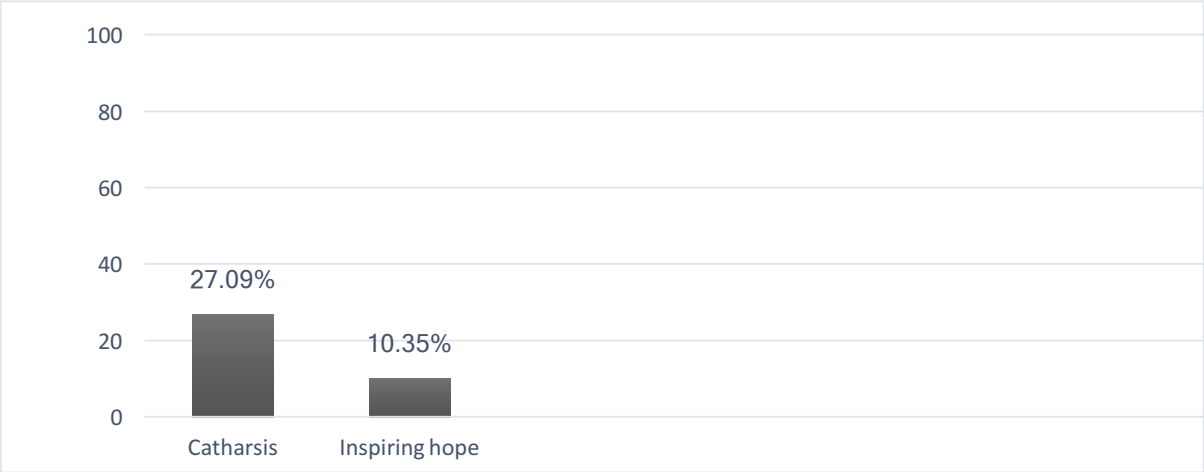
This section highlighted the emotional concerns that individuals faced as a result of different psychosocial stressors. The following section outlines interventions that were used by counsellors to support individuals in distress.

Nature of Intervention Approaches

The following section aims to capture psychological support interventions used by volunteer counsellors that were noted to alleviate the distress of individuals diagnosed with Covid-19. Data from the call feedback forms and interviews with counsellors will be discussed below.

Figure 10

Counselling Interventions Outlined in Call Feedback Forms (N=246)



Data from the call feedback forms conveyed that 10.35% counsellors used interventions that inspired hope while according to 27.09% counsellors, their interaction facilitated catharsis in the individuals they spoke to.

Establishing a Therapeutic Framework

Through the in-depth interviews, counsellors got a chance to elaborate further on the interventions used by them to respond to client concerns. Counsellors described a few techniques that they used to establish a basic therapeutic framework, based on which they carried out the conversation further.

Non-judgemental and Reflective Listening. Some volunteer counsellors highlighted that using non-judgemental and reflective listening was an effective intervention in itself as it made people feel understood. Keshav (M, 45 years) described how he used this technique. He said,

> One of my main interventions is to listen to them attentively and make them realise that I'm with them, I'm listening to them and not judging them. No matter what they are saying it is alright for them to talk. So I encourage them to talk...maybe in the first 30 seconds, 1 minute or so they may not open up and I try my best to open up doors for them where they can feel easy to talk to me. (Keshav)

Another counsellor, Roohi (F, 50 years) expressed that she facilitated the session in a way wherein individuals were encouraged to talk while she actively listened to them and provided support. In her words,

> I want them to speak more because the times that we live in, people don't get a lot of space to speak and express and that in itself will help. So I think listening is very helpful and I keep asking them small questions to keep them talking and give my inputs when needed… (Roohi)

Individuals reported that they did not find the right space to talk about their troubles and also didn't wish to burden their family members and friends with their concerns. The call with the counsellor proved to be helpful for them as they anonymously could talk to a professional without the fear of being judged.

Expressing Empathy. Expressing empathy towards the client is considered to be an integral part of a therapeutic relationship and volunteer counsellors also voiced the importance of this tool in providing support to individuals in distress. As outlined by Shalini (F, 22 years), "there was really nothing more effective apart from empathy or verbal support that I could offer to clients." Keshav (M, 45 years) reiterated that empathy was a tool that always helped in his conversations as people felt validated. In his words, "empathizing with them has always helped. I would say if I trust my patient that okay whatever they are saying I have to go with that (sic) and I should not carry my judgments about anybody, then they feel good."

Holding and Containing Distress

Few counsellors said that the conversation offered a safe space for individuals to vent their concerns and counsellors intervened by providing holding and making sense of their issues. In cases where individuals expressed grief about the loss of a loved one, holding and validating distress was an effective intervention, according to few counsellors. Meenal (F, 25 years) described,

> when it came to loss or when somebody was grieving, they would go on sharing. So it was me listening and at the end telling them how sorry I was to know that they have gone through this loss and I can't even begin to comprehend the difficulty that they have been in… (Meenal)

Using Supportive Techniques to Enhance Coping

Few counsellors mentioned using supportive techniques to help the clients cope better. Kriti (F, 23 years) outlined that she often supported the clients by highlighting their strengths. She said, "I give them a lot of support and strength that even after so much they

have been resilient and come quite far…I ask them to explore resources they already have." Other counsellors also said that incorporating elements like reassuring the client, validating their stance and constant encouragement helped them to look beyond their concerns and find solutions within themselves.

Emotional Regulation. Few counsellors specified using techniques that helped in emotional regulation of individuals. Shalini (F, 22 years) described how she helped some clients deal with their anxiety related concerns. She said,

> When it comes to things like anxiety, I try to introduce the client to some methods to manage anxiety especially grounding and deep breathing…how they can calm themselves down if they need it and in the future they can use it (Shalini)

Namrata (F, 30) believed that using this technique aided in her conversations with police personnel. She mentioned,

> Initially I was getting a lot of problems with police personnel in terms of sleep or fear, panic. Not very major but incorporating mindfulness and relaxation techniques helped. I would majorly check that everybody has some activity with them because they would just be confined in their own room and isolated. (Namrata)

Generating Alternative Perspectives

Generating alternative interpretations in clients is a widely used technique in cognitively oriented therapies (Roberts et al., 2012). Some tenets of this intervention were used by counsellors in their conversation with individuals diagnosed with Covid-19.

Using Cognitive Techniques. According to few counsellors, cognitive techniques were helpful when individuals needed help in identifying and changing their thought patterns. Priyanka (F, 44 years) said,

> When people mention being fearful or worried or anxious, CBT helps a lot to reach out to them and I have been able to do so successfully. Recently also there were a few cases where I could use the CBT questioning and journaling. Both of these aspects have been successful to make them aware of their thinking… (Priyanka)

Other counsellors echoed the understanding that at times, the way people perceived their concerns was a problem in itself and it was important to modify that to help them adapt to the situation better. However, counsellors were also of the view that these techniques were successful only for clients who were psychologically aware and hence couldn't be applicable for all.

Fostering Hope by Highlighting Positives. This technique was mentioned by many counsellors as a way to inspire hope in individuals who felt distressed. They stated that when individuals recounted their problem saturated narratives, it was helpful to highlight the positive aspects in it for them to reflect on their narrative holistically. As described by Deepali (F, 54 years),

> Those who were frustrated or angry at the system, my approach was that I let them vent out, I heard and said more in the affirmative initially that "yes yes this is bad" and after some time I tried to make statements and see the other aspect of things. The entire idea is that I can help them see the brighter side of all this… (Deepali)

Rishabh (M, 24 years) used a similar technique to help individuals acknowledge the strengths and resources available to them. In his words,

> Mostly I let them speak about the situation so that they are able to unburden themselves and then I try to pick out anything that is motivating/rewarding in their lives that has happened. Anything that could support them in the past…like this happened and probably there is the chance of it happening again (Rishabh)

Counsellors mentioned that while it was important to bring out the positive aspects of individuals' narratives, they were also mindful to not trivialise the issues that people faced.

Referring to Specialized Services

Apart from the aforementioned counselling techniques to support people facing psychosocial concerns, counsellors found referring individuals to specialized services to be helpful. At times, they kept a resource list ready with them when they made calls in order to provide individuals with numbers of local NGOs, practicing counsellors, helplines and other resources that could be contacted for help. Keshav (M, 45 years) mentioned that while he did not have contact numbers of institutions, he told people to approach relevant authorities for their concerns. He said,

> If something is serious, I see if I can link them to some place. For example, I tell them to talk to their local Panchayat or District Collector in case they have a complaint, approach the medical officer in the hospital closest to them for health emergencies. I just tell them what they can do and then leave it on them to take the decision. (Keshav)

Other counsellors also reported that they tried to disseminate accurate information by finding out about local resource that individuals could seek access to in case they needed to. Since the PSC helpline was a reverse helpline that couldn't be contacted by individuals in case they

needed immediate help, counsellors felt that it was their responsibility to provide individuals with an alternate resource that was accessible by them.

Data from call feedback forms outlined broad categories of interventions under the domains of catharsis and generating hope. Interviews with volunteer counsellors led to further elaboration on specific techniques that they utilized to help clients cope better with their stressors. Counsellors expressed that they supported individuals by establishing a therapeutic framework, contained their distress, used supportive techniques to enhance coping, helped generate alternative perspectives and referred clients to specialized services when needed.

Narratives of Resilience

While the previous sections brought out varying levels of emotional distress and the counselling interventions used by counsellors, it is also important to be mindful of narratives that highlighted resilience in the face of harsh circumstances triggered by the pandemic. As one of many possible outcomes to life challenges, resilience refers to a stable trajectory of mental health despite exposure to a serious stressor (Bonanno, 2004). Data from call records as well as interviews with counsellors revealed that a large majority of individuals diagnosed with Covid-19 were resilient through the crisis and were able to adjust to the events around them. A number of protective factors were seen to play a role in promoting resilience, like individual factors and support from family and community. Deepali (F, 54 years) described an instance where an individual suggested that she reach out to other people who might need her support more than him, even though he belonged to a vulnerable group himself. She said,

> I cannot forget about this elderly gentleman in his 60s who said "We are all fine…we have problems but we can handle it. If you really want to counsel and really want to encourage then please go and do that with the doctors, policemen, nurses and other frontline workers. They are tirelessly working and not even saying anything. We have come back to our homes and are recovering and fine but hats off to those people." (Deepali)

Despite experiencing multiple hardships, individuals exhibited resourcefulness and perseverance that helped them tide over tough circumstances. Priyanka (F, 44 years) highlighted this resilience in her narrative,

> In spite of so many hardships…like I spoke to a vegetable vendor and he said "ma'am I have a lot of financial issues but you know I had put some money here and there and I am managing." He earns only 200-300 Rs. a day but he was running the house somehow. So I think such people keep you motivated and make you realize your privilege. (Priyanka)

The role of family was highlighted by some individuals in helping each other overcome their distress and providing strength and support to one another in unprecedented times. One of the participant counsellors, Shalini (F, 22 years) shared,

> Recently I had a call with this man who said that they lived in a joint family and he had just lost his father...He said, "I lost my father and it's a huge loss but it gives me a sense that I still have a lot of these other people in my life who love me and care for me and their support is available at any time. It's a loss for the entire family so we are all supporting each other through it and I don't feel alone in the situation. (Shalini)

Few counsellors also brought forth narratives of individuals who drew upon faith to provide themselves with a sense of control and an understanding of their stressful situations. Individuals felt that they had a sense of divine support that would help them overcome distressing events. In the cultural context of India, spirituality, community and family offer collective avenues for coping which are known to bolster resilience in individuals. In the words of Kriti (F, 23 years), "I observed that some people were in so much trouble but they had faith that God will help them…they even told me that they had left everything on God and he will take care…I guess it made them feel better."

Counsellors shared that the positivity reflected by individuals in their time of crisis instilled hope in the counsellor and motivated them to continue providing their services to the initiative. As described by Shalini (F, 22 years), "sometimes when you call people, you get so much positivity out of them because they have taken the situation head on and in a very solution focused approach…it wants you to keep going"

Discussion

This chapter presented psychosocial concerns that emerged from the analysis of call feedback forms and counsellor interviews. The concerns, experienced by persons diagnosed with Covid-19, were found to be individual, interpersonal and systemic.

Prominent among sources of distress to people at an individual level were concerns pertaining to health. These included individuals' experience of Covid-19 symptoms, where more than half of the sample reported to be concerned about the persisting symptoms post the infection. The persistence of symptoms after the recovery, particularly fatigue and dyspnea have been reported in other studies as well (Carfi et al., 2020).

Fear of death was another concern for individuals. In the current pandemic, fear of dying has been linked to the anxiety related to Covid-19, and also linked to exacerbating of other mental health conditions (Menzies & Menzies, 2020). The unprecedented nature of the

pandemic brought with it a lot of uncertainty and unpredictability that had an extreme impact on the mental health of individuals affected.

About 25% of individuals when called reported concerns with unsatisfactory medical facilities and healthcare. The pandemic also shed light on the worrisome condition of health infrastructure in the country. As per media reports hospitals in India were overwhelmed due to an unprecedented surge in Covid-19 cases across the country (Deutsche Welle, 2020). A review done by Bajpai (2014) on the challenges confronting public hospitals in India revealed that the ratio of availability of beds per 1000 population was lower than some of the poorer countries in Sub-Saharan Africa, highlighting the woeful insufficiency of the country's medical facilities. Deficient infrastructure, inadequate manpower, unmanageable patient load, equivocal quality of services and high out of pocket expenditure contributed further to the challenges of healthcare accessibility in the country (Bajpai, 2014). The pandemic might have further challenged the existing shortcomings. Many individuals in the present study also mentioned distress related to the exorbitant cost of treatment in hospitals where there was little to no regulation on charges meted out for treatment. This is a pressing concern considering that India has nearly twice as many private hospitals as public ones (Thiagarajan, 2020). As the pandemic continues to spread, it has been recommended that the government regulate the rising costs of healthcare in private hospitals, which provides the bulk of the country's medical treatment.

Another major source of distress to individuals was financial loss. The pandemic and its associated containment measures have taken a heavy toll on economies and societies worldwide. More than 300 million full-time jobs are estimated to be lost worldwide in the second quarter of 2020 (International Labour Organization, 2020). As a part of the current study, about 87% of the sample shared that they had lost their source of livelihood in the pandemic, which was a major stressor.

Some groups were seen to be more vulnerable to the effects of the economic repercussions of the pandemic. Surveys conducted by the International Labour Organization reported that economically backward sections of the society were the worst affected. The sudden and unexpected announcement of the lockdown and closure of all transportation combined with a lack of a social safety net resulted in indignities, hardship and even deaths. In the present study, 21.49% of individuals with financial stressors mentioned that they were distressed due to mounting debts during the pandemic.

As per reports, the strict lockdown resulted in widespread economic distress and food insecurity as large sections of the population experienced high vulnerability and subsisted on

daily earnings without any savings to tide them over the halt in economic activity (Ray & Subramanian, 2020). Individuals who didn't have any source of sustenance amidst the economic standstill had no other option than to resort to taking loans. Many families were also not able to pay interests for previously taken debts during this time, which also led to worry and distress.

Besides the distress experienced by people at an individual level, the pandemic was noted to have brought up several interpersonal concerns. People diagnosed with Covid-19 brought forward interpersonal stressors like the worry of staying away from family members, fear of spreading the infection to them and grief due to the loss of loved ones. The fear of seeing their loved ones in danger was an underlying stressor observed in a majority of individuals. An early online study in May 2020 on the fear of Covid-19 with 439 respondents from 28 countries also revealed that the greatest source of distress in individuals was related to the perceived risk to their loved ones (Mertens et al., 2020). Some individuals reported that at times, children were separated from their caregivers and taken to quarantine centres once they were diagnosed with Covid-19, which was distressing for both. A study done in India on the psychological impact of quarantine on children and adolescents revealed that children in quarantine centres were more susceptible to mental health issues as compared to children quarantined at home because of their higher risk of infection and fear caused by parental separation (Saurabh & Ranjan, 2020). The emotional impact of the separation could be a matter of concern that could be addressed by mental health professionals while providing counselling support to individuals. Specialized training in grief counselling for counsellors might also be useful as many individuals and families were mourning the loss of their loved ones amidst the pandemic.

Stigma related concerns were observed in close to 19% of individuals that counsellors interacted with. Infectious disease outbreaks have historically been associated with stigma and prejudice (Bhattachraya et al., 2020). Stigmatization is an undesirable stereotype that can contribute to a range of adverse effects like anxiety, depression, devaluation, rejection, stress, health problems, exposure to risks and limitation of protective factors (Zolnikov & Furio, 2020). The present study also revealed that individuals diagnosed with Covid-19 were frequently stigmatized by people around them, often leading to varying levels of distress. As per literature, the level of stigma associated with Covid-19 was based on the fact that the disease had many unknowns. Humans are often afraid of the unknown and might find it easier to associate that fear with 'others' (World Health Organisation, 2020). Additionally, stigma related behaviours like labelling, hostility and ill-treatment were identified by

counsellors towards individuals diagnosed with Covid-19. “Othering” outlines the reductive action of labelling and defining a person as a subordinate in terms of category (Canales, 2020). In the face of a social crisis, those who had any association with the illness could be made to feel isolated and discriminated against by viewing the individual as someone different from others. This can have a negative impact on the treatment and prevention of the illness (Bhattacharya et al., 2020). Stigmatization might also take a heavy toll on the mental health of people who are recovering or have survived the illness, as well as frontline workers. Addressing stigma by developing mitigating strategies at a community level is thereby a critical priority. Stigma can be heightened by insufficient information so it is important to spread knowledge about Covid-19 (e.g., what causes it, how is it transmitted, treatment and prevention etc.) by involving various stakeholders in the community. News reporting could also be regulated to refrain from focussing on individual behaviours for having and spreading the virus, as it can increase stigma towards people who may have the disease. Instead, including content around basic infection prevention practices, symptoms of Covid-19 and ways to seek help could be helpful. It is also necessary to be mindful of the terms used to address individuals diagnosed with Covid-19, as coining terms like ‘Covid positive’ or ‘Covid patient’ can be discriminatory and increase the gap between self and others instead of bridging it. Acknowledging individuals as victims of the pandemic rather than the source is important. Such steps could not only ease the distress of individuals facing stigma, but could also help deal with rumours and misinformation that cause discriminatory behaviours.

Individuals conveyed that the aforementioned factors led to various effects on their emotional well-being and mental health, like feelings of anxiety, loneliness and fear, among other reactions. Anxiety in people diagnosed with Covid-19 was associated with exposure to the infection, uncertainty regarding the treatment process and outcomes, the well-being of loved ones, financial concerns, separation from loved ones, disruption in work life and having to juggle with multiple responsibilities as a caregiver. Past studies have documented the effects of infectious outbreaks and subsequent quarantine orders on both posttraumatic stress disturbance and psychological stress experienced in the general population (Brooks et al., 2020; Hawryluck et al., 2004; Lau et al., 2005). The uncontrollable and unpredictable nature of Covid-19 has been linked to extraordinary stress in the general population, as well as those diagnosed with the infection (Cooke, et al., 2020). About 24% individuals who reported emotional responses to the stressors mentioned experiencing generalized stress regarding different aspects of the pandemic.

Sadness and depressed feelings were reported by about 22% of individuals who were called. Hopelessness, sadness, irritability and lingering feelings of low mood have also been associated with previous outbreaks of infectious diseases like SARS, Ebola and MERS (Chew et al., 2020). Individuals also reported increased irritability and frustration since the time they had been diagnosed with the virus. An early study done in Italy and Spain on the psychosocial concerns faced by adolescents during the pandemic revealed that more than 30 percent of the sample reported issues like difficulties in concentrating, more irritability, restlessness and higher likelihood to argue with the rest of the family (Orgiles et al., 2020). Findings of the present study showed that although individuals from all age groups reported frustration related to the pandemic, frontline workers like police personnel and healthcare workers were more vulnerable to this concern due to their continuous hours of service and increased susceptibility towards stigma and hostility from people.

A study done in India on healthcare workers found that as compared to normal circumstances, there was an increase in pandemic related burnout that could lead to decreased patient satisfaction (Khasne et al., 2020). Anxiety, depression, insomnia, burnout and stress related concerns were also found commonly in healthcare workers (Gupta & Sahoo, 2020). Some of the measures that can be used to mitigate the psychological impact on healthcare workers include regular screening for mental health concerns and having institute-level mental health services that can be utilized by healthcare providers when needed.

The Covid-19 pandemic and the resultant lockdown presented unique stressors that could have blocked access to protective factors (Gruber et al., 2020). Studies on extreme stress exposure such as disease outbreaks have reported a higher prevalence of psychopathology and a lower rate of resilience as compared to studies examining only moderately aversive events (Chen & Bonanno, 2020).

It would therefore be important for current and future models of crisis management to actively take into account mental health impact of emergency situations and put in place guidelines to address this impact. Findings from the current study also pointed towards psychosocial support strategies used by counsellors to alleviate client distress.

Counselling and psychosocial support have played a key role in the pandemic to help individuals address their distress and cope with stressful events. Banerjee (2020) highlighted the specific role of mental health professionals in the pandemic which included a) education of the public about the common psychological effects of the pandemic, b)motivating the public to adapt strategies for disease prevention and health promotion, c)integrating their services with available health care, d)teaching problem solving strategies to cope with the

current crisis, e)empowering patients diagnosed with Covid-19 and their caregivers and f) provision of mental health care to healthcare workers. The Covid-19 pandemic has had widespread and severe impacts on routines and well-being of individuals. In stressful times like these, many people might be forced to adapt to a new normal to cope with the events around them.

Research has shown that most people are resilient even when facing highly aversive life events (Chen & Bonanno, 2020). Although the severity of exposure can influence outcomes, a number of factors have been shown to promote resilience, including personality as well as external factors such as social and interpersonal resources (Bonanno, 2020). Bonanno et al. (2008) highlighted steps to bolster resilience in people who were diagnosed with an infectious disease, which included mobilizing social support, increasing help-seeking behaviour and maintaining ongoing physical care to ensure resilience. Narratives of counsellors from the present study also revealed that a lot of individuals were resilient despite harsh circumstances. They mentioned different protective factors like familial support and dependence on faith for coping with their distress.

Through this chapter an attempt was made to capture the unheard voices of people diagnosed with Covid-19 in India, from the lens of volunteer counsellors. These narratives indicated that a diagnosis of Covid-19 could unravel a complex matrix of psychosocial challenges for people, with intrapersonal, interpersonal and systemic ramifications. The stories of trauma and resilience highlighted here may serve as a crucial bridge linking stakeholders perspectives and mental health policy initiatives during the pandemic.

Findings from the study:
Counsellors' experiences of the PSC Helpline, training and supervision

Following from the previous section that attempted a detailed understanding about the nature of psychosocial concerns faced by people diagnosed with Covid-19 and the interventions used by the counsellors to alleviate their distress, this segment focuses on counsellors' perspectives on being a part of the initiative and the impact it had on their personal and professional development The volunteer counsellors were asked to elaborate on their motivation to join the initiative and provide continued service, the challenges they encountered while counselling, and the role played by the initiative as well as supervision and training on their development. The themes obtained from the in-depth interviews are presented below.

Motivation to Join the Helpline

During the interviews, participants shared their experience during the pandemic and their motivations for volunteering for this initiative.

Concern About the Mental Health Impact of the Pandemic

Most participants reported that they were concerned about the potential mental health impact that the pandemic could have on people diagnosed with Covid-19 as well as on the general population. This was seen to play a key role in their decision to join the NDMA helpline initiative. One of the counsellors, Priyanka (F, 44 years) highlighted how the crisis of the economically backward sections in the country affected her volunteering decision. She said, "The migration issue and the suffering of the economically backward class really bothered me. I consider myself privileged and I wasn't able to do anything except watch it on the news so I joined the helpline to contribute from home."

Some other counsellors reported that there was a lot of confusion and fear in the initial days of the pandemic as people were generally unclear regarding the protocols to be followed. In such a situation, the counsellors wished to help them steer through their distress. Roohi (F,50 years) described,

> Initially I was bogged down with all the problems and was trying to understand the system, what patients are going through and what we were supposed to say. At that point Covid was very new. We were all lost about the information and what was going on. But I knew I had to help them… (Roohi)

Keshav (M, 45 years), another counsellor from the group, shared that he was involved in other initiatives in the pandemic and realised the need of mental health services at the ground level. Concerned about the emotional impact of the disease on individuals, he decided to write to different organizations where he could volunteer.

This theme highlighted the shared concern about the well-being of individuals during the pandemic that brought counsellors together to contribute towards the initiative.

Contributing Through Professional Training and Skills

Some counsellors had a desire to use their counselling skills and training in the field as a means to help individuals diagnosed with Covid-19. Prachi (F, 65 years) iterated that it was this desire that made her join the work and continued to keep her going. In her words,

> I have seen how it can help lift a person out of a moment of crisis, give clarity at the time of confusion, and generally contribute to the wellbeing of a person requiring support. I wanted to contribute something more to our society, given that I am privileged enough to be safe from this pandemic, and given that I have not suffered many of the adverse consequences of this pandemic which have affected vulnerable sections of our society. (Prachi)

A few counsellors were also of the view that this was the least they could do for their fellow citizens who were in the midst of a crisis. Namrata (F, 30 years) shared, "I thought it would help me connect with people and utilize my capacities and be a source of help and empower them sitting from my room." Another participant, Kriti (F, 23 years) outlined, "I saw a lot of people working with Covid-19 patients. I thought that if this world is suffering so much, what am I doing being a Psychologist? If I can do something at this time, it will be the bare minimum."

An added motivation for few participants was that they could reach out to a wider audience through a government backed project like the current initiative . One participant, Shalini (F, 22 years) said "We have made mental health a resource that is so difficult to access…I thought working with a government body will help me reach out to portions of society which otherwise I may not be able to reach." Another counsellor from the group, Keshav (M, 45 years) expressed how government initiatives had widespread reach and could have far reaching implications on policy making and laws.

> (Working) with NDMA is a bigger thing as compared to any other NGO because their reach would have been limited depending on which NGO it is. But with NDMA we can reach out to what is happening at a bigger scale, policy making and all. For example, with NDMA, now TISS is involved so I'm sure big changes can be brought about… (Keshav)

Counsellors reflected that even while they were faced with personal challenges of their own during the pandemic, concern about the mental health impact of the pandemic and the desire to reach out to a wider group of people in distress by utilizing their professional skills motivated them to volunteer with the initiative.

Challenges Faced by the Counsellors

Narratives of counsellors revealed a range of challenges that arose while providing psychosocial support to people diagnosed with Covid. While these challenges varied from counsellor to counsellor, some common elements were observed. This section explores narratives related to the professional challenges experienced by counsellors and the ways in which these were navigated.

Addressing Limitations in the Medium of Tele Counselling

For a few counsellors, moving away from the traditional and more familiar framework of counselling to brief tele counselling was a huge challenge. To build an initial rapport and then go on to address the clients' concerns within a short span was perceived to be difficult. Shalini (F, 22 years) said,

> Most of us are trained in that traditional multiple sessions of therapy system but to figure out how to fit in and introduce yourself, build some sort of connect with them and help them with their issue all in the span of 15-20 mins (is challenging). (Shalini)

In face to face therapy sessions, counsellors actively make use of client's non-verbal cues and body language as information in order to develop insights and provide emotionally attuned care. However, on a phone call, these cues become inaccessible and it is often difficult to track possible inconsistencies between client's words and their non-verbal responses. In her narrative, Nivedita (F, 30 years) described,

> What happens is that since this is not face to face counselling, we are not able to see their non-verbal actions…how are they speaking. We have to understand their underlying feelings just by listening to them. In face to face counselling, when a person is saying something and their body language says something else, we can talk about it (Nivedita)

The inability to observe the client physically was seen by some as a barrier to forming a good therapeutic alliance in the format of tele counselling.

Addressing Practical Needs and Finance Related Concerns

Some volunteer counsellors brought forth their difficulties in navigating the conversation when clients shared practical needs and finance related concerns. Dealing with

such situations made the counsellors feel ill-equipped as they were not able to help individuals access basic resources for their immediate needs. Individuals wanted assistance in procuring financial help and other necessities while this did not fall within the realm of the PSC helpline work or within the professional boundaries of counselling Priyanka (F, 44 years) outlined,

> Majorly my first and foremost challenge is addressing their financial concerns. I have no way other than making them feel hopeful and also reassure them that I will forward it to authorities…it questions my ability to address the person's concerns then and there. For that person it's a need they want at that moment. (Priyanka)

Counsellors also reflected that while helping the clients directly by providing them with financial and other resources was not possible at all times, they could assist in helping them cope with distress that emerged as a result. Providing this necessary support and therapeutic presence was seen as a means by which clients could feel empowered to reach out to resources on their own.

Supporting Clients with Recent Bereavement

Grieving the loss of a loved one whilst coping with the fear and anxiety of the pandemic can be overwhelming for most people. Some counsellors voiced their challenge of working with clients who were dealing with the loss of a loved one. Keshav (M, 45 years) stated, "When I make the call and the family member gives me the news of the death of the patient, I am blank…like "What do I say now?" Shalini (F, 22 years) highlighted that there was hardly anything she could say to the client in that moment that would make them feel better, apart from being there with them in their moment of grief. She said,

> When somebody talks about losing a loved one, it takes me a second or two to figure out my next steps. There are certain moments where there is nothing concrete I can do for them…the maximum extent I can do is to provide them some sort of support or a space for them to vent or speak or express… (Shalini)

For some, specific training in this area and continued exposure to clients dealing with loss played a huge role in acquiring the skills needed to support others in distress. It was observed by counsellors that while they did get better at supporting people dealing with grief through experience, it still remained a challenge.

Navigating Ethical Dilemmas

At different stages of their professional journey, counsellors are inevitably confronted and troubled by the choice between 'right versus wrong' or 'right versus right' (Kidder, 1995). These contribute to the emergence of ethical dilemmas, which can be challenging and complex to navigate.

Boundary Related Dilemmas. Most volunteer counsellors reported facing boundary related dilemmas such as managing the extent of self-disclosure that was appropriate with clients and titrating the scope of the support they could offer. One of the counsellors, Nivedita (F, 30 years) highlighted that few individuals wished to have regular call backs with her, which was a dilemma since it was beyond the scope of providing psychological first aid to people in crisis. In her words, "In few cases, people got dependent and asked me if I could call them frequently or if they could call back on the same number… it was difficult to explain that these were not supposed to be regular calls."

Women counsellors recounted a greater difficulty in navigating dilemmas related to self-disclosure as on one hand they acknowledged the clients' right to know who they were speaking to but also didn't feel comfortable sharing their personal details. Men, on the other hand, were reportedly more comfortable in divulging some additional details about themselves in the conversation as they believed there was a chance that clients would doubt the genuineness of the call otherwise. In the words of Rishabh (M, 24 years),

> For this kind of initiative, the boundary conflict is that we cannot share our personal information. But if somebody asks me, I do tell them where I am based and what my name is etc. because otherwise they are not going to entertain you or connect with you…they think we are calling from a sim card or an insurance policy company. (Rishabh)

Given the nature of the work, counsellors were also confronted with people who were in dire situations and it was sometimes difficult for them to draw the line between offering basic psychosocial help and stepping out of their professional boundary to provide additional help. Namrata (F, 30 years) mentioned,

> The boundary dilemma was about a person who was separated from his son and was left with his wife and grandchild in the village and had no financial support. So thoughts about supporting him were there but then the professional boundary comes in that this is not something which is a long term solution and I can only do temporary support to him (sic). I can't keep helping people because there are many people and how long can I go? (Namrata)

Value Conflicts. Few counsellors brought forth instances where their personal values and beliefs conflicted with the themes that were brought up in the counselling sessions. One of the counsellors, Meenal (F, 25 years) narrated an anecdote where the client's religious views were opposed to hers and it made her feel slightly offended. She said,

> "There was one caller who was a [name of religious group] and he was saying something like "[name of religious group that counsellor belonged to] are like this…" and at that particular time the value conflict came in that I want to defend but I refrained from doing so." (Meenal)

On the other hand, Roohi (F, 50 years) explained that at times, there was something that she strongly believed in but could not openly express her opinion to her clients.

> When I hear of injustices done by the system…I have so many people who tell me that this (Covid-19) a big sham to earn money and people are put in hospitals forcibly. It's not only these patients but people outside also. A lot of times it is a reality that what they are saying is actually happening there, not everywhere but medical negligence is definitely there. At that time, I feel that I understand but I cannot say these things to clients. (Roohi)

While it was not easy to steer through these dilemmas, counsellors found a way through them and addressed their feelings in supervision sessions or amidst themselves, which was helpful.

Transference and Countertransference. On exploring their experiences with transference and countertransference, some counsellors reflected on instances where they felt that clients had projected their feelings about someone else onto them or the other way around. While experiences of transference were heart-warming for counsellors at times, it also made them uncomfortable. Prachi (F, 65 years) narrated a specific case where an individual expressed his concern towards the health of the counsellor after he realised that she was close to his mother's age. She said,

> He was making genuine enquiries about my health and wellbeing. He seemed to have guessed I was elderly, as at some point, in response to his worry about my catching Covid if I went out, I think I said I worked from home as I was retired. After that he said that if I was his mother's age then I was very vulnerable to Covid indeed, and I should take extra care not to catch it. He continued talking about his worry and anxiety about both me and his mother, in the same breath for a while… A rather disconcerting and at the same time quite a touching experience. (Prachi)

Keshav (M, 45 years) expressed that he often felt emotionally attached to family members of the patient when the person was deceased. This was a challenging situation for him as he could possibly be crossing his professional boundary. He said,

> Many times I connect emotionally with them although I try to disconnect and talk more professionally. The moment they say that the person is no more, I feel like "What do I say now? How do I connect with them? It is such a big loss." This has happened many times when it happens with a child or something where I feel I am projecting my emotions on people… (Keshav)

While situations of transference and countertransference could be difficult to navigate in a therapeutic alliance, counsellors did not see it as a major concern in the current work due to the brief nature of the calls. Being aware of their feelings and conducting the session in the 'here and now' helped them to steer effectively through the call.

Dealing with Limitations of the Role

Inability to offer immediate help that the clients needed, other than counselling, was seen as a major challenge for some volunteer counsellors. For some participant counsellors, there was often a retrospective question of whether they had done enough to make even a slight difference in the client's condition. Meenal (F, 25 years) stated that she frequently wondered whether she could do anything more to make the person open up about their concerns, which could then take the conversation forward. She outlined, "after every call I question myself that was there something that I could have done better…that others would have done differently? Or was something else that I could have done to probably get the person to talk or share more?"

Additionally, Keshav (M, 45) expressed how in certain situations it was difficult to keep oneself detached and solely remain in the shoes of a counsellor. According to him,

> sometimes people talk about extreme poverty and they don't know their future… how are they going to support themselves. Although I try to maintain my emotions and keep myself grounded and stay disconnected, but there are definitely times when we connect and get affected. I know I can do more for them but I have to stick to my job. (Keshav)

Few counsellors also highlighted their observation about peoples' increased expectations when they were informed that the call was made by a government body. Generally, people did not realise at first that the conversation was aimed at addressing only their emotional health and was not a helping hand for all their issues. It was therefore challenging for counsellors to remain within their professional role and try to explain to the client about the purpose of the call and the limited support they could offer.

Impact of Working with the Helpline on Counsellors' Development

Narratives of the volunteer counsellors captured how working on the NDMA helpline initiative impacted them personally and professionally. In their journey of volunteering on the present project, they came across and interacted with a range of people from different backgrounds, cultures and degrees of physical and psychological vulnerability. Counsellors expressed that it brought them closer to the ground reality of how things were unfolding in the pandemic, which taught them a great deal.

Reaching Out to a Large Group of People

One of the benefits of working on this initiative, as pointed out by some volunteer counsellors, was the capacity to reach out to maximum people in need of psychosocial assistance and care. For some fresh graduates who did not have many years of professional experience, this seemed like an ideal opportunity to work with a varied range of clients and hone their counselling skills. According to Nivedita (F, 30 years),

> If I look at myself in the last 2-3 years, I have not gotten so many counselling sessions as much as I got through NDMA.. Till date, I have done 1000-2000 calls and in about 500 calls I have even spoken up till 5 minutes. Over here my skills have become vast because I have gotten many cases to handle… (Nivedita)

Additionally, one of the participant counsellors, Priyanka (F, 44 years) opined that speaking to a diverse group of people made her understand how they were shaped by their background. She said, "there was so much to take away for me because I got the opportunity to speak with people of different cultures and understood how they were different because of their culture and economic backgrounds…"

Increased Understanding of Ground Realities

Some counsellors echoed the view that their decision of working with this initiative had been an eye-opening experience, where they had an opportunity to closely observe things happening at the ground level. Being in the comfort of their homes, it was difficult to recognize the challenges that people were facing, and this initiative gave them a means to have a deeper awareness of the state of affairs in the country. Meenal (F, 25 years) believed that it was an experience which brought her closer to reality as she had distanced herself from it before she started working with NDMA. According to her,

> when the whole thing with Covid started, you really don't think that this will happen to me or somebody I know. You distance yourself from situations that are not really comfortable. So it was a new situation and it opened my eyes to another reality, the actual reality that people are experiencing these things and how it affects them. (Meenal)

While counsellors reported stories of resilience in the way individuals were handling the situation and the help they received from others, it was also upsetting for them to hear about isolated incidents of social alienation and isolation from community members.

Thus counsellors were thankful for the initiative started by NDMA to broaden their perspective towards understanding the nature of psychosocial concerns that people faced in a disaster context. They believed that their experience of working with this initiative impacted them greatly in their professional growth and development.

Role of Training and Supervision on Counsellors' Professional Growth and Development

The training and supervision sessions conducted by the TISS Rahbar team were seen to play a key part, by volunteer counsellors, in their professional growth and development. Counsellors greatly valued these sessions for their role in bringing the group closer with a common goal to work on, for inviting the perspectives of different individuals and building specific skills and knowledge base for the current work. They also believed that there were a lot of takeaways from these sessions that they could carry forward to their professional careers.

Building Knowledge

According to counsellors, the training and supervision sessions enriched their theoretical and conceptual understanding of counselling frameworks, which helped them work with vulnerable groups. Keshav (M, 45 years), who was also active in other volunteering services during Covid apart from the current initiative, said that he used the knowledge he gained in his other projects as well,

> A lot of theoretical knowledge that we were given during our training has helped me in terms of looking at a problem holistically. I'm also involved at the ground level and because of the training, I am able to connect with them. So that has helped me a lot looking at it on both sides...both virtually on phone and on the ground level in person also. (Keshav)

Counsellors especially highlighted that training helped them integrate knowledge on both 'psychological' and 'social' aspects of psychosocial care. In the words of Roohi (F, 50 years),

"I think the training was important and done well…usually we started with the basic needs things and we were also dealing with the emotional support."

Learning Practical Skills

Apart from enhancing knowledge, counsellors consistently highlighted the role of training and supervision in providing them with practical skills that could be readily applied to their work. Deepali (F, 54 years) described concrete tools shared by trainers that helped bridge theoretical learning with application. She said,

> There have been some suggestions on the type of phrases to use (in difficult situations) ...sometimes I find myself short of vocabulary or worldly wise statements. So it helps to understand more theoretical things and constantly apply what we had heard or learned. (Deepali)

Some counsellors highlighted how supervision helped them acquire skills for working with brief formats of tele counselling. In the words of Meenal (F, 25 years), "I think that transition from what we think is actual counselling to this tele counselling was done beautifully by both of them in the whole process of training."

One of the counsellors mentioned how he benefited from the practical approach of skill building in sessions, especially as his prior training had not equipped him with these skills. Rishabh (M, 24 years) described,

> Its a great learning curve at this point…just couldn't have come at a better point. I haven't done my MPhil so there is a lot of practical gap between the theory and practical part. Internships are there but you don't cover all of these aspects. (Rishabh)

Thus counsellors outlined the educative role of training and supervision in skill development and learning by drawing from the experiences of trainers.

Engaging in Reflective Practice

In the field of mental health, reflective practice can be understood as an act of being self-aware and cognizant of one's practice (British Psychological Society, 2008). According to the counsellors, training and supervision sessions helped in increasing their self-awareness and reflective capacities, guided them to process difficult emotions that were brought up during their work and helped clarify their own values and biases.

One of the volunteer counsellors emphasized the importance of reflective practice in therapy and how the sessions enhanced those skills. Priyanka (F, 44 years) said, "basically being aware…so the more supervision and training we have, it helps me become more aware of my feelings and thoughts and I'm able to structure my conversation better." Another

counsellor, Keshav (M, 45 years) shared that being in the reflective space of supervision sessions, he was able to reflect on his own values and beliefs, that guided the way he conducted counselling with his clients. He said,

> When we are counselling, we are looking at it from our own beliefs, our own values, our own thoughts we are having. Even the information we are getting, we are putting in our own mind and then we are churning it out and doing the process. (Keshav)

Counsellors specifically highlighted the collaborative and safe space created during training and supervision sessions that facilitated reflective practice and encouraged counsellors to share their thoughts freely.

Accessing Peer Learning and Support

Thrown into a new and complex role of remote psychosocial care during a pandemic, most counsellors expressed their appreciation about having the chance to learn from peer experiences. As described by Keshav (M, 45 years), "during supervision sessions, the case studies presented by different counsellors gave us live feedback about what is happening. It provided a lot of insight into the practical aspects of the work."

Counsellors outlined that listening to fellow members talk about their specific cases or observations, they could gauge if the approach they were using was right and also reflect on what could be done differently. Deepali (F, 54 years) mentioned,

> (training and supervision) helps me to self-check if what I am doing is correct or not. That becomes the basic part of learning for me…whether I should do it differently or how I am doing or assessing or accepting things is fine… (Deepali)

Few counsellors highlighted that understanding the nuances of a concern brought up by a client gave them an idea about how it could be handled in different ways, based on an individual counsellor's approach and value system. The group also shared a common feeling about team building and had a shared sense of spirit towards their goal, which was facilitated by the training and supervision sessions. The counsellors mentioned that when they virtually met and interacted with their team members on regular intervals, it strengthened their bond and they began seeing each other as a source of support. Shalini (F, 22 years) described,

> Post training and the commencement of supervision, the group of counsellors have become a lot more interactive. There is a lot more conversation happening there and I think a lot more people have become comfortable talking on the group and a slight sense of community is coming up with people who are trying to handle a similar situation and sharing experiences.

(Shalini)

Counsellors emphasized that they greatly valued the support of fellow team members and the shared space of learning that was created amongst them.

Benefiting from Facilitators' Approach to Training and Supervision

Counsellors also expressed that they greatly benefitted from the way facilitators led the sessions. One of the counsellors, Shalini (F, 22 years) appreciated that the sessions were structured based on the needs presented by them. She said,

> The fact that the training was over a period of time and they didn't try to stuff everything into one long session and do it. Secondly the fact that it was contextualized...We were initially given a form to fill about the issues we were facing. So that really helped…- Shalini

Another counsellor, Roohi (F, 50 years) mentioned that the key takeaway for her was the facilitation style and approach of the trainers themselves.

> Personally I feel I learnt a lot from the trainers...from the way they handled our queries itself. From the way they explained things, from the way they calmly talk to us. Other than the content of the training, I picked up a lot from them as trainers. (Roohi)

The group echoed a similar view that the role played by facilitators in their professional growth through the course of the work was immense.

Increased Professional Competence

Counsellors shared how learning in supervision and training brought a renewed sense of competence in their professional skills as they found themselves applying new approaches and techniques in their work. Namrata (F, 30 years) mentioned that once she was trained and she acquired the necessary skills, she felt more confident to probe into difficult issues. She said,

> When this training happened on stigma and discrimination, it really helped me…. If I had a call with them then I checked up with them if they are facing any stigma or if people are being very discriminatory around them. Initially I would try to escape to be really frank. I would think what will I do from here sitting in my room? (Namrata)

In the view of another counsellor, Priyanka (F, 44 years), the training made her feel content about the way she was able to navigate a session.

> I was speaking to a young boy who was 20 years old and who had just lost his dad. After seeking permission, he really wanted to talk and my call went to around 45 mins and he really

> wanted to share and vent out…. I felt I was able to do justice to the call, especially after the training. (Priyanka)

This section attempted to bring into forefront the experiences of volunteer counsellors while providing counselling services to individuals diagnosed with Covid through the helpline initiative. Motivations to volunteer included concerns about the psychosocial impact of the pandemic and a desire to help individuals in distress. Challenges that came up during the work were related to limitations of the counsellors and the initiative, the therapeutic process and navigation of ethical dilemmas. The protective scaffolding of training and supervision was seen to be of immense benefit for volunteer counsellors to help them navigate through the challenges of clients, deal with their own distress and further their skills and knowledge for the work they were doing.

Discussion

In the ongoing pandemic, mental health professionals have played a crucial role in providing psychosocial support to individuals in distress and helping them cope with stressors. Counsellors' motivation to contribute to the collective crisis has been witnessed right from the start of the pandemic with the growing number of volunteer-run mental health services across India.

Counsellors in the present study were faced with various challenges while providing counselling services, that included difficulties in navigating ethical and boundary related dilemmas, limitations about their role and supporting clients with recent bereavement. Documentation of one of the first mental health initiatives from China also highlighted similar difficulties faced by counsellors in offering tele counselling services during the pandemic such as systemic challenges, technical difficulties, challenges pertaining to the therapeutic process and ethical dilemmas. (Chen et al., 2020).

In the background of these challenges, counsellors in the present study affirmed the importance of training and supervision to navigate through tough situations during calls and enhance their skills and knowledge for the current work. This finding is particularly significant in the Indian context, given the need for standardised training and supervision for mental health professionals (Sriram, 2016).

In the pandemic context, in order to ensure quality mental health care for the population, there is a need to focus attention to mental health professionals themselves. Two key priorities include building the competence of professionals at the forefront of providing psychosocial care, and enhancing their well-being. Specialized training is seen to play a key

part in enhancing competence. Responding to the unprecedented challenges of the pandemic requires unique competencies in the areas of psychosocial first aid, supportive counselling, trauma informed care and bereavement support. At present, no existing model covers all these aspects. Therefore, training needs to be tailored and contextualised to meet the unique requirements in the current situation. At the same time, training also needs to be accessible and affordable for mental health professionals.

Besides training, supervision is the most widely established medium to enhance competence of mental health professionals and support their well-being. According to a model given by Inskipp and Proctor (2001), supervision has three functions, which include the formative (teaching counselling skills and theories) normative (maintaining professional norms and standards) and restorative (promoting the well-being of the counsellor). While all three dimensions of supervision must be balanced, in the pandemic context it perhaps becomes crucial to especially pay attention to the restorative aspects of supervision. During this time, counsellors are likely to be challenged by higher caseloads and prolonged exposure to trauma while they navigate their own personal challenges during the pandemic. A model of supportive supervision proposed by the Red Cross looks at fostering a supportive relationship between supervisor and supervisee(s). Its main goal is to create a safe and collaborative space to promote the quality of work, technical competencies, and well-being of the person being supervised (Red Cross and Red Crescent, 2020).

Nurturing a space for discussion of challenges and processing the emotional impact of crisis work through supportive supervision is even more important in the current situation due to the increased emotional exhaustion faced by counsellors during Covid-19 response. The demanding nature of psychotherapy during the pandemic makes clinicians an especially vulnerable group when it comes to susceptibility towards burnout (Rokach & Boulazreg, 2020). A key element of supportive supervision at this time therefore is ensuring counsellor self-care. While self-care might be most effective when individually tailored, following measures like taking some time off, following a healthy sleep and diet routine, having cultivated stress outlets and engaging in meaningful relationships outside of therapy might be helpful.

Conclusions

The explorations of the current study found a range of psychosocial concerns experienced by individuals diagnosed with Covid-19, like health and medical concerns, appetite and sleep related disturbances, financial and logistical concerns, stigma and relational concerns. This had an emotional impact on individuals and they experienced responses associated with stress, loneliness, boredom, anxiety, fear, helplessness, sadness, frustration and hopelessness. Psychosocial interventions like the establishment of a therapeutic framework, holding and containing distress, using supportive techniques to enhance coping, generating alternative perspectives and referring to specialized services were found to be effective by volunteer counsellors in alleviating the distress of individuals.

Experiences of counsellors while working with the NDMA Psychosocial Care Helpline were also explored. Large-scale psychosocial care initiatives have not been documented earlier in the Indian context. Therefore, findings from the study have significant implications, some of which have been underlined below.

Insights from the present study suggest the need to acknowledge psychosocial and mental health care as being critical to the acute and long term response to disasters. With the widespread mental health impact caused by the Covid-19 pandemic, it becomes important to incorporate psychosocial support services in national and local Covid-19 response plans. In the context of disasters, mental health services could be integrated at all levels of disaster response while addressing medical, financial, logistical and other needs of people.

Tele counselling has proved to be an effective tool in providing psychosocial support to individuals during the current pandemic. Centralized helplines like the one initiated by NDMA can be a highly effective medium to reach out to people in distress during large-scale disasters. Reverse helplines can also be an innovative bridge to extend help towards the unreached, and facilitate proactive, prompt and responsive support in the aftermath of a crisis. These helplines can be started in different regional languages and be integrated into networks to maximize resources by creating local and national level linkages. There could be a provision for referral services (for example with hospitals, nursing homes, psychiatrists and social workers etc.) for those requiring specialized psychosocial support.

Having clear protocols for linkages with specialized services might also be necessary for individuals reporting high risk due to domestic violence, child abuse, or suicidal ideation etc. Further, follow up mechanisms for high risk populations need to be in place while running

such helplines during an ongoing pandemic.

The mental health needs of certain vulnerable groups like police personnel, medical professionals, persons with disabilities and the elderly might require special attention. Specialized helplines to support these groups with a provision of post-recovery follow up could be included as a part of crisis psychosocial support. There is also a need to document initiatives for future reference and incorporate the feedback provided by clients for contextualizing the services according to the needs presented.

The findings of the study revealed that stigmatization of individuals diagnosed with Covid-19 could take a heavy toll on their mental health and developing mitigation strategies to address stigma should be a key priority. Ground level initiatives to spread accurate information regarding the pandemic (e.g. what causes it, how is it transmitted, treatment and prevention etc.) by involving various stakeholders in the community could be emphasized. Regulation of news reporting could be beneficial in shifting the attention from blaming individuals and communities of spreading the virus, to infection prevention practices and ways to seek help in case of a positive diagnosis. Being mindful about the terms used to address individuals diagnosed with Covid-19 could also be helpful to reduce discrimination.

One of the implications of the present study is the need for specialized training for counsellors in navigating the unique psychosocial context of Covid-19 in India. It is necessary that the skills training be contextualized, made culturally relevant and tailored to the specific challenges experienced by counsellors in the current context. Training must have clearly defined competencies across the domains of knowledge, skills and reflective practice. Specific skills in the areas of psychosocial first aid, supportive counselling, trauma informed care and bereavement support need to be emphasized. Training may also involve components of perspective-building for counsellors to recognize and work with intersectional dimensions of mental health in India that include caste, class, gender, and other dimensions. The sessions must include concerns of ethics and specific ethical concerns that might come up during remote counselling.

Supervision was seen as a critical support for counsellors in the current study. A supportive, flexible, responsive and warm approach by supervisors was found to be most beneficial. Practices of seeking counsellor feedback after each supervisions session and contextualizing the sessions according to counsellor needs could be incorporated in designing supervision for crisis work. Diverse methodologies like process recall, experiential exercises, reflective dialogue, art based activities, reflective journaling, case based discussion, skill building etc. might contribute to enriching supervision practice. Additionally, supervision

could focus on counsellor motivation and find ways to sustain it when exposure to trauma is involved. Reflective activities can also be incorporated to a larger extent to ensure an aware counselling practice. Most importantly, self-care of counsellors is necessary and needs to be proactively addressed. Supervision needs to help counsellors process the impact of prolonged exposure to trauma, prevent burnout and compassion fatigue.

There is a need to monitor and evaluate programs that address mental health concerns created by the pandemic. This will help in providing insights for future models of crisis intervention based on the effectiveness of programs.

References

Action Aid. (2020, June). Workers in the Time of COVID 19. ActionAid, New Delhi, India. Retrieved from https://www.actionaidindia.org/wp-content/uploads/2020/05/Workers-in the-Time-of-COVID-19-l-Rapid-Assessment-in-Bihar-Final.pdf

Adams, J. (2002). *Environmental health in emergencies and disasters: a practical guide*. World health organization.

Adhikari, S. P., Meng, S., Wu, Y. J., Mao, Y. P., Ye, R. X., Wang, Q. Z., ... & Zhou, H. (2020). Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: a scoping review. *Infectious diseases of poverty*, *9*(1), 1-12.

Bajpai, V. (2014). The challenges confronting public hospitals in India, their origins, and possible solutions. *Advances in Public Health*, *2014*.

Banerjee, D. (2020). The COVID-19 outbreak: Crucial role the psychiatrists can play. *Asian journal of psychiatry*, *50*, 102014.

Bao, Y., Sun, Y., Meng, S., Shi, J., & Lu, L. (2020). 2019-nCoV epidemic: address mental health care to empower society. *The Lancet*, *395*(10224), e37-e38.

Barber, J. P., Stratt, R., Halperin, G., & Connolly, M. B. (2001). Supportive techniques: are they found in different therapies?. *The Journal of psychotherapy practice and research*, *10*(3), 165.

Barbisch, D., Koenig, K. L., & Shih, F. Y. (2015). Is there a case for quarantine? Perspectives from SARS to Ebola. *Disaster medicine and public health preparedness*, *9*(5), 547-553.

Batra, B. J., & Chaudhry, S. (2005). International human rights standards on post-disaster resettlement and rehabilitation. *working document, Habitat International Coalition–Housing and Land Rights Network and People's Movement for Human Rights Learning in collaboration with the United Nations Special Rapporteur on Adequate Housing, available at: www. pdhre. org/HIC-PDHRE. pdf (accessed 4 May 2012)*.

Bhattacharya, P., Banerjee, D., & Rao, T. S. (2020). The "untold" side of COVID-19: Social stigma and its consequences in India. *Indian Journal of Psychological Medicine*, *42*(4), 382-386.

Blumenstyk, G. (2020). Why coronavirus looks like a 'black swan'moment for higher ed. *Chronicle of Higher Education*.

Bonanno, G. A. (2020, March 30). Psychological science and COVID-19: Remaining resilient during a pandemic. Retrieved from the Association for Psychological Science website:https://www.psychologicalscience.org/news/backgrounders/backgrounder-1-resilient.html

Bonanno, G. A., Ho, S. M., Chan, J. C., Kwong, R. S., Cheung, C. K., Wong, C. P., & Wong, V. C. (2008). Psychological resilience and dysfunction among hospitalized survivors of the SARS epidemic in Hong Kong: a latent class approach. *Health Psychology*, *27*(5), 659.

Bonnano, G. A. (2004). Loss, trauma and human resilience: Conceptual and empirical connections and separateness. *American Psychologist*, *59*(1), 20-28.

Boscarino, J. A., Adams, R. E., & Figley, C. R. (2011). Mental health service use after the World Trade Center disaster: utilization trends and comparative effectiveness. *The Journal of nervous and mental disease*, *199*(2), 91

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*.

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, *22*(4), 16-31.

Carfì, A., Bernabei, R., & Landi, F. (2020). Persistent symptoms in patients after acute COVID-19. *Jama*, *324*(6), 603-605.

Carter WN (1991). Disaster management: a disaster manager's handbook. *Manila, Asian Development Bank.*

Chen, S., & Bonanno, G. A. (2020). Psychological adjustment during the global outbreak of COVID-19: A resilience perspective. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S51.

Chen, S., Li, F., Lin, C., Han, Y., Nie, X., Portnoy, R. N., & Qiao, Z. (2020). Challenges and recommendations for mental health providers during the COVID-19 pandemic: the experience of China's First University-based mental health team. *Globalization and health*, *16*(1), 1-10.

Chew, Q. H., Wei, K. C., Vasoo, S., Chua, H. C., & Sim, K. (2020). Narrative synthesis of psychological and coping responses towards emerging infectious disease outbreaks in the general population: practical considerations for the COVID-19 pandemic. *Tropical Journal of Pharmaceutical Research*, *61*(7).

Cooke, J. E., Eirich, R., Racine, N., & Madigan, S. (2020). Prevalence of posttraumatic and general psychological stress during COVID-19: A rapid review and meta-analysis. *Psychiatry research*, *292*, 113347.

Coronavirus: India's public health system on the verge of collapse: DW: 18.09.2020. Retrieved December 06, 2020, from https://www.dw.com/en/coronavirus-indias-public-health-system-on-the-verge-of-collapse/a-54978362

CPI(M)-CITU. (2020, April). Survey of Migrant Workers in Distress in Delhi under COVID-19 Lockdown. Retrieved from https://www.docdroid.net/uJ1YFIJ/cpim-citu-survey-ofmigrant-workers-in-delhi-24-april-2020-pdf

Duggal, C., Dua, B., & Ullas,N., (2020). Psychotherapy Supervision in India: From supervisee perspectives to contextual models of practice. *Report Submitted to the Research Council, Tata Institute of Social Sciences.*

Fan, L. C. (2005). The impact of SARS on suicide and accident mortality [Master's thesis, National Taipei University of Nurse and Health Sciences Institutional Repository].

Fegert, J. M., Vitiello, B., Plener, P. L., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and adolescent psychiatry and mental health*, *14*, 1-11.

Galappatti, A., & Richardson, S. (2016). Linking mental health and psychosocial support and disaster risk reduction: applying a wellbeing lens to disaster risk reduction. *Intervention*, *14*(3), 223-231.

Galea, S., Ahern, J., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., & Vlahov, D. (2002). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England journal of medicine*, *346*(13), 982-987.

Goldmann, E., & Galea, S. (2014). Mental health consequences of disasters. *Annual review of public health*, *35*, 169-183.

Golechha, M. (2020). COVID-19, India, lockdown and psychosocial challenges: What next?. *International Journal of Social Psychiatry*, 0020764020935922.

Gopal, A., Sharma, A. J., & Subramanyam, M. A. (2020). Dynamics of psychological responses to COVID-19 in India: A longitudinal study. *PloS one*, *15*(10), e0240650.

Goyal, K., Chauhan, P., Chhikara, K., Gupta, P., & Singh, M. P. (2020). Fear of COVID 2019: First suicidal case in India!. *Asian journal of psychiatry*, *49*, 101989.

Grover, S., Sahoo, S., Mehra, A., Avasthi, A., Tripathi, A., Subramanyan, A., ... & Chakraborty, K. (2020). Psychological impact of COVID-19 lockdown: An online survey from India. *Indian Journal of Psychiatry*, *62*(4), 354.

Gruber, J., Prinstein, M. J., Clark, L. A., Rottenberg, J., Abramowitz, J. S., Albano, A. M., ... & Forbes, E. E. (2020). Mental health and clinical psychological science in the time of COVID-19: Challenges, opportunities, and a call to action. *American Psychologist*.

Guha-Sapir, D., Vos, F., Below, R., & Ponserre, S. (2012). *Annual disaster statistical review 2011: the numbers and trends*. Centre for Research on the Epidemiology of Disasters (CRED).

Hawryluck, L., Gold, W. L., Robinson, S., Pogorski, S., Galea, S., & Styra, R. (2004). SARS control and psychological effects of quarantine, Toronto, Canada. *Emerging infectious diseases*, *10*(7), 1206.

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., ... & Ford, T. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *The Lancet Psychiatry*.

Hsieh, K. Y., Kao, W. T., Li, D. J., Lu, W. C., Tsai, K. Y., Chen, W. J., ... & Chou, F. H. C. (2020). Mental health in biological disasters: From SARS to COVID-19. *International journal of social psychiatry*, 0020764020944200.

Inchausti, F., MacBeth, A., Hasson-Ohayon, I., & Dimaggio, G. (2020). Telepsychotherapy in the age of COVID-19: A commentary.

Inskipp, F., & Proctor, B. (2001). Group supervision. *Supervision in the mental health professions: A practitioner's guide*, 99-121.

International Labour Organization. (2020, May). ILO Monitor: COVID-19 and the world of work. (Fourth edition) Updated estimates and analysis. Geneva: International Labour Organsaition Retrieved from https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefing not e/wcms_745963.pdf

Jayakumar, P. B. (2020). Alcohol non-availability kills more than coronavirus in Kerala; foreign liquor served as 'medicine'. *Business Today*.

Kesar, S., Abraham, R., Lahoti, R., Nath, P., & Basole, A. (2020). Pandemic, informality, and vulnerability: Impact of COVID-19 on livelihoods in India. *CSE Working Paper*, *2020*.

Khasne, R. W., Dhakulkar, B. S., Mahajan, H. C., & Kulkarni, A. P. (2020). Burnout among healthcare workers during COVID-19 pandemic in India: Results of a questionnaire-

based survey. *Indian Journal of Critical Care Medicine: Peer-reviewed, Official Publication of Indian Society of Critical Care Medicine*, *24*(8), 664.

Kidder, R. M. (1995). *How good people make tough choices*. New York: Morrow.

KO, C. H., YEN, C. F., YEN, J. Y., & YANG, M. J. (2006). Psychosocial impact among the public of the severe acute respiratory syndrome epidemic in Taiwan. *Psychiatry and Clinical Neurosciences*, *60*(4), 397-403.

Lange, K. W. (2020). Mental health problems in COVID-19 and the need for reliable data. *Movement and Nutrition in Health and Disease*, *4*.

Lau, J. T., Yang, X., Pang, E., Tsui, H. Y., Wong, E., & Wing, Y. K. (2005). SARS-related perceptions in Hong Kong. *Emerging infectious diseases*, *11*(3), 417.

Loiwal, M. (2020). 20% increase in patients with mental illness since coronavirus outbreak: Survey. *India Today*, *31*.

López-Ibor JR, J. J. (2006). Disasters and mental health: New challenges for the psychiatric profession. *The World Journal of Biological Psychiatry*, *7*(3), 171-182.

Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., ... & Mazzulli, T. (2003). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Cmaj*, *168*(10), 1245-1251.

Meduri, A. (2006). The Disaster Management Act, 2005.

Meng, H., Xu, Y., Dai, J., Zhang, Y., Liu, B., & Yang, H. (2020). Analyze the psychological impact of COVID-19 among the elderly population in China and make corresponding suggestions. *Psychiatry Research*, *289*, 112983.

Menzies, R. E., & Menzies, R. G. (2020). Death anxiety in the time of COVID-19: Theoretical explanations and clinical implications. *The Cognitive Behaviour Therapist*, *13*.

Mertens, G., Gerritsen, L., Duijndam, S., Salemink, E., & Engelhard, I. M. (2020). Fear of the coronavirus (COVID-19): Predictors in an online study conducted in March 2020. *Journal of Anxiety Disorders*, 102258.

Minihan, E., Gavin, B., Kelly, B. D., & McNicholas, F. (2020). Covid-19, Mental Health and Psychological First Aid. *Irish Journal of Psychological Medicine*, 1-12.

Nagaraja, D., & Murthy, P. (2008). Mental health care and human rights. *New Delhi: National Human Rights Commission*.

National Disaster Management Guidelines—Management of Biological Disasters, 2008. A publication of National Disaster Management Authority, Government of India. ISBN 978-81-906483-6-3, July 2008, New Delhi.

Natural Disasters Organization (1992). Australian emergency manual: community emergency planning guide, 2nd ed. Dickson.

Neria, Y., Nandi, A., & Galea, S. (2008). Post-traumatic stress disorder following disasters: a systematic review. *Psychological medicine*, *38*(4), 467.

Orgilés, M., Morales, A., Delvecchio, E., Mazzeschi, C., & Espada, J. P. (2020). Immediate psychological effects of the COVID-19 quarantine in youth from Italy and Spain.

Pancani, L., Marinucci, M., Aureli, N., & Riva, P. (2020). Forced social isolation and mental health: A study on 1006 Italians under COVID-19 quarantine.

Patton, M. Q. (1990). Qualitative evaluation and research methods. SAGE Publications, inc. Publications Ltd.

Peng, Y. C., & Tsai, J. C. H. & Lin, E. C. L (2004). Lessons learned from the anti-SARS quarantine experience in a hospital-based fever screening station in Taiwan. *American journal of infection control*, *38*(4), 302-307.

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *New England Journal of Medicine*

Psychosocial Support IFRC – Mental Health Matters. *https://pscentre.org/wp-content/uploads/2020/05/Supportive-supervision-during-COVID-19.pdf*

Qiu, J., Shen, B., Zhao, M., Wang, Z., Xie, B., & Xu, Y. (2020). A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: implications and policy recommendations. *General psychiatry*, *33*(2).

Rajkumar, R. P. (2020). COVID-19 and mental health: A review of the existing literature. *Asian journal of psychiatry*, 102066.

Ray, D., and Subramanian, S. (2020). India's Lockdown: An Interim Report. National Bureau of Economic Research Working Paper w27282.

Roberts, D. L., Kleinlein, P., & Stevens, B. (2012). An alternative to generating alternative interpretations in social cognitive therapy for psychosis. *Behavioural and cognitive psychotherapy*, *40*(4), 491.

Rokach, A., & Boulazreg, S. (2020). The COVID-19 era: How therapists can diminish burnout symptoms through self-care. *Current Psychology*, 1-18.

Sahoo, S., Bharadwaj, S., Parveen, S., Singh, A. P., Tandup, C., Mehra, A., ... & Grover, S. (2020). Self-harm and COVID-19 Pandemic: An emerging concern–A report of 2 cases from India. *Asian journal of psychiatry*.

Satapathy, S., & Bhadra, S. (2009). Disaster psychosocial and mental health support in South & South-East Asian countries: A synthesis. *Journal of South Asian Disaster Studies*, *2*(1), 21-45.

Saurabh, K., & Ranjan, S. (2020). Compliance and Psychological Impact of Quarantine in Children and Adolescents due to Covid-19 Pandemic. *Indian Journal of Pediatrics*, 1.

Shah, K., Bedi, S., Onyeaka, H., Singh, R., & Chaudhari, G. (2020). The role of psychological first aid to support public mental health in the Covid-19 pandemic. *Cureus*, *12*(6).

Sriram, S. (2016). Counselling in India: An Introduction to the Volume. *Counselling in India*, 1–11. doi: 10.1007/978-981-10-0584-8_1

Stranded Workers Action Network. (2020, June 5). To leave or not to leave. Retrieved June 17, 2020, from http://strandedworkers.in/mdocs-posts/to-leave-or-not-to-leave/

Swartz, H. A. (2020). The Role of Psychotherapy During the COVID-19 Pandemic.

Thiagarajan, K. (2020). Covid-19 exposes the high cost of India's reliance on private healthcare. *bmj*, *370*.

United Nations International Strategy for Disaster Reduction. (2005). *Hyogo framework for action 2005-2015: Building the resilience of nations and communities to disasters. Geneva, Switzerland: United Nations International Strategy for Disaster Reduction.*

United Nations International Strategy for Disaster Reduction. (2015). *Sendai framework for disaster risk reduction 2015-2030. Geneva, Switzerland: United Nations International Strategy for Disaster Reduction.*

United Nations International Strategy for Disaster Reduction. (2009). *2009 terminology on disaster risk reduction. Geneva, Switzerland: United Nations International Strategy for Disaster Reduction.*

United Nations Office of the Disaster Relief Co-ordinator (1991). Mitigating natural disasters. Geneva.

Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., McIntyre, R. S., ... & Ho, C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. *Brain, behaviour, and immunity*.

Wang, P. S., Gruber, M. J., Powers, R. E., Schoenbaum, M., Speier, A. H., Wells, K. B., & Kessler, R. C. (2007). Mental health service use among Hurricane Katrina survivors in the eight months after the disaster. *Psychiatric services*, *58*(11), 1403-1411.

World Health Organization (1999a). Community emergency preparedness: a manual for managers and policy-makers. Geneva.

World Health Organization. (2003). *Mental health in emergencies: Mental and social aspects of health of populations exposed to extreme stressors* (No. WHO/MSD/MER/03.01). World Health Organization.

World Health Organization. (2013). *Guidelines for the management of conditions that are specifically related to stress*. World Health Organization.

World Health Organization. (2020). *Mental health and psychosocial considerations during the COVID-19 outbreak, 18 March 2020* (No. WHO/2019 nCoV/MentalHealth/2020.1). World Health Organization.

Zhang, W. R., Wang, K., Yin, L., Zhao, W. F., Xue, Q., Peng, M., ... & Chang, H. (2020). Mental health and psychosocial problems of medical health workers during the COVID-19 epidemic in China. *Psychotherapy and psychosomatics*, *89*(4), 242-250.

Zolnikov, T. R., & Furio, F. (2020). Stigma on first responders during COVID-19. *Stigma and Health*.

Annexure A

PARTICIPANT INFORMATION SHEET FOR CALL FEEDBACK

Title of the project: Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India

This Participant Information Sheet (referred to as PIS) gives you important information about this research study. It describes the purpose of the study, the risks and possible benefits of participating in the study.

Please take time to review this information carefully. Please ask for an explanation in case you do not understand word/s or sentence/s in the PIS. After you have read the PIS, you are free to talk to the /researchers about the study and ask them any questions you have. You will be given a copy of the PIS and the signed informed consent document for your future reference.

Your participation in the study is voluntary. You have the right to withdraw from the study at any stage without giving reasons for your withdrawal.

What is this study about?

The sudden and unexpected outbreak of the Covid-19 pandemic has brought about a number of unprecedented challenges to the healthcare system of the country, both in terms of physical and mental health. The mental health crisis that has been brought about by the pandemic goes largely unnoticed. Based on past studies in the aftermath of major disasters and epidemics, it is predicted that the Covid-19 pandemic can result in an onset of psychiatric illness in a large population, while also exacerbating symptoms for people who are already experiencing a mental illness. Self-isolation and quarantine has affected the usual activities, routines and livelihoods of people and can lead to increased loneliness, insomnia, drug use or self-harm behaviour (WHO, 2020). In such a situation, the role of counsellors is quite integral in providing timely support to people in distress. The aim of this study is to gain an understanding of the psychosocial concerns experienced by persons testing positive for the virus, as observed by you in your phone counselling session, your response to their concerns and positive feedback(if any) received from people. Knowing your perspectives will provide insight into the psychosocial status of the persons diagnosed with the Covid-19 virus. By filling this gap in research, the basis for designing and formulation of future psychosocial

interventions can be formed, to adapt to future mental healthcare delivery challenges in the country.

2. What is the rationale for the selection or screening of the respondents?

Most of our knowledge of the psychosocial concerns and the consequent response of the mental health professional is derived by literature from other countries. The experiences of counsellors in India is likely to be different as the concerns brought up during their session with clients testing positive for Covid would be unique to the Indian setting.

3. What is the relevance of the information being collected to the community or respondents?

Information gathered from the counsellors can help document the entire process of psychosocial support delivery to Covid positive persons by the National Disaster Management Authority, in collaboration with TISS, Mumbai. This can help in formulating and implementing policies and interventions for psychosocial care for future crisis situations.

4. Who can take part in this research study?

To bring in different perspectives, this study will include mental health professionals with different backgrounds, who are a part of the NDMA psychosocial initiative for persons testing positive with Covid-19. This will include:

- Clinical Psychologists
- Counselling Psychologists
- Counsellors and
- Psychiatric Social Workers

5. How long will you be in the research study?

You will be required to complete an informed consent form if you are willing to share your feedback responses for the calls you made as a part of the initiative. The forms will be used for further analysis to explore the nature of psychosocial concerns shared by people diagnosed with Covid-19, the counsellor's response to the concerns and the positive feedback received from people.

6. What are the possible risks and inconveniences that you may face by being in the research study?

There are no known risks that you may face by sharing your call feedback form. Complete confidentiality will be maintained and the responses will be used for research purposes only.

7. What are the positive benefits to you being in the research study?

By being a part of this study, you will contribute in generating insights on the unique psychosocial concerns faced by people in the Covid-19 pandemic and the interventions that have worked in alleviating their concerns. It will also help in highlighting the positive responses from people who have been benefitted from the initiative.

8. How will your privacy and confidentiality be maintained?

All information obtained from this study will remain strictly confidential and will be utilized for research purposes only. Your identity will remain confidential and you will be identified with a pseudonym in any publication or presentation of this study.

9. Will you have to bear any expenses or costs by participating in the research study?

You will not be compensated for your participation in the study.

10. Whom do you call if you have questions or problems regarding rights as a participant?

If you have any questions or concerns pertaining to this study, please call on the contact number given below, and we will do our best to address your queries:

Name of Principal Institution: Tata Institute of Social Sciences, Mumbai

Dr. Chetna Duggal
Associate Professor,
School of Human Ecology
Tata Institute of Social Sciences
Mumbai 400088
Ph: 022-25525346
email id: chetna.d@tiss.edu

OR

The IRB Secretariat,

Doctoral Scholars Office,
Tata Institute of Social Sciences
Ph:22-25525642
email id: irb.submissions@tiss.edu

Annexure B

Informed Consent Form for Call Feedback

Project Title: Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India

I_____ have read the participant information sheet for the project titled 'Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India'. The information contained in the participant information sheet regarding the nature and purpose of the study, safety, and its potential risks / benefits and expected duration of the study and other relevant details of the study including my role as a study participant have been explained to me in the language that I understand.

- I have had the opportunity to ask queries, which have been clarified to my satisfaction.
- I understand that my participation is voluntary and that I have the right to withdraw from the study at any stage without giving any reasons for the same.
- I understand that the information collected during the research study will be kept confidential. My identity will be kept anonymous and I will be identified by a pseudonym.
- The representatives of sponsoring agencies, government regulatory authorities, ethics committee may wish to examine my records/study related information at the study site to verify the information collected. By signing this document, I give permission to these individuals to access my records.
- I hereby give my consent willingly to participate in this research study.

For Limited or non readers: I have witnessed the consent procedure of the study participant and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of the consenting person

Witness

Name of the Person administering the consent

Ms. Tanya Srivastava
Programme Manager,
Psychosocial Care Helpline Initiative,
National Disaster Management Authority.

Dr. Chetna Duggal
Associate Professor,
School of Human Ecology,
Tata Institute of Social Sciences
Mumbai 400043

Annexure C

Call Feedback Form

- Date of calling

- Patient's details
    - Patient's name
    - Age
    - Gender
    - District
    - State

- Has the patient deceased?
    - Yes
    - No

- Is a call back required?
    - Yes
    - No

- Psychological problems faced by patient
    - Minor
    - Critical

- Other problems (facilities, food, services etc.)

- Positive remarks by patient (if any)

Annexure D

PARTICIPANT INTAKE SHEET FOR INTERVIEW

Title of the project: Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India

This Participant Information Sheet (referred to as PIS) gives you important information about this research study. It describes the purpose of the study, the risks and possible benefits of participating in the study.

Please take time to review this information carefully. Please ask for an explanation in case you do not understand word/s or sentence/s in the PIS. After you have read the PIS, you are free to talk to the /researchers about the study and ask them any questions you have. You will be given a copy of the PIS and the signed informed consent document for your future reference.

Your participation in the study is voluntary. You have the right to withdraw from the study at any stage without giving reasons for your withdrawal.

What is this study about?

The sudden and unexpected outbreak of the Covid-19 pandemic has brought about a number of unprecedented challenges to the healthcare system of the country, both in terms of physical and mental health. The mental health crisis that has been brought about by the pandemic goes largely unnoticed. Based on past studies in the aftermath of major disasters and epidemics, it is predicted that the Covid-19 pandemic can result in an onset of psychiatric illness in a large population, while also exacerbating symptoms for people who are already experiencing a mental illness. Self-isolation and quarantine has affected the usual activities, routines and livelihoods of people and can lead to increased loneliness, insomnia, drug use or self-harm behaviour (WHO, 2020). In such a situation, the role of counsellors is quite integral in providing timely support to people in distress. The aim of this study is to gain an in-depth understanding of the psychosocial concerns experienced by persons testing positive for the virus, as observed by you in your phone counselling session, your response to their concerns, the challenges you face while counselling individuals diagnosed with Covid-19 and the role of training and supervision in adapting to the unique needs and expectations of the said population. Knowing your perspectives will provide insight into the psychosocial status of

the persons diagnosed with the Covid-19 virus. By filling this gap in research, the basis for designing and formulation of future psychosocial interventions can be formed, to adapt to future mental healthcare delivery challenges in the country.

2. What is the rationale for the selection or screening of the respondents?

Most of our knowledge of the psychosocial concerns and the consequent response of the mental health professional is derived by literature from other countries. The experiences of counsellors in India is likely to be different as the concerns brought up during their session with clients testing positive for Covid-19 would be unique to the Indian setting. Additionally, the counsellors views on the effectiveness of the training and supervision models can be used to adapt to the future needs of supervision during crisis counselling and the professional development of counsellors providing psychosocial support.

3. What is the relevance of the information being collected to the community or respondents?

Information gathered from the counsellors can help document the entire process of psychosocial support delivery to Covid positive persons by the National Disaster Management Authority, in collaboration with TISS, Mumbai. This can help in formulating and implementing policies and interventions for psychosocial care for future crisis situations.

4. Who can take part in this research study?

To bring in different perspectives, this study will include mental health professionals with different backgrounds, who are a part of the NDMA psychosocial initiative for persons testing positive with Covid-19. This will include:

- Clinical Psychologists
- Counselling Psychologists
- Counsellors and
- Psychiatric Social Workers

Participants will be selected based on their accessibility and suitability to share perspectives that will enrich the study.

5. How long will you be in the research study?

You will be required to complete an intake questionnaire and participate in an online (Skype) or telephonic interview. The questionnaire can be filled and shared via email. This study will require you to give approximately two hours of your time. The interview can be completed over more than one session, depending on your availability and convenience. The interview will be audio-recorded and transcribed, and will be used for research purposes only. The transcript of the interview will also be shared with you.

6. What are the possible risks and inconveniences that you may face by being in the research study?

There are no known risks that you may face by being in this study. If, however, you experience any distress during the interview, the interviewer (who is a trained counsellor) will check if you would like to skip the question, take a break and stop the recording, or terminate the interview. The interviewer will take immediate steps to extend emotional support to you using empathic listening, validation or offering silence, till you feel comfortable enough to proceed.

7. What are the positive benefits to you being in the research study?

By being a part of this study, you will contribute in generating insights on the unique psychosocial concerns faced by people in the Covid-19 pandemic. The perspectives shared by professionals like you will help formulate more effective interventions and strategies for crisis counselling, while also coming up with tailor-made training and supervision models for future psychosocial support for vulnerable populations. As a result of sharing your experiences, you might also find it helpful to reflect on your journey from the time you were a part of this initiative and critically evaluate the influence the training and supervision may have had in your telephonic sessions with the concerned population. At the end of the study, the findings will be shared with you and themes that emerge may be of interest to you as a practitioner in the field.

8. How will your privacy and confidentiality be maintained?

All information obtained from this study will remain strictly confidential and will be utilized for research purposes only. The interview will be audio-recorded and stored in a digitally encrypted format, accessible only to the researcher. Your identity will remain confidential and you will be identified with a pseudonym in any publication or presentation of this study.

9. Will you have to bear any expenses or costs by participating in the research study?

You will not be compensated for your participation in the study.

10. Whom do you call if you have questions or problems regarding rights as a participant?

If you have any questions or concerns pertaining to this study, please call on the contact number given below, and we will do our best to address your queries:

Name of Principal Institution: Tata Institute of Social Sciences, Mumbai

Dr. Chetna Duggal
Associate Professor,
School of Human Ecology
Tata Institute of Social Sciences
Mumbai 400088
Ph: 022-25525346
email id: chetna.d@tiss.edu

OR

The IRB Secretariat,
Doctoral Scholars Office,
Tata Institute of Social Sciences
Ph:22-25525642
email id: irb.submissions@tiss.edu

Annexure E

Informed Consent Form for Interview

Project Title: Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India

I_____ have read the participant information sheet for the project titled 'Psychosocial support for persons diagnosed with Covid-19: Experiences of volunteer counsellors from India'. The information contained in the participant information sheet regarding the nature and purpose of the study, safety, and its potential risks / benefits and expected duration of the study and other relevant details of the study including my role as a study participant have been explained to me in the language that I understand.

- I have had the opportunity to ask queries, which have been clarified to my satisfaction.
- I understand that my participation is voluntary and that I have the right to withdraw from the study at any stage without giving any reasons for the same.
- I understand that the information collected during the research study will be kept confidential. My identity will be kept anonymous and I will be identified by a pseudonym.
- The representatives of sponsoring agencies, government regulatory authorities, ethics committee may wish to examine my records/study related information at the study site to verify the information collected. By signing this document, I give permission to these individuals to access my records.
- I hereby give my consent willingly to participate in this research study.
- I hereby give my consent for audio recording of the interview.

For Limited or non-readers: I have witnessed the consent procedure of the study participant and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of the consenting person

Witness

Name of the Person administering the consent

Ms. Tanya Srivastava
Programme Manager,
Psychosocial Care Helpline Initiative,
National Disaster Management Authority.

Dr. Chetna Duggal
Associate Professor,
School of Human Ecology,
Tata Institute of Social Sciences
Mumbai 400043

Annexure F

Intake Questionnaire for Interview

1. Private Code: (To be filled in by researcher)
2. Today's date: Day___ Month ___ Year _____
3. Date of Birth: Day____Month ___ Year _____
4. Gender: Male___ Female ____ Other ____
5. Location : City/Town _____ State_____

6. What is your professional identity? How do you refer to yourself in professional contexts? [tick as many as apply]
Psychiatrist
Psychotherapist
Counsellor
Psychologist
Clinical Psychologist
Counselling Psychologist
Psychiatric Social Worker
Other [Please Specify_____]

7. How long is it since you started practicing psychotherapy?
[Include practice during training but exclude periods when you did not practice.]
_____years _____months

8. **What is/are the academic or professional degree/s you have earned? Please mention post graduate degrees and above. [Also indicate the field of study and countries where you earned your degree].**
Please specify any additional training in psychotherapy (ongoing diploma/ short term courses) as well

Name of Course	Country	Duration	Relevant to current practice (Yes/No)

9. How many hours per week of counselling work (direct client contact in individual or couple/family session) do you typically do in each of the following settings? (Specify as many as applicable)

	Hours per week
Govt. Hospital Inpatient facility	
Govt. Hospital Outpatient facility	
Private Hospital Inpatient facility	
Private hospital outpatient facility	
Individual private practice – clinic	
Individual private practice – home	
School setting	
College setting	
Workplacce/corporate setting	
Social services agency (Governmental)	
Non Governmental Organization	
Other [Please specify]	

10. How much is your current therapeutic approach guided by each of the following theoretical frameworks? [please rate all] 0=Not at all**, 1**=Slightly**, 2**=Somewhat**, 3**=Moderately**, 4**=Greatly**, 5**=Very greatly

Analytic/Psychodynamic..... **0 1 2 3 4 5**
Behavioural..... **0 1 2 3 4 5**
Cognitive..... **0 1 2 3 4 5**
Humanistic/Existential..... **0 1 2 3 4 5**

Interpersonal**..... 0 1 2 3 4 5**
Supportive**..... 0 1 2 3 4 5**
Systemic (family systems)**..... 0 1 2 3 4 5.**
Other [Specify]**:**_____

How much do you view your orientation as.
Eclectic/Integrative?**.....0 1 2 3 4 5**

11. From where did you get to know about the NDMA Psychosocial Helpline? (please tick on whatever applies)

Social media_____
Colleagues/Friends_____
NDMA website_____
Others (please specify)_____

12. For how long have you been working with the initiative?
_____months _____days

13. How many hours in a day and how many days in a week do you dedicate for making calls to persons diagnosed with Covid-19?

_____hours in a day
_____days in a week

Annexure G

Interview Guide

Part I: Introduction

I would like to start by understanding your professional journey so far...

- When did you start practicing as a counsellor?
- Could you describe your professional journey so far?
- What professional settings have you worked in over the years?

Could you please tell me about your experience as a volunteer counsellor in the NDMA psychosocial helpline

- How did you find out about the initiative?
- What motivated you to volunteer as a counsellor for the NDMA Psychosocial helpline?
- Could you elaborate on your experiences while working with this initiative?
- What keeps you motivated to continue providing your counselling services for this initiative?

Part II: Psychosocial concerns of Covid-19

I am sure that throughout your experience of working with the initiative, you must have come across a range of psychosocial concerns as shared by the persons testing positive for the virus as well as their family members…

1. Please share what were the concerns shared by people during the phone counselling sessions you conducted?
    - Could you outline the concerns associated with practical and basic needs like medical help, food and shelter requirements etc.?
    - What concerns or worries did people share regarding the pandemic?
    - Were there experience about stigma and discrimination that people were facing after testing positive for Covid-19?
    - What were some of the other psychosocial concerns shared by people you reached out to over call?
        - What were the emotional reactions that were shared by the clients?
            - Were there issues like loneliness, feelings of depression or anxiety, self-harm behaviours?
        - Were there any specific cases of grief/loss that you came across?

        - Were there experiences of trauma shared by people?
        - In your calls did you come across people sharing concerns around abuse and violence?
        - Any other specific concerns that you want to talk about?
2. What was your experience of talking to family members of people tested positive for Covid-19, when you couldn't talk to the individual personally?
    - Did they bring up any psychosocial concerns as faced by the family or the individual? If yes, what were they?
3. In your experience how did social factors (e.g., gender/religious identity/class/caste) impact the concerns presented in the counselling sessions?

Part III: Interventions and responses of therapists

Taking forward from the psychosocial concerns that you highlighted previously, I wanted to understand the immediate response or the therapeutic skills/interventions that you use to support the client…

- How do you respond to the concerns that are brought in during the call with persons diagnosed with Covid-19?
- What are some of the psychosocial/counselling interventions you used to provide psychosocial care and what worked well?
- Could you elaborate on a specific case where you felt that you were adequately successful in providing the necessary support needed by the client?

Part IV: Challenges faced by the Counsellors

As a professional, there may have been occasions when you experienced difficulties in certain situations while counselling individuals and families who tested Covid positive. I would like to understand some of these challenges that may have come up for you.

1. Could you describe some of the challenges that you face while working with this population?
    - Could you describe ethical dilemmas and value conflicts that might have come up for you in this current experience?
    - Could you describe some experiences with transference/countertransference that might have come up during the calls?
    - Were there any experiences where you questioned or felt limited in your role and skills as a therapist?

2. Could you describe some of these challenges that might have affected you personally as a therapist?
3. How did you deal with these challenges?

Part V: Supervision and Training

As a mental health professional, training and supervision can prove to be beneficial to improve skills and produce better outcomes for clients. I wanted to understand your views on the same...

1. What were some of the areas of knowledge specific to this work for which you felt you needed training?
2. As you continued this work, what were some of the skills that you became aware of needing to build?
3. How would you describe your experience of receiving training in psychosocial support? What aspects of the training did you find beneficial?
4. How would you describe your experience of supervision sessions? What aspects of the supervision sessions did you find beneficial?
5. What impact did the training and supervision sessions have on your professional growth and development?
6. Would you have any suggestions on how supervision and training sessions can be strengthened to enhance skills/development and better address the needs of crisis counselling?

Annexure H

Ethics Clearance Report, IRB, TISS

टाटा सामाजिक विज्ञान संस्थान
Tata Institute of Social Sciences

Institutional Review Board
Ethics Clearance Report

Serial No. of IRB Meeting	2020-2021	26
Project Title	Psychosocial support for persons diagnosed with CoVid-19: Experiences of volunteer counsellors from India	

Name of Faculty In-charge/Project Coordinator/Principal Investigator
Dr Chetna Duggal

Date of Submission to the Committee	1	7	0	8	2	0	2	0
Date of Submission to other IRB's(if applicable)								
Date of the First Review	2	4	0	8	2	0	2	0

The IRB suggested the following recommendations regarding the ethical component of the study:

1. The role of the two institutions (TISS and NDMA) needs further clarification.
2. The researchers could consider adding certain safeguards to ensure that the counsellors can refuse to take part in the study.
3. The volunteer counsellors have previously signed a non-disclosure agreement with the NDMA. The agreement template needs to be submitted to the IRB.
4. Greater clarification is required regarding the process by which the call feedback forms will be accessed.

All suggested changes have been successfully incorporated and the study has been approved by the IRB.

Signature of the Chairperson

Signature of Member Secretary

Date of Issue: September 20, 2020

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About the Authors

Dr. Chetna Duggal is an Associate Professor in the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. She has completed her Ph.D. from TISS, Mumbai and her M.Phil. in Clinical Psychology from NIMHANS, Bangalore. She is a Psychotherapist with over 15 years of experience and has worked with children, adolescents, couples and families. She teaches courses on psychotherapy and counselling in the Masters and M.Phil. programmes and supervises trainee counsellors and practitioners. She is the Project Director for *Rahbar***,** an initiative to promote training, supervision and professional development for mental health practitioners in India. She also heads the School Initiative for Mental Health Advocacy (SIMHA), an initiative that endeavours to promote well-being of young people in schools through advocacy, research and capacity building. She is the trustee of Apnishala, an organisation working towards making life skills education accessible to children from underprivileged contexts. She has been an invited J1 Visiting Scholar at The Chicago School of Professional Psychology, US. She has a keen interest in psychotherapists and counsellors training, supervision and reflective practice, and has conducted research and authored book chapters and papers on the same.

Ms. Maitreyee Mukherjee is a Senior Consultant for Psychosocial Care and Social Vulnerability Reduction at the National Disaster Management Authority (NDMA), New Delhi. She has over 19 years of experience in the development sector in India and abroad and has been associated with different agencies like UNDP, IFAD, Oxfam (Great Britain), Action Aid, Aga Khan Foundation and University of Leeds among other national and community based organizations. She has completed her Masters in Social Work from Tata Institute of Social Sciences, Mumbai followed by another Masters in Development Studies and Gender at the University of Leeds, United Kingdom. Ms. Maitreyee has also authored several manuals for State Disaster Management Authority, Meghalaya, which include i) Gender Mainstreaming in Disaster Management, ii) Emergency Education in Disaster Management and iii) Inclusions of persons with disability in Disaster Management.

Ms. Bakul Dua is a Clinical Psychologist based in Bengaluru. She has over 12 years of experience in clinical practice, research and advocacy and has worked in clinical and community contexts across Delhi, Mumbai and Bengaluru. She comes from a multidisciplinary background in the humanities, having completed her M.Sc. in Cultural

Studies from at the London School of Economics, followed by a second Master's degree in Counselling Psychology from the Tata Institute of Social Sciences and an M.Phil. in Clinical Psychology from the National Institute of Mental Health and Neurosciences (NIMHANS). She is the Project Coordinator of *Rahbar* – a field action project at TISS which provides training and supervision to mental health professionals across India. Through *Rahbar*, Ms. Bakul has been involved in designing and delivering trauma informed, culturally sensitive and evidence-based training modules and supportive supervision to mental health health professionals in resource constrained settings. She works as a psychotherapist in independent practice in Bengaluru and is also a Consultant Clinical Psychologist at Fortis la femme hospital in Bengaluru where she specializes in perinatal mental health. Ms. Bakul trained in Mentalization Based Therapy under Dr. Anthony Bateman and also teaches University level courses on attachment and mental health, psychodynamic therapies and psychotherapy research. She is currently a Ph.D. scholar at the School of Human Ecology at TISS and is exploring intersections between culture, gender and mental health.

Ms. Tanya Srivastava has completed her Masters in Applied Psychology with a specialization in Counselling Psychology from Tata Institute of Social Sciences, Mumbai. She has worked with adolescents and adults from diverse socio-economic backgrounds and vulnerabilities. Ms. Tanya has a keen interest in couple and family based therapy and has also completed her Master's thesis on the changing dynamics of intimate relationships in urban India. She is currently working as a Research and Program Associate for the psychosocial initiatives of NDMA. She hopes to contribute to the field of mental health through advocacy and building spaces which are safe, inclusive and accessible to all.