Psychosocial Support during the COVID-19 pandemic

A Training Manual for Counsellors

April 2021

Rahbar
A Field Action Project of the School of Human Ecology

Tata Institute of Social Sciences
In collaboration with
National Disaster Management Authority

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By

Rahbar

A Field Action Project of the School of Human Ecology
Tata Institute of Social Sciences, Mumbai

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In Collaboration With
National Disaster Management Authority

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FOREWORD

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.

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 was a unique intervention as 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. Another advantage was that these counselling services were conducted from a remote place. The tele-counselling services, in the form of psychological first aid, helped the patient and family deal with the mental health concerns of the pandemic along with providing transparent, genuine and timely information to them.

NDMA collaborated with 'Rahbar' of 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, Rahbar has also supported NDMA with the research and documentation process.

The Rahbar team along with the NDMA have collaborated to address the gaps in training and supervision of the mental health professionals addressing the psycho-social concerns of individuals who tested positive for COVID-19. They conducted 4 weekly training sessions in the month of June, 2020 and 12 weekly supervision sessions (from June to August, 2020) in this regard. This manual is a culmination of the learnings and insights from the training and supervision collaboration and will be responsive to the needs and challenges of counsellors working in this area. It is an effort to provide a documentation of the conceptual framework for providing brief psychosocial intervention through telephonic services.

This manual is for counsellors with basic training in mental health counselling, who are currently working in India to address psychosocial concerns during the COVID-19 pandemic. This is a complete manual in itself designed to be used by practitioners who can read English and it does not need access to any other resources or in-person training.

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PREFACE

The Covid-19 pandemic is undoubtedly the biggest disruptor the world has experienced in nearly a century. With over 2.5 million deaths worldwide as of February 2021, and the surge in waves of infections continuing in many parts of the world, health care systems everywhere have been stretched beyond capacity. Besides the devastating physical health outcomes and high mortality rates, the pandemic has had severe reverberations for mental health and well-being of people. Disrupted access to basic needs, social and economic instability, isolation, misinformation, fear of contagion, rising death toll and stigma have created an environment of prolonged fear and uncertainty resulting in shared trauma across communities. Recognizing that access to mental health services is a critical part of the response at this time, governments across the world have begun to emphasize psychosocial care as an essential part of the public health response to Covid-19.

In the context of the lock down and social distance measures in place, crisis and helpline counsellors have been the backbone of timely and accessible mental health support in India. Recent research has indicated that these counsellors perceive major gaps in their knowledge and skills while supporting people with Covid-19 because their trainings were not adequate to deal with a crisis of such enormous and unprecedented scale. Studies have documented that counsellors are struggling with adapting existing psychological care frameworks to the format of tele-counselling and find prolonged exposure to crisis and trauma emotionally challenging. It is increasingly being acknowledged that counsellors themselves need support to navigate the personal and professional challenges of carrying out counselling work at this critical time.

Recognizing the need to support mental health professionals in India during the pandemic, *Rahbar*, a field action project of the School of Human Ecology, TISS, launched a special initiative for training and supervising counsellors in April 2020. Since then, *Rahbar* has supported over 350 counsellors and multiple organizations across India and Nepal in providing mental health support to people diagnosed with Covid-19. The present manual is an outcome of *Rahbar's* intensive engagement with counsellors during the pandemic and aims to empower mental health professionals

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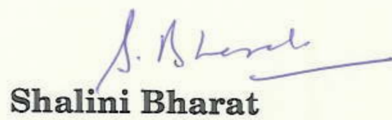
with the skills, knowledge and attitudes that are especially relevant in the delivery of psychosocial support at this time of grave crisis and disruption.

The manual is anchored by the core values of community care and support that make Tata Institute of Social Sciences an institute of excellence. The framework of psychosocial support for people affected by Covid-19 outlined in the manual draws on various perspectives of evidence-backed, trauma-informed and contextually responsive mental health care. The manual is informed by a commitment to social justice and provides concrete guidelines for counsellors to situate mental health work during the pandemic in the intersecting identities of caste, class, gender and religion. A key highlight of the manual is that the well-being and professional development of counsellors has been emphasized in the form of activities for supervision, self-care and reflective practice.

I appreciate the efforts of the *Rahbar* team led by Dr Chetna Duggal, Associate Professor, School of Human Ecology, in developing this valuable resource for the benefit of counsellors at this critical time. I sincerely thank the National Disaster Management Authority (NDMA) for its vision in creating a timely and responsive helpline for mental health support during the pandemic. It was NDMA's emphasis on the need for training and supervision for counsellors that led to the collaboration with *Rahbar* and made this manual possible. I hope this manual will benefit counsellors across the country as they continue to address the mental health sequelae of Covid-19 over the long term.



Shalini Bharat

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First and foremost, we thank Shri. G.V.V. Sarma, Member Secretary (ex), NDMA, Shri. Sandeep Poundrik, Additional Secretary (ex), Mitigation, NDMA and Shri.Vijay Nemiwal, Joint Advisor, Mitigation, NDMA, Shri. Sanjeeva Kumar, Member Secretary NDMA and Shri. Ramesh Kumar Ganta, Joint Secretary (Mitigation), NDMA. It is their foresight and vision that brought mental health support to the forefront of disaster management services during the pandemic. Under their leadership, NDMA launched a Psychosocial Care Helpline through which volunteer counsellors provided psychosocial care to persons diagnosed with CoVid-19. Our deepest gratitude to Ms. Maitreyee Mukherjee, Senior Consultant, Psychosocial Care and Vulnerability Reduction, NDMA, who has been leading the helpline since its inception and was instrumental in the collaboration between TISS and NDMA for training and supervision of helpline counsellors. The suggestion to document the training and supervision sessions in the form of counselling framework and manual for the benefit of counsellors across the country also came from her and we thank her for being an unwavering source of support and encouragement throughout this initiative.

We are grateful to Prof. Shalini Bharat, Director, Tata Institute of Social Sciences, for extending her 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 training and supervision to counsellors across India during the pandemic, which provided the foundation for this manual.

The volunteer counsellors associated with NDMA's Psychosocial Helpline who were part of the training and supervision sessions carried out by Rahbar contributed significantly to the compilation of this manual. It is through our interaction with them over a period of seven months that we gained insights on psychosocial concerns of people affected by Covid-19 and the needs of mental health professionals during the pandemic, which provided the conceptual and practical framework for this manual. Ms. Tanya Srivastava, Research Associate, NDMA played a key role in meticulously documenting the work of the helpline, supporting counsellors, and ensuring effective coordination between TISS and NDMA.

In putting together this manual we drew upon evidence based models and resources developed by various international organizations and practitioners across the world. We are grateful to the World Health Organization, British Association for Counselling & Psychotherapy, Gottman Institute and Dr. Wim van Brakel for granting us permission to use their resources in the manual. We have taken due care to appropriately credit their work in relevant chapters.

We would also like to extend our gratitude to Ms. Padmaja Mushahary for generously sharing her experience with us and granting us permission to include the narrative of her journey with Covid-19 in the manual.

The compilation of this manual would not have been possible without Ms. Oshin Chawla. It is thanks to her artistic expertise that endless pages of text were brought to life through a creative visual layout and design.

We thank all the mental health professionals across India who have been tirelessly working on the frontlines since the beginning of the pandemic to provide timely and responsive care to individuals and families impacted by the pandemic. This manual is dedicated to their efforts and we hope it serves as an effective resource and guide for all mental health professionals.

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List of Abbreviations

APA: American Psychological Association

BACP: British Association for Counselling and Psychotherapy

CDC: Centers for Disease Control and Prevention, United States

IFRC: The International Federation of Red Cross and Red Crescent Societies

ILO: International Labour Organization

MoHFW: Ministry of Health and Family Welfare, Government of India

NCRB: National Crime Records Bureau, India

NCTSN: National Child Traumatic Stress Network

NDMA: National Disaster Management Authority, Government of India

NICABM: National Institute for the Clinical Application of Behavioral Medicine, Connecticut, United States

NIMHANS: National Institute of Mental Health And NeuroSciences, India

PFA: Psychological First Aid

SAMHSA: Substance Abuse and Mental Health Services Administration

TISS: Tata Institute for Social Sciences, India

UNDP: United Nations Development Programme

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Author Bios

Dr. Chetna Duggal is Associate Professor at 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. 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, M.A in Counselling Psychology from the Tata Institute of Social Sciences (Gold medalist) and M.Phil. in Clinical Psychology from the National Institute of Mental Health and Neurosciences (Gold medalist). She is currently a doctoral scholar at the School of Human Ecology at TISS. She is the Project Coordinator of Rahbar – a field action project at TISS which provides training and supervision to mental health professionals across India. 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. She 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.

Ms. Mrinalini Mahajan is a clinical psychologist working as a private practitioner. She has experience of working with individuals with psychiatric difficulties as well as children who are survivors of sexual abuse. Her special interest is in working with individuals with histories of trauma which also aligns with her research interest. She has an MPhil in Clinical Psychology from NIMHANS (Bangalore), an MA in Clinical Psychology from TISS, Mumbai (Silver Medalist) and a BA (Hons.) Psychology from Delhi University (Gold Medalist). Her therapeutic work is a reflection of her beliefs about acknowledging and appreciating the role of social justice, intersectionality and socio-political frameworks in the sphere of mental health.

Ms. Ritika Chokhani is a clinical psychologist who works with young people and their families, through her private practice in Mumbai. She has a combined experience of 5 years working in government-run, NGO-run and privatised mental health- and disability-focused healthcare institutions. She has an MPhil in Clinical Psychology from NIMHANS (Bangalore), an MSc in Developmental Psychology and Clinical

Practice from University College London, and a BA in Psychology from the University of Mumbai. Through her work as a therapist, researcher and trainer, she advocates for therapy to be informed and guided by principles of social justice and has a deep respect for the diverse solutions young people have to their problems

About the Manual

Background

This manual has been developed by Rahbar in collaboration with the National Disaster Management Authority (NDMA). Rahbar ('guide' or 'companion' in Urdu) is a field action project of the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. Rahbar was established in 2019 as a platform for promoting training and supervision for mental health practice in India. The vision of Rahbar is to co-create responsive, supportive, and culturally sensitive spaces for training and supervision for mental health professionals, especially those in resource constrained contexts, in order to ensure access to quality mental health care for all. Since 2019, Rahbar has been involved in developing professional support programmes for supervisors and mental health professionals.

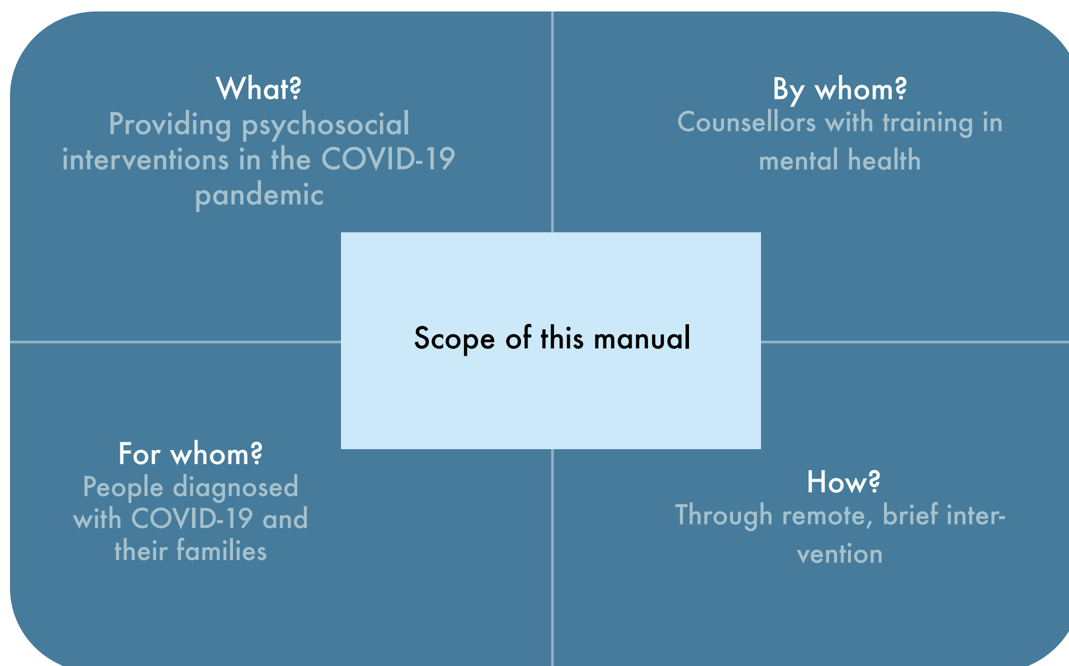
In March 2020, Rahbar launched a special initiative aimed at promoting skill building, reflective practice and professional well-being for counsellors during the COVID-19 pandemic. The acute spread of the pandemic brought new opportunities and challenges for mental health professionals across the country. During the early phase of the pandemic, mental health professionals responded to the growing mental health needs of the population by launching volunteer-run helplines and mobilizing pro bono initiatives for crisis intervention. A leading example of such a response was the innovative 'reverse' helpline of the National Disaster Management Authority (NDMA). Through this Psychosocial Care Helpline, NDMA mobilised 120 volunteer counsellors to provide brief psychosocial support to over 1 lakh individuals diagnosed with COVID-19, between April 2020 and February 2021.

From May to December 2020, Rahbar provided training and supervision support to the volunteer counsellors team of the NDMA helpline. Intensive engagement with counsellors over seven months through didactic modules, case discussions, role plays and reflective activities provided the Rahbar team an in-depth understanding of the mental health challenges of people diagnosed with COVID-19, as well as of the gaps perceived by counsellors in terms of knowledge and skills. During this process, Rahbar conducted regular needs assessments and feedback reviews with counsellors to ensure that training and supervision content was constantly informed by the evolving needs and challenges on the ground. As a result of this experience, the Rahbar team was able to evolve an evidence-informed and contextualised framework of psychosocial support for persons diagnosed with COVID-19 in the Indian context.

This manual, an outcome of the collaboration between Rahbar and NDMA, is an attempt to disseminate this framework of psychosocial support to equip counsellors with key competencies in addressing the specific mental health concerns that have emerged in the context of the pandemic. Integrating international best practice guidelines with the voices of persons diagnosed with COVID-19, the needs of counsellors on the frontlines, and practice based insights of trainers and supervisors, the manual aims to be a resource for mental health professionals not only in India, but across the world.

Scope

This manual is aimed at helping mental health professionals to provide psychosocial support and care to individuals diagnosed with COVID-19 and their families. The interventions described in this manual can be conducted by counsellors and other mental health professionals (e.g., social workers, psychologists, psychiatrists etc) who have training in mental health. The interventions can be applied in brief (1-2 sessions) and remote (over telephone) contexts.



Overview

This manual is divided into three sections:
Section 1: Need for psychosocial support during the pandemic. This section describes the impact of the COVID-19 pandemic, with a specific focus on its impact on mental health in the Indian context.

Section 2: Frameworks of psychosocial support. This section describes the various frameworks that lay the foundation of the psychosocial interventions described in this manual. This includes the following chapters:

- **Theoretical underpinnings.** This chapter describes the theories which guide psychosocial support work.
- **Value-based framework.** This chapter describes the core values which lay the foundation for the framework of psychosocial support described in the manual.
- **Ethical perspectives.** This chapter describes the ethical perspectives that guide telecounselling during the pandemic.
- **Telecounselling skills.** This chapter describes the skills and competencies counsellors can use in conducting telecounselling sessions.
- **Personal and professional development.** This chapter describes the key frameworks we can use to aid our personal and professional development as counsellors, viz. reflective practice, supervision and self-care. Throughout the manual, exercises for reflective practice, supervision and self-care have been woven in to help counsellors to reflect on their work and promote professional development.

Section 3: Psychosocial Interventions. This section describes in detail how counsellors can intervene when working with specific concerns described by their clients. Each chapter in this section starts with an introduction about the relevance of a particular concern in the pandemic. We then describe the scope and the limitations of the role of the mental health professionals, with respect to that particular concern. Key concepts informing the theoretical framework of the interventions are discussed. Subsequently, clear and detailed guidelines for counsellors are presented on identifying concerns, preparing to intervene and providing interventions. We have also mentioned certain pitfalls that we need to avoid. This section includes the following chapters:

- **Addressing basic needs.**This chapter focuses on helping clients who may experience difficulties with meeting practical needs such as food and water.
- **Sharing information.** This chapter describes the ways in which we can share information about COVID-19 with clients.
- **Reducing emotional distress.** This chapter discusses the theoretical foundation of working with emotions in counselling and how we can support clients who present with high levels of distress.
- **Containing anxiety.** This chapter focuses on specific frameworks and techniques for supporting clients to manage anxiety in the pandemic.
- **Responding to low mood.** This chapter elucidates specific frameworks and techniques to help clients who are experiencing low mood in the pandemic.

- **Regulating anger.** This chapter describes specific frameworks and techniques to support clients who are experiencing anger in the pandemic.
- **Assuaging guilt.** This chapter discusses specific frameworks and techniques to understand the experience of guilt in the pandemic and the ways for us to intervene.
- **Working with grief.** This chapter focuses on grief in the context of the pandemic and helps in identifying ways of supporting clients in bereavement through brief counselling.
- **Managing risk for suicide.** This chapter describes how to understand and mitigate the risk for suicide in the context of the pandemic, through brief and remote counselling.
- **Mitigating stigma.** This chapter discusses the impact of stigma on mental health in the context of COVID-19 and what we can do as mental health professionals to manage it.
- **Nurturing narratives of resilience.** This chapter discusses opportunities counsellors may have to identify clients' stories of hope and resilience in the pandemic, as well as interventions to build hope and support resilience at individual, family and community levels.

Section 1- Need for psychosocial support during the pandemic

1 The outbreak of COVID-19

The World Health Organization (WHO) recognized the outbreak of COVID-19 as a Public Health Emergency in January 2020). By March, the virus had spread to more than 115 countries and COVID-19 was declared a worldwide pandemic. Several countries adopted measures such as nation-wide lockdowns and home-confinement strategies to prevent further transmission of the disease (Pulla, 2020). This led to social distancing, isolation and quarantine to become the norm in a matter of days.

India reported its first case of COVID-19 on 30 January 2020 in the state of Kerala. By February, this number rose to 3 (Reid, 2020). The rapid spread of the pandemic led the government to curb the spread of the virus using measures such as higher diagnostic testing, contact tracing and social distancing (Economic Times, 2020).

Notably, a nationwide lockdown was announced by the Government of India on 24 March 2020 (Ray & Subramanian, 2020). Although the lockdown was initially announced for 21 days, it was extended twice, thus lasting for nearly two months in total (Ray & Subramanian, 2020). During this time, all non-essential movement was banned and people were asked to stay at home. Travel by road, air or railway was completely suspended. Most commercial and cultural establishments such as restaurants, historical sights and monuments, places of religious worship, cinema halls and malls were closed down. All educational institutions such as schools and colleges were completely shut down and examinations postponed till further notice. Most private and public companies asked their employees to work from home. Only essential services, such as grocery shops, pharmacies and hospitals were allowed to stay open (Firstpost, 2020).

1. Impact of the pandemic

The consequences of the pandemic were multifold. This section briefly summarises the ramifications of the pandemic on the health of Indian citizens and the healthcare system and discusses the socio-economic sequelae of the pandemic and the lockdown.

1.1 Impact on health and healthcare

As of 12th February 2021, there were more than 1.35 lakh active cases of COVID-19, upwards of 105 lakh individuals who have acquired and survived COVID-19 and more than 1.5 lakh deaths reported due to COVID-19 in India (Ministry of Health and Family Welfare, 2021). As of January 2, 2021, India had the second-highest number of COVID-19 cases and COVID-19 deaths in the world (Deccan Herald, 2021). The physical burden of COVID-19 included symptoms such as mild to moderate respiratory illnesses characterized by fever, dry cough, tiredness, difficulty breathing or shortness of breath, and loss of the ability to smell and taste. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer were more likely to develop serious illness.

In this scenario, India's healthcare system was under major pressure. Even prior to the pandemic, the availability of doctors (7.8 per 10,000 population) and nurses (21.1 per 10,000 population) was low in India, as compared to the world average (Dwivedi et al., 2020). A report, by the International Institute for Population Studies in April 2020, reported that COVID-19 dedicated hospitals, ventilators and available laboratories were also insufficient for the burden of COVID-19 (Dwivedi et al., 2020). In this background, healthcare workers were required

to work under stressful conditions and for long working hours to bridge the gap between need and availability. Many students in training were put on COVID-19 duty due to a shortage of doctors (Sethi & Laha, 2020). In some places, healthcare professionals had to work without proper protective equipment (McMohan et al., 2020). They were also more vulnerable to acquire COVID-19 due to frequent contact with individuals diagnosed with the same. Overall, such circumstances lowered the morale of healthcare workers and created high levels of strain on the healthcare system.

1.2 Socio-economic impact

The pandemic had severe economic repercussions for the country (The Economic Times, 2020). Many companies had to temporarily reduce their operations, with transport and tourism being greatly affected. The export-import sector, agricultural sector and private healthcare sector also experienced losses. The manufacturing industry suffered major set-backs as the importing of medical equipment became costlier (The Economic Times, 2020). The government announced economic packages for providing relief, consisting of reforms, infrastructure building, support to stressed businesses and a certain amount of direct cash support (Hindustan Times, 2020). Despite this, the progress after the lockdown continued to be slow. India's unemployment rate surged to 26% post the lockdown, with an estimated 14 crore people having lost their jobs (Business Today, 2020).

The pandemic also brought social inequalities to the forefront. According to Ray and Subramanian (2020), those who were part of the informal economy were more impacted by the pandemic, as they generally engage in work that cannot easily be moved online (e.g., domestic workers). One community that was disproportionately affected in the pandemic was the community of migrant workers. With factories and workplaces shut down, a millions of migrant workers had to deal with the loss of income, food shortages and uncertainty about their future. The government had taken steps and schemes to provide food for the workers, but the distribution systems were inadequate. A survey published by 'The Hindu' (Shaji, 2020) stated that 96% migrant workers did not get rations and 90% of them did not receive wages during the lockdown. It was estimated that approximately 10 million migrant workers attempted to return home, though no official statistics are available (Sharma, 2020). Women, too, were disproportionately affected in the lockdown, with increased burden of domestic work, increased risk of domestic violence and a greater likelihood of losing jobs (Ray & Subramanian, 2020). The religious and ethnic minorities experienced high levels of stigma and discrimination in the pandemic after becoming falsely associated with spread of the COVID-19 virus (Naqvi & Trivedi, 2020). Other marginalized communities on whom the impact of the lockdown has been described include sex workers, transgender individuals, domestic workers and people who are homeless (Goel, 2020; Mishra, 2020; Sehgal, 2020).

Students, too, suffered the consequences of socio-economic inequalities. With most educational institutions opting for online teaching methods, students who did not have access to technology such as mobile phones, laptops and a high-speed Internet connection were left behind (UNESCO, 2020).

The government started easing up the lockdown measures through a series of "unlock" procedures since May 2020. However, the direct health impact and the indirect socio-economic sequelae of the pandemic and lockdown have had significant and long-lasting repercussions for the mental health of Indian citizens.

1.3 Impact on mental health

The pandemic seems to be a unique form of a stressful event with researchers calling it an 'ongoing cardiac stress test' (Horesh & Brown, 2020). Some researchers believe that the impact

of COVID-19 can be better understood from the lens of peritraumatic stress (Gallagher, 2020). Peritraumatic stress is defined as traumatic stress during or immediately following a traumatic event.

Van der Kolk (2020) has highlighted the stages of pre-trauma in the current global scenario as being characterized by:

Lack of predictability: the disruption in routines or change in the world's timelines are a direct consequence of the pandemic.

Immobilization: the adaptive fight or flight reactions seem improbable in the current context. Since the scientific understanding of the pandemic is still lacking, prevention and treatment do not have clear guidelines, thus, making it difficult to fight the pandemic. The option of flight is also not available to us as mobility is limited and quarantine also happens at home. The only alternative response available to us is "freeze" which causes immobilization of behavioral adaptation.

Loss of social connection: There is a sudden and unnatural interruption in social connectivity and physical engagement. Attunement over technology is difficult, and impossible for some, thus making the very nature of human interactions difficult and absent in many cases.

Numbing out and spacing out: dissociation between thoughts and affect is natural and an adaptive response in the current overwhelming situation. Yet dissociation as a mental state is not acknowledged, understood or recognized by the masses.

Loss of sense of time and sequences: there is an overwhelming sense of timelessness - that "this will last forever"/ "no end in sight" - leading to decreased negative affective tolerance.

Loss of safety: there is a loss of physical sense of safety, social safety, job loss and loss of social connection. The loss of privacy/space in cramped up urban spaces may lead to interpersonal difficulties.

Sense of purpose: meaning making of the current adversity and finding one's role and purpose is dependent on both the presence of existential safety and satiation of basic needs such as food, safe shelter and jobs; as well as on the psychological mindedness.

Thus, the pandemic is likely to have an impact on the mental health of the individuals. WHO defines mental health as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 1948, p. 100). In other words, mental health is not just the absence of mental illness, but the presence of well-being.

Determinants of mental health and well-being are considered to be psychosocial (Sturgeon, 2007). 'Psychosocial' can be defined as the influence of psychological and social factors on an individual's mind or behavior (Oxford English Dictionary, 2012). In the pandemic, a psychosocial understanding of mental health is the need of the hour. Psychological factors in the pandemic include emotions (e.g. anger, guilt, grief), thought processes (e.g. hopelessnesses, helplessness associated with the pandemic), beliefs (e.g. about the outbreak, its attribution, those affected by it), and so on. Social factors in the pandemic include access to family and community networks in quarantine, economic factors, stigma and discrimination, cultural practices and so on. Psychological and social factors interact with each other to influence mental health.

In the community, the various psychological reactions to pandemic include stress, anxiety, panic, pervasive feelings of hopelessness and desperation, frustration, uncertainty and an increase in suicidal behaviours (Barbisch et al., 2016; Duan & Zhu, 2020; Thakur & Jain, 2020). Although these are typically associated with mass outbreaks of any disease, the pandemic is unique due to the increased escalation of new cases and the vast

amounts of inadequate and/or false information available in the media thereby increasing the stress, uncertainty and anxieties related to the virus and its impact on health (Serafini et al., 2020).

A large scale study (n=1653) was conducted by Grover et al. (2020) in India to understand the psychological impact of lockdown on citizens. The results indicated that about two-fifth (38.2%) of the participants reported clinically-significant anxiety and 10.5% of the participants reported clinically-significant depression. Overall, 40.5% of the participants reported either significant anxiety or depression. Moderate level of stress was reported by about three-fourth (74.1%) of the participants and 71.7% reported poor well-being. Similarly, Roy et al. (2020) found high levels of anxiety around acquiring COVID-19 in a study conducted across 25 states and union territories across India and concluded that 80% of the participants needed mental health intervention.

The media also reported various instances of suicide in India during the times of COVID. D'Souza et al. (2020) found certain explanations for COVID-19-related suicides such as (i) the fear of contracting the disease, (ii) the fear of spreading the disease to others (e.g., family, friends, hospital patients), (iii) mental health difficulties caused by financial problems (e.g., losing job, not being able to earn money during lockdown, etc.), (iv) depression secondary to social isolation, quarantine, etc., (v) extreme difficulties in accessing food, (vi) xenophobia, and (vii) being unable to buy alcohol.

Further, the role of social media in influencing people's mental health is also relevant. India now has over 350 million social media users (Kadam & Atre, 2020). In this context, rapid dissemination of rumours and misinformation created an atmosphere of panic (Kadam & Atre, 2020), leading to serious implications.

The following paragraphs will briefly summarise the current knowledge about the mental health impact of the pandemic on different groups.

People diagnosed with COVID-19 : As a group, people diagnosed with COVID-19 can be said to be the most affected in the pandemic. In a meta-analysis of 31 studies conducted in China, Deng et al. (2020) found that the approximate prevalence of depression was 45%, anxiety was 47% and sleep disturbances was 34% amongst individuals diagnosed with COVID-19 across different studies. In an early systematic review, Rogers et al. (2020) warned of the possibility of neuropsychiatric sequelae of acquiring COVID-19, including depression, anxiety, fatigue, post-traumatic stress disorder and dysexecutive syndrome.

A unique feature of the pandemic were the quarantine measures imposed to mitigate the spread of the COVID-19. They were associated with mental health difficulties such as emotional disturbance, depression, stress, mood alterations, insomnia, post-traumatic stress symptoms, anger and emotional exhaustion (Serafini et al., 2020). According to Brooks et al. (2020), fear of being infected, frustration and boredom, having inadequate basic supplies and poor access to information were major stressors during quarantine. Longer duration of quarantine was associated with poorer mental health outcomes (Brooks et al., 2020).

A recent study, conducted by the National Disaster Management Authority (NDMA), aimed to document areas of concern expressed by people diagnosed with COVID-19 in India when contacted by a mental health professional through a 'reverse helpline'. The reported concerns could be grouped under the following categories:

- **Health concerns:** People diagnosed with COVID-19 were worried about the severity and persistence of their symptoms, possibility of death due to COVID-19 and fear of recurrence of the infection after recovery. Anxiety was increased in the presence of comorbid health conditions.

- **Concerns about medical facilities and services:** People faced multiple issues related to testing, diagnosis and treatment, such as a lack of proper guidelines for hospitalization and discharge, inadequate conditions in medical facilities (e.g., poor quality of food, uncleanliness) and improper adherence to social distancing protocols. Some participants also reported that they experienced hospital staff as uncooperative and uncaring towards them.
- **Behavioral and emotional concerns:** Individuals reported loss of appetite, sleep disturbances, sadness, loneliness and boredom due to self-isolation. Anxiety about the diagnosis, uncertainty regarding the progression of the illness and helplessness were found to be common. Some people reported frustration at being called repeatedly for contact tracing.
- **Relational concerns:** Individuals reported fear of and guilt about spreading the infection to others. They expressed worry about the health of their loved ones and loneliness at being away from them. Some individuals were in grief due to bereavement.
- **Stigma-related concerns:** Individuals experienced alienation and hostility from other members of the community, due to the labeling and stereotyping following a COVID-19 diagnosis. Systemic factors influenced stigma.
- **Financial concerns:** The diagnosis of COVID-19 exacerbated financial difficulties in addition to the other financial distress of the pandemic. Some people also expressed concerns about overcharging and fraudulent practices of the hospitals.
- **Logistical concerns:** Since information regarding guidelines and protocols was still developing, there was limited consistency in the protocols. Thus, logistical difficulties such as basic necessities, arranging for visits to the hospital, quarantine centre or testing centre posed challenges.

Healthcare professionals. An online survey conducted in May 2020 amongst healthcare professionals (primarily from Maharashtra) found that 47% of participants reported symptoms of depression, 50% reported symptoms of anxiety and 45% reported having a poor quality of life (Suryavanshi et al., 2020). The authors identified work-environment related stressors and being single as key risk factors for combined anxiety and depressive symptoms amongst healthcare professionals. Similarly, Rehman et al. (2020) found healthcare professionals experienced more stress, anxiety, and depression in the pandemic as compared to other professionals such as teachers, researchers and corporate professionals. Due to their frequent contact with individuals with COVID-19, healthcare professionals may be frequently quarantined, putting them at risk of experiencing the common psychological difficulties associated with the same (Brooks et al., 2020). Further, along with other frontline workers, healthcare professionals also bore the brunt of stigmatizing attitudes in the pandemic as they were perceived to have high virus contact. They were asked to leave the neighborhood, denied access to their houses or receive threats about their families (Bhattacharya et al., 2020). Another relevant concern that has been raised is that healthcare workers are at higher risk of experiencing bereavement overload in the pandemic as they may be witness to multiple losses (Zhai & Du, 2020).

Marginalized communities. As marginalized communities suffered a disproportionate socio-economic impact of the pandemic, their mental health was also likely to be disproportionately impacted. Rehman et al.'s (2020) study showed that individuals with limited supplies for sustaining the lockdown reported the most mental health difficulties. They also found that family affluence was found to be negatively correlated with stress, anxiety, and depression. Further, Chander et al. (2020) briefly summarised the mental health concerns of migrant workers temporarily staying at relief camps in Bengaluru city, Karnataka in June

2020. In another research conducted with migrant workers staying in Mumbai city, Maharashtra, it was found that they had to contend with multiple psychosocial challenges such as fears about contracting the illness, uncertainty about the future and helplessness in the face of financial challenges, emotional distress and difficulties experienced by their families (Duggal, Ray & Konantambigi, in press). Other vulnerable groups such as women, children, young people, sexual minorities and people with pre-existing mental health conditions and substance use disorders, too, experienced mental health difficulties (Balaji & Patel, 2020). Although the mental health needs of marginalized communities have been highlighted (Banerjee & Bhattacharya, 2020; Dubey et al., 2020), we have been unable to find further empirical research that systematically documents the mental health impact of the pandemic on marginalized communities in India. This in itself can be seen to be one way in which the mental health care needs of marginalized communities are disproportionately attended to.

1.4 Hope and resilience during the pandemic

Research suggests that altruistic and prosocial behaviours increase during stressful situations (Buchanan & Preston, 2014). The pandemic, too, has been replete with stories of how people have shown resilience and compassion. For example, people provided rations for their elderly neighbours or took responsibility for the street animals in their locality. We also heard of other initiatives where restaurants delivered free food to those in need (Sheoran, 2020). The moniker of 'COVID-19 warriors' was given to frontline workers such as healthcare professionals, police professionals, cremators and sanitation workers, who continued their work despite risk to themselves (Bhatia, 2020). Several individuals with influence, such as actors, celebrities and businessmen launched initiatives to help others in the pandemic, such as arranging transport for migrant workers (Bhatia, 2020).

Factors found to be associated with increased resilience during COVID-19 included social support from family, friends and loved ones, increased physical activity, exposure to sunlight and maintaining spiritual health (Killgore et al., 2020). Technology was also an important factor in supporting the resilience of people. A number of endeavours such as virtual counseling services, free online workouts, ideas for new hobbies and virtual social gatherings were made possible through the use of technology (Cleland et al., 2020).

Reflective Exercise

- What has been your experience of the pandemic in terms of your mental health?
- Were you or someone you know, diagnosed with COVID-19 or quarantined? If yes, how would you describe that experience?

2. Role of the mental health professional

I tested positive for COVID-19 in the first week of July. It all started around midnight of 3rd July. It began with uneasiness and difficulty falling asleep. Slowly, I started experiencing chills and developed a headache and bodyache. The next morning when my COVID-19 test results were declared, my fears came true.

As my symptoms worsened over the next few days, I was admitted to the hospital. I felt immensely guilty wondering if I had unknowingly infected other people. I called up my primary contacts and apologized to them. While in the isolation ward, I received many calls and texts from family, friends, colleagues… at the same time, I also faced indifference and lack of compassion from a few.

Post my discharge, I had to quarantine for 14 days. With my uncle's help, I was transferred to a facility where I was the only person on the whole floor. I received appropriate medical attention and food. However, it was the isolation that really bothered me. Negative thoughts engulfed me. I blamed myself for everything. I was anxious all the time and worries kept me up all night. Don't get me wrong; I have stayed in self-imposed isolation in my house since March when the outbreak happened. This was completely different. You have a COVID-19 positive tag which determines a differential treatment and you are all alone in a room without any resources to entertain yourself. Thankfully, I had family members and a few friends who kept me company through video chats/calls during the whole duration of my stay there. I started taking walks in the deserted corridor and kept myself busy by reading and working on my initiative. My second test came out positive as well. That meant I had to stay under quarantine for a few more days. I was heartbroken. I was frustrated and had a few emotional breakdowns. In the coming days, I pulled myself together and continued working on my initiative. On 5th of August, a month after my ordeal began, I finally tested negative. Subsequently, I was shifted to a post-covid facility where I was under quarantine for 14 days again. Post-this, I decided to shift to my home post COVID-19. My experiences with COVID-19 reminded me of how family plays such an important role in one's life. We tend to most often overlook this and prioritize other things in life.

~Padmaja Mushahary, Clinical Psychologist and survivor of COVID-19, who started the Heal Together initiative to provide support to people affected by COVID-19

As a country, India was already struggling with its mental health infrastructure before the pandemic (Kakuma et al., 2011). As Banerjee and Bhattacharya (2020, p. 589) write, 'In a country with such a heterogeneous and socially diverse population along with a preexisting knowledge–attitude–practice gap and stigma related to mental health, this sudden surge of psychosocial issues can easily overwhelm the available health care workforce (two psychiatrists and one psychologist per 400,000 people)'.

Yet, despite the constraints of the context, the mental health community in India rose up to the task. There was a rise in e-counselling services and webinars on mental health (Balaji & Patel, 2020). Many governmental, non-governmental and private organizations offered pro-bono services and helplines (Roy, Singh et al., 2020). For example, the NDMA helpline, a reverse helpline for facilitating help for people diagnosed with COVID-19, made over 1 lakh calls. Mental health professionals volunteered for these helplines in addition to their other responsibilities (Paonam, 2020). Several

institutions took up responsibilities to publish various resource materials and advisories on their websites (Roy, Singh et al., 2020). For example, a series of written and audio-visual guidelines aimed at prevention of mental health difficulties were released by the Government of India on topics including taking care of the mental health of children and elderly in the lockdown, addressing stigma, managing stress, safely quitting tobacco and so on (Dandona & Sagar, 2021).

Such initiatives support the idea that in a resource-constrained setting such as India, it is not enough to merely provide intervention to people diagnosed with mental health disorders. Mental health professionals do not merely have a curative, but also a preventive and promotive role, in the pandemic (Wendimagegn & Bezuidenhout, 2019; WHO, 2002).

Promotive role. Promotive interventions are aimed at increasing well-being and positive mental health. Mental health promotion strategies are generally more universal than prevention strategies (WHO, 2002). For example, promoting active lifestyles in the lockdown might help people to improve their well-being. Mental health professionals could also coordinate with public health, medical and emergency response-related teams to proactively address mental health needs of individuals.

Preventive role. Our role as mental health professionals may help in preventing mental health difficulties. Preventive work can involve universal interventions or interventions that are aimed towards people who are judged to be at risk of developing mental health difficulties (WHO, 2002). For example, people diagnosed with COVID-19 might be judged to be at risk of mental health difficulties and can be preemptively provided intervention to prevent the same.

Curative role. Curative interventions involve providing interventions after a mental health difficulty has been identified. Considering the psychological and psycho-social impact of the current pandemic, providing adequate psychological services is the need of the hour (Serafini et al., 2020). For example, mental health professionals might provide telemedicine and telepsychotherapy services to individuals who have developed mental health difficulties in the pandemic.

The COVID-19 pandemic has been an unprecedented global event that has had profound repercussions on the health and socio-economic well-being of citizens. Apart from physical health, mental health has also been significantly impacted, with people diagnosed with COVID-19, healthcare professionals and marginalized communities being especially at risk of mental health difficulties. There is a need to use a psychosocial framework to address mental health needs in the current context by addressing preventive, and curative dimensions of mental health care. Hence, the current manual draws on multiple approaches and perspectives to illustrate how psychosocial support can be extended to the individuals affected by the pandemic.

The next section in this manual will describe the various theoretical approaches and core values that inform this manual, the key skills and ethical perspectives that need to be considered when working in the pandemic and the importance of attending to personal and professional development for mental health professionals in the pandemic.

References

Agrawal, S. (2020, September 7). Govt launches KIRAN, a 24×7 helpline for people to seek mental health counselling. *The Print.* https://theprint.in/health/govt-launches-kiran-a-24x7-helpline-for-people-to-seek-mental-health-counselling/497542/

Balaji, M., & Patel, V. (2020, July 29). Mental Health and COVID-19 in India. *India Development Review.* https://idronline.org/mental-health-and-covid-19-in-india/

Banerjee, D., & Bhattacharya, P. (2020). "Pandemonium of the pandemic": Impact of COVID-19 in India, focus on mental health. Psychological Trauma: *Theory, Research, Practice, and Policy, 12(6)*, 1–5. https://doi.org/10.1037/tra0000799

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.

Bhatia, A. (2020, December 31). Yearender 2020: Meet The COVID Heroes Of India. NDTV. https://swachhindia.ndtv.com/yearender-2020-meet-the-covid-heroes-of-india-54758/

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.

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Buchanan, T. W., & Preston, S. D. (2014). Stress leads to prosocial action in immediate need situations. *Frontiers in Behavioral Neuroscience, 8, 5.*

Business Today. (2020, April 22). India's unemployment rate hits 26% amid lockdown, 14 crore lose employment: CMIE https://www.businesstoday.in/sectors/jobs/india-unemployment-rate-hits-26-amid-lockdown-14-crore-lose-employment-cmie/story/401707.html

Cava, M. A., Fay, K. E., Beanlands, H. J., McCay, E. A., & Wignall, R. (2005). Risk perception and compliance with quarantine during the SARS outbreak. *Journal of Nursing Scholarship, 37(4),* 343-347.

Chander, R., Murugesan, M., Ritish, D., Damodharan, D., Arunachalam, V., Parthasarathy, R., Raj, A., Sharma, M. K., Manjunatha, N., Bada Math, S., & Kumar, C. N. (2020). Addressing the mental health concerns of migrant workers during the COVID-19 pandemic: An experiential account. *International Journal of Social Psychiatry.* https://doi.org/10.1177/0020764020937736

Cleland, J., McKimm, J., Fuller, R., Taylor, D., Janczukowicz, J., & Gibbs, T. (2020). Adapting to the impact of COVID-19: Sharing stories, sharing practice. *Medical teacher, 42(7)*, 772-775.

D'Souza, D. D., Quadros, S., Hyderabadwala, Z. J., & Mamun, M. A. (2020). Aggregated COVID-19 suicide incidences in India: Fear of COVID-19 infection is the prominent causative factor. *Psychiatry research, 290,* 113-145.

Dandona, R., & Sagar, R. (2021). COVID-19 offers an opportunity to reform mental health in India. The Lancet Psychiatry, 8(1), 9–11. https://doi.org/10.1016/S2215-0366(20)30493-4

Deccan Herald (2021, January 2). Coronavirus Worldometer: 15 countries with the highest number of cases, deaths due to the Covid-19 pandemic. https://www.deccanherald.com/international/coronavirus-updates-cases-deaths-country-wise-worldometers-info-data-covid-19-834531.html#1

Deng, J., Zhou, F., Hou, W., Silver, Z., Wong, C. Y., Chang, O., Huang, E., & Zuo, Q. K. (2020). The prevalence of depression, anxiety, and sleep disturbances in COVID-19 patients: a meta-

analysis. Annals of the New York Academy of Sciences, 1–22. https://doi.org/10.1111/nyas.14506

Duan, L., & Zhu, G. (2020). Psychological interventions for people affected by the COVID-19 epidemic. *The Lancet Psychiatry, 7(4),* 300-302.

Dubey, S., Biswas, P., Ghosh, R., Chatterjee, S., Dubey, M. J., Chatterjee, S., ... & Lavie, C. J. (2020). Psychosocial impact of COVID-19. Diabetes & Metabolic Syndrome: *Clinical Research & Reviews.*

Duggal C., Ray, S. & Konantambigi, R. (2021). *The nowhere people: Migrant workers' experience of COVID-19 in India* [Project Report submitted to the Research Council, Tata Institute of Social Sciences].

Dwivedi, L. K., Rai, B., Shukla, A., Dey, T., Ram, U., Shekhar, C., Dhillon, P., Suryakant, Y., & Unisa, S. (2020, April 25). *Assessing the Impact of Complete Lockdown on COVID-19 Infections in India and its Burden on Public Health Facilities: A Situational Analysis Paper for Policy Makers.* Mumbai: International Institute of Population Sciences.

Firstpost (2020, March 25). Narendra Modi on Coronavirus Outbreak LIVE Updates: India under complete shutdown for 21 days starting 12 pm tonight, says PM. https://www.firstpost.com/health/narendra-modi-on-coronavirus-speech-live-updates-streaming-watch-india-pm-address-to-nation-on-covid-19-today-latest-news-lockdown-janata-curfew-8182241.html

Gallagher, S. (2020, April 15). Coronavirus tips: How to curb your anxiety about Covid-19

Goel, I. (2020, May 4). Impact of Covid-19 on Hijras, a Third-Gender Community in India. *Society for Cultural Anthropology*. https://culanth.org/fieldsights/impact-of-covid-19-on-hijras-a-third-gender-community-in-india

Grover, S., Sahoo, S., Mehra, A., Avasthi, A., Tripathi, A., Subramanyan, A., Pattojoshi, A., Rao, G., Saha, G., Mishra, K., Chakraborty, K., Rao, N., Vaishnav, M., Singh, O., Dalal, P., Chadda, R., Gupta, R., Gautam, S., Sarkar, S., … Janardran Reddy, Y. (2020). Psychological impact of COVID-19 lockdown: An online survey from India. *Indian Journal of Psychiatry, 62(4),* 354–362. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_427_20

Hindustan Times (2020, May 13) In FM's address, emphasis on 'Atamanirbhar Bharat' as she explains the term in 4 languages. https://www.hindustantimes.com/india-news/in-finance-minister-nirmala-sitharaman-s-address-emphasis-on-atma-nirbhar-bharat-as-she-explains-the-term-in-4-languages/story-Z8FMRoJgvJ6bnFoehCEl9M.html

Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call to close critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice, and Policy, 12(4)*, 331-335. http://dx.doi.org/10.1037/tra0000592

Kadam, A. B., & Atre, S. R. (2020). Negative impact of social media panic during the COVID-19 outbreak in India. *Journal of Travel Medicine, 27(3)*, 57.

Kakuma, R., Minas, H., Van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. The Lancet, 378(9803), 1654–1663. https://doi.org/10.1016/S0140-6736(11)61093-3

Killgore, W. D., Taylor, E. C., Cloonan, S. A., & Dailey, N. S. (2020). Psychological resilience during the COVID-19 lockdown. *Psychiatry research, 291*, 113-116.

Lai, C. C., Shih, T. P., Ko, W. C., Tang, H. J., & Hsueh, P. R. (2020). Severe acute respiratory

syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): the epidemic and the challenges. *International Journal of Antimicrobial Agents*, 105924.

McMahon, D. E., Peters, G. A., Ivers, L. C., & Freeman, E. E. (2020). Global resource shortages during COVID-19: bad news for low-income countries. *PLoS neglected tropical diseases, 14(7*), e0008412.

Ministry of Health and Family Welfare [MoHFW]. (n.d.). Home. Retrieved 12th February, 2021 from https://www.mohfw.gov.in/

Mishra, S. K. (2020, July 21). No income, no food, no government relief: Sex workers of Kamathipura pushed to the brink. *Firstpost.* https://www.firstpost.com/india/coronavirus-outbreak-no-income-no-food-no-government-relief-sex-workers-of-kamathipura-pushed-to-the-brink-8623201.html

Naqvi, M., & Trivedi, U. (2020, April 24). A New Wave of Anti-Muslim Anger Threatens India's Virus Fight. *Bloomberg.* https://www.bloomberg.com/news/articles/2020-04-23/a-new-wave-of-anti-muslim-anger-threatens-india-s-virus-fight

Paonam, T. (2020, July 6). A day in the life of a mental health professional. *India Development Review*. https://idronline.org/a-day-in-the-life-of-a-mental-health-professional/

Press Trust of India, The Economic Times (2020, May 27). India facing its worst recession in current fiscal, says Crisil. https://economictimes.indiatimes.com/news/economy/indicators/india-facing-its-worst-recession-in-current-fiscal-says-crisil/articleshow/76004775.cms

Raj, D (2020, April 8). Migrants pay price of staying back in Delhi. *The Telegraph (India).* https://www.telegraphindia.com/india/coronavirus-lockdown-migrants-pay-price-of-staying-back-in-delhi/cid/1762978

Ray, D., & Subramanian, S. (2020). India's lockdown: An Interim Report. *NBER Working Paper Series (No. 27282).* http://www.nber.org/papers/w27282

Rehman, U., Shahnawaz, M. G., Khan, N. H., Kharshiing, K. D., Khursheed, M., Gupta, K., ... & Uniyal, R. (2020). Depression, anxiety and stress among Indians in times of Covid-19 lockdown. *Community mental health journal, 1-7.*

Reid (2020, January 30). India confirms its first coronavirus case. *CNBC.* https://www.cnbc.com/2020/01/30/india-confirms-first-case-of-the-coronavirus.html

Rogers, J. P., Chesney, E., Oliver, D., Pollak, T. A., McGuire, P., Fusar-Poli, P., Zandi, M. S.,

Lewis, G., & David, A. S. (2020). Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. *The Lancet Psychiatry, 7(7),* 611–627. https://doi.org/10.1016/S2215-0366(20)30203-0

Roy, A., Singh, A. K., Mishra, S., Chinnadurai, A., Mitra, A., & Bakshi, O. (2020). Mental health implications of COVID-19 pandemic and its response in India. *International Journal of Social Psychiatry.* https://doi.org/10.1177/0020764020950769

Roy, D., Tripathy, S., Kar, S. K., Sharma, N., Verma, S. K., & Kaushal, V. (2020). Study of knowledge, attitude, anxiety & perceived mental healthcare need in Indian population during COVID-19 pandemic. *Asian Journal of Psychiatry, 51*(102083). https://doi.org/10.1016/j.ajp.2020.102083

Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet, 395*(10227), 912–920. https://doi.org/10.1016/S0140-6736(20)30460-8

Rubin, G. J., & Wessely, S. (2020). Coronavirus: the psychological effects of quarantining a city. *The BMJ Opinion.*

Sehgal, D. G. (2020, September 16). The situation of marginalised sections amid lockdown and legal relief. *IP Leaders*. https://blog.ipleaders.in/situation-marginalised-sections-amid-lockdown-legal-relief/#Effect_of_COVID-19_on_the_marginalised_sector

Serafini, G., Parmigiani, B., Amerio, A., Aguglia, A., Sher, L., & Amore, M. (2020). The psychological impact of COVID-19 on the mental health in the general population. QJM: *An International Journal of Medicine, 113(8)*, 531-537.

Sethi, A., & Laha, G. (2020, December 2). India: Many MBBS Students Are Being Put on COVID Duty in Improper Conditions. *The Wire*. https://science.thewire.in/health/mbbs-students-covid-19-duty-gujarat-stipend-fair-treatment/

Shaji, L. (2020, May 20). Flattening the Curve at the Expense of One's Constitutional Rights?". Centre for Constitutional Research and Development. https://ccrd.vidhiaagaz.com/migrant-workers-flattening-the-curve-constitutional-rights/

Sharma, Y. S. (2020, September 16) Labour minister Gangwar clarifies his response on migrant workers in Parliament". *The Economic Times.* https://economictimes.indiatimes.com/news/economy/policy/labour-minister-gangwar-clarifies-his-response-on-migrant-labourers-in-parliament/articleshow/78142699.cms

Steenbarger, B. (2002). Brief therapy. In Hersen, M., & Sledge, W. (Eds.), *Encyclopedia of Psychotherapy* (pp. 349-358). New York: Elsevier.

Suryavanshi, N., Kadam, A., Dhumal, G., Nimkar, S., Mave, V., Gupta, A., Cox, S. R., & Gupte, N. (2020). Mental health and quality of life among healthcare professionals during the COVID-19 pandemic in India. *Brain and Behavior, 10(11),* 1–12. https://doi.org/10.1002/brb3.1837

Thakur, V., & Jain, A. (2020). COVID 2019-suicides: A global psychological pandemic. *Brain, behavior, and immunity.*The Economic Times (2020, April 8). India may have to sell itself out of this crisis, says Rajiv Bajaj. https://economictimes.indiatimes.com/news/politics-and-nation/view-must-sell-ourselves-out-of-this-crisis/articleshow/75038503.cms

The Economic Times (2020, March 20). PM Narendra Modi forms economic response task force, calls for 'Janata Curfew'".
https://economictimes.indiatimes.com/news/politics-and-nation/pm-narendra-modi-forms-economic-response-task-force-calls-for-janata-curfew/articleshow/74715013.cms?from=mdr

Tsai, J., & Wilson, M. (2020). COVID-19: a potential public health problem for homeless populations. *The Lancet Public Health, 5(4),* e186-e187.

Van der Kolk, B. (2020). Steering ourselves and our clients through new and developing traumas. Available from https://catalog.psychotherapynetworker.org

Wendimagegn, N. F., & Bezuidenhout, M. C. (2019). Integrating promotive, preventive, and curative health care services at hospitals and health centers in Addis Ababa, Ethiopia. *Journal of Multidisciplinary Healthcare, 12,* 243–255. https://doi.org/10.2147/JMDH.S193370

WHO. (2002). P*revention and Promotion in Mental Health.* Geneva: Author. WHO. (2020). Director-General's remarks at the media briefing on 2019 novel coronavirus on 8th February 2020.
http://www.who.int/dg/speec hes/detail/direc tor-gener al-s-remar ks-at-themedia-briefingon-2019-novel-coronavirus-8-february-2020

Zhai, Y., & Du, X. (2020). Loss and grief amidst COVID-19: A path to adaptation and resilience. *Brain, Behavior, and Immunity, 87*, 80–81. https://doi.org/https://doi.org/10.1016/j.bbi.2020.04.053

Section 2: Frameworks of psychosocial support

1 Theoretical underpinnings

It is now well-recognized that disasters have complex, multi-faceted and long-lasting implications for the mental health of people who experience them (Cohen, 2002; Norris et al., 2002). The prevalence of mental health problems in populations that are affected by disasters has been found to be two to three times higher than that of the general population (Math et al., 2015). The field of disaster mental health has examined several approaches in response to disasters, including psychological debriefing, psychological first aid, cognitive-behavioural approaches, crisis intervention, screening and triage models, problem-solving interventions, rumour control and conflict mitigation (Halpern & Vermeulen, 2017; Norris et al., 2002). When we are working in disaster mental health, we leave behind the familiar props and structures of routine clinical practice and encounter a context that is unpredictable and unexpected (Halpern & Vermeulen, 2017).

Most experts identify two major types of disasters: natural (e.g., earthquakes, floods, hurricanes) or human-made (e.g., oil spills, bombing, train accidents) (Eshghi & Larson, 2008). Pandemics, such as COVID-19, are a unique form of a disaster, since measures to control the spread of the virus, such as mass quarantine, lockdown and restrictions on activities can have as much, and perhaps more, impact than the disease itself (Smith et al., 2020). A pandemic is also largely 'unseen'; COVID-19 can spread without manifesting any symptoms, which differentiates it from other weather-related and human-made disasters that can be easily located (Dzigbede et al., 2020). Hence, in the pandemic, people are facing novel and specific concerns that have emerged in the course of these unique circumstances.

The current manual attempts to bring together theories and concepts from relevant models of psychosocial counselling to inform interventions:

- Psychological first aid approach
- Ecological systems framework
- Brief intervention approach
- Evidence-informed practice and practice-based evidence.
- Trauma-informed care
- Integrative approach

1. Psychological First Aid Approach

PFA is a well-known, evidence-informed approach to providing psychosocial support in the immediate aftermath of a disaster (Shultz & Forbes, 2013). It can be defined as 'a compassionate and supportive presence designed to mitigate acute distress and assess the need for continued mental health care' (Everly & Flynn, 2005). The first goal of PFA is to reduce the immediate distress of the person that has occurred in the aftermath of a traumatic event. The second goal of PFA is to assess and determine which clients need urgent care and long-term care. Accordingly, clients can be followed up or referred to appropriate services. Psychological first aid approaches have been found to be more effective than 'psychological debriefing' (Bisson et al., 1997; Hobfoll et al., 2007). Psychological debriefing was an older approach in which people were asked to recount the details of a traumatic event as well as their thoughts and feelings during the experience which was found to be unhelpful According to experts, PFA is a crucial and relevant approach during the COVID-19 pandemic to deal with mental health concerns (Shah et al., 2020).

Some widely-used models of PFA include the Johns Hopkins RAPID Model, the WHO Look, Listen and Link model and the National Child Traumatic Stress Network Model. The Johns Hopkins RAPID Model was developed at Johns Hopkins University

in USA (Everly & Lating, 2017). The components of the model involve:

- **Rapport and Reflective Listening** - The first step of PFA is to build rapport with the client. We need to listen carefully to understand the client's unique concerns. It is important to not have preconceived notions of what we are going to do; many a times, the client will lead us to where and how they need help.
- **Assessment** - Assessment involves determining who needs support and what is the kind of support needed.
- **Prioritization** - Prioritization involves determining who needs more urgent support, what kind of support they may need and what action (e.g. referral) needs to be taken.
- **Intervention** - Intervention involves all the actions we take to help and support the client.
- **Disposition and follow-up** - This involves following-up with the client to observe how effective intervention was and whether the client is able to return to adequate functioning. If not, the client might be referred to appropriate services. According to this model, follow-up is an essential part of PFA (whether done by the same professional or another professional).

The Look, Listen, Link Model for PFA was introduced by the World Health Organization (WHO, 2011) and widely adopted by the International Federation of Red Cross and Red Crescent Societies (IFRC, 2018, 2020). It introduced the 3 basic action principles of PFA as:

- **Look:** This refers to the assessment of who needs help and what kind of help they need. This also involves assessing who needs more urgent help and who is more seriously distressed, in order to ensure safety.
- **Listen:** This refers to approaching people who need support and listening actively and reflectively to their concerns, with the aim of helping them feel understood and helping them feel calmer.
- **Link:** This refers to providing different forms of support to people, such as providing information, making referrals and supporting problem-solving.

The National Child Traumatic Stress Network Model for PFA was developed by the National Child Traumatic Stress Network and the National Center for PTSD (Brymer et al., 2006). It has eight core actions:

- **Contact and Engagement:** To establish contact with clients in a compassionate and helpful manner.
- **Safety and Comfort:** To enhance current physical and emotional safety and comfort.
- **Stabilization:** To help reduce immediate distress and calm clients who are overwhelmed.
- **Information Gathering:** To assess current needs and concerns.
- **Practical Assistance:** To provide practical help to clients as needed.
- **Connection with Social Supports:** To help clients connect with their existing sources of social support and establish/ facilitate new sources of support.
- **Information on Coping:** To provide information about normal stress reactions and helpful coping mechanisms.
- **Linkage with Collaborative Services:** To help clients link to appropriate services that they may need.

In the 2009 guidelines produced by NDMA, psychosocial first aid [PFA] was the main approach recommended in the acute response phase of a disaster. Further, in disaster mental health approaches, survivors are not viewed as suffering from disorders, but rather experiencing extreme, but understandable, stress due to their experiences (Halpern & Vermeulen, 2017). Flexible and individualized intervention is crucial; there is no one-size-fits-all approach (Halpern & Vermeulen, 2017). For example, one client may need only a few minutes of warm and supportive listening from the counsellor, whereas another client who is at

risk of harm may need more prolonged, directive and intensive intervention. Both practical and emotional support can be provided, as required.

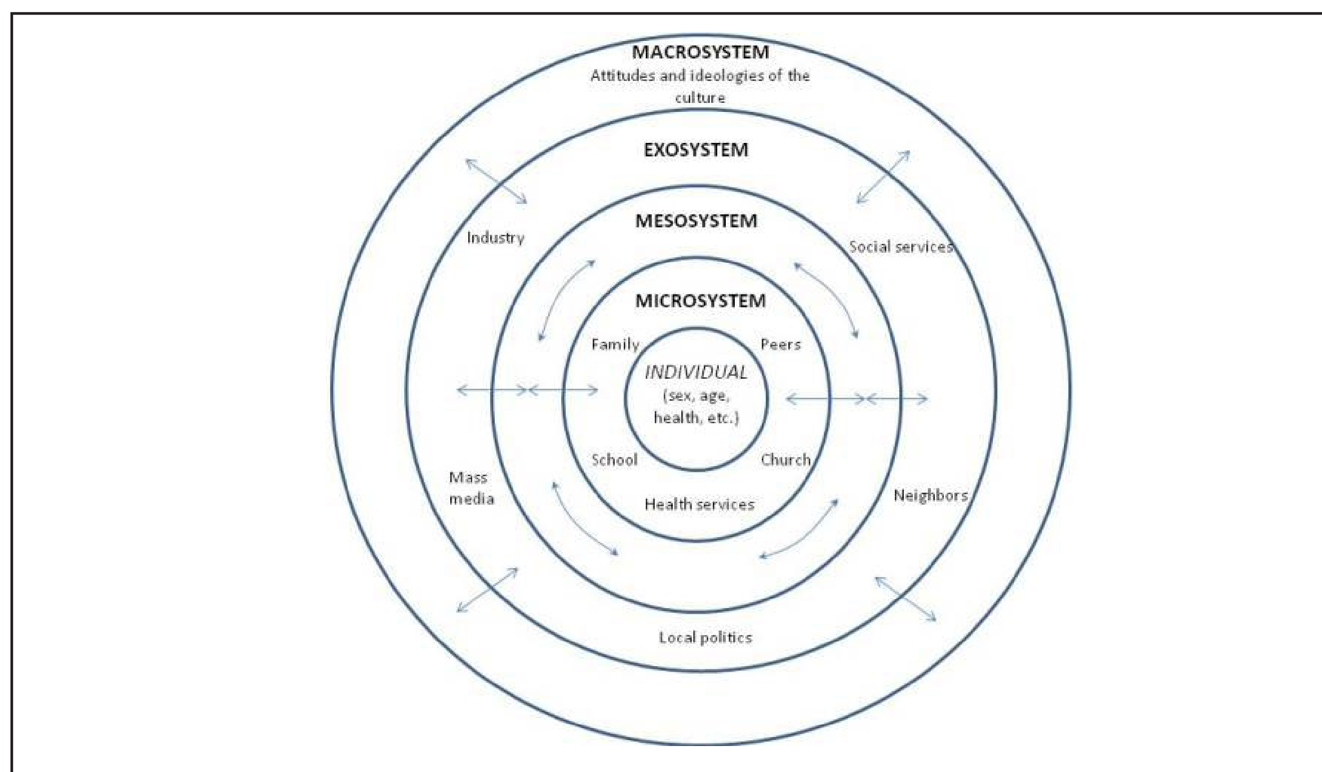
Hence, psychosocial support in the pandemic can be informed by a PFA approach that emphasizes active listening and engagement as a way to reduce distress in disaster settings, focuses on both practical and emotional needs, is flexible and individualized and involves rapid assessment and prioritization of client needs.

2. Ecological systems framework

Mental health and well-being are intricately linked with the environment. One of the most well-known models for understanding the interaction between the environment and the individual is Bronfenbrenner's (1979) ecological systems model. The model states that there are five environmental or 'ecological' systems influencing the individual and their mental health:

- **Microsystem:** consisting of family, school, peers, religious affiliation, workplace and neighbourhood.
- **Mesosystem:** consisting of the interrelationships between the various microsystems e.g., how a client's spouse interacts with their workplace can influence a client's mental health.
- **Exosystem:** consisting of economic, political, education, government and religious systems.
- **Macrosystem:** consisting of overarching beliefs and value systems in the individual's environment.
- **Chronosystem:** consisting of environmental events and transitions across the lifespan of the individual.

Hence, mental health is influenced by the interrelationships between an individual and the various aspects of their environment. For example,



Source: By Hchokr at English Wikipedia, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=50859630

an elderly woman (age and gender being individual factors) who has poor access to social support in the lockdown (a microsystemic factor) and is extremely worried about acquiring COVID-19 from individuals from a particular religious community (an exosystemic factor) may develop mental health difficulties during the pandemic, as a result of the interaction of these factors.

3. Brief intervention models

The number of sessions that comprise a 'brief' intervention is not fixed; it can range from single-session therapies to 20 or more sessions in the psychodynamic tradition. The goal is to use time effectively rather than restrict oneself to a certain arbitrary number of sessions. The essential components of brief interventions can be summarised as (Holmes, 1994; Steenbarger, 2002):

- **Focused:** Brief interventions have a specific focus, rather than being exploratory. It is important to do a quick assessment to find this focus. In practice, assessment and intervention often overlap and are combined.
- **Here-and-now:** Brief interventions are focused on addressing the current needs and concerns of the client, rather than analyzing the past or the childhood.
- **Active involvement of the counsellor:** The counsellor must be active in using skills and providing support to the client, rather than acting as a blank slate.
- **More doing, less insight:** Brief interventions often involve active problem-solving and reduction of distress and focus less on exploration and insight into long-term patterns of the client.

Psychosocial support during the pandemic can be provided within a brief and remote counselling framework. Brief refers to interventions that can be carried out in 1-2 sessions and involve a focused, active involvement on the part of the counsellor aimed at supporting clients with here-and-now concerns. Remote refers to interventions that can be carried out over the telephone. In a resource-constrained country such as India, brief interventions were felt to be the need of the hour in the pandemic, as they can optimize the use of the scarce resources that are available. They can be used to provide support to those for whom brief contact may suffice and assess the need for continued mental health care and refer those who need more support. Interventions that can be applied within a remote context were chosen due to the social distancing requirements in the pandemic and the inaccessibility of in-person mental health services in all parts of India.

4. Evidence-informed practice and practice-based evidence

While evidence-based practices are approaches to prevention or treatment that are validated by some form of documented scientific evidence, evidence-informed practices use the best available research and practice knowledge to guide program design and implementation (Child Welfare Information Gateway, n.d.). Considering that the pandemic is a novel situation, evidence-based interventions for working in the pandemic are still in the process of being researched and understood. Mental health practitioners had to rely on adapting existing models of intervention to the present context. Thus, evidence-informed practices were the key sources of intervention.

At the same time, as mental health professionals were working in the pandemic, they were facing real-life clinical situations and were in a position to understand what was working at the ground level. Thus, they were collecting what can be termed as 'practice-based evidence' (Staller, 2006). For example, through experience, a counsellor may realize that, in a particular context, many clients may be uncertain and skeptical of being called by a mental health professional and hence it is important to sensitively introduce the rationale for the call in a way that normalizes help-seeking and reduces the stigma around mental health.

Practice-based evidence is a bottom-up approach and can produce situated, contextualized or local knowledge (Midgley, 2010).

The interventions mentioned in this manual integrate both evidence-informed approaches and practice-based evidence. Evidence-informed practice has been primarily drawn from global and context-specific research on effective interventions to address mental health difficulties in disaster settings. Practice-based evidence has been primarily drawn from the experiences of counsellors, trainers and supervisors associated with crisis helplines during the pandemic.

5. Trauma-informed

Over time, the definition of trauma has evolved from a focus on the objective presence of an extra-ordinary or life-threatening event to a survivor's experience of an event. Trauma is now defined as 'resulting from an event or a set of circumstances that is experienced as physically or emotionally harmful by the survivor and has lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being' (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Decades of trauma research have led to the realization that it is not enough to merely use trauma-specific interventions to treat trauma (SAMHSA, 2014). Trauma-informed approaches have been developed with the idea that the entire context (including the organizational context) in which interventions for trauma are provided need to operate using certain principles of care to address the needs of trauma survivors. According to SAMHSA (2014), the four Rs of a trauma-informed approach are:

- Professionals **R**ealize the impact of trauma on individuals, families, groups, organizations and communities and understand the potential paths for recovery.
- Professionals can also **R**ecognize the signs of trauma, which may be gender, age and context-specific.
- Professionals **R**espond by integrating knowledge about trauma into their practices, procedures and policies.
- Professionals seek to actively **R**esist re-traumatization.

This broad framework can be distilled into six key principles of a trauma-informed approach (SAMHSA, 2014):

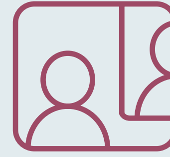
- We aim to ensure physical and physiological safety of our clients as the highest priority.
- We aim to be transparent in our interactions and maintain trust in our relationships with clients, family members and colleagues we are working with.
- We aim to be collaborative and meaningfully share power and decision-making with our clients.
- We are respectful of the lived experience of trauma survivors and their ability to help each other.
- We accord a high importance to the voice and choice of clients, as trauma survivors have historically been subjected to coercive experiences and treatments that have disregarded their autonomy.
- We are responsive to the cultural, historical and gender-based needs of clients.

Trauma-informed approaches also bring the unique lens of the neurobiological underpinnings of trauma responses, thereby leading to various body-based techniques to regulate distress and enhance safety in the pandemic (van der Kolk, 2014). As the COVID-19 pandemic can be conceptualized as a traumatic event, psychosocial support in the pandemic needs to incorporate a trauma informed lens i.e., it aims to ensure emotional safety as the highest priority, emphasizes collaboration, choice and transparency, privileges the lived experience of people and seeks to resist re-traumatization.

6. Integrative approach

Ideological differences among theoretical orientations have a long history in psychotherapy and counselling (Norcross, 2005). As the field has matured, the integration of various psychotherapeutic approaches has become a mainstay in the field. The goal ofw integration is to look beyond single-school approaches in counselling and to learn and apply diverse ways of counselling to enhance efficacy and applicability (Norcross, 2005). The advantages of integration include: it can combine effective elements from different approaches, it lends itself to greater flexibility and individualization, it fits well within time-limited approaches and it recognizes the immense commonality between different orientations (Norcross, 2005).

Strategies for supporting clients during the COVID-19 pandemic can be found in virtually all psychotherapeutic and counselling disciplines. Hence, psychosocial support in the pandemic need not be restricted to a single school of counselling, but can integrate cognitive-behavioural, emotion-focused, interpersonal, narrative, existential and other approaches to inform interventions.



Reflective Exercise

- Have you ever practiced counselling in a disaster setting?
  - What were some unique aspects about it that differed from routine counselling practice?
  - Are there any learnings or reflections you have from the experience?
- How comfortable are you with the inherent limitations of the scope of brief work?
  - How might these limitations impact your sense of competence? (For example, we may not be able to help people process their grief completely or reach an 'end-point' to the work. We may only be able to provide brief support)
  - How might you feel about having to constantly initiate new relationships with new clients and end previous relationships?
- Practice-based evidence is discussed in this chapter as a crucial aspect that informs our work. Can you think of any examples of practice-based evidence that you may have incorporated in your practice?
- Which theoretical orientation/s do you identify yourself as being from?
  - What are your views of an integrative approach to counselling in the pandemic?
  - What disadvantages could there be in using an integrative approach?

The current framework for providing psychosocial support...	The current framework for providing psychosocial support...
IS aimed at providing emotional and practical support to reduce distress	IS NOT a process of psychotherapy or complete treatment
IS an assessment of current needs of the client	IS NOT a process aimed at diagnosis
IS a brief intervention	IS NOT a long-term intervention
IS an intervention in which follow-up is preferred	IS NOT a one-off intervention
IS aimed at referring those in need to appropriate services	IS NOT acting as a one-stop destination for all the person's needs
IS taking a compassionate and supportive stance to people's distress	IS NOT attacking defences or making interpretations about psychic conflicts
IS being respectful of people's readiness and consent to be supported	IS NOT 'debriefing', that is, it does not require asking for details of a traumatic event

Summary of the Psychosocial Support Framework in the Current Manual

This chapter discussed the key theoretical underpinnings of providing psychosocial support in a disaster context, with specific reference to the COVID-19 pandemic. The next chapter will describe the core values that can inform the framework of psychosocial support in the pandemic.

Referances

Agrawal S., Yadavar S. (2020 April, 2). Locked Down and Anxious, More and More Indians Are Making Panic Calls, Seeking Therapy. https://theprint.in/health/locked-down-and-anxious-more-and-more-indians-are-making-panic-calls-seeking-therapy/392224/

Aponte, H. J., & Ingram, M. (2018). Person of the therapist supervision: Reflections of a therapist and supervisor on empathic-identification and differentiation. *Journal of Family Psychotherapy, 29(1)*, 43–57.

Balaji, M., & Patel, V. (2020, July 29). Mental Health and COVID-19 in India. India Development Review. https://idronline.org/mental-health-and-covid-19-in-india/

Baldwin, C. (1991). Life's companion: Journal writings as a spiritual quest. New York: Bantam Banks.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16(03)*, 317-331.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. Professional Psychology: Research and Practice, 38(6), 603

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. Professional Psychology: Research and Practice, 44(3), 150–157.

Bernard, J. M. , & Goodyear , R. K. (2007). Fundamentals of clinical supervision (4th ed.). Upper Saddle River, NJ: Pearson Education.

Berryman, M., Glynn, T., & Woller, P. (2017). Supervising research in Māori cultural contexts: a decolonizing, relational response. Higher Education Research & Development, 36(7), 1355-1368.

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.

Bradbury-Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. *Journal of Clinical Nursing.* https://doi.org/10.1111/jocn.15296

British Psychological Society (BPS). (2008). Criteria for the accreditation of postgraduate training programmes in clinical psychology. *Leicester: British Psychological Society.*

Butler, L. D., Carello, J.,&Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy, 9(4)*, 416–424.

Clandinin, D. J., & Connelly, F. M. (1991). Narrative and story in practice and research. In D. Schön (Ed.), The reflective turn: Case studies in and on educational practice (pp. 258–282). New York: Teachers College Press.

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: *A meta-analysis. Training and Education in Professional Psychology, 10(4)*, 188–197.

Connelly, F. M., & Clandinin, D. J. (1988). Teachers as curriculum planners: Narratives of experience. New York: Teachers College Press.

Dave S. (2020, March 26). Covid-19: Companies

Rope in Psychiatrists, Experts for Emotional Counselling of Work from Home Employees. The Economic Times.
https://economictimes.indiatimes.com/topic/26th-march

Duggal, C., Dua, B., & Ullas, N. (2020). Psychotherapy Supervision in India: From Supervisee Perspectives to Contextual Models of Practice [Report]. Mumbai: Tata Institute of Social Sciences.

Dwivedi, L. K., Rai, B., Shukla, A., Dey, T., Ram, U., Shekhar, C., Dhillon, P., Suryakant, Y., & Unisa, S. (2020, April 25). Assessing the Impact of Complete Lockdown on COVID-19 Infections in India and its Burden on Public Health Facilities: A Situational Analysis Paper for Policy Makers. Mumbai: International Institute of Population Sciences.

El-Ghoroury, N., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology, 6(2)*, 122–134.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58(11)*, 1433-1441.

Gandhi, A., & Rajan, P. (2013). Role of Counselling Supervision in Enhancing Counselling Skills and Expertise. Social Sciences, 74(2).

Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice, 1(3-4)*, 37-61.

Gibbs, G. (1988). Learning by Doing: A guide to teaching and learning methods. Oxford: Further Education Unit, Oxford Polytechnic.

Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of selfcare utilization. Training and Education in Professional Psychology, 7(1), 53–60.

Guy, J. D. (2000). Self-care corner: Holding the holding environment together: Self-psychology and psychotherapist care. Professional Psychology: *Research and Practice, 31(3)*, 351–352.

Hanna, F. J., & Ottens, A. J. (1995). The role of wisdom in psychotherapy. *Journal of Psychotherapy Integration, 5,* 195–210.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. Psychotherapy: *Theory, Research, Practice, Training, 46(2)*, 203–219.

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian journal of psychiatry, 54,* 102-300.

Kissil, K., & Niño, A. (2017). Does the Person-of-the-Therapist Training (POTT) promote self-care? Personal gains of MFT trainees following POTT: A retrospective thematic analysis. *Journal of Marital and Family Therapy, 43(3),* 526-536.

Kramen-Kahn, B., & Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. Professional Psychology: Research and Practice, 29(2), 130.

Kumaria, S., Bhola, P., & Orlinsky, D. E. (2018). Influences that count: professional development of psychotherapists and counsellors in India. Asia Pacific *Journal of Counselling and Psychotherapy, 9(1)*, 86-106.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. Psychotherapy: Theory, Research, Practice, Training, 38(4), 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Lavender, T. (2003). Redressing the balance: The place, history and future of reflective practice in clinical training. Clinical Psychology, 27, 11-15.

Lewis, G.J., Greenberg, S.L., & Hatch, D.B. (1988). Peer consultation groups for psychologists in private practice: A national survey. P*rofessional Psychology, 19*, 81-86.

Liu, S., Yang, L., Zhang, C., Xiang, Y. T., Liu, Z., Hu, S., & Zhang, B. (2020). Online mental health services in China during the COVID-19 outbreak. *The Lancet Psychiatry, 7(4)*, e17-e18.

Loughran, J. J. (2002). Effective reflective practice: In search of meaning in learning about teaching. *Journal of Teacher Education, 53(1)*, 33-43.

McBrien, B. (2007). Learning from practice– Reflections on a critical incident. Accident and Emergency Nursing, 15(3), 128-133.

McMullen, K. B. (2001). Experienced counsellors' narratives: Storied reflections of four meaningful lives. Unpublished master's thesis, University of Saskatchewan, Saskatoon, Canada.

Milne, D. (2009). Evidence-based clinical supervision. Principles and practice. Chichester, UK: BPS Blackwell.

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. Training and Education in Professional Psychology, 6(1), 55.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality, 41(1)*, 139-154.

Norcross, J. C., & VandenBos, G. R. (2018). Leaving It at the Office: A Guide to Psychotherapist Self-Care (2nd ed.). New York: The Guilford Press.

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional psychology: Research and practice, 32(4)*, 345.

Orlinsky, D. E., Rønnestad, M. H., & Collaborative Research Network of the Society for Psychotherapy Research. (2005). How psychotherapists develop: A study of therapeutic work and professional growth. American Psychological Association. https://doi.org/10.1037/11157-000

Pakenham, K. I. (2017). Training in acceptance and commitment therapy fosters self-care in clinical psychology trainees. Clinical Psychologist, 21(3), 186-194.

Paterson, C., & Chapman, J. (2013). Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport, 14(3)*, 133-138.

Pines, A., & Aronson, E. (1988). Career burnout: Causes and cures. Free Press.

Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling, 42(1)*, 1-20.

Rosenberg, A. R. (2020). Cultivating Deliberate Resilience During the Coronavirus Disease 2019 Pandemic. JAMA Pediatrics, 174(9), 817–818. https://doi.org/10.1001/jamapediatrics.2020.1436

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practice, 38(1)*, 88–96.

Schon, D. F. (1983). The reflective practitioner. New York: Basic Books.

Skovholt, T. M., & Trotter-Mathison, M. (2011). The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals (2nd ed.). Routledge/Taylor & Francis Group.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counselling for longevity: Self-care and burnout prevention strategies for counsellor resilience. *Journal of Career Development, 27(3)*, 167–176.

Thome, J., Coogan, A. N., Fischer, M., Tucha, O., & Faltraco, F. (2020). Challenges for mental health services during the 2020 COVID-19 outbreak in Germany. *Psychiatry and clinical neurosciences.*

Thompson, N., & Pascal, J. (2011). Reflective practice: an existentialist perspective. *Reflective Practice, 12(1)*, 15-26.

Vostanis, P., & Bell, C. A. (2020). Counselling and psychotherapy post-COVID-19. Counselling and Psychotherapy Research, 20(3), 389-393.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research,* 7(1), 54-65.

Williams, I. D., Richardson, T. A., Moore, D. D., Gambrel, L. E., & Keeling, M. L. (2010). Perspectives on self-care. *Journal of Creativity in Mental Health, 5(3)*, 320-338.

Wityk, T. L. (2003). Burnout and the ethics of self-care for therapists. Alberta Counsellor, 28(1), 4–11.

Wong-Wylie, G. (2007). Barriers and facilitators of reflective practice in counsellor. Canadian Journal of Counselling and Psychotherapy, 41(2).

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. Training and Education in Professional Psychology, 11(4), 283–289.

2 Value-based framework

Values are freely-chosen ideas that can give us purpose and direction in life (Plumb et al., 2009). Unlike goals, values can never be achieved or completed; they act as a compass through which they guide our actions and decisions (Plumb et al., 2009). Our values are shaped by our identities and experiences and in turn shape our practices (Proctor, 2014). There is increasing recognition that it is neither possible nor desirable to be value-neutral in counselling (Proctor, 2014; Rappaport & Seidman, 2000) and instead, mental health professionals must examine and explicitly state their values (Rangarajan & Duggal, 2016; Lazarus et al., 2009). Consciously or unconsciously, these values are reflected in our professional practices. In the context of the COVID-19 pandemic, values can be an important anchor to guide our approach especially as we navigate an unfamiliar landscape of mental health care during crisis.

First and foremost, the values informing mental health professionals' approach to counselling need to be responsive to the socio-economic-cultural context of the pandemic. The pandemic can be understood as a 'multidimensional stressor' as its effects are visible in the educational, occupational, socio-cultural, economic and political spheres of individuals, families, and communities (Gruber et al., 2020). Members of marginalized communities such as migrant workers or those belonging to the Dalit communities were disproportionately impacted by the pandemic (Agormoorthy & Hsu, 2020). For example, individuals belonging to marginalised communities were at a higher risk for contracting COVID-19, as they live in areas with high population densities, rely on public transport for commuting and are employed in informal-economy jobs that cannot easily be moved online (Gruber et al, 2020). Organizations also highlighted human rights violations that occurred in the pandemic, such as indiscriminate punishment for violating the lockdown (Human Rights Watch, 2021). Thus, our approach to psychosocial support in the pandemic can be guided by a framework of values that acknowledges the impact of structural oppression. This involves recognizing that the pandemic was not, as it was initially believed, an 'equalizer'. Certain groups were more impacted by the pandemic than others and we need to advocate for the rights of clients from these groups.

The values guiding mental health work during the pandemic also need to take into account the influence of cultural context on people's ideas and beliefs. For example, in the Indian context, access to healthcare services is inhibited by the lack of availability and the mistrust that people may have towards both public and private hospitals. Additionally, there is belief in alternate forms of medicine such as Ayurveda, Homeopathy and Sidha (Venkata-Subramani & Roman, 2020), with wide-spread support for unproven remedies. As mental health professionals, we can ensure that we respect and are curious about clients' worldviews, however different it may be to ours. This value can guide us to work sensitively with specific cultural nuances that may influence people's ideas and beliefs about help-seeking and treatment in the pandemic.

Another important lens which can inform our values in a disaster context is the acknowledgement of people's strengths. Even in the face of socio-economic and cultural challenges that the pandemic presented, individuals and communities found ways to help themselves and others. For example, women's self-help groups in India sewed more than 19 million masks for frontline personnel in the pandemic and set up over 10,000 community kitchens to feed people across the country (World Bank, 2020). Hence, it is important that we appreciate the strengths, resources and

knowledge that people bring on board and include them as partners in their care, rather than focusing only on deficits or adopting an expert position on what is likely to help (Rashid & McGarth, 2020). Such an approach also reduces the risk of furthering demoralization and stigmatization of marginalized communities as 'helpless' (Rashid & McGarth, 2020).

In the COVID-19 pandemic, physical distancing became the need of the hour but it also brought with it emotional distancing that disrupted relationships, and led to feelings of isolation and loneliness. The relationship between the counsellor and client may become an important consideration in managing this isolation (Carter, 2020). Overall, the counselling relationship has been shown to play an important role in the experience and recovery of individuals following a disaster (Hoffman & Whitmire, 2002; Young 2006). The significance of this relationship is highlighted by Schore and Schore (2008, p. 17) who emphasise, "At the most fundamental level…psychotherapy is not defined by what the therapist does for the patient, or says to the patient.… Rather, the key mechanism is how to be with the patient, especially during affectively stressful moments". Research also indicates that during crisis intervention, focusing on relational processes is more beneficial than merely applying intervention techniques, as it can contribute to increasing emotional safety and feelings of connections with others (Hoffman, 2020).

Drawing from this understanding of mental health in the pandemic, this chapter outlines the core values that could provide a foundation for psychosocial support during the pandemic outlined:

- Social justice informed
- Sensitive to culture and context
- Strengths-based
- Collaborative and empowering
- Rooted in acceptance, curiosity and empathy

1. Social justice informed

"COVID-19 does not discriminate" is a statement that we have heard many times in the pandemic. But does it really not? Let's consider these two stories.

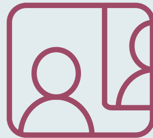
Shrikant is a 65 year old man from the Dalit community working as a waste-picker in Bengaluru. His son died in a car accident 10 years ago. He feeds his family by selling recyclable waste every day and earns around Rs. 200/- per day. When the lockdown was announced, Shrikant had a vague sense of what was happening but did not have the resources to take precautions such as sanitizing his hands, wearing a mask etc. As factories stopped production, he became more and more disheartened as he could not sell the material he found. He had to sustain his family using his meager savings. He was forced to search for other work, but people were reluctant to give him other work as he was not from their caste. Shrikant, hence, took up work in waste disposal in a new COVID-19 center that was set up by the government. After 2 weeks, he developed a fever and was diagnosed with COVID-19. Due to his age and his other health conditions, he had to be admitted to the ICU in a government hospital.

Mohit is a 25 year old upper-caste man working in a MNC in Bengaluru. He earns around Rs. 200000/- per month. His family has ancestral lands in Karnataka and earns off these lands every year. Hence Mohit does not need to contribute any of his salary to his family. When the lockdown was announced, Mohit was already completely aware of what was going on and had ordered 10 bottles of sanitizer and various N95 masks from an online centre. His company announced work for home for all employees for the next six months. Mohit could comfortably manage to

be at home with his family and not interact with anyone else, thus reducing his risk of getting COVID-19. Mohit's costs of travel/ food/entertainment reduced and he began to save more. He also got more time to spend with his family. He said 'The lockdown actually is such a boon! It made us all take a break from our hectic lives!'

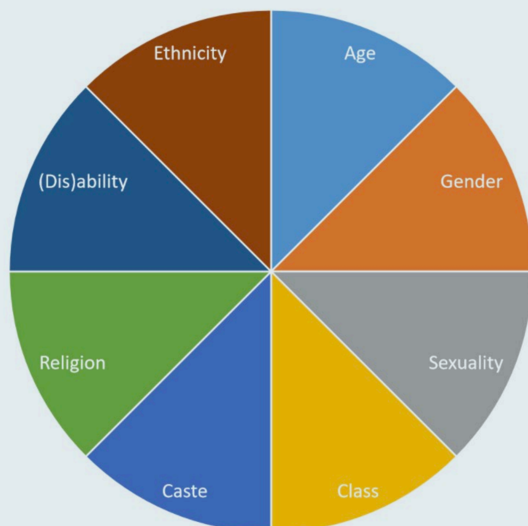
These two vastly differing narratives suggest that COVID-19 does discriminate in an unequal world. A belief in social justice involves recognizing that there are certain groups of people who are more vulnerable to the impact of the pandemic and its circumstances

Before reading onwards, let's take a few minutes to do the reflective exercise below.



Reflective Exercise

Look at the picture below. For each of the dimensions, try and reflect on your identity and the impact that it has on your lived experience.



- Which of your identities may privilege you in society?
- Which of your identities may disadvantage you?

- In the COVID-19 pandemic and the lockdown, how do your identities privilege you and how do they disadvantage you?
  - In terms of access to a doctor and hospital in case you need it?
  - In terms of access to food and water?
  - In terms of access to shelter? In terms of being sure that you'll have continued access to shelter in the months to come?
  - In terms of feeling safe at home? In terms of having an avenue in case you do not feel safe at home?
  - In terms of access to new employment in case you lose work?
  - In terms of being able to take precautions against COVID-19?
  - In terms of how you'll be treated if you get COVID-19?
  - In terms of being able to travel to where you want?
  - In terms of being able to access online classes/work etc?
  - In terms of how you'll be treated if you speak out on social media about an injustice?

According to the National Association for Social Workers (n.d., cited in Morgaine, 2014), social justice is the view that everyone deserves equal economic, political and social rights and opportunities. Key ideas to keep in mind when referring to social justice include:

Using a rights-based approach. This refers to the idea that every single person has a right to certain basic needs such as food, water, shelter, health, freedom of speech etc. This should not be

dependent on who they are, how much they earn, how much they work or any other conditions. In the context of major inequalities that exist in India, research has found that:

- Women are more likely to get lower wages than men for the same job profile (Agrawal, 2014).
- Dalit, Bahujan and Adivasi face atrocities because of their identities (Mamgain, 2014).
- Policy making in India often excludes people who have disabilities (Alur, 2002).
- People from the transgender community face discrimination in healthcare settings such as being forced to stay in 'male' wards, verbal harassment by staff and even denial of medical services (Chakrapani, 2010).

Thus, there is a need to be aware of these inequalities and understand how aspects such as sex, gender, caste, class, sexuality, disability, ethnicity etc shape people's problems. This can translate into sensitivity during counselling by explicitly asking about the dimensions of their identity and not making assumptions about the same. For example, asking a woman who mentions a romantic relationship, *'What does your boyfriend do?'* assumes that she is heterosexual. We can instead ask, *'What does your partner do?'*

Another consideration is that the lack of access to resources or inequality is not the fault of the individual and not their sole responsibility to remedy. Thus, our focus is on validating the injustice and empowering clients to advocate for their rights, rather than supporting them to accept unfair circumstances.

Being aware of personal biases and identities. All of us may have certain subtle biases about certain groups we need to be aware of. For example, around mid-March 2020, large sections of the media were reporting about an outbreak of coronavirus linked to the Tablighi Jamaat, and were also using words such as 'corona jihad' 'terrorists' to falsely insinuate that minority communities were in a large part, responsible for the spread of the coronavirus in India (Bajoria, 2020). If, as counsellors belonging to a different religion, we were to have this subtle belief, we might behave differently in a conversation with a person from a minority community who was diagnosed with COVID-19.

Further, our identities shape our relationship with the client, whether we want them to or not. Sometimes, it is our prerogative to bring up the 'elephant in the room'. This can make a sensed power differential explicit and bring openness to the conversation. For example, if the counsellor identifies as a man and is speaking to a woman about domestic violence, asking, *'How does it feel to speak about this with a man?'* or if the counsellor is speaking to a person from a different religious background about stigma, saying *'I'm aware that I'm not from the same religious background as you, how does it feel to talk about this with me?'* can be useful.

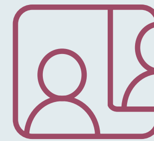
Considering intersectionality. Intersectionality is the recognition that multiple marginalized identities add to each other or 'intersect'. A woman from a minority religion is likely to face more discrimination than a man from a minority religion. A woman from a minority religion who is disabled is likely to face even more! Thus, different marginalized identities intersect with each other and lead to greater levels of exclusion than one marginalized identity. Hence, when speaking to someone with multiple marginalized identities, we can ensure that we are not speaking for them or over them about their experiences. For example, if the counsellor is an upper-caste woman and their client is a Dalit woman, it may not be appropriate to equate their experiences and say, *'Yes, as a woman myself, I totally understand how it must feel for you when you are not allowed to go work!'* She cannot totally understand the Dalit woman's experiences of discrimination, as she does not have the multiple marginalized identities of the client. It is likely that her being a Dalit woman excludes her more as compared to the counsellor's experiences as an upper-caste woman.

2. Sensitivity to context and culture

Culturally and contextually-sensitive psychosocial care involves adapting, instead of merely replicating, the Western models and ideas that are taught during our training. At its core, cultural competence can be thought of as being flexible about how things should be. For example, there exists a thriving and robust respect for complementary and alternative medicine practices in many parts of India. Clients may say, 'I don't want to be admitted to the hospital, I will take homeopathy treatment' or 'I am taking some turmeric and some asafoetida in hot water everyday, so I feel I am more immune to COVID-19. I don't feel I have to take so many precautions because of this'. As counsellors, we can try to respect the client's beliefs, even if we may not agree with the practices.

The examples and metaphors we use can be adapted to our culture and context. Hence, it may not be appropriate to talk about 'buying groceries online' when we are speaking to someone who does not have Internet access or to refer to 'going out for dinner to a restaurant' to someone for whom this might be a rare or non-existent experience. Even something seemingly simple such as 'Is your bed and bedroom comfortable?' when discussing sleep hygiene may be insensitive, if we consider that having a bed and bedroom is not a given for everyone! Similarly, metaphors from Ramayana or Mahabharata may be inappropriate for people who are not practicing Hindus. If the client is a woman, demanding to speak to her when a man picks up the phone might also seem culturally inappropriate, especially if the counsellor identifies as a man. The situation might have to be approached more sensitively, by first introducing oneself to the man, providing detailed information on what is the aim and scope of the call and only then might the counsellor be passed on to the client he wants to speak to.

Sensitivity to culture also involves recognizing that when we say 'culture', we are not just referring to an all-encompassing pan-Indian culture. Rather, we can recognise that there are cultures and subcultures and sub-subcultures and so on. Hence, we cannot assume that everyone is part of the sameculture and we may need to be open to learning and understanding about other cultures.



Reflection Exercise

- Which different cultures and subcultures do you identify as being a part of?
- Consider the specific cultures and subcultures you have identified. In the pandemic, what cultural ideas, beliefs or practices may act as barriers in seeking or responding to counselling for people who are a part of these cultures?
- How could you engage with these ideas, beliefs and practices in a sensitive manner?

3. Strengths-based

Strengths-based practice refers to the idea that there is more to a person than their problems i.e. all individuals have positive assets, strengths and resources in their lives that they can and are drawing upon. This is reflected in White and Epston's (1990) well-known idea that the problem is the problem, the person is not the problem. In the pandemic, too, we have heard various narratives of how people have helped themselves and each other in innovative and inspiring ways.

Hence, when we operate from a value of being strengths-based, we recognize that clients have other dimensions to their lives than the concerns or problems they may be sharing with us. We

also recognize that clients are resourceful and are probably doing all they can already to help themselves. Our role in counselling is thus to identify and build on clients' interests, strengths and resources, rather than suggesting ideas or directions that do not take into account these aspects.

In practice, being strengths-based may reflect in our listening stance. When clients are speaking, it is important that we do not attend to only stories of struggle that clients share but also make an effort to identify and listen for their stories of resilience. For example, when a client mentions having tried various new activities in quarantine to keep themselves from being bored but nothing has worked, before moving on to discuss solutions to the client's problem, we can pause and reflect, *'It sounds like you were really resourceful and tried various different things on your own'* . Sometimes, a strengths-based approach may also involve initiating conversations about client assets and strengths. For example, a simple question such as, *'As part of the session, I like to ask about strengths as well. Can you tell me a story about a success you have had in the past?'* can introduce a useful new dimension into the session.

4. Collaborative and empowering

This value refers to the idea that we and the client exist as equal partners in the counselling relationship. The meaningfulness (or helpfulness) of the relationship arises out of the equal contribution of the client and counsellor and not because the expert counsellor is providing help to a non-expert client. Thus, this value involves a focus on collaboration and empowerment.

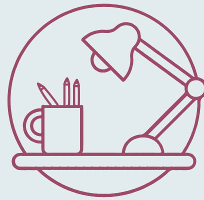
When we are collaborative, we share with clients an equal amount of control and contribution in the session. We take a non-expert stance i.e., we accept that we do not know what is best for clients and we are figuring it out with them, not for them.

Secondly, we support clients to empower themselves. According to Mosedale (2005, pg. 244), empowerment is a process where people start 'making decisions on matters which are important in their lives and being able to carry them out'. Empowerment involves clients becoming aware of power dynamics at work in their life but also developing skills and capacity for exercising reasonable control over their lives (McWhirter, 1991). Another goal of empowerment is to support the empowerment of others in their community. For example, many citizens' initiatives were started in the pandemic.

The table below summarizes what this value might look like:

We are being collaborative when…	We are not being collaborative when…
We give the client an opportunity to speak about what they want to speak about. Although sometimes we may prioritize our needs (conducting a risk assessment), we never exclusively talk about what we want to talk about.	We control the agenda of the session.
We ask the client for feedback and listen to that feedback without being defensive	We believe that we know the right way and the client doesn't

We support clients to make their own decisions	We make decisions for clients
We respect clients' opinions on what may work/what may not	We support the client to use and activate their own resources We consider the client helpless and try to rescue them or fix their problems
What else can you think of?	



Practice Exercise

Sometimes, what we intend to be empowering, may actually end up being disempowering. It is not so easy to distinguish between what may be empowering and what may not be so.
You could reflect on the following situations and think about whether these may be empowering, disempowering or both. It may be helpful to discuss with a colleague to understand that there can be different perspectives on the same situation.

A. When a client reports that they are feeling low since the past few weeks in the lockdown, the counsellor tells them that they have depression which is biological and based in the brain.
B. A counsellor, wanting to be helpful, tells a client who is highly distressed because of testing positive for COVID-19, that it is mandatory to do a follow-up call with the counsellor, because the counsellor believes it will be good for the client.
C. A counsellor, afraid of making a client feel disheartened, does not directly tell the client that they are not eligible for a certain government policy to provide free rations that the client is asking about.
D. A counsellor thinks that a client would benefit from more specialised and intensive therapy, but the client is skeptical. The counsellor gives the client a referral and tells the client, 'You definitely need therapy'.
E. A counsellor, trying to empathize with a client who is complaining about the pandemic says, 'Yes, the situation is horrible. I hear you, there is nothing really that we can do about it, is there?'

5. Rooted in acceptance, curiosity and empathy

The relationship between the counsellor and the client is the cornerstone of counselling. . Carl Rogers was the strongest proponent of the effects of the therapeutic alliance, famously proclaiming empathy, congruence and unconditional positive regard as the primary mechanism for therapeutic change (Rogers, 1957). The importance of the therapeutic alliance has been validated by research as well. Multiple systematic reviews and meta-analyses have found that common factors such as the therapeutic relationship determine a larger percentage of the outcome of therapy than techniques or other therapy-related factors (Lambert & Barley, 2001; Horvath and Symonds, 1991). Poor therapeutic alliance is also a major predictor of premature dropout from therapy (Horvath & Symonds, 1991).

In brief interventions, too, alliance plays a crucial role (Levenson et al., 2002). Competencies such as effective management of time, establishing a collaborative focus on goals, aligning with clients (e.g., in terms of matching their language and affect with the client) and establishing an equitable power balance by giving clients' the lead may be particularly important in brief interventions (Spiers & Wood, 2010). Other components of the therapeutic alliance, such as the importance of establishing an interpersonal bond (mutual liking, trust), remained the same in essence, regardless of brief or long-term intervention (Spiers & Wood, 2010).

When conducting brief telecounselling interventions, our relationship with the client can be built on the core values of acceptance, curiosity and empathy (Hughes, 2007).

Acceptance involves receiving the client's communication with willingness and readiness. It does not translate into agreement with the client; rather it is accepting that what the client is saying is their truth. We can aim to accept all emotions expressed by the clients, their perspectives, opinions and thoughts, and their social identities. At the same time, we may endeavour to accept our own judgements and try to work on these.

For example, we may be unconsciously judgmental about:

Things we may be unconsciously judgmental about

Accepting that we are all fallible to such judgements paves the way for us to consciously prevent it from percolating in our work.

Curiosity is the basis for understanding the client and their subjective experience of the world. Curiosity comes from a respectful stance of not-knowing i.e., we are asking questions to which we do not know the answers. Curiosity is not aimed at obtaining the details of what happened, because we want to know. Curiosity in the counselling process means not assuming or taking for granted what the client is feeling or experiencing, but respectfully exploring it together with the client.

Empathy can be simply defined as 'the ability to understand and share in another's emotional state or context' (Cohen & Strayer, 1996, p. 988). Empathy involves putting ourselves in the position of the client and experiencing what they are experiencing from their frame of reference. Empathy requires genuineness (Hughes, 2007). Clients can tell if we are just going through the motions or verbally using the right words. To empathize with someone, we need to actually empathize with them. Secondly, empathy is a shared experience (Hughes, 2007; Wiseman, 1996). It is not something we feel towards the client but keep to ourselves and reveal nothing of our feelings. It is something we feel with the client and which they experience as being valuable. Over phone, we can convey empathy through words, sounds, tone of voice and also silences.

Reflective Exercise

(Adapted from Hughes, 2007)

Imagine that the following statements were made to you by a client: *'I don't want to talk about it*

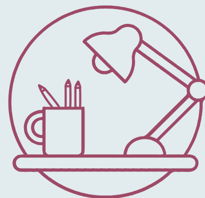
'You are not able to help me'. 'You don't even care what happens to me!''

'What can you do for me? Nothing'

- How might you respond? If you challenge the statement, what might happen? If you don't, would that mean you are accepting that you are incompetent?
- When we accept such a statement, we are accepting that this is the client's subjective experience at this moment. We are not necessarily agreeing that it is our reality or the reality or anyone else's reality. Consider one way in which we can proceed:

Client: This is a waste of time
Counsellor: (taken aback, because they felt they were being helpful) Thanks for sharing that with me, it must be difficult to feel that way
Client: Obviously
Counsellor: Sounds like you feel you are spending so much time talking to me and it's not helping
Client: Yes
Counsellor: That must be very frustrating for you.
Client. It is! Nothing can help.
Counsellor: It's not just me, you feel that nothing can help you

- How does the counsellor accept the client's feelings in the vignette above?
- What does this acceptance facilitate?



Practice Exercise

Do you think that empathy is a skill that can be developed? How does one develop empathy?

Experiences of feeling hurt, anxious, abandoned, uncertain etc are ultimately universal human experiences. It is these very emotions that connect us. One way to practice empathy is to try to connect to something in yourself that knows that feeling the other person is describing. It involves asking yourself the question 'When did I feel like this?' and 'How does it feel to feel like this?'

You could try to do this now using the excerpt below:

I was diagnosed with COVID-19 3 days ago and was asked to quarantine for 15 days. I live alone and had to grapple with the arranging for basic necessities like groceries. As I finished with this arrangement, I thought I would finally be able to rest. And now, I got a call from my mother saying that I have lost my grandmother. Due to the quarantine rules, I will not be able to attend any rituals or last rites.

- How do you think the person who wrote this is feeling?
- Has there been a time in your life that you have felt like this? How has that felt for you?

This chapter described the need for value-informed practice in the pandemic. It discussed the key values that inform the psychosocial support strategies that are described further in the manual. The next chapter describes the ethical perspectives that will guide counselling in the pandemic.

References

Agoramoorthy, G., & Hsu, M. J. (2020). How the Coronavirus Lockdown Impacts the Impoverished in India. *Journal of racial and ethnic health disparities, 1-6.*

Agrawal, T. (2014). Gender and caste-based wage discrimination in India: some recent evidence. *Journal for Labour Market Research, 47,* 329–340. https://doi.org/10.1007/s12651-013-0152-z

Alur, M. (2002). "They did not figure": Policy exclusion of disabled people in India. International *Journal of Inclusive Education, 6,* 101-112.

Bajoria, J. (2020, May 1). CoronaJihad is Only the Latest Manifestation: Islamophobia in India has Been Years in the Making. *Human Rights Watch.* https://www.hrw.org/news/2020/05/01/coronajihad-only-latest-manifestation-islamophobia-india-has-been-years-making

Carter J. A. (2020, May 22). Providing relationship-oriented psychotherapy during COVID-19. APA https://www.apaservices.org/practice/news/relationship-psychotherapy-covid-19

Chakrapani, V. (2010). H*ijras/transgender women in India: HIV, Human Rights and Social Exclusion* (Issue Brief). India: United Nations Development Programme.

Cohen, D., & Strayer, J. (1996). Empathy in conduct-disordered and comparison youth. *Developmental Psychology,* 32, 988–998. https://doi.org/10.1037/0012–1649.32.6.988

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

Halpern, J., & Vermeulen, K. (2017). *Disaster Mental Health Interventions: Core Principles and Practices.* New York, Oxon: Routledge.

Hoffman L. (2021). Existential–Humanistic Therapy and Disaster Response: Lessons From the COVID-19 Pandemic. *Journal of Humanistic Psychology 61 (1)*, 33-54.

Hoffman, L., & Whitmire, A. J. (2002, June). *The relationship between approach to coping and stress-related growth in response to the events of September 11, 2001*. Poster session presented at the American Psychological Society's Annual Conference

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38(2), 139–149. https://doi.org/10.1037/0022-0167.38.2.139

Hughes, D. A. (2007). *Attachment-focused family therapy.* New York: W W Norton & Company.

Human Rights Watch. (2021). *India: Events of 2020 [World Report 2021].* https://www.hrw.org/world-report/2021/country-chapters/india

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2009). *Intentional Interviewing and Counseling: Facilitating Client Development in a Multicultural Society* (2nd edition). Belmont, CA: Cengage Learning.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38(4)*, 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Lazarus, S., Baptiste, D., & Seedat, M. (2009). Community Counselling: Values and Practices. *Journal of Psychology in Africa, 19(3),* 449–454. https://doi.org/10.1080/14330237.2009.10820314

Levenson, H., Butler, S. F., Powers, T. A., &

Beitman, B. D. (2002). *Concise guide to brief dynamic and interpersonal therapy.* Washington, DC: American Psychiatric Publishing.

Maddrell, A. (2020). Bereavement, grief, and consolation: Emotional-affective geographies of loss during COVID-19. *Dialogues in Human Geography, 10(2)*, 107-111.

Mamgain, R. P. (2014). Social exclusion, discrimination and atrocities on scheduled castes in India: The worrying spots and future challenges. *Journal of Economic & Social Development, X(1),* 17-30.

McWhirter, E. H. (1991), Empowerment in Counseling. J*ournal of Counseling & Development, 69,* 222-227.
https://doi.org/10.1002/j.1556-6676.1991.tb01491.x

Morgaine, K. (2014). Conceptualizing Social Justice in Social Work: Are Social Workers "Too Bogged Down in the Trees?" *Journal of Social Justice, 4,* 1-18.

Mosedale, S. (2005). Policy Arena. Assessing Women's Empowerment: Towards a Conceptual Framework. J*ournal of International Development, 17,* 243–57.

Plumb, J. C., Stewart, I., Dahl, J. A., & Lundgren, T. (2009). In search of meaning: Values in modern clinical behavior analysis. *Behavior Analyst, 32*(1), 85–103.
https://doi.org/10.1007/BF03392177

Proctor, G. (2014). *Values and Ethics in Counselling and Psychotherapy.* London: Sage Publications.

Rangarajan, R., & Duggal, C. (2016). Exploring values of therapists in India. In S. Sriram (Ed.), *Counselling in India: Reflections on the process* (p. 91–112). Springer Science + Business Media. https://doi.org/10.1007/978-981-10-0584-8_6

Rappaport, J., & Seidman, E. (2000). *Handbook of community psychology.* New York: Kluwer Academic/Plenum.

Rashid, T., & McGrath, R. (2020). Strengths-based actions to enhance wellbeing in the time of COVID-19. I*nternational Journal of Wellbeing, 10(4)* 113-132.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting andClinical Psychology, 22,* 95-103.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical social work journal, 36(1),* 9-20.

Spiers, J. A., & Wood, A. (2010). Building a therapeutic alliance in brief therapy: The experience of community mental health nurses. Archives of Psychiatric Nursing, 24(6), 373–386. https://doi.org/10.1016/j.apnu.2010.03.001

Venkata-Subramani, M., & Roman, J. (2020). The Coronavirus Response in India–World's Largest Lockdown. *The American journal of the medical sciences, 360(6)*, 742-748.

Vostanis, P., & Bell, C. A. (2020). Counselling and psychotherapy post-COVID-19. *Counselling and Psychotherapy Research, 20(3)*, 389-393.

White, M., & Epston, D. (1990). Narrative Means to Therapeutic Ends. New York, London: W. W. Norton & Company. Wiseman T. (1996). A concept analysis of empathy. *Journal of advanced nursing, 23(6)*, 1162–1167. https://doi.org/10.1046/j.1365-2648.1996.12213.x

World Bank. (2020, April 11). In India, women's self-help groups combat the COVID-19 (Coronavirus) pandemic.
https://www.worldbank.org/en/news/

feature/2020/04/11/women-self-help-groups-combat-covid19-coronavirus-pandemic-india

Young, B. H. (2006). The immediate response to disaster: Guidelines for adult psychological first aid. In E. C. Ritchie, P. J. Watson, & M. J. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practitioners*

3 Ethical perspectives

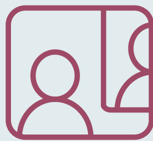
Ethics refer to well-founded standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues (Velasquez et al., 2015). Ethics help in determining the choices that the mental health professional makes in order to recognise the client's rights and uphold the professional quality of the work. The COVID-19 pandemic with its rapid spread of infection and preventive measures such as social distancing changed the way mental health practitioners worked. Many of them had to quickly transition to providing remote services or emergency services, although they were trained in face-to-face modalities. As a result, many of them faced new ethical challenges and ethical dilemmas (Maldonado-Castellanos, 2020). Ethical dilemmas may be understood as "problems for which no choice seems completely satisfactory, since there are good, but contradictory reasons to take conflicting and incompatible courses of action" (Kitchener, 2000; p 2.).

Certain unique areas where counsellors experienced ethical challenges and ethical dilemmas when providing telepsychiatry/psychotherapy during the pandemic include (APA, 2020; Stoll et al., 2020):

- **Data security, privacy, and confidentiality:** Freely available software may be less secure. For example, the counsellor may be using a particular platform for their sessions without realising that other clients may be able to join in the session. The counsellor may face an ethical dilemma between using accessible, freely available software and using expensive, but more secure software.
- **Competency and preparedness for practitioners:** Providing remote services requires particular competencies and special knowledge, which, ideally, practitioners should be trained for to assure appropriate standards of clinical care. For example, the organization where the counsellor works suddenly asks them to work from home and conduct online sessions. But the counsellor may not understand the platforms that they are being asked to use. On the one hand, they may want to take some time to learn to use it properly. On the other hand, the organization expects them to start working and catering to clients as soon as possible.
- **Social justice concerns:** Fair access to telepsychotherapy services such as online access, video/audio connectivity, and broadband capability, a safe and private setting to have a session and importantly, access to mental health providers may not be easily available to all. Counsellors may face ethical dilemmas about how much time they are able to devote to each client and whether the choice of phone-based or video-based sessions for a particular client is fair.
- **Clinical safety of clients:** Practitioners need to ensure that telecounselling is appropriate for the client's concern. For example, the counsellor may face an ethical dilemma about whether they should have a session with a client who is at high risk of harm to themselves, with on one hand, telecounselling not being adequate for the client's concerns and on the other hand, it not being possible to have a face-to-face session.
- **Informed consent for services:** There is a lack of agreed ethical norms about obtaining digital informed consent which may cast doubt about its validity among practitioners (Wykes, et al., 2019). For example, a teenager may request the counsellor to have a telephonic session which they may not want their parents to know about. The dilemma may be whether the counsellor should take consent from the parents or not.

- **Confidentiality:** With family members spending more time at home, it can be difficult to maintain the confidential space which is key to the therapeutic relationship. The counsellor may face a dilemma between ensuring the client's right to privacy versus accepting some limitations to absolute privacy when all members of a family may be at home.
- **Maintaining boundaries:** With the boundaries between personal and professional settings blurring, keeping these separate might be difficult. For example, the counsellor may realise that their cousin may be diagnosed with COVID-19 and is having difficulties in sleep. The dilemma may be whether they should intervene and suggest a strategy or not.
- **Adequate self-care** is extremely important as well, considering that we are affected by the pandemic as well. The counsellor may face an ethical dilemma between devoting additional time to pro-bono volunteering for helplines of their organization versus saying no and taking personal time for themselves.

Ethical guidelines are one of the ways in which we will be able to know the actions that may be most helpful to the clients. A thorough knowledge of ethics is thus, an important component of practising as per the standards of the profession.



Reflective Exercise

- Were you practising remote counselling before the pandemic?
- If yes, then how did this pandemic change the way you practised?
- If no, did you have any apprehensions about working telephonically?
- What were some of the difficulties that you experienced during this process?

Ethical Guidelines for telecounseling during the COVID-19

Ethical guidelines provide a framework of principles and standards that mental health professionals can aspire to fulfill and enforce when making decisions regarding their services (APA, 2010). The benefits of adhering to ethical guidelines include ensuring the client's physical safety as well as psychological safety, upholding the quality of care provided and maintaining the profession's reputation.

There are certain common ethical principles across different ethical codes and guidelines.

Autonomy : Having respect for a clients self- determination that is, understanding that the clients are the expert on their lives and

Non Malefiecnce : Taking active steps to minimize or avoid exploitation of ,and harm to our clients.

Beneficene: Doing good being helpful and providing benefit to others in our professional

Justice : Providing all individuals equal and fair access to treatment regardless of their caste, class, gender, socio- economic status

Fidelity: Meeting our obligations to others based on our professional roles and priortizing their concerns.

In India, ethical guidelines for mental health professionals have been released by various organizations such as the National Academy Of Psychologists, Indian Association of Clinical Psychologists and Rehabilitation Council of India. The Mental Health Care Act (2017), too, refers to ethical principles and ethical guidelines in the field.

In the COVID-19 pandemic, mental health professionals faced challenges such as shifting to telecounselling, facing network and connectivity related issues, obtaining informed consent, and maintaining boundaries between personal and professional lives while working from home. While acknowledging these difficulties, the Indian Council of Medical Research and Department of Clinical Psychology, NIMHANS released certain ethical guidelines to keep in mind while conducting telecounselling. Some key points mentioned in these guidelines include are:

- Before starting sessions, counsellors will benefit from familiarizing themselves with the software itself, and other logistics involved in delivering remote services. This involves knowing how to troubleshoot software and hardware and network-related problems that may arise. Ensuring that the data is not being shared by either party by disabling the recording option for the duration of the session may be helpful.
- We will have to discuss in advance the procedure for rescheduling the appointments which have been affected by technical and connectivity-related difficulties. In case, there are technical difficulties in the session, the session should be terminated and a new appointment must be given.
- Adequate time must be allotted to the procedure for informed consent to allow the clients to make a careful decision about tele-counselling. The advantages (such as limiting potential exposure to the COVID -19 for both therapist and client, the convenience of staying home to name a few) and disadvantages (for example, possibility of a session being hacked or overheard on either end) will have to be clearly listed.
- We can encourage clients to find a private, quiet, soundproof place to talk and make alternate arrangements for childcare. We can also ensure that other applications and notifications are silenced.
- It is important to maintain professionalism, including dressing for work, sticking with regular start and stop times and It would also involve keeping the background devoid of any personal artifacts. For video-conferencing, care needs to be taken that both the therapist and the client are clearly visible.

These can be accessed at the following links for further information:

- http://nimhans.ac.in/wp-content/uploads/2020/04/Guidelines-for-Telepsychotherapy-Services-17.4.2020.pdf

- Guidance Document for Psychosocial Counselling for Health care providers and their family members during COVID-19 (ICMR, 2020). https://www.researchgate.net/publication/343281681_Guidance_Document_for_Psychosocial_Counselling_for_COVID_Positive_Patients_and_Their_Family_Members_during_COVID-19_

Ethical decision making

Ethical codes are not set in stone; rather they are principles that guide practice. Each therapeutic situation is unique and sometimes the counsellor must interpret the ethical codes described above to see if these match the needs of the concerned situation. Ethical decision making is the practical process through which counsellors base their actions and choices on informed, sound judgement. This process draws on values, principles and standards of behaviour that inform professional practice (Cottone & Claus, 2000).

The figure below shows an ethical decision-making model developed by Dr. Lynne Gabriel for British Association of Counselling and Psychotherapy (BACP).

BACP (2017) Decision making for ethical practice: a 12-step decision making model. BACP: Lutterworth.

Questions for consideration

Stop, think, identify the situation or problem

- Why do I think there's a potential problem here?
- What is it that concerns me about this?
- How did I become aware that there might be a problem?
- Am I being affected by others thoughts, events or situations?
- Do I need to respond urgently or can I give myself time?

Construct a description of the situation

- Who is this mainly about?
- Is anyone else involved?
- What has happened?
- What are the key facts in the case?

Consider whose ethical issues or challenge it is

- Mine?
- My supervisor's or supervisee's?
- The client's?
- The counselling organisation's?
- Someone else in the client's life?
- Who holds the greatest responsibility?

Review the situation in terms of the BACP *Ethical Framework for the Counselling Professions*

- Is my supervisor available to discuss this, using the BACP *Ethical Framework*?
- Where's my copy of the *Ethical Framework*? Download a copy from www.bacp.co.uk.
- Is my client aware of the *Ethical Framework*?
- Does the client have a copy of 'Our commitment to clients'? Download a copy from www.bacp.co.uk.
- Is there relevant guidance in the good practice section of the *Ethical Framework*?

Consider principles and values of relevance to the issue

- Which ethical principles and values are being called into question?
- Are they in conflict and do they need to be weighed up against one another, for example, autonomy versus beneficence?
- Does one override the others in these circumstances?

Reflect upon the relational processes that have played out in the situation

- How would you describe the relationship between counsellor and client, counsellor and supervisor, client and others?
- How have those relationships been affected by this situation?
- Can you detect a parallel process in operation?
- Is a relationship at risk of breakdown, depending on the action taken?

Identify what support is available

- Who needs supporting? The client, the counsellor or others in the client's life?
- Where can support be obtained? For example, from a supervisor, line manager, colleagues, GP, friends or others in the client's life
- What resources could help me? For example, legal advice from my insurance company, *Good Practice in Action* resources or the Ethics hub on the BACP website.
- Is a consultation required with a GP, medical or psychiatric consultant?
- Is there an organisational policy or procedure to follow?

Identify an ethical goal

- What am I trying to achieve, as far as ethical practice is concerned?
- What would be a satisfactory outcome for all concerned?
- What would achieve the most good and the least harm?

BACP (2017) Decision making for ethical practice: a 12-step decision making model. BACP: Lutterworth.

Some other questions that may be helpful when we are engaging in the process of ethical decision-making include:

Motivation	• Whose need is this action serving? • If I engage in this action will it be in my client's best interest?
Justice	• Would I take the same course of action with another client in a similar context? • Would my decision be different if the client was famous, or a public figure, or influential in some way?
Publicity	• Would I want my behavior reported in the press? • Could I defend the course of action to a wider professional or public audience?
Universality	• Would I recommend the same course of action to another counsellor in the same situation?

Ethical Decision-Making in Action

While speaking to a person diagnosed with COVID-19, they disclose their identity and we recognize them as a celebrity. They are extremely grateful and impressed by our work and request that they would like to meet us to understand more about our work and leave a gift for us as a token of their appreciation.

Let us understand the process of ethical decision-making using this example. The first question to ask ourselves is 'what is the dilemma here?'. One concern is whether we should reveal identifying information about ourselves to this client. It might feel good to know that a celebrity knows us personally after we have helped them. However, professional protocols mandate that the counsellor should not meet the clients outside the work set-up. Another dilemma would be to ask if we should take the gift. If we say 'no', the client might feel offended and feel that we don't care about their feelings. But the ethical principles clearly state that we must not accept gifts from the clients.

The second question would be the values that are involved in this process. One personal value could be recognition. It feels good to be recognised for our good work and appreciated for the same. The celebrity's endorsement may be a boost for our career. If we work as private practitioners, they may potentially come back as a client. Similarly, the gift could be a symbol of prestige and appreciation. Both the gift and their endorsement of the quality of work would have positive effects on our career and self-esteem. Secondly, it is possible that we might find it difficult to say no to the client. The client might feel hurt or rejected about us saying no.

This might make us feel uncomfortable.

The next question would be what ethical principles are relevant to the dilemma. The ethical principle in conflict is boundaries. There is a possibility of a dual relationship which extends beyond the client-counsellor relationship. The gift is also a symbol of such a relationship because counsellors do not accept gifts.

The last question is the course of action to be taken by the counsellor. Some questions that we need to ask ourselves could be

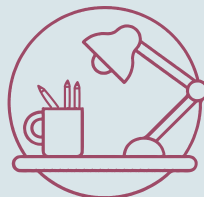
Whose need is being served here? The answer is likely to be our own.

- Will accepting the invitation and the gift be in the client's best interest? It is unlikely that this will benefit the client. The client may feel indebted. This might make the relationship more unequal and highlight the power imbalance.
- Would we accept the invitation or the gift from another client in a similar context? It is unlikely that we will meet other clients outside of the professional set-up or accept gifts from everyone that we have worked with.
- Would the decision be different if the client was not famous? This is an important question because we need to rule out the possibility that we are using the fame and celebrity status of our client for furthering our gains.
- It is possible that this may advance our career but what could be the disadvantages? Would it give a message to our future clients that they also need to give us gifts? How will this change our perception in their eyes?
- Could we defend this meeting and gift to a wider professional or public audience? It is possible that other counsellors may not be happy about this course of action. It is possible that the agency for which we work may have strict policies against such meetings or gifts. What would you say to them?
- Would we recommend meeting clients and accepting gifts to other counsellors in the same situation? If yes, what could be the reasons? If no, what would make us say no to them?.

Answering some of these questions would help us in taking our decision. We could also clarify the agency rules, read ethical guidelines and consult with our supervisor/ a senior colleague to understand their stance on our situation.

This was one illustrated example which helped us to understand how the decision-making process can be carried out. The aim of ethics training is to go beyond a set of rules telling us 'what to do (or not)' and instead inculcate the process of 'how to think', using ethical decision-making models.

This chapter discussed the ethics of working in the sphere of mental health during the COVID-19 pandemic and the unique challenges it presented. We also discussed the models of ethical decision-making when facing an ethical dilemma.



Practice Exercise

You can use the examples below to work through ethical dilemmas for yourself.

- A middle-aged man diagnosed positive for COVID-19 who has been working as a school teacher shares with us that he is feeling highly anxious as he has lost his job. He has a family to support and a spouse with chronic illness and the terms of his termination from school were extremely unjust. While he was expressing his anger, he suddenly stopped and remembered the name of the organization that we are calling from. He said, "The organization you are calling from is the one of stakeholders of the school. Now that you understand my position could you put in a good word with them about me?" What will you do?
- Ms. Maneeta is a 45 years old female who has tested positive for COVID-19 and is currently self-isolating. She is very worried about how her neighbours will treat her now that she is positive. She tells you that she has not told anyone about it for the same reason. As you speak with her, you realize that she stays in the same building as your cousin. You feel tempted to warn your cousin that she has tested positive. What do you do?

This chapter has described the relevant ethical perspectives that telecounselling during the times of COVID-19 presented. It also discussed what can be the unique challenges that may emerge and how to make decisions ethically. The next chapter will describe the key skills which help in providing telecounselling.

References

Callahan, J. L. (2020). Introduction to the special issue on telepsychotherapy in the age of COVID-19. *Journal of Psychotherapy Integration*, 30(2), 155.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78(3)*, 275-283.

Department of Clinical Psychology; NIMHANS . 2020. Guidelines for Tele-Psychotherapy Services. https://nimhans.ac.in/wp-content/uploads/2020/04/Guidelines-for-Telepsychotherapy-Services-17.4.2020.pdf

Janardhana, N., Muralidharan, K., Gangadhar B.N. & Bharath, S. (2020). Psychosocial Counselling for Health care providers and their family members during COVID-19.

Kitchener, K. S. (2000). *Foundations of ethical practice, research, and teaching in psychology.* Lawrence Erlbaum Associates Publishers.

Maldonado-Castellanos, I. (2020). Ethical issues when planning mental health services after the COVID-19 outbreak. *Asian Journal of Psychiatry, 54*, 102285.

National Disaster Management Guidelines: Psycho-Social Support and Mental Health Services in Disasters, 2009. A publication of the National Disaster Management Authority, Government of India. ISBN 978-93-80440-00-2, December 2009, New Delhi.

Stoll, J., Müller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers in psychiatry, 10,* 993.

Tandon, R. (2020). COVID-19 and mental health: preserving humanity, maintaining sanity, and promoting health. *Asian journal of psychiatry.*

Velasquez, M., Andre, C., Shanks, T., & Meyer, M. J. (2015). Thinking ethically. *Issues in Ethics,(August), 2-5.*

Wykes, T., Lipshitz, J., & Schueller, S. M. (2019). Towards the design of ethical standards related to digital mental health and all its applications. *Current Treatment Options in Psychiatry, 6(3),* 232-242.

4 Telecounselling skills

During the pandemic, restrictions on physical contact have meant that psychosocial support usually needs to take place remotely either on the phone or via online platforms (IFRC Reference Centre for Psychosocial Support, 2020). Therapy delivered through telephone is the only method of access to mental health services for those who do not have a high-speed Internet connection (Rosen et al., 2020). Hence, telecounselling can be seen as an opportunity to provide access to counselling services for people who may not have the means to seek counselling otherwise. In a systematic review, telemental health care has been shown to be an effective and adaptable alternative to conventional mental health care (Langarizadeh et al., 2017).

Essentially, skills in telecounselling can be seen as an adaptation of the skills required for face-to-face counselling by mental health professionals (Ormond et al., 2000). The relationship between the counsellor and the client is the primary mechanism of change in counselling (Rogers, 1957; Lambert & Barley, 2001) and microskills are the foundational skills that help us build this relationship, by facilitating attunement with the client (Ivey, Ivey & Zalaquett, 2009). Attunement to the therapeutic relationship and use of microskills may require more effort in telecounselling, with non-verbal markers being more difficult to attend to (Inchausti et al., 2020). Due to the absence of visual cues, there may be an increased focus on verbal and vocal cues, with counsellors needing to be cautious about the phrases and words that they may be using (Ormond et al., 2000). Establishing a therapeutic presence (a 'telepresence') may also be more challenging, as the therapist may not be able to receive real-time feedback about their reactions (Rosen et al., 2020). Other considerations such as when and where to make the phone call, how to seek the client's consent for the call and how to appropriately document the call are also important (Ormond et al., 2000).

Taking into account these considerations, this chapter will focus on the skills and competencies the counsellor can use to build and sustain a helpful therapeutic relationship with the client in a brief, telecounselling context.

1. Before the session.

We can keep some of these considerations in mind when we are preparing to start the session:

- Reviewing the ethical guidelines for telecounseling in the Indian context as suggested in Chapter 3 (Section 2). These can give us an idea about practical guidelines that will help us in navigating this new sphere of telecounselling.
- Ensuring privacy and minimum distractions in the work from home set-up. If limited by space concerns and unable to find a solitary space for our work, we can consider using ear-phones or head-phones so that conversations with the client cannot be heard by others around us.
- Doing a self check-in ('How am I doing? What am I feeling?').
- Minimising technical difficulties such as sitting in a good network or connectivity area, having power back-ups and internet back-ups.
- Carrying out tasks or rituals to orient ourselves before starting sessions (e.g., breathing deeply for 2 minutes, changing into professional clothes)
- Remembering to have a notebook, pen and other resources (e.g., database of referrals) as needed for ensuring appropriate documentation.

2. Starting the session.

We can start the call by introducing ourselves

and the purpose of the call. When explaining the purpose, it is useful to mention, *'You can talk as much or as little as you want to, there is no pressure to talk'*. *After this, we need to obtain consent, 'Do I have your permission to continue this call?'* This is especially important in reverse helplines when counsellors are the ones initiating calls with clients. Checking comfort is also useful, *'Is this a comfortable time to talk? Are you in a comfortable space right now to talk?' In telephonic sessions, doing a voice check is helpful, 'Are you able to hear me clearly?'*

At the start of the call, it is important to get any information we need to record as per our organizational guidelines. Different organizations may have different protocols based on the services that they are providing. For example, if the client is calling the helpline, it may be important to spend some time on collecting the demographic details for our own records. We can ask permission for the same, *'In this helpline, we record where clients are calling from. Is it ok if I ask you where are you calling from?'* It is important to clarify any concerns the clients may have about sharing this information. However, if the helpline is a reverse helpline, then we may already have certain demographic details. In this situation, we may not ask the clients about the same.

It may also be useful to decide with the client what will be done if the call gets disconnected ('Before we start talking, I wanted to check - can I call you back if the call gets disconnected?'). We may need to note down a call back number if it is not available automatically.

3. Throughout the session.

Microskills form the nuts and bolts of counselling. Microskills involve the specific actions or responses that the counsellor uses in a session. In telephonic counselling, we do not have body language, gestures or facial expressions to convey our understanding and warmth. Tone of voice, intonation, volume and emphasis on words are the non-verbal avenues available to use.

Key considerations when working without non-verbal cues

- Use a gentle, calm tone of voice.
- Speak slowly and clearly.
- Speak only a little at a time. If we speak 6-7 sentences at one time and the client has lost track in the middle, we will not understand as there will be no visual cues to show us that they are lost or confused.
- Pause enough to allow the client to respond.
- Conduct frequent checks for understanding through paraphrases and summaries as well as explicitly asking *'Does that make sense?' 'Have I understood correctly?'*
- Respect any verbal or non-verbal indication that the client does not want to talk and ask permission again to continue the call if we sense that the client is feeling pressurized/anxious/wants to stop.

Keeping this difference between in-person counselling and telecounselling in mind, the microskills we will be using in our sessions are described below. The microskills are adapted from Ivey, Ivey and Zalaquett's (2009) microskills hierarchy.

Listening: Listening is one of the key skills used by counsellors. It involves being fully present in the moment. Listening to reply or thinking of the next question we are going to ask, may lead to us missing out on the nuances of what the client is trying to convey to us. We may not be able to understand the client's experience completely. Being present in the moment does not mean that our minds do not wander; rather it means that when it does, we gently bring it back and focus on the client's words again. If it is happening too often, it may be an indication for us to check in with ourselves and consider the need for self-care or supervision. We

have to be careful to not interrupt. Providing space for the client to finish speaking is important. Instead of interrupting, we can wait for a natural pause in the conversation which we can then use to make a response. Face-to-face interactions allow us to convey that we are listening by making eye-contact or nodding or through our facial expressions. This is not possible through the phone. We may have to convey that we are listening by saying 'Hmmm' 'uh-huh' 'I see' and so on.

Reflective Exercise

You are not listening to me when...

You do not care about me;
You say you understand before you know me well
enough;
You have an answer for my problem before I have finished telling you what my problem is;
You cut me off before I have finished speaking;
You are dying to tell me something or want to correct me;
You feel critical of my grammar, accent, culture, or way of doing and saying things;
You are communicating to someone else in the room;
You are trying to sort out the details and are not aware of the feelings behind the words;
You sense my problem is embarrassing and you are avoiding it;
You need to feel successful;
You tell me about your experience which makes mine seem unimportant;
You refuse my thanks by saying you haven't done anything.

You are listening to me when....

When you come quietly into my private world and let me be;
You really try to understand me when I do not make sense;
You grasp my point of view when it goes against your sincere conviction;
You realize the hour I took from you has left you feeling a bit tired and drained;
You didn't tell me the funny story you were just bursting to tell me;
You allowed me the dignity of making my own decisions even though you felt I was wrong;
You didn't take my problem from me but trusted me to deal with it in my own way;
You gave me enough room to discover for myself why I felt upset and enough time to think for myself what was best;
You held back the desire to give me good advice;
You accepted my gift of gratitude by telling me it was good to know I had been helped.

- What resonated with you from the above poem?
- What underlying values do you think the poet is referring to?
- Would you want to intervene if someone is making a decision that you feel is absolutely wrong? Why/why not? Might it depend on what is the kind of decision?
- In the poem, the poet doesn't want to be given advice. What can be unhelpful about advice? Are there situations in which advice can be helpful?

Open and Closed Questions. Open-ended questions are questions that start using 'what', 'how', 'could', 'can' and 'would'. These questions allow the client the freedom to lead the conversation in the direction they consider important and invite them to give more details. For example, we can ask, *'How did you feel at that time?' 'What are some of the challenges you are facing?'* 'Could', 'can' or 'would' questions have an added advantage of giving the client the option of not responding. If we want to go into the specifics of a situation, we may ask *'Could you give me an example?'* A 'Why' question is often associated with being questioned or interrogated and hence we may want to avoid it. A more open question might be *'What makes that important for you?'*

Closed-ended questions are questions that generally have limited possibilities for answers such as yes or no. For example, asking *'Did you feel angry when he said that?' or 'What is your name?'* are examples of closed-ended questions. Questions are important but let's try to ensure that every statement we make is not a question. The client may feel interrogated. This is especially important in the context of telecounselling where the client may not have access to our non-verbal cues to understand our genuine curiosity. Instead, it will be the tone of our questions that will ensure that clients feel our interest in their stories; and not a compulsion to answer them. Reflections and summaries are also important and useful ways of moving the conversation forward.

Reflection of content and feeling. A reflection, as the word suggests, is when we mirror the client's emotions or content back to them. A reflection can consist of a reflection of content (also called a paraphrase), a reflection of feelings or often, a reflection of both feeling and content. A reflection of content is useful when we want to understand a situation further and/or help the client feel understood. It generally involves using different words than the client to convey the key essence in what the client has said. A reflection of feeling is a powerful statement that can shift the conversation to the client's emotional experience and deepen the conversation.

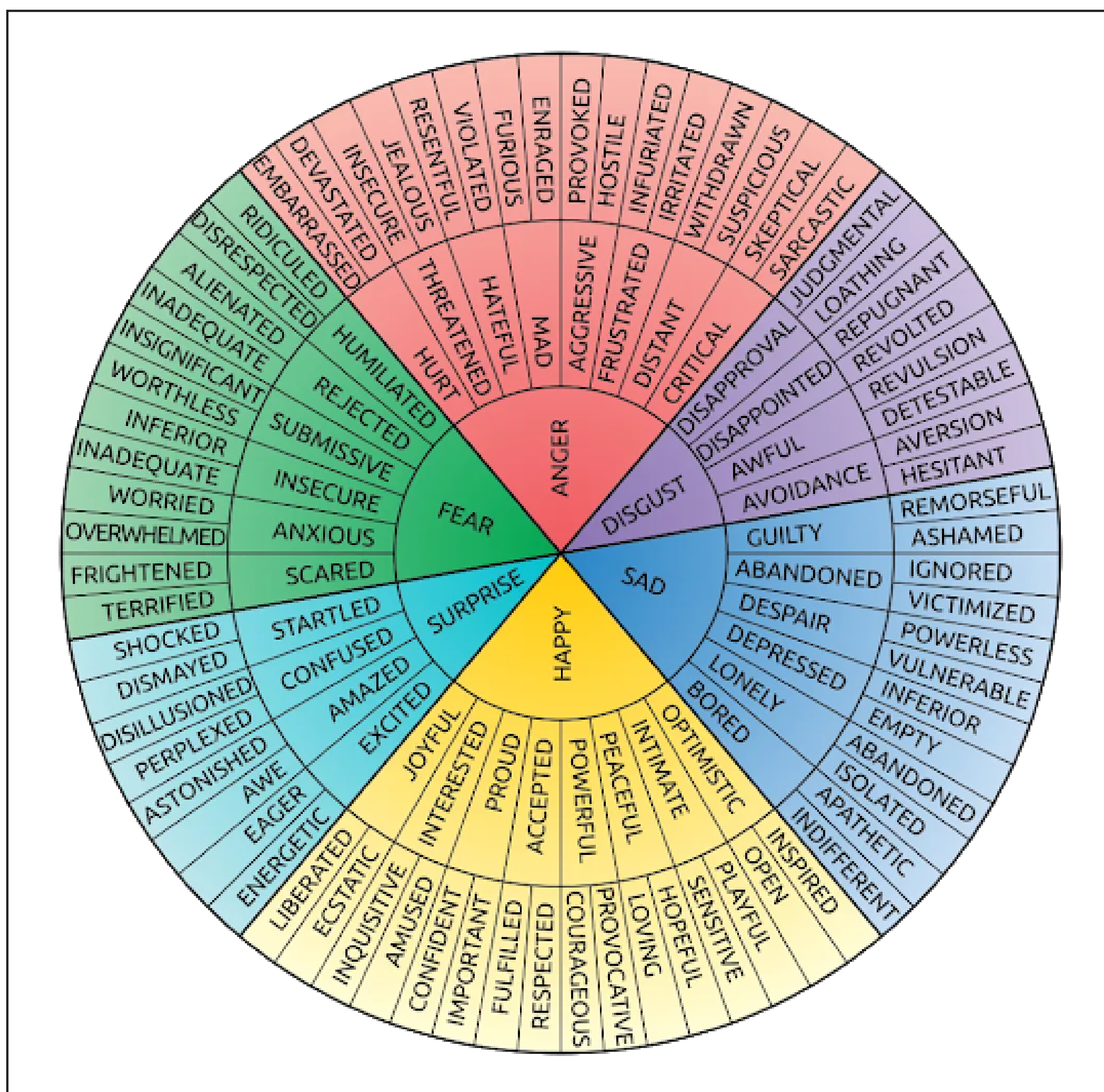
Client: The doctors told me they were coming with my COVID-19 results, I was waiting for them for 2 hours, but they didn't.	**Reflection of feeling:** *I'm hearing that you expected the doctors to come and you felt angry that they didn't* The counsellor adds a feeling word 'angry'; this is a key aspect of a reflection of feeling.
Client: They told me the doctors were coming with my COVID-19 results, I was waiting for them for 2 hours, for 3 hours even... (trails off)	**Reflection of content:** *Sounds like you waited for very long for your doctors to let you know about the results?*

A simple reflection of feeling can simply involve identifying the client's explicit emotion. A more complex reflection of feeling can involve naming emotions that the client might not have explicitly stated but that the counsellor senses.

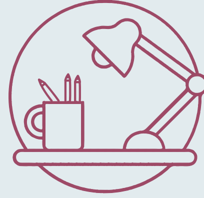
Generally, it is a good idea to use stems such as *'sounds like…'* or *'am I right in understanding that….'*

or 'I am getting the sense…is that right?' or 'I'm hearing that…' This offers an opportunity to the client to modify or clarify the reflection. This clarification is especially important in telecounselling as we do not have the visual cues to understand how the client may be feeling. We may mistake the client's emotions and the client may not be able to clarify if the space for doing so is not provided to them.

It is useful to review a 'feeling wheel' such as the one below to develop a vocabulary of emotion words. It may also be useful to consider what translations we might use for each of these words in the languages that we use to communicate with the clients. We may want to collaborate with our colleagues to have a rich repertoire of words describing feelings in different languages.



Feeling Wheel. Source: Designed by Glenn Trigg, https://www.glenntrigg.net/emotions-wheel/ (Reproduced under CC by 4.0)



Practice Exercise

Consider the following statements made to you by a client and try reflection as a response.

1. *There are so many things happening. My mother got COVID-19 and she's in the hospital, the hospital is far away so there is no way to travel there. I just don't know what to do. My employer is also not calling me back as all construction has stopped.*
2. *I was so careful, but I still got diagnosed. I don't know how. I stayed home all the time, washed my hands, did everything. I don't know what I did wrong. Is it because of me that I got COVID-19?*
3. *We are all quarantining at home. Things are going well. We are getting more time to spend with each other but sometimes fights happen and then it is very upsetting.*

Organizing and Prioritizing. Sometimes, clients mention many different issues and it all seems overwhelming, both for them and for us. Organizing the client's key concerns may be helpful. For example, saying 'Sounds like a lot of things are going on for you. I hear 3 different issues that are troubling you - your relationship with your sister, your work and your wife's diagnosis of COVID-19, have I got that right?' Prioritizing is also an important and crucial skill. We are almost always prioritizing certain aspects of our clients' narratives, as it is often not possible to attend to or address everything someone may have said. The key skill is to learn to be conscious about when and what we are prioritizing and how that influences the direction of the conversation. We can also ask the client directly about their priorities. For example, we may say, 'We have discussed these different concerns you are having right now. Which of these issues seems most important for us to talk about?' This is even more important in the context of brief telecounseling where we may have only one or two calls with the clients. Organizing and prioritizing may help to focus our interventions.

Observing the unsaid. While it is not possible to visually observe clients on the phone to gauge their moment to moment emotional experience, we can utilise auditory cues and listen for hesitations, signs of strong affect (e.g., rapid breathing) or tone of voice. If the client is having difficulty expressing their feelings or thoughts spontaneously, we can choose to comment on something we notice in real-time to bring that aspect alive in the session e.g., 'I'm sensing that you are finding it difficult to talk about your COVID-19 diagnosis right now as we speak, is that so?' 'I'm noticing that you are breathing fast while we discuss your father's quarantine experience, are you feeling anxious right now?' It is important that our tone is gentle and is not perceived as a judgment on the aspect that is being pointed out.

Universalizing. Universalizing is recognizing that suffering and struggle are a shared aspect of humanity. In essence, it conveys to the client that they are not alone. Some subtle ways of normalizing include 'It is understandable that when so many things around you are going wrong, you feel anxious and distressed' or 'When

you describe all things that have been happening at your end, I cannot find it in myself to judge your emotions as something out of the ordinary'. At times, providing specific feedback to the client about common reactions may be helpful, 'In the pandemic, many people have reported that they are scared of acquiring COVID-19, they are feeling lonely in quarantine and have trouble sleeping'. If not used sensitively, normalizing can carry with it the risk of trivializing the client's struggles and their uniqueness. It can make the client feel unheard if normalizing is interpreted as, 'There's no big deal in what I'm going through. Everyone goes through it and I shouldn't feel entitled to my pain' 'If what I'm feeling is normal, does it mean that nothing can or should be changed?'

4. Ending the session.

At the end of the session, it is useful to summarize. It involves attending to key thoughts, feelings and facts mentioned by the client and restating them as accurately as possible in the context of a longer conversation. We may say "I'm aware that we have 10 minutes left in our conversation. Is it okay if I summarize what we've discussed so that we are on the same page?" (taking permission for a summary is important). We can then proceed to mention the key points in our conversation and highlight the significant conclusions or actions that have been collaboratively decided upon. This may be especially important in one-session formats as there may not be a second session to consolidate the work. We can also ask for feedback, 'How are you feeling after this call?' or 'How did you find this session to be?' It is also important to decide clearly with the client about whether there will be a follow-up or not and the approximate time-frame for the same.

We may have to remember that summarizing can also be helpful during the session to find a focus and prioritize the same with the client, check our understanding, transition to a new topic and move the conversations ahead.

Let's Avoid...

Diagnosing or pathologizing. Given that people will have experienced a lot of stress in the pandemic situation, most reactions are understandable and normative. This means that we should avoid using words such as 'symptoms' 'disorder' 'condition' and avoid labelling 'You seem to have depression, you seem to have OCD'

Assuming everyone will be traumatized or in distress. If a client appears to be doing well, respect that.

Persisting with asking questions when the client is clearly reluctant. Client has a right to say no or not answer your questions. It is not something that the client has to comply with.

Making unrealistically positive comments e.g., 'Everything will be fine' or 'Don't worry, things will work out in the end'

Making judgmental or interrogative statements
e.g., 'Why did you go out when you knew it was unsafe?' Using a tone that conveys shock ('Everyone in your family got COVID?') may also be perceived as judgmental.

Self-disclosing our own experiences. Let's avoid making statements such as 'I was quarantined too, I felt exactly like you do!' without careful thought and consideration.

Letting the session devolve into an unstructured conversation. The goal of intervention is to understand the client's needs. It includes listening to the client's story but also asking specific questions to clarify certain details. It is a respectful, fluid process of asking questions gently interwoven into the fabric of a client-led conversation.

Self-Care Exercise

When we hear stories of people facing hardships and difficulties, it can be a challenge for us to stay hopeful. We are, after all, facing the same pandemic as well. It becomes important to assess how we are taking care of ourselves and follow it up with plans to do the same. The following questions may help us identify the different domains of self-care that we may be engaging in already and those which we may need to nurture more (Kramen-Kahn, 2002):

Professional attributes: Do I look competent and professional to my clients? Am I being perceived as warm, caring, and accepting even when I engage in remote counselling?

Peer supervision: Do I regularly engage in case consultation with other professionals remotely to enhance my learning?

Leaving the work at the office: After finishing my work day, am I able to disengage from my work by switching off my computer? Am I able to maintain a balance between my personal and professional life even in the pandemic?

Social support: Am I getting time to nurture my support network of family and friends?

Relaxation: Am I able to engage in leisure activities to relax myself?

Attitude towards work: Am I feeling renewed and energized by my work? Am I looking forward to it? Am I able to act in accordance with the ethical standards of telecounselling?

Attitude towards clients: Am I able to maintain objectivity regarding my client's difficulties? Am I able to maintain good boundaries with them? Am I able to maintain a sense of humour with clients?

Personal care: When I need it, will I be able to access personal therapy? What about continuing the process of therapy online?

References

IFRC Reference Centre for Psychosocial Support. (2020). Remote Psychological First Aid during COVID-19. Copenhagen.

Inchausti, F., MacBeth, A., Hasson-Ohayon, I., & Dimaggio, G. (2020). Psychological intervention and COVID-19: What we know so far and what we can do. *Journal of Contemporary Psychotherapy* , *50*, 243-250.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2009). Intentional Interviewing and Counseling: *Facilitating Client Development in a Multicultural Society (2nd edition)*. Belmont, CA: Cengage Learning.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, research, practice, training, 38(4)*, 357-362.

Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: *A systematic review. Acta Informatica Medica, 25(4)*, 240–246. https://doi.org/10.5455/aim.2017.25.240-246

Ormond, K. E., Haun, J., Cook, L., Duquette, D., Ludowese, C., & Matthews, A. L. (2000). Recommendations for telephone counseling. *Journal of Genetic Counseling*, 9(1), 63-71.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology, 21(2)*, 95-104.

Rosen, C. S., Glassman, L. H., & Morland, L. A. (2020). Telepsychotherapy during a pandemic: A traumatic stress perspective. *Journal of Psychotherapy Integration, 30(2)*, 174-187.

5 Framework for personal and professional development

Mental health professionals experienced unique challenges during the pandemic. In a short period of time, the roles and responsibilities of the professional helper increased. Some members of the mental health community had to transition to providing remote services without being adequately prepared and trained for the same. Providing these services also created new challenges such as dealing with poor internet connections or searching for alternatives when clients did not have access to technology. Mental health professionals also had to take a more proactive role in spreading awareness about the mental health impact of the pandemic (Liu et al., 2020).

As the need and scope of the professional helper's role expanded, the pressure on the mental health community also significantly increased (Thome et al., 2020). Such circumstances increased the risk of mental health professionals experiencing helplessness, perceived therapeutic inefficiency and burnout (Joshi & Sharma, 2020). The community also faced the risk of vicarious traumatization due to exposure to stories of violence (Bradbury-Jones & Isham, 2020). Further, the pandemic was a lived reality for mental health professionals well. Some may have also experienced health risks, isolation, grief and economic uncertainty while navigating the same with clients (Vostanis & Bell, 2020).

Even prior to the pandemic, in India, the ratio of mental health professionals to people was low as compared to the world average (Dwivedi et al., 2020). The workload of mental health professionals in India were very high (Duggal, Dua & Ullas, 2020). Despite these constraints it was seen that from the early days of the pandemic, the community came forward to volunteer to work in psychosocial helplines in large numbers (Agrawal & Yadaver, 2020) and started new initiatives (Balaji & Patel, 2020). Hence, during the pandemic, an already small community of mental health professionals experienced an even higher workload, while grappling with the implications of the pandemic on themselves.

These challenges indicate the need to consider the personal and professional development and well-being of mental health professionals in the pandemic. It is believed that the lived experience of counsellors tends to translate into self-awareness within professional roles (Aponte & Ingram, 2018). It is through the use of self and interpersonal skills that the process of therapy unfolds (Lambert & Barley, 2001). Research indicates that engaging in reflective practice, supervision and self-care allows mental health professionals to sharpen skills (Berryman, et al. 2010) and encourages professional growth and development (Ronnestad & Skovholt, 2003).

This chapter will describe reflective practice, supervision and self-care as frameworks for promoting personal and professional development for mental health professionals.

1. Reflective Practice

Reflective practice refers to the ability to reflect on one's actions and experiences to further the process of continuous learning (Schon, 1983). It involves stepping outside of ourselves and actively examining our personal experience in the moment, in a deliberate and purposeful manner (Wong-Wylie, 2007). Reflective practice is important because experience alone does not lead to learning. Learning occurs through the intentional and purposeful ability to look within ourselves, that allows us to try to understand and examine our experiences (Loughran, 2002).

1.1 Why is it important?

Learning to be an effective counsellor is an ongoing and lifelong process (Ronnestad & Skovholt, 2003). It requires cultivation of specific professional knowledge (knowing a particular concept), learning new skills (learning how to translate it into practice) and attitudes (understanding and imbibing the values and principles that inform the concept).

Let us take an example to understand this better. As a counsellor, Ms. Antara may have learnt from her training that empathy involves putting the self in her client's shoes and seeing the world as they view it. This is the knowledge component as she had learnt it. Through the course of her training, she learns specific skills and techniques of developing and demonstrating empathy such as reflection, paraphrasing etc. This is the skills component. After (or maybe during) the session, she consciously looked within, thought about her moment to moment experience with the client in the room, tried to identify her feelings and understand her behaviours in the session, examined her ability to experience empathy with this client and then asked herself what she could do differently in the next session to be more attuned. This final component is that of reflection.

Hence some benefits of engaging in reflective practices involve:

1. Allowing us to slow down our work and promote self awareness. Reflective practice keeps us constantly aware of our own feelings and attitudes which enter into the counselling process (Paterson & Chapman, 2013). This is especially important in the context of the pandemic as we may experience a number of emotions because of personal struggles associated with it.
2. Increasing our awareness of our own biases, values and personal experiences and how these can sometimes become blind spots (McMullen, 2001). All of us are capable of engaging in stereotyping and stigmatizing others. Such practices are common during periods of pandemic (Bhattacharya et al., 2020).
3. Helping link theory to experience and vice versa and prevents us from becoming too technical (Thompson & Pascal, 2011).
4. Building an understanding how we are impacting the client and how the client is impacting us (McBrien, 2007). For example, we may have to take into account when we are feeling tired and exhausted due to the increased work demands and take appropriate breaks during that time.
5. Cultivating professional wisdom. Research indicates that engaging in reflective practice was one of the key factors that distinguished exceptional therapists from others (Hanna & Ottens, 1995).
6. Constantly reflecting on the congruence between ourselves as person and professional (Connelly & Clandinin, 1988). It may be useful for us to make meaning of the experience during the pandemic both as an individual as well as a mental health professional.

1.2 Models of reflective practice

Schon's model of reflection. Donald Schon (1983) was the first to suggest two types of reflection that professionals engage in:

- **Reflection-on-action:** This is the type of reflection that we do after the situation or event. We may look back at the situation, at our thoughts/feelings about it and analyze what we did retrospectively, including whether we would want to do something different the next time. For example, after the session with a client who is expressing suicidal ideation, a counsellor contacts their supervisor to process what happened in detail.
- **Reflection-in-action:** This is the type of reflection that professionals engage in-the-moment as they work on a task. Professionals rapidly analyze and reflect on the situation and decide on their course of action in the moment.

For example, imagine that a client at high risk of suicide agrees to a referral, but only if the counsellor agrees to continue regular sessions with them. In that moment in the conversation, we have to rapidly analyze the situation and decide what to do next and say next.

Schon suggests that over time, the continued use of reflection-on-action leads to an increased intuitive repertoire for the professional and an increased capacity to reflect-in-action.
Tony Lavender (2003) adds two other types of reflection to this:

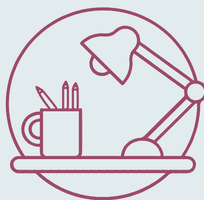
Reflection about impact on others: This involves reflecting about our own interpersonal impact on others. Essentially, it refers to understanding how we are perceived by others and influence them.

Self-reflection: This involves reflecting about our own personal lives, histories and vulnerabilities. An understanding of our vulnerabilities and the contexts in which they may be triggered can lead to a deeper understanding of our clients' difficulties as well as a more considered reaction in the face of challenging situations that bring up difficult thoughts and emotions for us.

Schon (1983) also discusses the **role of others** in reflection. A mentor or a supervisor can ask the appropriate questions to help one reflect. Similarly, conversations with colleagues or even friends can stimulate reflections.

Reflection-in-action	Reflection-on-action	Reflection about impact on others	Self- Reflection
Real world situations	In one-on-one or group supervision	Feedback from others	Personal therapy
Role-plays or other simulations (eg. writing down in the moment reflections as they occur)	With colleagues	Group tasks/team tasks including team bonding exercises etc	Deliberate reflection using all the previously described methods such as journaling, through art-work, etc
	Thinking	Watching videos of yourself working/ interacting with others	Working through difficulties in our professional and personal lives
	Writing notes/ prose/poetry	Completing question-naires/measures	
	Creative forms e.g. drawing, painting,		
	Listening to session recordings/viewing videos		

The table above (content adapted from Lavender, 2003) suggests some ways in which we can facilitate these different types of reflection.



Practice Exercise

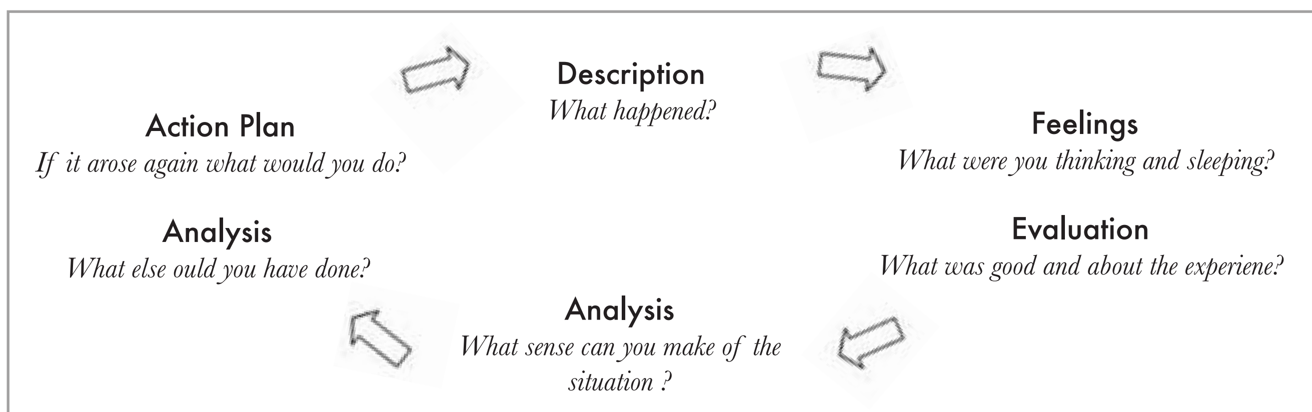
Try to think about a moment or an encounter with a client in session that you found difficult or challenging. Try to use the framework outlined above to reflect on it (you may find writing your reflections in a separate document or on paper to be helpful)

- Reflection-in-action: What were you thinking and feeling at that moment in the session? How did you decide what to do next?
- Reflection-on-action: Thinking back to it now, how do you make sense of that moment or encounter? Would you like to do anything differently the next time around in such a situation?
- Reflection about impact on others: How do you think your actions impacted the client's words/actions? What kind of interpersonal impact did you have on your client? (i.e. perhaps you made them feel safe with you, perhaps you made them secure that they would not be judged)
- Self-reflection: Do you think that your personal history and experiences impacted this encounter in any way? How did this experience impact you personally?

After finishing this exercise:

- How was your experience of this exercise?
- What did you learn from this exercise?
- Was there anything surprising or unexpected that you discovered?

Gibbs' model of reflection. Gibbs' reflective cycle (1988) is a model used to give structure to learning from experience. We can use it as a framework for examining our experiences, thinking about what went well and what could be changed. The stages of the model are described below :



Source: By User GSE843 (Public domain, via Wikimedia Commons) Gibbs' model of reflection

Stages	Sample questions
Description- "What happened?"	• *When did it happen?* • *Where did it happen?* • *Who was present at that time?* • *What action did we take? What about others?* • *How did the situation end?* • *What had brought us to the situation in the first place?* • *What were we expecting to happen?*
Feelings- "What were our thoughts and feelings and how did they impact us?"	• *What feelings did we have during the situation?* • *What about the feelings before the situation? What about after?* • *What are our views about other people's feelings in the situation? What about their feelings now?* • *What were our thoughts during the situation?* • *What are our thoughts about the situation now?*
Evaluation- "What worked and what did not work at that time?"	• *What according to us was the good part of the experience? What about the bad part?* • *What, according to us, went well? What did not?* • *How did we contribute to the situation? Was it positively or negatively?* • *What about others? How did they contribute to the situation?*
Analysis- "What meaning did we make of the experience?"	• *What did we think led to things going well? And what did not?* • *How did we make sense of the situation?* • *What knowledge or technical skills that we have learnt from academic literature can help us in understanding the situation?*
Action- "What will I do differently?"	• *If we were in a similar situation again, what would we do differently?* • *What will be some of the skills that I will require to do this? How will we develop these skills?* • *How can we ensure that we act differently next time?*

1.3 Reflective Writing

"Writing bridges the internal and external world and connects the paths of action and reflection" (Baldwin, 1991; p. 9). This statement may help us in understanding how reflective writing may serve as a mirror for reflecting the experiences of mental health professionals. We can record our personal views, understandings, ideas or observations and opinions in this process.

Certain questions that we can keep in mind when starting with the process of reflective journaling are described below.

Beginning questions for reflective journaling

As mentioned previously, the pandemic has been a stressful time for the mental health community. As mental health practitioners, we have faced some unique challenges during this time. We may want to take a few minutes to try to reflect on our own thoughts and feelings during the pandemic. We can ask ourselves the following questions:

- What has been my learning over the period of the pandemic? (This includes new skills, knowledge and insight that we may have gained)
- What has been my most valuable accomplishment during this time?
- If I was given another chance, what would I change? Why?
- What did I do right in this stressful time?
- During this pandemic, what are my achievements that I am proud of?
- What are some of the experiences that I had during this time that I am most thankful for?
- Is there any difference that I notice in myself this time after the experience of the pandemic as compared to last year? What are these differences?
- What kept me motivated during this time?
- What am I striving for once the pandemic ends?

(Adapted from Australian Institute of Professional Counsellors, 2018)

Throughout the manual we will find that reflective exercises have been interspersed with text in all chapters. These are placed to enhance our understanding of our own feelings and thoughts about certain concerns which have been raised in the text.

2. Supervision

Supervision is a 'formal arrangement for therapists to discuss their work regularly with someone who is experienced in both therapy and supervision' (BACP, 2008). Supervision has also been defined as "An intervention provided by a senior member of a profession to a junior member or members of the same profession. This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to clients that she, or he or, they see(s) and serving as a gatekeeper of those who are to enter a particular profession" (Bernard & Goodyear, 2009; p. 7).

Milne's (2009) model summarises these different dimensions of supervision:

- **Formative:** Helping the supervisee develop their professional knowledge and skills
- **Normative:** Monitoring that the supervisee is following the norms of the profession
- **Restorative:** Supporting the supervisee's well-being and providing emotional support

Although these definitions allude to a senior professional supervising a more junior professional, in practice, the term supervision is applied to a broad number of formal arrangements which can be accessed through experts or peers

2.1 Why is it important?

Supervision has been identified by therapists as one of the top influences on their professional development, regardless of level of experience, background and theoretical orientation (Orlinsky & Ronnestad, 2005; Wheeler & Richards, 2007). Research evidence suggests that supervision may enhance client outcomes (e.g. Bambling et al., 2006).

The various benefits of supervision identified by therapists and counsellors in different studies include improvement in knowledge and skills, enhancing self-awareness and reflective capacity, support in resolving ethical dilemmas, help in dealing with burn-out, availability of someone during crisis and distress, gaining in confidence and self-efficacy and decrease in professional isolation (Duggal, Dua, & Ullas, 2020; Wheeler & Richards, 2007).

Supervision is compulsory in most training programs of mental health professionals around the world. For example, the American Psychological Association mandates that doctoral-level interns in psychology should receive 4 hours of supervision per week. Similarly, the Rehabilitation Council of India (RCI) cites supervised clinical work as necessary for the degree of MPhil in Clinical Psychology. Interestingly, while supervision is mandated in training, the situation for practicing therapists is different, especially in India.

This is an important consideration as counselling and therapy in our context is challenging due to the certain constraints on resources (limited infrastructure and human resources). Therapists and counsellors face a host of difficulties in their work such as:

- Having to play multiple roles. For example, a counsellor may also be asked to do the work of a social worker or a legal guide especially in the pandemic where the resource constraints in the field of mental health were brought under spotlight.
- High workloads. Counsellors are often asked to see several clients in a day to keep up with demand for the need for mental health services during the pandemic.
- Mental health problems that are embedded in structural and social issues such as poverty and unemployment were increased during due to the economic impact of the pandemic.
- Adapting Western models of therapy and counselling to the Indian context. For example, certain words that are used in the counselling literature may not have adequate translations in regional languages.
- Negotiating boundaries with families in a collectivistic culture. For example, parents of adult clients may be interested in knowing the details of what their children have shared with the counsellor. This is especially difficult during the lockdown period where family members had to live in close proximity.
- Navigating the role of an expert. Clients for whom therapy is a novel concept, may want solutions and instant fixes especially when told that they would be meeting the counsellors for a brief time.
- Working in a patriarchal and heteronormative context. For example, mental health issues of women such as violence may be rooted in patriarchal structures which may have gotten exacerbated during the pandemic.

Potentially, supervision can be one route through which therapists and counsellors in India navigate these challenges and develop professionally and personally. When counsellors have received supervision, they have found it to be useful. For

example, counsellors working with individuals affected by HIV/AIDS found that supervision was useful in helping them to deal with burn-out, feeling emotionally-supported, enhancing knowledge and self-awareness as well as helping sort out administrative hurdles (Gandhi & Rajan, 2013). In another study in India, novice counsellors found that supervision could help in various ways, such

Barriers to supervision

While supervision can be considered to be important, there can be different kinds of barriers to supervision, especially in India (Duggal, Dua & Ullas, 2020; Kumaria, Bhola & Orlinsky, 2018). Some of these barriers include:

- Difficulty in finding appropriate supervisors, especially if working with specialist populations. For example, the author had a great difficulty in finding a supervisor who was experienced in working with children and adolescents and was willing to do one-on-one supervision
- Lack of supervisors having adequate experience and training in supervision itself
- Lack of time for supervision due to high work-loads
- Lack of resources for supervision (e.g. not having a high-speed Internet connection, not having expert supervisors in the area where one is, difficulty in affording paid supervision)
- Unfavourable institutional conditions
- Negative beliefs and myths about supervision (e.g. not considering supervision as important to professional growth)
- Past negative experiences of supervision, leading to hesitation in accessing further supervision

2.2 Types of Supervision

Supervision can be undertaken in different formats. Some of these formats include:

Individual vs. group. Supervision can occur in a one-on-one format or it can take place within a group format. Groups can have a leader/facilitator or can function as leaderless groups.

Expert vs. peer. The professional can seek supervision from an expert (i.e. a professional in their field who is senior to them and has more knowledge, skills and experience) or the professional can seek supervision from peers (i.e. professionals in the field who are at approximately the same level of knowledge, skills and experience). The power dynamics in these two formats will differ, with power dynamics being more pronounced in expert supervision.

If we want to access expert supervision, we can follow a simple process as described below:

- **Search for potential supervisors** through word-of-mouth (through recommendations of colleagues, professors, other individuals in the field) and/or doing formal research (e.g. online).
- **Approach the potential supervisor** through a call/email/text message to discuss the possibility and logistics of supervision. Since supervision is highly under-utilized in India, many professionals may not explicitly advertise that they conduct supervision. Hence, approaching someone directly may be the only way to know if they are open to supervision.
- **Consider various factors** in determining whether to go forward with the supervision. This includes considerations related to the supervisor such as style of supervision, theoretical orientation, relationship with the supervision as well as logistical concerns like cost, frequency and duration of supervision session.

However, in a resource-constrained country such as India, it may not be possible or feasible for us

to access expert supervision. Peer supervision may offer a viable alternative in such cases. Peer supervision can be accessed one-on-one (e.g. scheduling a meeting with a colleague to discuss a case) or more commonly, in the form of peer supervision groups. According to Lewis et al. (1988), peer supervision groups are "regularly scheduled meetings of three or more professionals who provide mutual help with private practice issues" (p. 81). In setting up a peer supervision group, we can follow these steps:

- **Identify the members.** We will need to make a decision about the number of members of the group, who will be suitable candidates and whether it will be a closed or open group, that is, whether the same members will be present throughout or whether the addition of new members will be permitted every session. Generally, closed groups are preferable because they allow the members to become comfortable with each other and deepen the discussion. Finally, we will have to decide on logistics such as frequency time, duration and format (online vs meeting face to face).
- **Define the group task.** For example, will the group be focussed on discussing clinical cases or will the group discuss specific process issues that come up in counselling or have a dual focus?
- **Setting group norms** like the general format and rules of the group. For example, if the group is discussing clinical cases, how will members take turns to discuss cases and what will be the format of a case discussion? What steps will be taken to ensure client confidentiality; How will feedback be sought and given
- **Navigating group processes.** Once a group has started, processes that may impact a peer supervision group and may need to be navigated include:
  - Managing shame around exposing one's work to one's peers by being supportive and non-judgmental of each other.
  - Staying on task to prevent the discussion from becoming a peer therapy group or a more social group.
  - Sharing the task of leadership by sharing equal responsibility for the group's functioning.
- **Reflecting on the dynamics within the group to understand interpersonal processes within the group and encouraging safety.** For example, when a particular case is being discussed, the dynamics of the case may be repeated in the dynamics of the group. This is called the parallel process (Ekstein & Wallerstein, 1963).

Private vs. organizational. Supervision can be sought in the context of a private practice (i.e. the counsellor initiates and negotiates supervision on their own terms/conditions) or it may be sought within the context of the organization the counsellor is located in (i.e. the supervision may be mandated or may be subject to certain requirements and processes as per the protocol of the organization). In case we do not have access to supervision in our organization, we can consider bringing up the need for the same with the respective heads in the organization. It is possible that we may want to seek expert supervision outside of the organization sometimes. It might be helpful to clarify this with the authorities, as there will be certain ethical concerns that need to be discussed and addressed (e.g. confidentiality of client information, maintaining privacy of organizational processes).

In-person vs. online/telephonic. Supervision can be face-to-face or it can occur via a video-conferencing or telephonic medium. In these times of social distancing, the latter option is becoming a popular choice for counsellors.

Reflective Exercise

- Have you sought supervision? What were your reasons for accessing supervision? What were your apprehensions?
- What were some of the barriers you faced in the process?

Throughout the manual we will find that supervision exercises have been added at the end of all chapters. These are placed to highlight themes which may be undertaken during supervision so as to enhance our learning in supervision.

3. Self-care

Self-care can be defined as the "ability to refill and refuel oneself in healthy ways" (Gentry 2002, p. 48), which may include "engagement in behaviours that maintain and promote physical and emotional wellbeing" (Myers et al. 2012, p. 56) and which "lessen the amount of stress, anxiety, or emotional reaction experienced when working with clients" (Williams et al. 2010, p. 322). It is reflective not only of the behaviour or practices but also having a caring attitude towards oneself (Kissil & Niño 2017). It involves knowing our needs and then taking action to meet them (Colman et al. 2016; Pakenham, 2017). Self-care is now being recognised not just as a luxury but as a clinical and ethical imperative in the mental health professions (Norcross & Guy 2007).

3.1 Why is it important?

Research has shown that mental health professionals face many challenges and stressors over the course of their career that are unique to their profession. Self-care can be a useful way for managing these challenges and stressors.

The field of mental health involves working in a culture where there is one-way caring (Guy 2000). This is reflected in the fact that we are required to show empathy, compassion and patience but not expect the same in return from our clients (Skovholt et al. 2001). Even the therapeutic alliance, a key aspect of therapeutic work requires emotional and psychological involvement while at the same time maintaining appropriate boundaries. This one-way relationship has to be established and maintained with all our clients (Skovholt & Trotter-Mathison, 2011).

In fact, mental health practitioners have an ethical duty to provide responsible caring, maximizing benefits and minimizing harm for their clients. In order to provide effective care to their clients, practitioners must first be well themselves (Norcross & Guy 2007). To promote responsible caring, several regulating bodies have, therefore, included practitioner self-care in their code of ethics.

Research has shown that self-care practices reduce stress (El-Ghoroury et al. 2012), burnout (Wityk 2003), secondary traumatic stress (Butler et al., 2017) and professional impairment in terms of overall decrease in therapeutic effectiveness (Bearse et al., 2013; Harrison & Westwood, 2009). At the same time, engaging in self-care practices has been found to be associated with more well-being (Colman et al. 2016), more positive affect, flourishing academic career as well as clinical performance as per their self-reports (Zahniser et al. 2017), with high levels of satisfaction (Butler et al. 2017), and high quality of life (Goncher et al. 2013). This may lead to increase in behaviours which ultimately lead to more sustainable careers and a greater sense of personal accomplishment (Rupert & Kent 2007).

As mental health professionals, we may have our own unique set of strengths and vulnerabilities. We need to learn to offer empathy, tolerance,

acceptance, compassion, and realistic appreciation of our own humanness as well. Caring for self is thus a gift we can give to ourselves which will indirectly translate into a gift to others. This is demonstrated by research evidence which supports that high self-compassion shows a positive relationship with adaptive psychological functioning (Neff, et al., 2007). Self-care becomes an ethical responsibility towards ourselves and our clients. The pandemic brought personal and professional challenges as described above. In such a scenario, it became even more imperative that the ethical principles of self-care be adhered to.

3.2 Dimensions of self-care

This section will describe the various dimensions of self-care that we can consider undertaking.

We can begin with understanding and paying attention to factors which may serve as personal risk factors such as presence of stresses in personal life, physical or mental health difficulties that we may be facing and warning signs such as increased boredom or lack of focus, hoping that we may get cancellation from certain clients, decreased enjoyment from our work (Barnett et al., 2007).

We can also try to see if we are engaging in some positive career sustaining behaviours like identifying and maintaining a balance between personal and professional lives, looking for opportunities to diversify professional activities, scheduling breaks, taking care of rest, diet and physical activities, caring for our own emotional, physical, interpersonal, and spiritual needs (Kramen-Kahn & Hansen, 1998).

Norcross and VandenBos (2018) have elucidated certain dimensions of self-care that we can consider:

- **Valuing the person of the counsellor:** This refers to how we can understand our unique identities, qualities and strengths as a counsellor and try to find ways of nourishing these aspects of ourselves.
- **Recognizing the hazards:** It is important to acknowledge some of the challenges of being a counsellor, such as ambiguity about outcomes, high emotional investment, exposure to suffering and physical isolation.
- **Refocusing on the rewards:** At the same time, it is important to refocus on the rewards of being a counsellor or a therapist and what are the unique rewards that the profession offers us.
- **Minding the body:** This refers to how we can take care of our bodies, such as ensuring an appropriate amount of physical activity, nourishing food and adequate sleep in our day.
- Nurturing relationships: Even though we are building and sustaining relationships all the time, we can sometimes neglect the meaningful relationships in our own lives. Taking effort to nurture and sustain our professional and personal relationships can be an act of self-care.
- **Setting boundaries:** Boundaries are not only protective, but they are also therapeutic. It is important that we set boundaries in our personal and professional lives, including setting caseload boundaries and saying no when appropriate.
- **Restructuring cognitions:** This refers to being cognizant of and evaluating our own thought processes, such as monitoring when we are making comparisons to others or setting

Burnout, secondary traumatization, and compassion fatigue

Due to our professional training and perhaps our personal dispositions, we may take on the role of caregivers easily. But when it comes to our needs, issues, and concerns, we may turn a blind eye (O'Connor, 2001). Thus, we need to understand the detrimental effects

overly high standards for ourselves.

of burnout, vicarious traumatization and compassion fatigue.

Burnout: "A state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). It can manifest as:

- **Physiological.** Fatigue, physical depletion, irritability, headaches, gastrointestinal disturbances, back pain, weight changes, and changes in sleep pattern.
- **Behavioural.** Loss of enthusiasm, coming to work late, accomplishing little despite long hours, quickness to frustration and anger, becoming increasingly rigid, difficulty making decisions, increased withdrawal from colleagues and irritation with co-workers
- **Psychological.** Depression, emptiness, negative self-concept, pessimism, guilt, self-blame for not accomplishing more and feelings of omnipotence
- **Spiritual.** Loss of faith, meaning, and purpose, feelings of alienation, feelings of estrangement, despair, changes in values and changes in religious beliefs
- **Clinical.** Cynicism towards clients, daydreaming during sessions, hostility and boredom towards clients, quickness to diagnose and blaming clients

• **Secondary traumatization:** We may feel as emotionally as distressed as the client. This may get overwhelming for us and thus may interfere with our work (Figley, 1995). Some of the symptoms are:
  - Intrusive thoughts or images of personal or work-related trauma events
  - Lowered frustration tolerance, irritability or outbursts of anger
  - Dread of working with certain people/situations
  - Feelings of depression, loss of hope and optimism, sadness, upset
  - Decreased feelings of competence, sense of purpose/ enjoyment with career
  - Feeling hardened, detached, cynical

• **Compassion fatigue:** It is defined as a tense state where we may be preoccupied with the story of our client's trauma and show certain symptoms similar to the client such as re-experiencing the traumatic events, avoidance /numbing of reminders, persistent arousal (e.g., anxiety) to name a few (Figley, 2002). Some symptoms that we can be careful about are:
  - Headaches
  - Nausea
  - Sleeplessness
  - Intrusive imagery
  - Increased feelings of vulnerability
  - Difficulty trusting others
  - Emotional numbing or flooding

Reflective Exercise

Sometimes, self-care becomes a chore; something on our to-do list that we are unable to find time for. In such a scenario, we may even end up feeling guilty for not taking care of ourselves! At times like this, it is important to remember that self-care is not just individual. Self-care requires the systems in which we currently work to create cultures of self-care. For example, setting workload boundaries may not be possible in an organizational context that overloads employees and has little flexibility.

- How can your family, friends and colleagues support self-care?
- How can the community in which you live support self-care?
- How can your organizational structures support self-care?
- How does your society and culture view the notion of 'self-care'? Do you think this needs to change?

Throughout the manual we will find that self-care exercises have been added at the end of all chapters. These are specific to the themes described in the chapter.

This chapter described the need for personal and professional development for mental health professionals in the pandemic. It also highlighted the importance of engaging in reflective practice, self-care and supervision. The next section will describe psychosocial interventions specific to certain difficulties that clients may face during the pandemic.

References

Agrawal S., Yadavar S. (2020 April, 2). Locked Down and Anxious, *More and More Indians Are Making Panic Calls, Seeking Therapy.* https://theprint.in/health/locked-down-and-anxious-more-and-more-indians-are-making-panic-calls-seeking-therapy/392224/

Aponte, H. J., & Ingram, M. (2018). Person of the therapist supervision: Reflections of a therapist and supervisor on empathic-identification and differentiation. *Journal of Family Psychotherapy*, *29(1),* 43–57.

Balaji, M., & Patel, V. (2020, July 29). Mental Health and COVID-19 in India. *India Development Review.* https://idronline.org/mental-health-and-covid-19-in-india/

Baldwin, C. (1991). *Life's companion: Journal writings as a spiritual quest*. New York: Bantam Banks.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research*, *16(03),* 317-331.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice*, *38(6)*, 603

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice*, *44(3)*, 150–157.

Bernard, J. M. , & Goodyear , R. K. (2007). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson Education.

Berryman, M., Glynn, T., & Woller, P. (2017). Supervising research in Māori cultural contexts: a decolonizing, relational response. *Higher Education Research & Development*, *36(7),* 1355-1368.

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.

Bradbury-Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. *Journal of Clinical Nursing.* https://doi.org/10.1111/jocn.15296

British Psychological Society (BPS). (2008). *Criteria for the accreditation of postgraduate training programmes in clinical psychology.* Leicester: British Psychological Society.

Butler, L. D., Carello, J.,&Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9(4)*, 416–424.

Clandinin, D. J., & Connelly, F. M. (1991). Narrative and story in practice and research. In D. Schön (Ed.), *The reflective turn: Case studies in and on educational practice* (pp. 258–282). New York: Teachers College Press.

Colman, D. E., Echon, R., Lemay, M. S., McDonald, J., Smith, K. R., Spencer, J., & Swift, J. K. (2016). The efficacy of self-care for graduate students in professional psychology: A meta-analysis. *Training and Education in Professional Psychology*, *10(4*), 188–197.

Connelly, F. M., & Clandinin, D. J. (1988). *Teachers as curriculum planners: Narratives of experience*. New York: Teachers College Press.

Dave S. (2020, March 26). Covid-19: Companies Rope in Psychiatrists, Experts for Emotional Counselling of Work from Home Employees. *The*

Economic Times. https://economictimes.indiatimes.com/topic/26th-march

Duggal, C., Dua, B., & Ullas, N. (2020). *Psychotherapy Supervision in India: From Supervisee Perspectives to Contextual Models of Practice* [Report]. Mumbai: Tata Institute of Social Sciences.

Dwivedi, L. K., Rai, B., Shukla, A., Dey, T., Ram, U., Shekhar, C., Dhillon, P., Suryakant, Y., & Unisa, S. (2020, April 25). Assessing the Impact of Complete Lockdown on COVID-19 *Infections in India and its Burden on Public Health Facilities: A Situational Analysis Paper for Policy Makers.* Mumbai: International Institute of Population Sciences.

El-Ghoroury, N., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6(2),* 122–134.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58(11)*, 1433-1441.

Gandhi, A., & Rajan, P. (2013). Role of Counselling Supervision in Enhancing Counselling Skills and Expertise. *Social Sciences*, *74(2)*.

Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice*, *1(3-4*), 37-61.

Gibbs, G. (1988). Learning by Doing: *A guide to teaching and learning methods*. Oxford: Further Education Unit, Oxford Polytechnic.

Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of selfcare utilization. *Training and Education in Professional Psychology*, *7(1),* 53–60.

Guy, J. D. (2000). Self-care corner: Holding the holding environment together: Self-psychology and psychotherapist care. *Professional Psychology: Research and Practice*, *31(3)*, 351–352.

Hanna, F. J., & Ottens, A. J. (1995). The role of wisdom in psychotherapy. *Journal of Psychotherapy Integration*, *5*, 195–210.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. Psychotherapy: *Theory, Research, Practice, Training*, *46(2)*, 203–219.

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian journal of psychiatry, 54*, 102-300.

Kissil, K., & Niño, A. (2017). Does the Person-of-the-Therapist Training (POTT) promote self-care? Personal gains of MFT trainees following POTT: A retrospective thematic analysis. *Journal of Marital and Family Therapy, 43(3)*, 526-536.

Kramen-Kahn, B., & Hansen, N. D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. *Professional Psychology: Research and Practice*, *29(2),* 130.

Kumaria, S., Bhola, P., & Orlinsky, D. E. (2018). Influences that count: professional development of psychotherapists and counsellors in India. *Asia Pacific Journal of Counselling and Psychotherapy*, *9(1)*, 86-106.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38(4)*, 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Lavender, T. (2003). Redressing the balance: The place, history and future of reflective practice in clinical training. *Clinical Psychology*, *27*, 11-15.

Lewis, G.J., Greenberg, S.L., & Hatch, D.B. (1988). Peer consultation groups for psychologists in private practice: A national survey. *Professional Psychology, 19*, 81-86.

Liu, S., Yang, L., Zhang, C., Xiang, Y. T., Liu, Z., Hu, S., & Zhang, B. (2020). Online mental health services in China during the COVID-19 outbreak. *The Lancet Psychiatry*, *7(4),* e17-e18.

Loughran, J. J. (2002). Effective reflective practice: In search of meaning in learning about teaching. *Journal of Teacher Education*, *53(1)*, 33-43.

McBrien, B. (2007). Learning from practice– Reflections on a critical incident. *Accident and Emergency Nursing, 15(3)*, 128-133.

McMullen, K. B. (2001). *Experienced counsellors' narratives: Storied reflections of four meaningful lives.* Unpublished master's thesis, University of Saskatchewan, Saskatoon, Canada.

Milne, D. (2009). *Evidence-based clinical supervision. Principles and practice.* Chichester, UK: BPS Blackwell.

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. *Training and Education in Professional Psychology, 6(1)*, 55.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality,* 41(1), 139-154.

Norcross, J. C., & VandenBos, G. R. (2018). Leaving It at the Office: *A Guide to Psychotherapist Self-Care* (2nd ed.). New York: The Guilford Press.

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional psychology: Research and practice*, 32(4), 345.

Orlinsky, D. E., Rønnestad, M. H., & Collaborative Research Network of the Society for Psychotherapy Research. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* American Psychological Association. https://doi.org/10.1037/11157-000

Pakenham, K. I. (2017). Training in acceptance and commitment therapy fosters self-care in clinical psychology trainees. *Clinical Psychologist*, 21(3), 186-194.

Paterson, C., & Chapman, J. (2013). Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport*, 14(3), 133-138.

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures*. Free Press.

Posluns, K., & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, 42(1), 1-20.

Rosenberg, A. R. (2020). Cultivating Deliberate Resilience During the Coronavirus Disease 2019 Pandemic. *JAMA Pediatrics*, 174(9), 817–818. https://doi.org/10.1001/jamapediatrics.2020.1436

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practice,* 38(1), 88–96.

Schon, D. F. (1983). *The reflective practitioner.* New York: Basic Books.

Skovholt, T. M., & Trotter-Mathison, M. (2011). The resilient practitioner: *Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (2nd ed.). Routledge/Taylor & Francis Group.

Skovholt, T. M., Grier, T. L., & Hanson, M. R.

(2001). Career counselling for longevity: Self-care and burnout prevention strategies for counsellor resilience. *Journal of Career Development*, 27(3), 167–176.

Thome, J., Coogan, A. N., Fischer, M., Tucha, O., & Faltraco, F. (2020). Challenges for mental health services during the 2020 COVID-19 outbreak in Germany. *Psychiatry and clinical neurosciences.*

Thompson, N., & Pascal, J. (2011). Reflective practice: an existentialist perspective. *Reflective Practice*, 12(1), 15-26.

Vostanis, P., & Bell, C. A. (2020). Counselling and psychotherapy post-COVID-19. *Counselling and Psychotherapy Research*, 20(3), 389-393.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research,* 7(1), 54-65.

Williams, I. D., Richardson, T. A., Moore, D. D., Gambrel, L. E., & Keeling, M. L. (2010). *Perspectives on self-care. Journal of Creativity in Mental Health*, 5(3), 320-338.

Wityk, T. L. (2003). Burnout and the ethics of self-care for therapists. *Alberta Counsellor*, 28(1), 4–11.

Wong-Wylie, G. (2007). Barriers and facilitators of reflective practice in counsellor. *Canadian Journal of Counselling and Psychotherapy*, 41(2).

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology,* 11(4), 283–289.

Section 3- Psychosocial Interventions

1 Addressing basic needs

Basic needs are generally understood as those minimum requirements which are needed for us to sustain a decent life (Chiappero-Martinetti, 2014). They involve food, clothing, and shelter as well as access to essential services such as clean drinking water, sanitation facilities, education, healthcare and public transport. Basic needs are an important consideration for the development of any country (International Labour Organization,1976).

Basic needs are one of the first aspects of people's lives that get disturbed during disastersand emergencies. Thus, mobilizing resources to fulfill these needs becomes a criticalresponse in any disaster. The response from governmental and non-governmentalassociations to disasters generally entails assessment of basic needs and provision of food,water, shelter, and medical needs to those who are impacted by the disaster or emergency. Taking care of these needs helps to prevent disease (through provision of medical care),starvation (through provision of food) and ensuing violence when the needs are not met(Centre for Disease Control, 2014). In fact, all models of Psychosocial First Aid used duringemergencies and disasters (such as the John Hopkins Rapid Model, Look, Listen, LinkModel, and the National Child Traumatic Stress Network Model) highlight the importance ofaddressing basic needs. Across these models, important components include learning aboutavailable resources and support, identifying people whose basic needs are not being met and linking them to these resources. This involves thinking about and answering important questions like who is providing for basic needs such as emergency medical care, food, water, shelter or tracing family members and where and how can people access those services during times of disaster. The belief underlying these interventions is that most people who have faced a disaster will not have long-lasting mental health concerns but will recover over time if their basic needs are met (WHO, 2011).

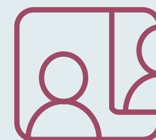
After the World Health Organization (WHO) declared COVID-19 a pandemic in January 2020, many countries put in measures such as lockdowns to limit the spread of the virus.Due to the enforcement of such measures, many low- and middle-income countries experienced disruptions in their ability to provide health, hygiene, and other social services to families (UNICEF, 2020). It is further anticipated that the repercussions of the pandemic might be felt long-term. An estimated 235 million people will need humanitarian assistance and protection in 2021 (Global Humanitarian Overview, 2021) which is nearly 40 percent higher than the number in 2020.

In India, the pandemic itself, the subsequent lockdown and its economic repercussions has created difficulties in providing for the basic needs for all. It has been estimated that more than 120 million people lost their jobs or economic activities during the lockdown (Cenat et al., 2020). The lockdown disproportionately affected marginalised communities because of the loss of livelihood and lack of food, shelter, health, and other basic necessities. For example, even though children all over the country were affected, those most vulnerable came from families where parents were working in the informal sector and did not have the option of working from home. Thus, basic needs have been highly affected during the COVID-19 crisis and addressing these needs has become an important consideration.

1. What is our role as mental health professionals?

Mr. G is a 34-year-old migrant laborer who was staying in the big city when the lockdown started. He had come to the city 7 years ago to find work and since then had been living in his shanty with other people from his village.

He used to be a daily wage-earner and would spend a part of his wages on buying groceries and paying rent and the rest would be sent back home. Thus, when the pandemic struck and the work reduced considerably, he had limited savings, and started worrying about how he would pay his rent. He could not afford to buy food and he would have to go without it for long periods of time. He would also feel highly anxious, experiencing breathlessness, dizziness and heart palpitations. Once, when he fainted, his friends rushed him to the hospital. Among other things, he also underwent a COVID-19 test for which he tested positive. He was asked to go home and follow all the precautions. At home, he got a call from a counselor asking about his mental health. He said that while he feels anxious and sad, all of this is related to his concerns about food and his family. If the counsellor really wants to help him, she should help him in finding food and reaching home. He does not think that he requires any other assistance



Reflective exercise

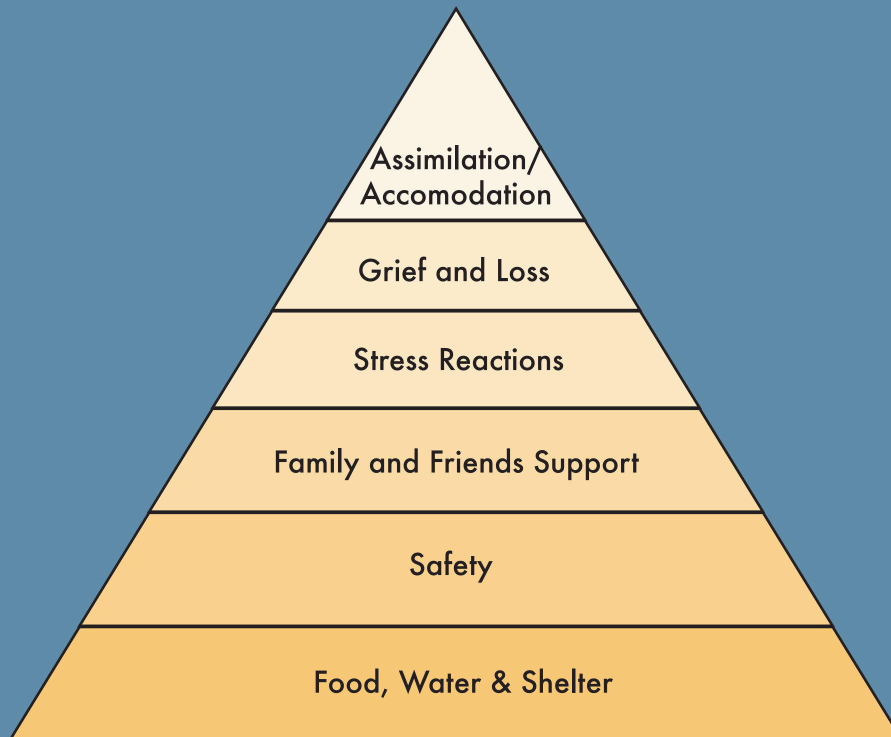
- What are your thoughts about the role of mental health professionals in addressing the basic needs of the individuals diagnosed with COVID-19?
- What could be some of the difficulties or unique challenges that you anticipate in helping clients with meeting their basic needs?

The WHO (2003) emphasizes that just like physical health and illness, mental health and illness are also influenced by socio-economic and environmental factors . Social, biological and psychological factors interact at multiple levels to influence mental health. Therefore, we cannot separate mental health from other concerns such as poverty that plague our country. Ensuring that good food, nutrition, safe housing, and physical safety is available to all becomes important for promoting mental health of people. These domains cannot be divorced from one another. While it might seem that addressing the issue of basic needs of clients may fall outside the purview of our work as counsellors and could be best may be handled by our colleagues from allied disciplines, we can contribute by assessing and addressing these needs. Sometimes, we may feel ill-equipped to answer these questions as our training seldom focuses on how to address these needs. But the need of the hour is such that we may be the only point of contact for any source of external help to assist clients with their practical needs. Hence it is important that we equip ourselves with a basic framework on how to support clients whose most pressing needs are practical rather than emotional in nature.

2. What key concepts and ideas can inform our practice?

The disaster survivor's hierarchy of needs model can inform our practice. This model is an extension of Maslow's hierarchy of needs (Jordan, 2013). At the base of the pyramid are basic needs. As ath-

erwe move towards the top of the pyramid, complex needs are encountered. The model covers deficiency, recovery and growth needs.



Deficiency needs. The bottom of the pyramid consists of deficiency needs. These are basic physical needs of water, food, and shelter and safety needs which are related to physical safety which may be directly or indirectly impacted.

Recovery needs. The next block are recovery needs (R-needs) which include family and friends support, managing stress reactions as well as dealing with grief and loss.

Growth needs. The last and highest level of the pyramid identifies growth needs (G-needs). The highest level of disaster recovery is the process of assimilation (i.e., incorporating the event into existing beliefs and values) or accommodation (i.e., changing the existing beliefs and values).

Thus, according to this model, the first step would be to address basic or deficiency needs and then move on to higher needs.

Disaster survivor's hierarchy of needs (Jordan, 2013)

3. How do we assess and intervene?

It may seem as though 'supporting clients with basic needs' involves solving their problems for them. An approach like that can be top-down, paternalistic and put us in the position of power as experts. Even while addressing basic needs, our role as mental health professionals remains to 'lead from one step behind', i.e., to create an empowering environment where our clients can be agents in solving their own problems. Acknowledging and respecting the person as the expert on their lives

would include:

- Acknowledging their strengths and how they have helped themselves
- Recognizing and identifying internal resources and capacity to cope
- Listening for people's preferred realities rather than imposing our own solutions
- Rather than solving the problem ourselves, empowering people to initiate their own solutions and mobilize their own resources
- Remembering that people are more than their problems. They are agents of change and are the experts on their lives.Looking for 'exceptions' in narratives of helplessness, such as small attempts to manage problems so far

3.1 Preparing to intervene

The primary work that we would be involved in is **resource coordination.**

3.1.1 Creating a database.

Resource coordination starts outside of the session by creating a database of resources and providing this information and referral to clients when we work with them in the session. This requires that we coordinate with other people in the community to get relevant and accurate information and also know whom to refer to in case client difficulties exceed our level of competence. Referring a client to a specialized resource or helpline is a critical intervention in its own right. This process also requires time and effort and we will have to be prepared to invest the same.

For this purpose, we can work with colleagues and other mental health professionals to develop a common pool of contact information for helplines, resources, NGOs as a group. This ensures that the task does not become the responsibility of a single individual and a wide net of geographical locations is covered. It also makes updating databases easier as new resources and information come to light during COVID-19. One example of generating such a database is given below.

RESOURCES							
Domain	**Name**	**Telephone**	**E-mail**	**Services offered**	**Communities Served**	**Catchment Area**	**Vetted by**
Medical							
Ration							
Shelter							
Domestic Violence							
Psychiatric Emergency							
Child welfare							

Sample Database

Support service	Phone number	How to refer
Mental health services		
Emergency medical service		
Fire services		
Social services		
Police		
Women's services		
Child protection services		
Legal services		
COVID-19 MHPSS Helpline		

Sample Database. Source: World Health Organization (2020)

3.1.1.1 Collecting data from different sources of basic needs

- **Social media:** We could keep an eye out for social media pages known for carrying articles which feature governmental and non-governmental organizations that can be helpful.
- **Traditional media:** TV, radio, newspapers and helplines can also be rich sources of information for those who do not have internet access. One useful source can be the local or regional newspaper which may provide us access to local or regional initiatives.

3.1.1.2 Cautions regarding data:

It is important that we do not forward the information just as we received. In the digital age, it is easy to spread information which may be misleading, non-useful and worse, endangering the client. This will be covered in the next chapter on sharing information. We could take the following steps when checking the veracity of the claims of the sources that we are forwarding:

Checking the resource. If the resource is mentioned in a social media post, we can check if the individual or the agency posting the numbers is reliable. For example, if the helpline number is available on the website or webpage

of an esteemed organization such as the World Health Organization or the Government, then it is probably more valid than a forwarded message on a social media platform which does not mention the source or cannot be traced back.

Checking the reliability. However, just because the message is availed through a reliable source does not mean that we can share it as it is. It is important that we check with the people who have quoted this resource. Did they have personal experience with the helpline? Are they well-informed? Do they have a stake in promoting the number? Do they benefit from its promotion?

Age and resource-based considerations. We have to remember that different media cater to different age-groups. Thus, checking if the same helpline or information is available across different media becomes important. For example, if a facility can be availed only by emailing to the relevant authorities, it is inaccessible to those who do not have email id. We can find out if there is a phone number which can give people similar access or a physical space where people can go to avail these services.

Vetting the resource. We can always call the number ourselves or have a trusted colleague vet the resource to assess how user-friendly these resources are. We can also try to call on an alternate number where our doubts about the helpline/organizations can be addressed.

3.1.1.3 Ways of vetting the source.

Some things that we can keep in mind during the checking process are:

Related to the helpline. We would have to know the helpline number, check if it is working, languages spoken by helpline staff, the quality of support provided, average wait-times and working hours of the helpline.

Related to the resources catered by the helpline. We would also need to know what services are provided by the helpline, where they would provide the resources, necessary resources or documents, if any, that are required by clients while calling, the fees, if any, and the approximate affordability.

3.2 Identifying the concern and providing interventions

The next task is to support clients in generating internal resources through in-session intervention. This would involve helping them identify resources in their own community and knowledge networks, engage in problem-solving, coordinating with family members, neighbours or community members and understanding and resolving obstacles that could probably influence this process. The goal of our intervention is helping clients to help themselves. During the times of crisis, people may feel that they do not have enough control over their lives. Thus, the best way to support clients is to help them regain control in certain aspects of their lives. This has an added advantage of enabling people to become self-sufficient.

3.2.1 STOP-THINK-GO

The WHO (2020) suggests a technique called the 'STOP-THINK-GO'. It can be understood as follows:

STOP: The first step is to help the person to take a pause. Asking the person to take a deep breath, prioritize and consider which problems require the most urgent attention. This can be done with the help of making lists on a piece of paper or phone or any other article that is available to the client.

Then, we need to consider if something can be done about the issues that the client is mentioning. One of the ways in which we can do so is by using "circles of control". A figure is given on the next page.

If you are feeling powerless to help others, it can be helpful to identify those problems you could do something about and those you cannot.Forgive and be gentle with yourself if you are unable to help in a particular situation.

Circles of Control Source: World Health Organization (2020)

These circles can be filled out in the session with the client. The circle in the centre can help them to identify and choose a task that they can be helped with in the session itself.

THINK: The next step is to encourage conversations which invite the client to think of solutions or ways in which the problem can be managed.

While prompting clients to think, it would be helpful for us to remember the strengths-based perspective that we have discussed earlier. In addition to questions regarding attempts made to solve their problems, inquiry about how others are managing the situation may provide ideas and hope to the clients. This might help clients feel less alone and allow them to draw from other people's experiences. They may also gain knowledge about the available resources \within their community and also those which are provided by the government. Some of the questions that can facilitate this process are -

- Do other people you know have similar problems? How have they managed?
- Is there someone who can help with managing this problem (e.g. friends, loved ones or organizations)?

GO: The last step is to help the client in choosing the way forward. We can start by listing out all the possibilities. At this stage, it is important that all of the options to manage that problem, no matter how impractical they may seem at the time, be written down. Only after that extensive list is drawn, we can start discussing the advantages, disadvantages, feasibility and resources required for each option. Some important questions that can facilitate this process for the client can be:

- **Related to their previous attempts.**
  - What have they tried so far?
  - How did they arrive at these options?
  - Who all have helped them so far?
  - What attempts have not worked out at all?
  - What has yielded partial success? In what way were these options unsuccessful?
  - What were some of the obstacles in implementing these options? Who or what

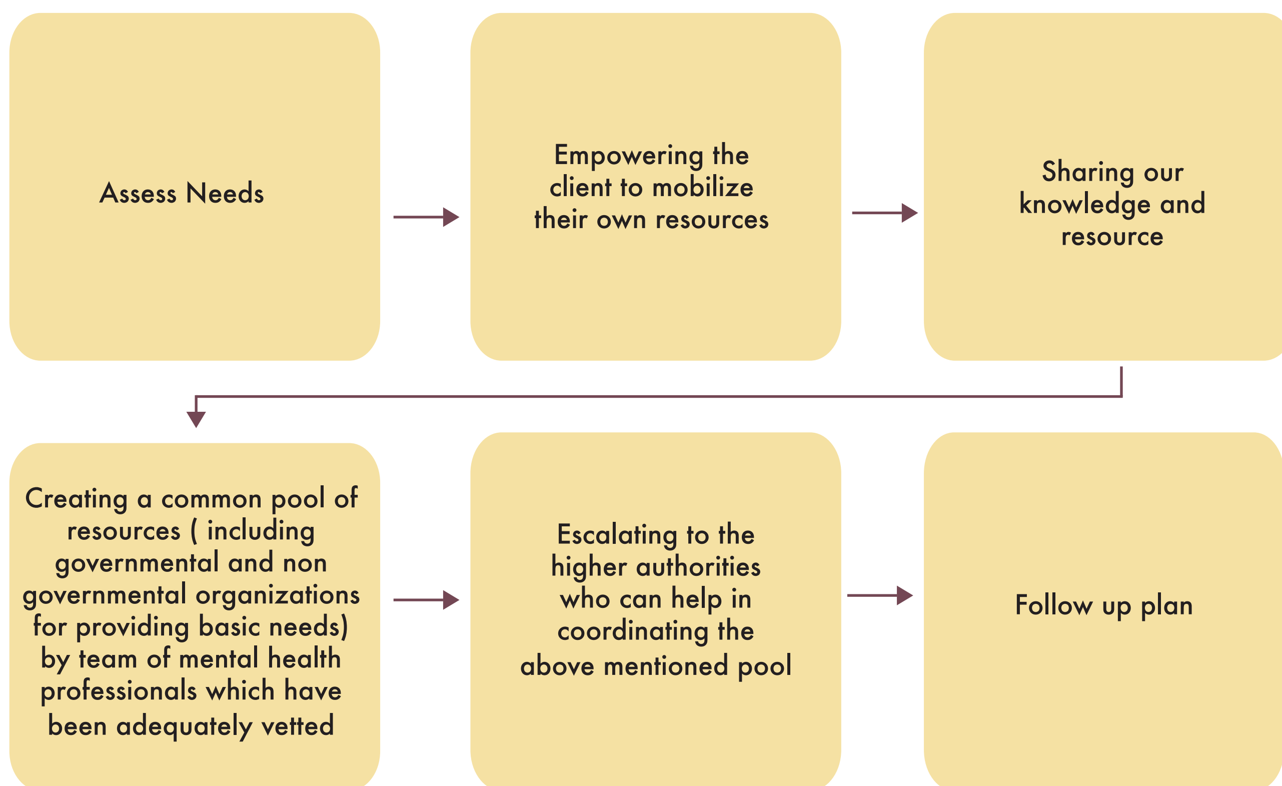
was helpful while implementing them?

- **Related to generation of new options.**
  - What other options are they aware of?
  - What resources do they think they will need for implementing these options?
  - What can be some of the obstacles that they can think of which may obstruct their attempts?
- **Tapping other resources.**
  - Whom can they contact for additional information (e.g. neighbor, friend, family, contacts, helplines)
  - What resources do they have access to? (NGOs, Government bodies, local leaders)
  - Do they have access to social media to connect with resources?
  - If not, do they know of someone who can have this access? Can they request them for help?

3.2.2 Empowering clients

The final step would be to try out solutions . It is possible that the first or seemingly best option does not work out. We have to be cognizant of this fact and also highlight it to the client. If one option does not yield a result, we will encourage them to choose and try any other option from the list. For this, an additional step that can be taken is to keep space for a follow-up call. We can plan for a follow-up call to check about the outcome of the previous call and if it does not work, plan for another solution. However, if the follow-up call is not possible, we can facilitate the person in carrying out this process with someone else as well.

The above mentioned model has been summarised in the figure below.



Summary of process

Let's avoid...

Trying to 'rescue the client' due to our own helplessness . Sometimes, in the face of distress that clients face, we may feel overwhelmed and want to rescue the clients by solving their problems. This may not be the best course of action for the clients who may not feel empowered by our actions.

Imposing our solutions to the problems that the clients are facing. This may go against our value of seeing clients as agents of change.

Defining people as their problems. If we look at people and only see their problems, we will only be looking at half the picture. Beyond every problem is a story of courage, strength and perseverance waiting to be shared.

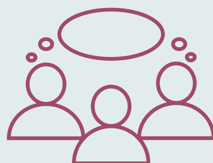
Trying to do everything on our own. It is important to seek help and coordinate with multi disciplinary professionals and other members in the community to ensure that we are able to care for ourselves and others as well.

Negating the client's attempts at problem solving. At times, we may feel that we have a better solution than the one offered by the client. It is then important for us to try to understand if the solution works from the client's perspective, and ensure that we chose the solution that is best suited to the client's needs, rather than our subjective understanding of which solution would work the best.

Accepting information as it comes. We will have to check the resource information before forwarding it further.

Distributing information uniformly, instead of matching it with the needs and resources of the client concerned. We will have to try to match the resources that we disseminate to match with the facilities that the client can avail. For example, we will have to ask the clients if they have access to the internet before giving them a list of websites which have databases for information.

4. How do we reflect on our work?



Supervision exercises

This chapter discusses a strengths-based approach that we can use with our clients. It is important for us to also reflect on our personal strengths and resources with our supervisors. We can use the following questions for reflection:

- What are the different areas of knowledge you draw upon as a counsellor? How did you acquire this knowledge?
- What are some skills that you have developed over time?
- What are some attitudes or values you work by that you are proud of?
- What are some resources you can draw upon? (e.g., mentors, peers, books)

Self-care Exercise

Meeting our physical needs plays a key role in keeping us healthy and motivated. Focusing on maintaining our own routine and physical fitness becomes important. But it is possible that in the middle of all the caregiving responsibilities that we have, we may miss out on prioritizing our health.

Take a piece of paper and try to write down the following questions. You can then ask similar questions to your family members and try to corroborate your answers with the answers from your family members..

- How is your sleep currently? How many hours of sleep are you getting each night? Do you look refreshed after waking up?
- How is your physical health? How often have you been feeling tired? Do you look tired and exhausted?
- How do you nourish yourself? Are you able to eat on time and drink enough water?

If there are discrepancies in the answers, then you may have to think and discuss how you can improve your health.

References

Cénat, J. M., Dalexis, R. D., Kokou-Kpolou, C. K., Mukunzi, J. N., & Rousseau, C. (2020). Social inequalities and collateral damages of the COVID-19 pandemic: when basic needs challenge mental health care. *International Journal of Public Health, 65(6)*, 717-718.

Centers for Disease Control and Prevention (CDC). Disaster Preparedness and Response: Complete Course. Facilitator guide, first edition. Atlanta (GA): CDC; 2014

Chiappero-Martinetti E. (2014) Basic Needs. In: Michalos A.C. (eds) Encyclopedia of Quality of Life and Well-Being Research. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-0753-5_150

Evans, A. A. (1976). Employment, Growth and Basic Needs-A One-World Problem. *Genève-Afrique/Geneva-Africa, 15(2)*, 77.

Jordan, K. (2015). The Disaster Survivor's Hierarchy of Needs: What Every Disaster Mental Health Worker Should Know. *American Counseling Association: Alexandria, VA, USA,* 7.

UNICEF. (2020). Situation tracking for COVID-19 socio-economic impacts. *New York: UNICEF.*

UNICEF. (2020). UNICEF humanitarian action for children 2021: overview.

World Health Organization, War Trauma Foundation and World Vision International. (2011). *Psychological first aid: Guide for field workers. WHO: Geneva*

2 Sharing Information

We currently live in an Information Age (Castells, 1996). A great deal of information is now present in a digital rather than printed form. Due to this, a large quantity of information is available easily and spreads quickly (Bawden & Robinson, 2008). There are two sides to this coin. On the one hand, the accessibility of any information we want is high (e.g., a Google search takes a few seconds as compared to going to the nearest library and looking up an encyclopedia). On the other hand, there is too much information available that may exceed our processing capabilities. Plus, much of this information may be unreliable or invalid, as anyone can put out information without any quality control (Bawden & Robinson, 2008).

The COVID-19 pandemic is being widely referred to as an 'infodemic' (Tangcharoensathien et al., 2020). Along with the spread of the virus, the rapid spread of information across global networks is playing a crucial role in the pandemic ("The COVID-19 infodemic", 2020). This includes information about the symptoms, transmission, precautions and management of COVID-19, information about its statistical spread, information about policies and procedures of the government (including lockdown and travel-related information) and information on the socio-economic-political implications of COVID-19.

On the plus side, the rapid spread of information is increasing access to valuable knowledge for people around the world (Tangcharoensathien et al., 2020). For example, an infographic on intubation of the respiratory system made in Hong Kong was quickly translated into multiple languages and disseminated around the world, benefiting many medical professionals (Chan et al., 2020).

Social media is also providing the general public with factual, timely and relevant advice as well as increasing communication between professionals and the public about COVID-19, its symptoms and precautions (O'Brien et al., 2020). In fact, such widespread sharing of information about COVID-19 may lead to a sense of unity in fighting the virus and increase compliance of the public to healthful behaviours (O'Brien, Moore, & McNicholas, 2020).

At the same time, there are challenges associated with the rapid spread and availability of information in the COVID-19 pandemic. One of the biggest challenges is misinformation. A wide variety of misinformation is being propagated, ranging from conspiracy theories calling the entire

Mythbusting (Source: World Health Organization, CC BY-SA) 3.0 IGO

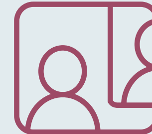
pandemic a hoax, to a range of false information on ways to prevent and treat COVID-19 ("The COVID-19 infodemic", 2020).

Such misinformation hinders healthy behaviours (Tasnim et al., 2020). The conspiracy theory that the pandemic is a hoax leads people to stop taking important precautions such as washing hands and wearing masks. Misinformation can also directly lead to serious health-related mishaps, such as when people in Nigeria overdosed on chloroquine after false news about its effectiveness in treating COVID-19 was propagated throughout social media (Tasnim et al., 2020). It also leads to increased stigma and discourages people from seeking healthcare, even when they are ill (Save The Children, 2020). Due to these reasons, combating misinformation is an important part of efforts to manage the pandemic ("The COVID-19 infodemic", 2020).

Another challenge is that information in the pandemic is constantly being modified. The Centers for Disease Control and Prevention (2020) changed its information about airborne transmission of COVID-19 multiple times, leading to controversy (Tanne, 2020). Similarly, national and state government policies with regards to COVID-19 are also in constant flux. For example, quarantine policies were constantly being revised across all the states in India (Explained Desk, 2020). Hence, information that is accurate at one time may turn obsolete hours later, leading to confusion and ambiguity.

Information is not disseminated in a vacuum. Politically, governments may want to be perceived as being in control, which could influence how they communicate information about the pandemic ("The COVID-19 infodemic", 2020). Commercial interests (e.g., companies looking to make a quick buck) may also drive misinformation (Eysenbach, 2020). False news about COVID-19 may get linked to certain social groups, sowing further seeds of polarization and disharmony (Eysenbach, 2020). Such factors complicate the management of information in COVID-19.

Let's pause for a moment and reflect on our own relationship to information and misinformation in COVID-19.



Reflective Exercise

"Lies spread faster than the truth on the Internet" (The result of an MIT study done by Vosoughi, Roy, and Aral [2018])

- Do you use social media or the Internet?
- What kind of information have you come across on social media/Internet with regards to COVID-19?
- From where do you personally seek out information you wish to know about COVID-19?
- What leads you to suspect that some information is false or not entirely true?
- How would you feel if you discover that some information you previously believed to be true is actually fake?

1. What is our role as a mental health professional ?

Aakash is a 50 year old man currently in quarantine as he has recently tested positive for COVID-19. When the counsellor calls him, he speaks at a rapid pace and starts discussing the number of deaths from COVID-19 in India over the past few days. He goes on to ask, "How many days of quarantine are required for me? What if 15 days is not enough? Can COVID-19 spread from me to my family members even after 15 days? When should I get re-tested? What precautions should I take to avoid giving it to my wife? I wish I knew how I could find out all this properly." Without waiting for the counsellor to reply, he continues, "I am checking many different websites everyday, so that I know exactly what is happening. I have also downloaded the Aarogya Setu app and I keep checking it for any updates about COVID-19. I want to know everything, but I am so confused, there are no clear guidelines. Somebody says something, then the next day, they will say something else. Can you tell me what to do?"

Experiences of counsellors working in helplines show that in the pandemic, many clients may have similar concerns such as Aakash's. They may present with requests for information or with concerns related to misinformation. Table 2.1 displays various categories of information we may be asked about:

Symptoms of COVID-19	I have fever and loss of sense of smell, does it mean I have COVID-19?
Precautions to take	What can we do to protect ourselves from COVID-19?
Getting tested for COVID-19	Should I get my mother tested? What are the different tests available for COVID-19?
Quarantine	How long will I have to quarantine for? Do I have to quarantine at home or somewhere else?
Prognosis for different groups	My father has diabetes, is he more at risk for dying?
Access to treatment	Which hospital is the best for COVID-19? How can we get beds?
Official policies and procedures	Is it true that if you eat garlic you will not get COVID-19? Can COVID-19 be transmitted through soap?
Information vs misinformation	Is it necessary to inform the government if you test positive for COVID-19? Is it compulsory to get tested if you have fever? Can you travel without a permit?

Types of information we may be asked about

The pertinent question here is: Considering the importance and complexity of information in COVID-19, is sharing and managing information part of psychosocial work?

Information has been identified as a basic need that psychosocial work can help to address in the aftermath of disasters and is a crucial aspect of models of PFA (WHO, 2011; IFRC Reference Centre for Psychosocial Support, 2018; Brymer et al., 2006). According to the NCTSN Model (Brymer et al., 2006; Vernberg et al., 2008), enhancing safety and comfort for people involves 'providing and clarifying risk-related information [and] giving information about the current disaster response and available services' (p. 383). In COVID-19 especially,

which is as much an infodemic as a pandemic, we believe that we cannot ignore client concerns about acquiring and managing information

The following points may help to clarify the scope and limits of our role in providing information during brief telephonic counselling:

- We share general information about COVID-19 but not specialist information e.g., advising a client on which medicines to take
- We aim to empower clients to seek out information for themselves. We do not act as a primary information helpline and proactively refer clients to other resources as required.
- We support clients with psychosocial concerns relating to information (e.g., information overload), however, we may not be able to carry out extensive or long-term interventions.
- We support clients in combating misinformation but do not attempt to argue or debate with them to convince them of our points of view.
- Is there any other scope or limit you can think of?

2. What key concepts and ideas can inform our practice?

This section describes the difference between information, misinformation and disinformation and key ideas for combating misinformation. We also discuss the concept of information overload. All of these ideas are critical to keep in mind as we intervene in this are

2.1 Getting accurate information and combating misinformation

WHO (2020) distinguishes between information, misinformation and disinformation. Information is data that are accurate to the best of our current knowledge. Misinformation is false information that is shared without knowing that it is false or without the intent of hurting others. Disinformation is false information created with the intent of profiting from it or causing harm.

Information, misinformation and disinformation

WHO's (2020) recommendations for combating misinformation can be grouped into three key concepts:

- Ensuring we get our information from accurate and reliable sources.
- Taking a critical stance towards information we receive rather than accepting it at face-value.
- Making careful, considered and responsible decisions to share information and not assuming that any and all information sharing is beneficial.

Figure 2.3 illustrates these key concepts and shows how a simple action by even one individual can significantly reduce the infodemic.

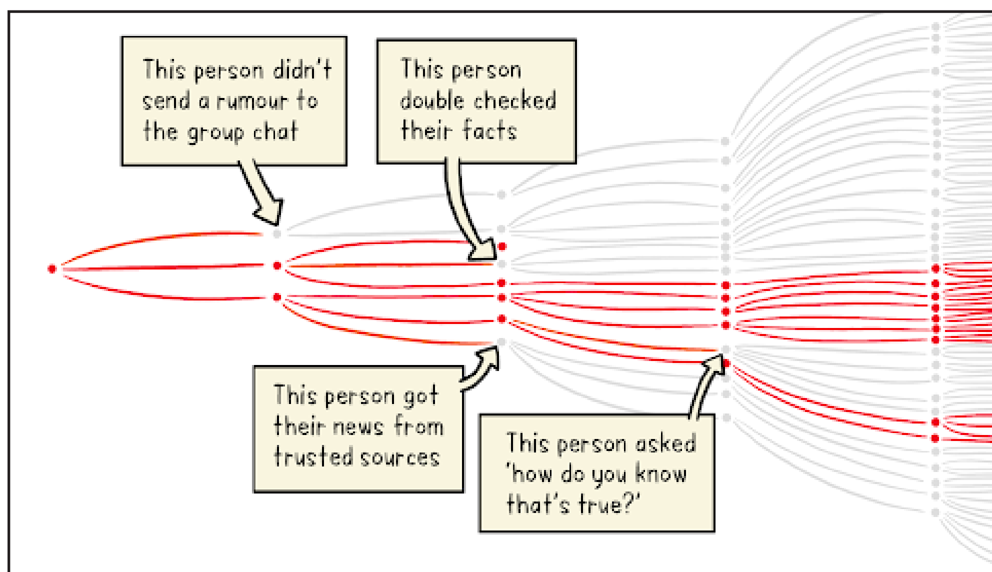
2.2 Information Overload

Information overload is when the amount of information available crosses one's processing capacities and can no longer be made use of efficiently (Bawden & Robinson, 2008). In the COVID-19 pandemic, researchers predict an increase in 'cyberchondria', i.e., continuous impulses to go online and find information about a health issue (Farooq et al., 2020). This search for more and more information can be fuelled by the uncertainty around the pandemic. As information overload reduces the efficiency with which we use information, it can decrease overall self-efficacy in coping with the pandemic (Farooq et al., 2020).

Much prior to the COVID-19 pandemic, in a paper aptly titled 'The dark side of information', Bawden and Robinson (2008) identified the consequences of the changing contexts in which information is available to humans now as compared to several decades earlier. They discuss how it can lead to the following:

Information anxiety is anxiety arising from the inability to access, make use of or act upon information (first defined by Wurman [1989]). One significant factor contributing to information anxiety may be the availability of too many choices of where to seek information from.

Information avoidance and/or information hypervigilance. Information avoidance occurs when people start avoiding relevant or useful information as there is simply too much information to deal with. The corollary is hypervigilance or constant monitoring of information. Some people may oscillate between hypervigilance and avoidance of information.



WHO: Flattening the infodemic, reproduced with permission of the World Health Organization http://www.who.int/news-room/spotlight/let-s-flatten-the-infodemic-curve

Loss of control. When faced with information overload, people may feel helpless and overwhelmed. Over a longer term, it can also lead to distractibility and more general damage to health and well-being.

Shallow novelty. Because it is not so easy to produce genuinely new information, old information is re-packaged and re-presented in various different ways, leading to an expectation of constant novelty for the consumers. This is called the phenomenon of shallow novelty.

3. How do we assess and intervene?

3.1 Preparing to intervene

Before we can work with clients in helping them acquire and manage information, there are certain ways in which we can prepare ourselves

3.1.1 Acquire accurate information.

In order for us to be able to share specific information with our clients, we need to possess this information in an accurate and reliable manner. This does not mean that we are aware of every single piece of information and stand in for medical professionals. However, awareness of basic information about different aspects of COVID-19 in India can help us in managing clients' needs for information. We can increase our knowledge by:

Reading up or listening to basic information about COVID-19 from reliable sources. This may include information about basic symptoms of COVID-19, tests for COVID-19, prognosis, precautions that can be taken as well as the latest policies and procedures specified by the national and respective state government where we work.Diversifying the sources we get information from (i.e., getting information from multiple sources) increases the reliability of the information.

Keeping updated about new information. Since information around the pandemic is extremely dynamic and ever-changing, it is also important to know about changes to previous statements and new information that is released.

Vetting all the information we receive (e.g., from Whatsapp groups or what we hear from family/friends). This is an action that will help us combat misinformation at a societal level as well as equip us to deal with misinformation that clients may bring up.

Online sources for accurate information

The official website of the Ministry of Health and Family Welfare, Government of India: This website provides reliable and accurate information on the status of COVID-19 in India, latest government guidelines and information about COVID-19 facilities in various states. It also includes an extensive section on awareness materials in English and Hindi about COVID-19. (https://www.mohfw.gov.in/)

MyGov Is a citizen participatory initiative run by the Government of India that has a section devoted to providing information on COVID-19 in India. It gives information on helplines, applying for travel passes as well as busts myths related to COVID-19. (https://www.mygov.in/covid-19/)

The website of the National Disaster Management Authority (NDMA) of India features reports and studies done on COVID-19. (https://ndma.gov.in/)

The official website of the World Health Organization provides reliable and verified information about COVID-19. It contains an extremely useful section on various myths pertaining to COVID-19 prevention and transmission called 'Mythbusters'.
(https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

Verified is an initiative by the UN to share verified and reliable information about COVID-19
(https://shareverified.com/en/about)

Wikipedia (https://en.wikipedia.org/) is likely to be more reliable than other unknown news sites that we may not have heard of. This is because although Wikipedia is crowd-sourced, WHO and Wikipedia have been working together to ensure accurate information (McNeil, 2020).

Note: Whatsapp forwards are unlikely to be a reliable source of information and are well-known for promulgating fake news and images (Farooq, 2018). Other common sources of misinformation include Google searches, blogs, self-published books and articles from predatory journals.

How to verify information that we receive (Adapted from WHO, 2020)

Let's take a curious stance towards any new information.Let's try not to immediately decide what we feel/think about it.

Let's check the source.
- Where is this information coming from?
- Is the source a trusted organization?
- If it is an individual, what are their credentials?
- If it is a scientific journal, is it a peer-reviewed journal?

Let's read beyond the headline.
Headlines can sometimes be 'click-bait' or sensationalized. Reading the full article or story can help us develop a more balanced view of the information being presented.

Let's check the date.
Some news stories or articles from several years ago may be re-shared as referring to current circumstances.

Let's check the writing style.
Some red flags that we can watch out for:

- Writing that contains a lot of spelling errors or grammatical mistakes or is poorly formatted
- Writing that uses extreme language or promises guarantees or miracles e.g., 'Miracle cure for COVID-19! Surefire way to cure COVID!'

A reverse image search that allows one to search for similar, related images may be helpful in finding out whether a forwarded image is fake or not. Google has a mechanism through which one can do a reverse im-

age search.
(https://support.google.com/websearch/answer/1325808)

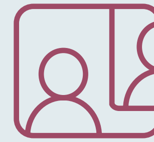
The YouTube Data Viewer tool by Amnesty International
(https://citizenevidence.amnestyusa.org/) can help in verifying the authenticity of a YouTube video by providing information such as upload date, upload time and allowing one to do reverse image searches for the content of the video.

AltNews is an Indian website dedicated to combating fake news. It verifies the authenticity of a news item and gives a detailed explanation of why it is false.
(https://www.altnews.in/topics/news/)

The RAND corporation website contains an entire database of web-based tools that can be used to combat disinformation.

3.1.2 Resource coordination.

Apart from direct sharing of information, we may also need to refer the client to other sources of information. We can prepare ourselves by maintaining a database of possible sources for different kinds of information. We can use a similar template to what is shared in Chapter X (Helping clients with basic needs).



Reflective Exercise

For this exercise, try to do a role-play with a colleague. If a colleague is not available, you could role-play with a friend or family member as well. Pretend that you are a client seeking information about COVID-19 testing. Ask the colleague or friend to play the role of a counsellor and behave as per the scenarios outlined below. Ask them to extrapolate from the small brief given below, but to keep with the theme outlined in the brief.

1. The counsellor does not ask you what you already know and starts telling you everything they know about COVID-19 testing.
2. The counsellor keeps saying that it is not within their role to provide you this information and they cannot help you.
3. The counsellor very strongly argues against your view that ‘COVID-19 tests show false results more than true results’ and presents you with a lot of different research claims to back it up.

Let us reflect on how it felt to ‘receive information’ in these different scenarios:

- Did you feel like you were being lectured or talked down to?
- Did you feel judged?
- Did you feel that your views and knowledge were not being given importance?
- Did you feel frustrated that what ysought was not being provided to you?

The French philosopher Michel Foucault said that 'Knowledge is Power' (in Foucault & Gordon, 1980). The power dynamics of being a recipient of information are often invisible to us because, as mental health professionals, we are often in a position of giving knowledge. The emotional impact of being in a position of having less knowledge and thereby, less power, is important to keep in mind.
What do you think the practice implication following from this might be?

3.2 Identifying the concern

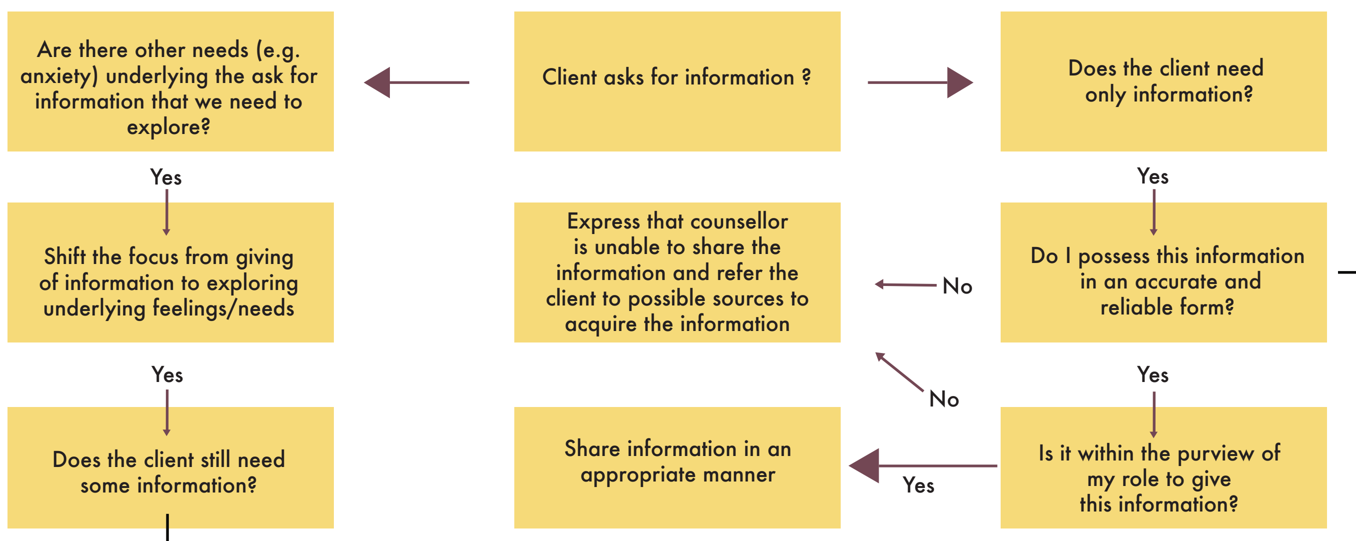
- There can be several indicators that the client has an information-related concern.
- They may directly ask us for information ('Do you know where to get tested for COVID-19?')
- They may directly ask us for ways to acquire information or combat misinformation ('Which site should I go to to find out about COVID-19?')
- They may keep talking about several pieces of information about COVID-19 and sound confused/anxious/helpless (See Aakash's example at the beginning of this chapter)

They may present us with misinformation that is significantly influencing their distress and/or functioning ('I read that people of a certain community are deliberately coughing and spreading COVID, I am getting very worried, how can I protect myself?')

3.3 Providing Interventions

After we have identified that the client has an information-related concern, we need to decide on the direction of intervention. Some questions we can ask ourselves to aid our decision-making include:

- **Does the client need only information or are there other needs underlying the ask for information?** For example, anxiety may be driving some clients' need for information and we may wish to discuss these feelings of anxiety rather than simply answering their questions/redirecting them to another source to get answers.
- **Do we possess this information?** If we are not sure about the information the client is asking for, we may need to refer the client to a more reliable source.
- **What kind of information can we ethically share?** For example, we cannot share specialist medical knowledge even if we know something due to our personal experiences.



Decision-making tree for managing information-related concerns

Practice Exercise

Read the case vignettes below. In each vignette, the client asks the counsellor for certain information. Try to decide which direction you might proceed in in each of these cases. (e.g., Will you share information? Refer the client to another source? Shift the conversation to the client's anxiety?). You could use the decision-making tree above to guide you.

A. Sharmila is a 31 year old pregnant woman who tested positive for COVID-19 before her delivery. She was asymptomatic but when she got retested after 14 days, she again tested positive. Her doctor advised her to proceed with the delivery and the couple had a healthy baby. However, the couple is confused about the second positive report and is wondering whether the baby has a risk of having COVID-19. They ask you whether it is possible that the baby has COVID-19 without them knowing, whether they should get the baby tested and how.
B. Shahid, a 24 year old man, is on the call with you and is very worried about getting COVID-19. He tells you that he is sharing his living space with two other people. He asks you 'Should I wash my soap before and after taking a bath? How many times should I wash it? Can COVID-19 be transmitted through footwear? Should I wash my chappal every time we step in the house? Should my room-mates also wash it? Can COVID-19 be transmitted if I touch the toilet seat that my room-mate has touched for five seconds?'
C. Mary is a 45 year old person who has recently tested positive for COVID-19. She tells you that she is doing well and has a mild cough. The older members in her family are quarantining at home as per procedure. She asks you whether it is true that drinking turmeric milk can cure COVID-19 within 24 hours. She also asks you if you are aware of some other general precautions her family members can take to avoid getting COVID-19.

Once we have made a decision about sharing information with a client, the next step of the process is how we share the information.

3.3.1 Direct sharing of information.

This refers to situations wherein we directly share our knowledge with the client. For example, the client asks us about some precautions to take during COVID-19 or the client asks our opinion about a purported miracle cure for COVID-19. In this case, we can:

Ask the client what they already know. This gives us a sense of the client's existing knowledge, the level of detail and depth they are looking for as well as whether they want new information from us or want to confirm something.

Ask the client their thoughts/feelings about what they already know. It is possible that the client may have some anxieties or doubts about what they are asking us and knowing this can help us navigate the conversation better.

Ask permission to share information, especially if combating misinformation. 'Can I share my knowledge about that with you?'

Use 'I statements' to clearly indicate that what we are saying is our knowledge and opinion, the client is not obligated to agree. 'From what I have read, I think that…' 'I have come to understand that' 'To the best of my knowledge'

Speak clearly without use of jargon and use short sentences that are easy to understand. For example, saying 'Research has found that some vaccines are more effective, some are less effective. None is 100% effective' is better than saying 'Randomized controlled trials have found several different vaccines to be efficacious at different levels in their Phase 3 trials and none delivers complete protection.'

Check for the client's understanding and satisfaction. *'Is that making sense?' 'Have I answered your question?'*

Share information with an open attitude. Let's not get too attached to the information we share and respect the client's boundaries. The client is not obligated to agree with us or accept the information we share at face-value.

Be honest about lack of knowledge. If we don't know something the client asks, let's be honest about our lack of knowledge rather than trying to give an approximate answer.

3.3.2 Empowering clients to seek out their own information and combat misinformation.

Apart from direct sharing of information, we can also empower people to seek out their own information and to combat misinformation.

Psycho-educating clients about information and misinformation. We can provide clients with information about information! Some facts we can psychoeducate clients about include:

- Misinformation is present and exists everywhere. '*There are a lot of rumours and fake news going around, not everything we read may be true' 'Studies have found that fake news gets shared at a much faster rate than true news'*
- The information available is constantly changing. *'Since COVID-19 is a relatively new virus, scientists are still researching about it... information about it is changing so what we discuss today may or may not be valid some time later'*
- The importance of vetting what information we receive. 'Doing a few simple things like checking the source of the information and the date can really help us in deciding if something is true or false'
- The importance of responsibly sharing information.Asking ourselves 'Why are we sharing this information? Whose agenda will it support?' before we share something can benefit our family and friends and prevent us from causing any harm to them.'

It is important that we time these statements appropriately when the client brings up the topic and avoid lecturing the client. Making a short statement and then asking *'What do you think?'* or '*What are your views?'* can also help with this.

Discussing where to acquire information from. Clients may want to understand where to get information from. In this case, we can help them problem-solve by asking *'Where do you think you could get the answers to these questions?' 'How have you got information you needed in the past?'* 'How have people around you been getting their information?' 'Do you have any ideas for how you could get answers to your questions?' We can

also ask them for their preference and capacities to source information *'Do you prefer searching online or calling or physically visiting a place? What is possible for you?' Depending on their answer, we can then help them narrow down: 'Is there a particular website you could check that you feel is reliable?' (or number you might want to call or place you might want to visit?) Do you think they will give you reliable information?*

Suggest reliable sources we know of. If the client is unable to come up with their preferred sources, we can suggest sources as per the database we have prepared. Let's try to make sure that our suggestions match the client's resources, context and educational background. For example, suggesting an online website to a client who does not have access to the Internet would be insensitive and unhelpful

Help the client to reflect on vetting information. We can engage the client in a discussion about vetting information, *'How do you generally check on the information you read or hear? How do you decide whether to trust something or not? Do you feel it is important to check information? What do you feel are some red flags for false news?'* If they do not vet information, these questions may help them reflect on the value of doing so. If clients seem interested, we can also share the processes recommended for vetting information (See the box above on 'How to verify information you receive').

Judicious self-disclosure. Careful self-disclosure can help normalize for clients that everybody can fall prey to misinformation, including mental health professionals, and hence reduce the feeling that they are being lectured at, e.g., 'I have found it helpful to pause and think for a second about why I am sharing some information' 'I am sometimes tempted to Google symptoms but then I have realized that for each and every symptom, Google will always tell me a serious disease that I may have'

Have a non-judgmental attitude to clients' beliefs and processes. Through this, we can be open-minded and help clients judge information as per their own value systems. For example, some clients may believe that it is extremely important for them to trust family and friends and may not want to check information that is received through them.

3.3.3 Helping clients with information overload.

Clients who are feeling the effects of information overload may often be anxious, helpless and overwhelmed. Initially, we may need to use some emotion regulation strategies (described in Chapter 3, Section 3) to support clients to calm themselves. Once we have ensured that clients are less distressed and ready to receive concrete suggestions on managing information overload, we can use the following interventions based on Bawden and Robinson's (2008) guidelines.

Information-life balance. We can encourage our clients to develop a healthy balance between accessing information and recreation/relaxation. This may include limiting time spent on social media, Internet and consuming news. Another method is to read or listen to an entire source of information properly and take time to reflect on it rather than skimming many different sources. Finally, we can adopt an attitude of 'satisficing', that is, being okay with 'good enough' information rather than searching for the perfect conclusion and perfect information (which usually does not exist!).

Taking control of one's information environment can reduce feelings of powerlessness and feeling overwhelmed. This can be done through use of tools such as filtering, unsubscribing to needless emails/alerts and disabling constant alerts on smartphones. Such 'push' notifications (e.g., an application sends a notification every time there is breaking news) can

make us feel compelled to look at the alert and reduce the sense of control we feel.

We can also examine and use our preferred coping strategies that we might have used in the past to our benefit e.g., 'I tend to avoid information when I feel overloaded, maybe I can just read 2 pieces of news a day just when I am having my morning coffee, so I am not totally avoiding all information.'

Strategies to address misinformation (e.g., accessing reliable sources, vetting before sharing) can also increase a sense of control one has over the information environment. Finally, we can help clients adopt certain rituals around information consumption, e.g., 'I will not read the news before bedtime as I want to enjoy a good sleep'. These rituals should be personal and collaboratively tailor-made with the client.

Remembering that people use and limit information in ways that are unique and personal. There are no standard recommendations that apply to everyone; every person must individually decide for themselves to what extent and how much they want to use information. Hence, our approach with clients is not to direct them to limit information consumption to a certain number of hours but engage in a meaningful discussion with them about their personal preferences. For example, with Aakash in the case vignette above, such a conversation could be initiated by asking, *'I am hearing that you are accessing a lot of different sources of information about COVID-19, can you tell me more about how this is affecting you?'*

Let's avoid

Trying to strongly convince the client about our point of view e.g., 'No, you are wrong, garlic does not cure COVID-19!' If a client is skeptical, we can encourage them to confirm the same information on their own through different reliable sources.

Suggesting standardized limits or directive rituals about information access or social media to every client e.g., 'You should be on social media for only 1 hour a day at most' 'You should never read the news before bed-time'

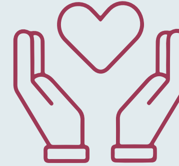
Overloading the client with information by sharing too many pieces of information without checking for the client's understanding and feedback**.** This is even more important on the telephone, as we do not have any visual feedback from the client's facial expressions.

Suggesting an inaccessible source to a client that is outside of the purview of their resources or no longer existent, e.g., suggesting an app to a client who does not own a smartphone or suggesting a defunct helpline

4. How do we reflect on our work ?

Supervision

- Sharing information can be directive in nature. If you work with a client with both emotional and informational concerns, how can you balance the directive and non-directive nature of work in the same session? Would you like to role-play this shifting of gears with your supervisor/ peers?
- Making decisions about whether to share information or to empower the client to seek out their information or to refer the client elsewhere can also be useful to discuss in supervision. Perhaps you could take some case examples and work through a decision-making process with your supervisor.
- How does your supervisor share information with you? Do they directly give you information on a certain topic? Do they ask you what you know? Do you appreciate their approach? You could reflect on how knowledge is shared in your supervision session itself - this may not only benefit your client but also make your supervision richer!



Self-Care Exercise

- It's not just our clients who are living through the pandemic and infodemic. We are, too! Are there times you feel 'overloaded' with information in the infodemic? How does this affect you?
- Would you like to make any changes to how you access and manage information? Would you like to implement any of the suggestions above or create your own?
- If yes, you could make a commitment to yourself about one small way in which you will take care of yourself in the infodemic.

References

World Health Organization. (2020). *Let's flatten the infodemic curve.* https://www.who.int/news-room/spotlight/let-s-flatten-the-infodemic-curve

McNeil, D. G. (2020, October 22). Wikipedia and W.H.O. Join to Combat Covid-19 Misinformation. *The New York Times.* https://www.nytimes.com/2020/10/22/health/wikipedia-who-coronavirus-health.html

Save The Children. (2020, June 1). Misinformation leads to increasing COVID-19 stigma in Sub-Saharan Africa.
https://www.savethechildren.net/news/misinformation-leads-increasing-covid-19-stigma-sub-saharan-africa

The COVID-19 infodemic. (2020, July 17). *The Lancet Infectious Diseases [Editorial], 20(8),* 875.
http://dx.doi.org/10.1016/S1473-3099(20)30565-X

Tasnim, S., Hossain, M., & Mazumder, H. (2020). Impact of Rumors and Misinformation on COVID-19 in Social Media. *Journal of Preventive Medicine and Public Health, 53,* 171–174.

Farooq, A., Laato, S., & Islam, A. K. M. N. (2020). Impact of Online Information on Self-Isolation Intention During the COVID-19 Pandemic: Cross-Sectional Study. *Journal of Medical Internet Research, 22(5)*, e19128.
https://doi.org/10.2196/19128

Bawden, D., & Robinson, L. (2009). The dark side of information: Overload, anxiety and other paradoxes and pathologies. *Journal of Information Science, 35(2), 180–191.*
https://doi.org/10.1177/0165551508095781

Farooq, G. (2018). Politics of Fake News: How WhatsApp Became a Potent Propaganda Tool in India. *Media Watch, 9(1)*, 106–117.
https://doi.org/10.15655/mw/2018/v9i1/49279

Wurman, R. S. (1989). *Information anxiety.* New York: Doubleday.

Foucault, M., & Gordon, C. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977.* New York: Pantheon Books

Bawden, D. (2001). *Information Overload* (Library and Information Briefing Series). Library and Information Technology Centre, South Bank University: London

Castells, M. (1996). T*he Rise of the Network Society, The Information Age: Economy, Society and Culture.* Malden, MA; Oxford, UK: Blackwell.

Chan, A. K. M., Nickson, C. P., Rudolph, J. W., Lee, A., & Joynt, G. M. (2020). Social media for rapid knowledge dissemination: early experience from the COVID-19 pandemic. Anaesthesia, 75(12), 1579–1582.
https://doi.org/10.1111/anae.15057

Eysenbach, G. (2020). How to fight an infodemic: The four pillars of infodemic management. *Journal of Medical Internet Research, 22(6).*
https://doi.org/10.2196/21820

Tangcharoensathien, V., Calleja, N., Nguyen, T., Purnat, T., D'Agostino, M., Garcia-Saiso, S., Landry, M., Rashidian, A., Hamilton, C., AbdAllah, A., Ghiga, I., Hill, A., Hougendobler, D., van Andel, J., Nunn, M., Brooks, I., Sacco, P. L., de Domenico, M., Mai, P., … Briand, S. (2020). Framework for managing the COVID-19 infodemic: Methods and results of an online, crowdsourced who technical consultation. *Journal of Medical Internet Research*, 22(6), 1–8.
https://doi.org/10.2196/19659

O'Brien, M., Moore, K., & McNicholas, F. (2020). Social media spread during covid-19: The pros and cons of likes and shares. *Irish Medical Journal, 113(4)*, 7–9.

Vernberg, E. M., Steinberg, A. M., Jacobs, A. K., Brymer, M. J., Watson, P. J., Osofsky, J. D., Layne, C. M., Pynoos, R. S., & Ruzek, J. I. (2008). Innovations in Disaster Mental Health: Psychological First Aid. *Professional Psychology: Research and Practice, 39(4)*, 381–388. https://doi.org/10.1037/a0012663

Tanne, J. H. (2020). Covid-19: CDC publishes then withdraws information on aerosol transmission. *BMJ, 370,* m3739. https://doi.org/10.1136/bmj.m3739

World Health Organization, War Trauma Foundation and World Vision International. (2011). *Psychological first aid: Guide for field workers.* WHO: Geneva

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P (National Child Traumatic Stress Network and National Center for PTSD). (2006). *Psychological first aid: Field Operations Guide* (2nd edition). Available on www.nctsn.org and www.ncptsd.va.gov.

IFRC Reference Centre for Psychosocial Support. (2018). *A Guide to Psychological First Aid for Red Cross and Red Crescent Societies.* Copenhagen.

Explained Desk. (2020, September 24). Explained: Here are the revised Covid-19 quarantine rules across India. The Indian Express.
https://indianexpress.com/article/explained/updated-covid-quarantine-rules-across-states-delhi-mumbai-west-bengal-kerala-karnataka-andhra-pradesh-tamil-nadu-6609090/

3 Reducing emotional distress

The COVID-19 pandemic is an unprecedented life event, characterized by worries about one's own health and that of family members, economic and lifestyle disruptions, social isolation and a complete upsetting of 'life as we knew it' (Bertuccio & Runion, 2020; Shanahan et al. 2020). These conditions are creating a 'perfect storm' (Reger et al., 2020) for inducing emotional distress in people (Shanahan et al., 2020)

More specifically, specific emotional reactions described in the COVID-19 pandemic include:

- **Anxiety:** Contracting COVID-19 and the health, social, emotional and financial consequences of the same is a major source of anxiety (Grover et al., 2020; NDMA, 2020).
- **Anger:** Anger has been reported due to poor management, invasions of privacy and perceived unethical practices or unfair circumstances.
- **Low mood:** Widespread lifestyle disruptions and decrease in social connection due to social distancing protocols have led to mood disturbances for many individuals.
- **Guilt:** The pandemic has led to scenarios wherein people are unable to perform certain actions, such as tending to a loved one who is sick or performing last rites for a loved one who has passed away. This has led to feelings of guilt and regret.

All these emotions will be discussed in detail in further chapters. Groups that may be particularly vulnerable to emotional distress include immunocompromised patients, older adults, individuals with previous medical and psychiatric conditions and women (Ghosh, 2020; Ornell et al., 2020). Individuals diagnosed with COVID-19 may also be at risk for emotional distress (Ornell et al., 2020; Rogers et al., 2020). There is another side to the coin. As the pandemic has progressed, Lwin et al. (2020) found that along with sadness, there was also a concurrent increase in social media posts expressing hope and gratitude. Shanahan et al. (2020) too, found, that some young adults reported an improvement in mood during the pandemic as compared to before. Open-ended comments from participants suggested that decreased workplace or educational pressures, increased amount of time available to spend with loved ones and on hobbies and the opportunity to sleep more could have contributed to this improvement in mood.

1. What is our role as mental health professionals?

The counsellor calls Naima, a 40 year old woman, currently in a government hospital. Upon picking up the call, Naima sounds extremely upset. Her voice is close to tears, high-pitched and she is breathing rapidly. She starts with saying that she lost her mobile phone which she left under the pillow while going to the washroom. The counsellor finds it hard to console her as there is no way to assure her that she will get it back. Then the client continues, 'When I reached the hospital, I was told to go to the 8th floor and that someone will be there to guide me. I went there and a man came and directed me to a room at the far end of the corridor. There was no one else in the room so I thought the other bed may be occupied by a lady and settled down. Then I noticed that the man is not leaving and there is no power in the room. I asked him why he was still there and he said, 'This is my bed'. I was shocked. I just screamed loudly and started shouting at him. Then some other patients gathered and a ward boy came and gave another room.'

As she speaks, the client starts crying on the phone.

As mental health professionals, working with people in emotional distress is a key aspect of our role. When conducting brief telephonic interventions, the scope of our role can include (but may not be limited to):

- Identifying that emotional distress is an area of concern for the client and bringing the same to their notice.
- Helping the client feel understood and validated, thereby reducing emotional distress.
- Equipping the client with strategies and tools to manage and reduce their distress.
- Referring the client, if needed, to more specialized services, in a manner that maximizes the chances of the client following up on the referral.

2. What key concepts and ideas can inform our practice?

2.1 Principles of working with emotions.

This section provides a brief outline of the key principles we can use when working with emotions in counselling. These principles are derived from emotional schema therapy (Leahy, 2015) and dialectical behaviour therapy (Linehan, 1993).

Emotions are as primary as cognitions. Emotions are part of the limbic system or the older brain. They are automatic and reflexive. In fact, Plato (1991) called them the first 'fluttering of the soul' in response to an event. Emotions are also evolutionarily adaptive (e.g., fear makes us protect ourselves). Hence, our bodies and brains are primed to emotion and it is difficult to have conscious control over the initial emotion we feel in response to something.

Throughout the history of psychology, there has always been a tension between emotion and cognition. Many philosophers have privileged 'rationality' and 'logic' above all else. This can lead to the assumption that thoughts can always manage or control emotions. However, because emotions are part of our older brain and because they are evolutionary adaptive, emotional responses cannot always be modified by rational thought.

Painful and difficult emotions are universal human experiences. Emotions such as sadness, anger, hurt, fear and so on are part of the human condition. Everyone experiences these emotions at some point in their lives and they generally do not last forever. In fact, it can be argued that they make life richer (Leahy, 2015). However, emotions can be overwhelming and distressing when their intensity or pervasiveness is high.

Hence, interventions do not aim to make clients erase or avoid difficult emotions such as anger, sadness, guilt. It is to be willing towards these experiences and accept them as part of being human.

Different emotions have different underlying needs, physiological reactions and behavioural responses associated with them. Emotions alert us to an underlying need to be addressed. For example, anger may occur when we experience an injustice. Sadness may alert us to a sense of loss or isolation. Once we are aware of a need, emotions can cue us to take action to address those needs. For example, we may respond to anger by taking action to stand up for our rights. We may respond to sadness by seeking out connection. Finally, emotions are accompanied by distinct physiological reactions. Anger is generally accompanied by high arousal whereas sadness is accompanied by low arousal.

Note: that emotions are often blended and co-occur. People may experience different emotions at the same time.

Hence, it is helpful to identify what one is feeling and give it words or label it. Understanding what one is feeling is itself a therapeutic act that is powerful in its own right. Giving something words

makes it more real and tangible and thereby increases motivation to change something (I am feeling angry >maybe I should do something about it). It ~~is~~ also helpful to understand why one is feeling something. Understanding the need underlying the emotion activates one's own resources and ideas of how to manage it (If I am feeling angry at the government, maybe I can write a post on social media about my feelings).

All emotions have a 'kernel of truth' and make sense in that person's context and history. Emotional reactions that may seem 'excessive' or 'irrational' to others, may hold a valid 'kernel of truth' for the person experiencing them (Linehan, 1993). Imagine if a client is experiencing anxiety about acquiring COVID-19 and forces each family member to take several showers a day. Initially, we may think of this reaction as excessive. Then imagine that we find out that the client has previously lost their mother to an infectious disease similar to COVID-19. The client's anxiety is more understandable now, in the context of their history. This is because emotions in the present often hold memories of the past.

Now, further imagine that we find out that the other family members in the client's home are overly relaxed about COVID-19 and do not wear masks or sanitize their hands when they go out. The client's 'irrationality' may make even more sense now. Hence, there is often bidirectionality to a situation or interpersonal interaction that may not always be obvious, but that we need to look for.

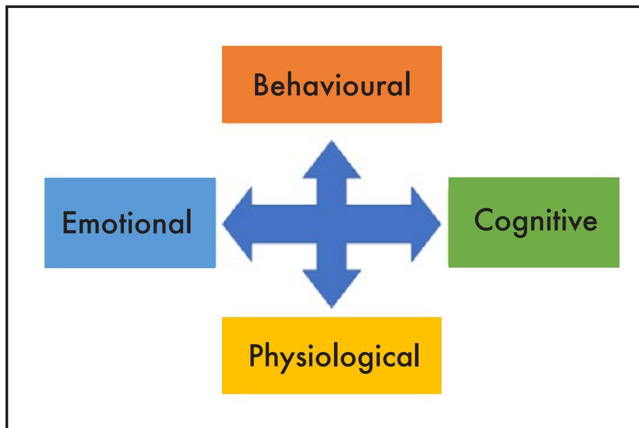
Emotions can be worked with. Once an emotion has been understood and validated, there is a possibility for some change. When we are working to change emotional responses, there are three concepts we can keep in mind.

- **Appraisal** is how we evaluate or view the emotion itself. For example, if a client feels worried about acquiring COVID-19 and appraises that worry as 'stupid' or 'unnecessary', they are experiencing a secondary emotion of shame about the worry itself. Such an appraisal of shame may add to their distress and lead to certain actions (e.g., suppressing worry, pushing themselves to take risks) that may worsen the worry itself.
- **Regulation** is how we manage the intensity of an emotion. It is possible to increase or decrease the intensity of an emotion through conscious efforts, as emotions are strongly linked to physiological reactionsThis is sometimes necessary in order to help us achieve the very goals that the emotion has alerted us to. For example, taking several deep breaths can reduce a felt sense of anxiety for some time and mobilize us to engage in problem-solving.
- **Response** is the behaviour or action following an emotion. For example, we may feel intensely angry at somebody and want to scream at them but we may or may not actually scream at them.

Emotional expression can differ based on culture, context and social norms. Charles Darwin famously proclaimed the existence of universal emotions (Darwin, 1998/1872). However, research has found that there are cultural differences in the experience and expression of emotions (Mesquita, 2003).

For example, gender socialization processes may mean that women are socialized to express anger less (Lerner, 1977). Hence, women may be reluctant to express anger or anger may be hidden under other emotions such as sadness or hopelessness when they speak to a counsellor. Further, in India, traditional social control mechanisms are used to induce shame in the individual for their actions (Patel, 2018). Individuals who have been raised in such a culture may have more internalized shame. One implication of this may be that we need to be observant for subtle indicators of shame in clients' verbal and non-verbal communication.

2.2 Intervention Framework



Intervention framework

This section describes a general framework for organizing intervention strategies when working with emotional distress (Figure above). Interventions we use can be categorized into four types: physiological, emotion-focused, cognitive and behavioural. Note that there are no strict boundaries between these different types of interventions and they all intersect and influence each other.

Physiological. Using physiological interventions refers to helping the client use their body to modulate their current, in-session arousal. For example, it may involve using grounding techniques, paced breathing or other physical actions aimed at regulating emotions felt in the body. We use this when clients present with a high degree of physiological discomfort and restoring a sense of safety and stability through the body takes precedence over more complex interventions.

Emotion-focused. Using emotion-focused interventions refers to listening for emotions, asking for emotions, identifying and naming felt emotions, validating emotions and psychoeducating the client about emotions. If the client is physically comfortable, responding verbally and experiencing mild to moderate levels of distress, we can start with using emotion-focused interventions.

Cognitive. Using cognitive interventions refers to modifying appraisals of a situation or of an emotion, engaging in problem-solving, evaluating beliefs, modifying thinking and so on. These can be useful when the client is feeling physically grounded, emotionally validated and is ready to engage in a higher order process of reflecting about cognitive dimensions about their concerns. Cognitive interventions can help to view emotional responses through a rational lens and hence modify them.

Behavioural. Using behavioural interventions refers to helping the client modify their behaviour outside of session, e.g., planning an activity schedule, building communication skills, reducing avoidance, increasing physical activity. Since the aim here is to modify behaviour outside of session, it is generally the intervention requiring the most engagement from clients. Behavioural interventions can help to 'test' or 'try out' certain beliefs or ideas we have and thus help modify emotional schemas and responses. It is not set in stone that behavioural interventions have to occur after cognitive interventions and often, cognitive and behavioural interventions go hand in hand.

3. How do we assess and intervene?

3.1 Preparing to intervene

Before we enter a session wherein we are working with a client in emotional distress, it would be helpful to:

Ensure that we are in a calm mindspace. If we are personally disturbed or stressed, this may influence how we respond to the client's emotions. We can regulate ourselves before entering sessions in any simple way we want (e.g., establishing a small ritual for ourselves of breathing deeply for two minutes before entering every session).

Have a database for referrals. With clients whose distress is extremely high, requiring more intensive and long term support, we may need to

refer to specialized services, including the emergency department of the nearest hospital. It would be helpful if we have the most important contacts noted down for immediate use.

3.2 Identifying the concern

Emotional distress can be expressed through verbal or non-verbal ways in telephonic counselling. If the client is able to speak, the following questions might help to elicit emotional concerns:

- (When the client has mentioned a specific incident/event) *How are you feeling about X?/ How did that make you feel?*
- *How has your mood been over the past week? How do you feel most of the time?*

To understand the level/severity of the distress, we can use scaling questions such as *'On a scale from 1 to 10, 1 being the least upset you could feel and 10 being the most, where would you put yourself currently?'*

To understand the consistency of the emotion, we can ask change questions such as *'Do you always feel like this or does it change?' 'How long does the feeling last?'*

To understand specific emotions that are predominating, we could ask:

- *Can you help me understand more about what you are feeling?*
- *What is the primary/main feeling you are experiencing?*
- *Which feeling dominates throughout the week/day?*
- *[If a more closed question is needed] Would you say that you were feeling more worried or more sad or more angry…? Would you say that you feel more low most of the time or more worried most of the time?*

Although such a question is sometimes artificial as different emotions often co-occur, it can be useful in helping the client reflect on specific emotions.

Some clients may not have an emotional vocabulary to directly express their feelings. For them, other questions can be used as indicators of emotional distress:

- *How is your sleep?*
- *How is your appetite?*
- *How are your day-to-day activities going? Are you able to function as well as you would like?*
- *Do you have any physical concerns such as headaches or body aches? Do you ever feel that your heart is beating fast? Do you ever feel breathless?*

Emotional distress might also be expressed nonverbally (Child Helpline International, 2009):

Silence. The call might start with complete silence or the client may suddenly become silent in between.
Crying. Sobbing may be heard on the phone but the client is unable to say anything.
Apparent confusion. The client is speaking in a way that is not understandable or the client seems disoriented to time, place and person.

'Testing calls'. A term used for calls that seem like pranks e.g., yelling/screaming into the phone/ laughing/telling implausible stories. Although some calls may be pranks, some of these so-called prank calls may hide more serious concerns. Hence, while a clear message should be given that the service is to use and not abuse, it is important to respond politely and seriously. The counsellor can say that they are there to talk when the caller is ready to use the service appropriately.

3.3 Providing Interventions

3.3.1 Immediate Intervention

When we are working with a client in emotional distress, the first judgment we need to make is: How severe is the distress? If the intensity of distress is high and the client is not in a position to process complex verbal statements, our next steps include:

Ensuring safety. Our primary goal is to ensure safety. We can orient the client by saying, *'My name is X, I can sense that you're feeling really upset/overwhelmed. There is no pressure to talk, I am here on the line. You can take your time and speak when you are ready.'* At this point, it is better to avoid asking complex questions or attempting a more complex reflection. When appropriate, we can ask, *'Are you in a safe place right now?'* We can also choose to enlist support by asking, *'Is there someone around you right now whom you know?'* We can make a decision together with the client about whether we want to speak to the companion and enlist their support in helping the client regulate themselves.

In such situations, we may also need to make a judgment about whether the client can be supported on the phone or whether they require more intensive intervention. If there are indicators of severe risk of harm to self or others (e.g., aggressive, completely disoriented, threatening immediate self-harm), we may need to advise the client or the client's companion to immediately go to the nearest hospital's emergency department.

There may be situations when the client is totally silent and does not respond to any of our attempts to communicate. In this case, we can try to stay on line for as long as possible. If we need to end the call as per organizational protocol, let's make sure to say, *'You can call back whenever you feel ready and someone will be here to take your call.'*

Helping the client to regulate their distress. If the client seems confused and/or agitated, we can ask the client to focus on our voice and speak slowly. We can ask simple yes/no questions or closed questions such as, *'Can you tell me where you are right now? Can you tell me what time it is? Can you tell me who is with you right now?'* If the client is rapidly breathing (or is showing other signs of high anxiety) but is unable to say anything else, we can say, *'I can hear that you are feeling anxious/panicked. Would it be okay if we tried something that may help you feel a little calmer and then we can talk?'* If the client agrees, we can use grounding or breathing techniques to help the client regulate their distress. *'Let's look at the surroundings, can you see anything red around you?* Okay, can you tell me any one red thing you can see? *Okay, can you hear anything around you?'* Alternatively, we can ask the client to breathe in and out slowly as we count. These techniques are described further in Chapter 4 (Section 3).

3.3.2 Further Interventions

Once the intensity of the client's distress has reduced, the client may be in a position to process verbal statements. Then we can use the following emotion-focused strategies.

Reflection and labelling. Supporting the client to express their emotions and helping them feel understood is therapeutic in itself. Hence, it is important to listen attentively to the client and use simple and complex reflections of feeling (Chapter 4, Section 2) appropriately. Using specific feelings words (e.g., guilty, frustrated, disappointed) can be helpful in clarifying the nuances of the felt emotion.

Emotional validation. Emotional validation is a core strategy in working with emotions. We start off with the assumption that the emotional reaction of the person is reasonable and makes sense, all things considered. Hence, we first search for this reason in the emotion, rather than trying to make the emotion reasonable. For example, when working with a client who is feeling very angry about a (seemingly) minor situation, the counsellor takes the approach, 'Hmmm, I wonder what is the reason this person is feeling so angry' rather than the approach, 'This person is unreasonably feeling angry when there is no reason to, their emotion is exaggerated'. Emotional expression without validation may actually be frustrating, whereas expression with validation is what is likely to lead to a shift in the emotion (Leahy, 2015).

Identifying and reflecting secondary emotions. We also need to keep an ear out for 'secondary emotions', for example, when clients

describe feeling anxiety about anxiety ('If I worry so much, I may have a panic attack!'), shame about sadness ('I should not be feeling so low, I'm being such a burden to everyone') and guilt about anger ('My mother has done so much for me, why do I feel angry at her?'). The second arrow metaphor can be used to illustrate the concept of secondary emotions: imagine that a bird is hit by one arrow and it causes the bird a lot of pain. Then imagine that she is hit by a second arrow which further increases the pain. The first arrow is unavoidable (e.g., it is natural to feel angry when there is an injustice). But the secondary emotion is like the second arrow that often worsens the state of pain and suffering.

Helping the client separate an emotion and a behavioural response. This essentially involves helping the client realize that there is a choice in what action to pursue following an emotion. We can discuss this with the client with relevant examples, *'We can feel very anxious and want to immediately Google a lot about our symptoms, but we can choose to pursue a different response if we think that will benefit us more'*.

If appropriate, we can then move on to cognitive and/or behavioural levels of intervention. Often, using emotion-focused approaches may be what is possible for brief work and it is not needed to have a cognitive or behavioural level of intervention as an end goal. It is important to ask ourselves *'What does this person need right now?'* as opposed to *'What do I want to achieve with this person?'*

More specific interventions for working with clients who are experiencing anxiety, anger, low mood or guilt are discussed in further chapters.

3.3.3 Referral and follow-up

For many clients who present to us in high distress, we may need to refer them to specialized services or schedule a follow-up call with them (as per our organizational protocol):

- All clients who present with high distress can be invited to call back to the service when they want (if this is possible) and provided a contact of an emergency service/helpline they can reach out to if needed.
- We can also let the client or caregiver know that they may need to take the client to the nearest hospital in case of very high distress that is unmanageable.
- We can refer the client to specialized psychological help. This is not a referral to a helpline or crisis service but rather a qualified professional or an organization that provides more long-term psychological help. Guidelines for when to make such a referral are given below. Aspects to keep in mind when making a referral are discussed in Chapter 9 (Section 3).
- If the client is too distressed, the referral might have to be given to the companion rather than the client.

Some indicators for referral to specialized psychological help

- Is confused and disoriented
- Is so distressed that they are unable to care for themselves or their children by, for example, not eating or keeping clean
- Loses control over their behaviour and behaves in an unpredictable or destructive manner
- Threatens harm to themselves or others
- Starts excessive and out-of-the-ordinary use of drugs or alcohol
- Presents symptoms of severe mental health conditions (e.g. delusions, hallucinations)
- Is experiencing violence or is being sexually abused in any way.

There can be multiple other indicators.

If follow-up is within our purview:

- We can fix up a specific time and day we will call to follow-up or they need to call you. Who will initiate the call should be made clear.

At the same time, we may need to provide alternative emergency contacts or refer to specialized psychological help in the interim as we may not have the bandwidth or training to provide emergency 24/7 help.

Let's Avoid...

Challenging the client e.g. 'Why didn't you tell somebody if you were being treated unfairly?'

Giving complex suggestions e.g., 'Could you get a piece of paper and pen and let's try to identify which aspects of the situation are in your control and which aren't?'

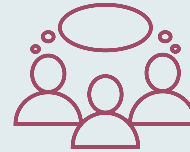
Giving too many suggestions and not waiting enough for the client e.g., 'Can we try doing some breathing? [no response] Okay, can we try another exercise that can help you feel calm?' After we have said something, it may take some time for the client to respond to us.

Asking open-ended questions that may be difficult to answer at that point e.g., 'What happened?' 'How are you feeling?'

Jumping to problem-solving e.g., 'Can we try to develop a list of activities you can do?' If we do this, the client may feel invalidated.

Leaving the phone line before the client is safe. As much as possible, we can try to stay on the line till we are reasonably sure the client is currently safe, e.g., with a caregiver, on the way to an emergency service

4. How do we reflect on our work ?



Supervision Exercise

All of us have certain beliefs about emotions, determined by our personal histories and relationships with significant others. Our own relationship with emotions can significantly influence how we respond to our clients' feelings. It might be important to reflect on these emotional responses in supervision. We can take a look at the statements below to understand some common beliefs we may have in this regard:

- If I allow myself to feel a difficult emotion, I may not be able to tolerate it
- If I allow myself to feel a difficult emotion, it may last forever
- There is a right and wrong way to feel in every situation
- I should be able to control my emotions
- Others do not feel the same way I do
- I am oversensitive/irrational/over-reacting

Self-Care Exercise

This chapter suggests some approaches we can use with clients who are in high distress. But such situations can be challenging for us to navigate especially in the sessions. We can try some of the ways listed below to regulate our own emotions both in and after the sessions:

- **Be in the moment:** In that moment in a session when we are working with a highly distressed client, we may panic or feel blank. Everything that we know and have learnt may seem very far from our minds at that moment. It can be helpful to take a few seconds to ground ourselves (e.g. taking a couple of deep breaths, looking around the room we are in) before returning our attention to the session. The most important part of bringing ourselves back in the moment would be to trust our knowledge and training.
- **Post-session reflection:** Reflecting on the session can be an act of self-care as we process our own emotions about what happened.
    - We can reflect individually through writing or drawing or any other method that seems comfortable for us.
    - We can reflect by discussing with peers who may have faced similar situations.
    - We can reflect in formal supervision sessions
- **Disengaging from therapeutic work:** After such a session, some of us may tend to ruminate over what occurred in the session. It may be helpful to consciously disengage from 'therapy' to other kinds of activities:
    - "Chop wood, carry water" (Norcross & VandenBos, 2018): engaging in more manual activities such as cooking or cycling, as different from more intellectual and emotional activities such as counselling. However, some manual activities that do not require a lot of thought (e.g., daily chores) may support rumination - let's try to be as mindful as possible when we are engaging in these activities.
        - Reading an engaging book or watching an engaging TV show or movie (not related to therapy!)
        - Social activities unrelated to our professional work

References

Bertuccio, R. F., & Runion, M. C. (2020). Considering Grief in Mental Health Outcomes of COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, 87–89. https://doi.org/10.1037/tra0000723

Child Helpline International. (2009). *Counselling Practice Guide.* Amsterdam: Author.

Darwin, C. (1998/1872). *The expression of the emotions in man and animals* (3rd ed.). London: Harper Collins; New York: Oxford University Press

Ghosh, R. (2020, September 17). Double Down: Covid impacts women disproportionately, we must ensure progress in women's empowerment is not erased. *Times of India.* https://timesofindia.indiatimes.com/blogs/talkingturkey/double-down-covid-impacts-women-disproportionately-we-must-ensure-progress-in-womens-empowerment-is-not-erased/

Grover, S., Sahoo, S., Mehra, A., Avasthi, A., Tripathi, A., Subramanyan, A., Pattojoshi, A., Rao, G., Saha, G., Mishra, K., Chakraborty, K., Rao, N., Vaishnav, M., Singh, O., Dalal, P., Chadda, R., Gupta, R., Gautam, S., Sarkar, S., … Janardran Reddy, Y. (2020). Psychological impact of COVID-19 lockdown: An online survey from India. *Indian Journal of Psychiatry, 62(4), 354–362.* https://doi.org/10.4103/psychiatry.IndianJPsychiatry_427_20

Leahy, R. L. (2015). *Emotional Schema Therapy.* New York: The Guilford Press.

Lerner, H. (1977). The taboos against female anger. *Menninger Perspective.* 5–11.

Linehan, M. M. (1993). *Cognitive-behavioral Treatment of Borderline Personality Disorder.* New York: The Guilford Press.

Lwin, M. O., Lu, J., Sheldenkar, A., Schulz, P. J., Shin, W., Gupta, R., & Yang, Y. (2020). Global Sentiments Surrounding the COVID-19 Pandemic on Twitter: Analysis of Twitter Trends. *JMIR Public Health Surveillance, 6(2),* e19447. https://doi.org/10.2196/19447

Mesquita, B. (2003). Emotions as dynamic cultural phenomena. In R. J. Davidson, K. R. Scherer, & H. H. Goldsmith (Eds.), *Series in affective science. Handbook of affective sciences* (p. 871–890). Oxford University Press.

Norcross, J. C., & VandenBos, G. R. (2018). *Leaving It at the Office: A Guide to Psychotherapist Self-Care (2nd ed.).* New York: The Guilford Press.

Ornell, F., Schuch, J. B., Sordi, A. O., & Kessler, F. H. P. (2020). '"Pandemic fear"' and COVID-19: Mental health burden and strategies. *Brazilian Journal of Psychiatry, 42(3), 232–235.* https://doi.org/10.1590/1516-4446-2020-0008

Patel, P. J. (2018). Shame and Guilt in India: Declining Social Control and The Role Of Education. *South Asia Research, 38(3)*, 287-306. https://doi.org/10.1177/0262728018796283

Plato. (1991). *The republic of Plato* (A. D. Bloom, Trans.). New York: Basic Books.

Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019 – A perfect storm? *JAMA Psychiatry,* 77(11), 1093-1094. https://doi.org/10.1001/jamapsychiatry.2020.1060

Rogers, J. P., Chesney, E., Oliver, D., Pollak, T. A., McGuire, P., Fusar-Poli, P., Zandi, M. S., Lewis, G., & David, A. S. (2020). Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. *The Lancet Psychiatry, 7(7)*, 611–627. https://doi.org/10.1016/S2215-0366(20)30203-0

Shanahan, L., Steinhoff, A., Bechtiger, L., Murray,

A. L., Nivette, A., Hepp, U., Ribeaud, D., & Eisner, M. (2020). Emotional Distress in Young Adults during the COVID-19 Pandemic: Evidence of Risk and Resilience from a Longitudinal Cohort Study. *Psychological Medicine.*
https://doi.org/10.1017/S003329172000241X

4 Containing anxiety

The COVID-19 pandemic has forced us all to confront a tremendous amount of uncertainty and unpredictability about the future (Siegel, 2020). Our expectation of having a safe and certain future and of having a predictable structure to our lives has been upset (Siegel, 2020). In such a situation, anxiety is an understandable and expectable emotional response.

Fear of contracting COVID-19 appears to be a major source of anxiety for the general population (Grover et al., 2020). This fear is further exacerbated by excessive media reporting and misinformation about COVID-19. Ways this fear can manifest include wearing masks and protective equipment when not required, investing a great deal of time in reading or watching COVID-19 related facts or avoiding such information, anxiety in interacting with family members who are sick and so on. A study conducted in March 2020, across 25 states or union territories in India, showed that more than 80% of participants reported preoccupation with thoughts of COVID-19, 37.8% reported paranoia about acquiring COVID-19, 46.1% reported panic related to news about COVID-19 in electronic and print media and 12.5% reported sleep difficulties (Roy et al., 2020). From these findings, the authors concluded that 80% of participants had mental health care needs.

A high percentage of individuals diagnosed with COVID-19 experience anxiety as well (Deng et al., 2020). According to a qualitative study conducted in China, individuals diagnosed with COVID-19 initially felt worried about the symptoms, the treatment and the progression of the disease itself (Hao et al., 2020). However, as the disease stabilized, individuals started feeling anxious about longer-term concerns, such as finances and employment (Hao et al., 2020). In India, individuals diagnosed with COVID-19 reported concerns such as worry about recurrence of the infection, about the persistence of symptoms (e.g., loss of smell) and about the possibility of death due to COVID-19 (Duggal, et al., 2020). Anxiety was increased when the person also had a comorbid health condition such as diabetes or heart disease (Duggal, et al., 2020) Participants also reported feeling anxious about being away from loved ones in quarantine, about spreading the infection to loved ones and about the quality of medical facilities, such as cleanliness of the wards or inadequate following of social distancing norms (Duggal, et al., 2020). Financial debt due to lockdown and added draining of resources due to treatment was another common source of anxiety (Duggal, et al., 2020).

1. What is our role as mental health professionals?

Shamir is a 27 year old man. He has been having flu-like symptoms similar to COVID-19 but is finding it very hard to decide whether or not he should get tested. He has several fears about what will happen if he tests positive. As a result, days are passing with his symptoms not improving. He is concerned about his IAS exams, how to get a test done, how he will get money if he needs hospitalization, what he will tell his parents, the possibility of infecting others, his neighbour's reaction and so on. When he calls the counsellor, he seems extremely confused. He gets breathless while talking to the counsellor and says he can't think clearly anymore.

As mental health professionals, supporting clients to manage anxiety may be a common concern that we are called upon to address (Duggal, et al., 2020, 2020). Anxiety may often co-occur with

low mood, hence it will be important to tailor our interventions to both these emotions. With respect to anxiety, our role can involve:

- Helping the client to reduce high physiological arousal that often accompanies anxiety
- Containing and validating the client's anxiety
- Psychoeducating the client about anxiety and helping them to reflect on their relationship with anxiety
- Equipping the client with tools and strategies to manage anxiety outside of the session

For clients who have a long-standing or chronic anxiety disorder, we may need to refer them to more specialized services.

2. What key concepts and ideas can inform our practice?

The basic framework for working with emotions (Chapter 3, Section 4) applies to managing anxiety, as with all other emotions. Specific concepts for working with anxiety include:

2.1 Anxiety is normative and can be adaptive.

Anxiety is an evolutionarily useful emotion that nature evolved to protect us from threat. It is the signal through which the brain and body interact with each other, alert us to danger in the environment, and prepare us for action.

Ordinarily, anxiety subsides once we have been alerted to the danger and taken steps to protect ourselves. However, for many people, anxiety can be persistent and difficult to control, making it an emotion that is no longer adaptive. When anxiety becomes excessive, people may overestimate the danger involved in a situation, strive for absolute certainty in future events, or start worrying about the symptoms of anxiety itself (e.g., 'I will go mad due to the worry') (Clark, 1989). Hence, interventions for anxiety involve helping the client deal with both the source of anxiety and the impact of anxiety. These can be done by labeling anxiety, identifying its triggers and normalizing it.

2.2 Anxiety involves high physiological arousal

Anxiety is generally accompanied by physiological and somatic symptoms, such as breathlessness, fast heart-beat, sweating, tremors, feeling 'on edge', flushes, chills and so on (Clark, 1989). At a high level of intensity, these can comprise a panic attack.

Evolutionarily, each symptom of anxiety serves a purpose of preparing us to fight, flee or freeze in the presence of danger (e.g., our heart beats faster to supply adequate blood and oxygen to our legs and other organs so that we can run, dilated pupils help us to see the predator better) (Clark, 1989). However, in the modern world, when threats are more intangible and not in the form of a physical predator, these physiological symptoms can interfere with adaptive responses to anxiety (Clark, 1989). Hence, several physiological and behavioural interventions for anxiety use various methods of relaxation to reduce physiological arousal.

2.3 Anxiety is expressed cognitively as worry

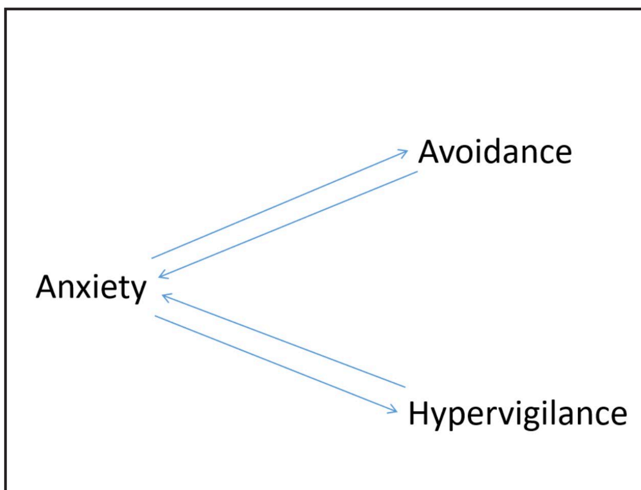
Anxiety is often expressed in our thought process as repetitive ruminative thinking or 'worry' (Borkovec et al., 2004). For example, when we are anxious, may continuously imagine a series of 'What Ifs' or worst-case scenarios in our minds.The focus of this worry may also be on aspects of our lives that are not in our control (e.g., 'What will the result of my COVID-19 test be?'). Worry is an ineffective attempt to problem-solve and tends to perpetuate anxiety (Borkovec et al., 2004). Further, research has found that certain groups of people are more prone to experiencing high levels of anxiety. This includes individuals who find it difficult to tolerate uncertainty, those who tend to feel very

responsible for situations around them, people who experience emotional dysregulation and those who may be excessively perfectionistic (Dugas & Koerner, 2005; Frost & DiBartolo, 2002; Kotov et al., 2010; Salkovskis et al., 1995). Hence, cognitive interventions for anxiety involve challenging such beliefs or modifying such thought processes.

2.4 Anxiety leads to avoidance and hypervigilance; avoidance and hypervigilance reinforce anxiety

When we are anxious or worried about something, we may either avoid that particular situation/activity/person/place or we may become hypervigilant towards it (Clark, 1989). For example, a client who is anxious about a COVID-19 test result might either avoid opening the document that contains their result or might obsessively search online about COVID-19 tests' false positive and false negative rates. Both avoidance and hypervigilance are ultimately perpetuated as they provide temporary negative reinforcement from feeling anxious. This, in turn, leads to continued anxiety and perpetuates a vicious cycle.

Hence, behavioural interventions for anxiety involve limiting hypervigilant behaviours or increasing approach behaviours.



Avoidance and Hypervigilance

3. How do we assess and intervene?

3.1 Preparing to intervene

Before we intervene, it can be helpful to:

Ensure that we are in a calm mindspace. When we listen to a person who is anxious, we may tend to feel anxious ourselves. Calming ourselves before a session (e.g., through a simple breathing exercise) can help us feel more regulated and contain the client's anxiety better.

Be familiar with various techniques to reduce physiological arousal. It may be helpful to familiarize ourselves with techniques such as grounding, breathing and so on before the session. Having ready scripts (e.g., for guided imagery, for mindfulness meditation) in an accessible place (e.g., on paper, stored on computer) can be helpful as we may not have time to search for scripts during a session.

3.2 Identifying the concern

In the absence of visual cues in telephonic counselling, there are various ways in which anxiety experienced by clients can be noticed. Certain verbal indicators through which clients communicate anxiety include:

- Seeking repeated reassurance 'Vaccine will come soon, won't it?'
- Repeatedly asking for solutions and advice
- Talking about worst-case scenarios and 'What ifs'
- Talking about somatic concerns (headaches, stomach aches, inability to sleep)
- Talking about minute plans and feeling distressed by ambiguity ('At what exact time can I expect your call?')

Certain non-verbal indicators of anxiety include:

- Being breathless/speaking rapidly or any other

sign of hyperventilation
- Speaking rapidly
- Seeming disoriented/confused and having difficulty in answering questions ('I don't know' 'I can't think')
- Being irritable and unable to absorb any of our inputs

Apart from this, we can explore how clients are evaluating their anxiety itself:

'What do you feel might happen if you continue to feel anxious?'

'What might happen if you lose control?' (Clients may have a fear of 'going mad' or even dying)

3.3 Providing Interventions

3.3.1 Physiological Interventions

These are immediate interventions that we can use in the session when we identify that a client has high anxiety. Before starting these interventions, we can ask the client's permission, 'Can I guide you through a method that may help you feel calmer?'

Offer. Would you like to drink a glass of water? Would you like to take a couple of minutes and come back? I will hold the line.

Grounding. Grounding is a technique that acts to reduce the client's physiological arousal by helping them situate themselves in the present with the use of their senses. The rationale is that when we are anxious, our mind is often racing and is focused on the future or the past, leading us to feel disconnected from our immediate environment. Grounding slows us down and establishes a sense of safety by anchoring us in our immediate physical environment. After asking the client's permission to use grounding, we can give the following instructions, modified as per client need:

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five red objects that you can see in the room, you don't need to tell me, just notice it for yourself [wait for a sufficient amount of time]
- Now try to notice what sounds you can hear around you. You can close your eyes if you want. Whatever sounds you can hear around you, notice them… [If client is having difficulty, prompt with what might be likely: can you hear the sound of the fan? Can you hear any vehicles?] [wait]
- Now I want you to notice any smells around you, take a deep breath and notice whatever you can smell [wait]
- Now, can you notice whatever you can feel? Touch whatever is in front of you or wherever you are sitting and notice how it feels on your skin...does it feel hard or soft? Smooth or rough? [wait]
- Now I want you to notice any tastes in your mouth, swallow and see if you can taste anything

Another variation is to structure it further by asking the client to notice 5 things they can see, 4 things they can feel, 3 things they can hear, 2 things they can smell and 1 thing they can taste.

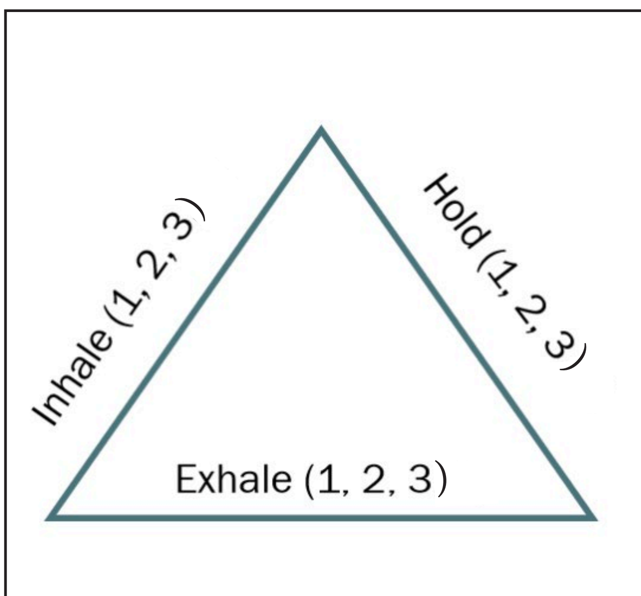
A shorter version of grounding involves 'dropping anchor'. For this, we can say to the client, 'Place your feet solidly on the ground and sense how the ground feels against your feet, sense the support it is giving you'. If the client is sitting on a chair, we can say, *'Place your feet on the floor and tense your leg muscles as if wanting to push your chair back without actually doing so, sense the firmness of the chair against your back, the support it is giving you'.*

We can also ask the client to find any object in their current physical surroundings that they find soothing to look at. We can ask the client to describe this object in detail to us *('How does it look? What colours does it have? How does it feel? How does it smell?')*. The client can also use this object as an anchor in the future, by focusing on it to ground themselves when they are in distress.

Different objects can be identified for different rooms in the client's home or the place they spend most of their time in.

Paced Breathing. When stressed, many individuals breathe in a more shallow manner, hyperventilate, or, in some cases, temporarily stop breathing altogether. Teaching people 'how to breathe' during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. We can say, *'Now, as I say, breathe in [count to 4 in our mind], hold [count to 5 in mind] and breathe out [Count to 6] [Repeat for a few counts] As you breathe, notice your breath going in and out, feeling it in the nose on the way in and sensing how it fills the lungs and expands the belly, sides of the chest and the lower back.'* Let's try to speak as slowly, gently and calmly as possible.

Triangle breathing. This is another simple breathing technique that asks the client to imagine or trace a triangle on a surface in front of them. The instructions are, *'Inhale as you trace one side of the triangle for 3 counts, hold as you trace the next side for 3 counts and exhale as you trace the last side for 3 counts' [Repeat]*



Triangle breathing

Guided Imagery. We can support clients through a guided imagery technique that involves visualizing a place of personal safety and calmness. We can ask the client, '*What place would you like to visualize? Is there a place that you think of as safe and calm?'* If the client has difficulty thinking of a place, we can offer options such as a beach, a quiet garden or a quiet hut on a mountain. We can then develop the imagery with the client using prompts such as, *'Close your eyes...allow yourself to feel comfortable...Imagine that you are on [client's preferred place]...What do you see on your beach? What do you hear? What do you feel? What do you smell? What do you taste? Who is with you?' Some clients may need more support and may require the counsellor to contribute details (e.g., 'You notice a gentle cool breeze flowing as you place both your feet slowly on the warm sand').* Ready scripts can easily be found online. This technique generally works best if clients are comfortable with visualizing. For some clients, imagery is difficult and can make them more anxious.

3.3.2 Emotion-focused Interventions

Labelling and validating. Giving a label to what the client is feeling or experiencing can be a source of relief as it signifies that somebody has understood *('I can hear that you are feeling really worried at the moment, is that right?')*. We can also validate our client's feelings e.g., *'It is understandable that you are feeling anxious because life has become less predictable and less in control'*.

Externalizing anxiety. This is a narrative therapy approach that aims to separate the person from the problem by using externalizing language (White & Epston, 1990). The first part of externalization is to use 'experience-near language' i.e., language that fits with the client's own description of the problem, rather than a technical or a clinical description. Hence, the client may use the word 'overthinking' or 'disturbance' rather than 'anxiety'. We can try to use similar words to the client. The second step in externalization

involves separating the problem from the person by using externalizing language. Hence, instead of saying *'So you feel that you are overthinking a lot'*, we can say, *'It sounds like the overthinking is coming and troubling you a lot'*.

Organizing and prioritizing. When we are anxious, multiple concerns can become jumbled together and feel like a 'mountain of unsolvable problems', leading us to feel helpless. We can support clients by first listening attentively and then using simple reflections and summaries to make clearer sense of their problems by separating them, naming them , organizing and prioritizing them. This can help clients to feel less overwhelmed and more contained.

Psychoeducating clients about anxiety. Clients may have various beliefs about anxiety such as 'I should never feel anxious' 'I may lose control over myself' 'Anxiety will last forever' and so on. We can discuss certain facts about anxiety with clients:

- *'It is not possible for the body to be in a constant state of anxiety forever, it will reduce.' We can offer a general metaphor of waves for emotions, 'Emotions are like waves, intense emotions come but they will subside after a while.'*
- *'It may not be possible to erase anxiety as it is human to feel anxious, but we can learn to manage it.'*
- *'Some amount of anxiety is helpful as it alerts us to danger and that we need to prepare. However, if anxiety becomes too high, we may not be able to function.' We can use an example of examinations for a student, 'What do you think is best for a student? To feel no worry, to feel a little worried or extremely worried?'*

Self-compassionate approach. This approach essentially externalizes anxiety and makes it more concrete (e.g. a ball located in the stomach), hence activating resources to manage it. We can ask clients to focus on their fear or worry and ask them, '*Can you find where it is in your body?'* Many clients may find it in their stomach or chest. We can then ask, *'How do you feel towards it?'* Clients may say 'scared' or 'annoyed' or that they don't want it. We can then suggest, '*Can you ask those parts of you that feel scared or annoyed towards it to relax? If the fear/worry was a child, how would you act towards it? Would you want to comfort it/reassure it or push it away?'*

Acknowledge contextual factors that add to uncertainty and helplessness. Factors such as the constant flow of information/misinformation contribute to anxiety. Certain identities make people more vulnerable to not receiving certain resources and services and hence understandably more anxious. For example, there were news reports of pregnant women being denied healthcare facilities in the pandemic (Chatterjee, 2020). We can be proactive in naming and acknowledge these aspects as clients may be hesitant to.

3.3.3 Cognitive Interventions

Helping the client evaluate cognitions (Clark, 1989). Clients may be making certain cognitive errors in evaluating a situation, for example, they may be overestimating the danger in a situation. We can help them realistically evaluate the situation for themselves by discussing aspects such as:

- Is what the client is saying/thinking a feeling or a fact?
- How would someone else think about the same situation? What would the client say to a friend who is in the same situation?
- Is the client's judgment based on how they are feeling rather than what is happening/what they are doing? (Emotional Reasoning)
- Is the client setting an unrealistic standard for themselves? (Unrealistic Expectations)
- Are they forgetting relevant facts or over-focusing on irrelevant facts? (Maximizing/minimizing)
- Are they thinking in all-or-nothing terms? (All-

or-nothing thinking)

- Are they over-estimating how responsible they are for the way things work out? (Personalisation)
- Are they over-estimating how likely an event is? Are they under-estimating what they can do to deal with a problem/situation? (Catastrophization)

When we identify a particular cognitive error, we can bring it to the client's notice by psychoeducating clients about the general concept ('*All of us tend to make certain errors in our thinking at some point or the other*'), the specific concept ('*This is called all-or-nothing thinking*') and providing a relevant example, '*All-or-nothing thinking is when we consider only two extremes of a situation. For example, I think that if I have not scored a full 100% on an exam, I am a failure. I can see only 100 or fail, there is no in-between*'. However, it is important to frame our intervention in a manner that the client is helped to evaluate their thinking for themselves. Continuing to convince or arguing with the client will be counter-productive.

Working with 'What ifs' (Padesky, 2020). When a client is speaking in terms of 'what ifs', we can follow the thread of 'what ifs' to the core fear ('*What if you do get a positive test result?' 'I might have to leave my children and get admitted…I might become sicker and sicker....I might die and leave my children all alone*'). Then there are two possible strategies for dealing with 'what ifs': either we can make a concrete plan for the 'what ifs' or we can try to arrest rumination over 'what ifs' and refocus on the present moment. Which strategy works better depends on the client and their personal style.

Making concrete plans involves prioritizing which 'what ifs' bother the client the most and move into making a 'then what?' plan e.g., '*What if I fall sick? Then I can first assess how seriously I am ill, then isolate myself if I am less seriously ill. If I fall very sick, I can get admitted to the nearby hospital. This is the hospital's emergency number to call.*'

Refocusing on the present moment involves helping the client realize the vicious cycle they have become trapped in and that 'what ifs' are not helping them to problem-solve or reduce worry.

Help the client distinguish between problem-solving and worry. People often believe that worry (continuously thinking about what ifs and hypothetical scenarios) will help them prepare for the future and move them towards solutions. However, worry is circular, never ending and non-specific. Problem-solving, on the other hand, is a concrete, structured and disciplined approach with a beginning and an end. One approach to problem-solving is described below. To deal with worry, we can ask the client to schedule a 'worry time' e.g., half an hour in the evening at 6 pm. When the client notices themselves worrying at any other time, they can tell themselves to postpone the worry to their 'worry time'. This approach can limit the amount of time spent worrying and can show the client that reducing worry time does not lead to unwanted outcomes.

Problem-solving strategies. This uses the model elucidated by D'Zurilla and Goldfried (1971). First, we help the client to separate a more concrete immediate problem (e.g. I need more information about my father's health) from a vague long-term 'what if?' Then we can focus on problem-solving the immediate, concrete problem.

- Step 1: Help the client define the problem 'So your main concern is that you want more information from the hospital about your father's condition'
- Step 2: Help the client generate possible solutions. The key here is to help the client brainstorm freely and not judge the solutions as workable/unworkable at this point.
- Step 3: Help the client consider the pros and cons of each solution. '*You would like to try doing X...X, what might be the advantages of this? What might be some problems with it?*'
- Step 4: Help the client narrow down to one or two options they would like to implement.

- Step 5: Help the client implement the chosen solution. We can ask about possible barriers and make if-then plans for the same e.g. *'If you call up the doctor's cell-phone and they do not pick up, then what would you want to do?'*

Working with uncertainty (McGonigal, 2020). The experience of uncertainty involves a sense of a loss of control. First, affirming the client's identity that's being challenged by this experience of uncertainty (e.g. a caring parent who feels a loss of control over their child's health; a competent wage-earner who feels a loss of control over how she'll provide for her family) is important. The parent might be thinking, *'If I were really a caring parent, I should be able to control this situation so it turns out okay.' Let's affirm this important identity by saying something like, 'One of the reasons this is so difficult for you is because you care so much, because you are so committed to being a caring parent'.*

Next, we can acknowledge what is difficult about the situation and help the client see the pain that is making them believe that they should be able to control this and fix everything. For example, we can acknowledge how difficult it may be for a caring parent to accept that no matter how 'good' and caring a parent they are, their child's health depends to a certain extent on external factors beyond their control, such as the medical care and disease circumstances.

Finally, we can shift the client's focus from control to choice, *'There is a lot you feel you cannot control in this situation and that's making you feel helpless…what can you choose in this situation? What can you bring to this situation?'* The aim of this is to try to get the client to the perspective that, *'I alone am not the cause of this suffering and I alone cannot resolve or cure this suffering' 'You can do your best but you can't do it all' and 'This is bigger than me'.*

Working with helplessness (Van der Kolk, 2020). Helplessness is oft-felt in the pandemic and is related to the experience of uncertainty. It is useful to name and identify the feeling for the client, as this may not be an easy emotion to explicitly verbalize. We can normalize helplessness in the current context and provide a rationale for the next step, '*We don't know what's going to happen and we don't know how to control the situation, the only thing we can control is our own reactions. What we can do is help ourselves become calm and have a sense of agency'*. Using this rationale, we can help clients to establish a sense of structure to their day and support clients to engage in one piece of physical activity. This can help to address the sense of timelessness and immobility that helplessness is usually associated with.

Balancing sharing of information (Siegel, 2020). Anxiety and seeking of information are often interlinked. We can share some information we know if asked, however, it is best to avoid being pulled into discussing and sharing news/ information about COVID-19 in the entire session. For example, a client may say 'Did you know that now there are 10,000 cases? Do you know X people are dying every day?' or may repeatedly ask you questions 'Do I need to wash my soap before I take a bath?' If this is happening, we can try to shift the conversation to a discussion about the anxiety underlying these questions, rather than remaining in the domain of sharing information. At the same time, discussing the process of where and how to access information may be helpful (Chapter 2, Section 3).

Strengths-based approach. This approach seeks to mobilize the client's strengths and resources through sensitive questioning. Some questions we can ask include:

- *Have you ever had to deal with similar issues in the past?*
- *How have you dealt with it then?*
- *How have you managed to keep going till now? What/who has helped you?*
- [Activate skills that are already present] *What are some strengths you have/that others say you have? What would I come to appreciate*

- *you if I knew you better? How did you develop about this skill? Where did you learn this from? What has this skill made possible for you in the past? How could you apply it to this problem currently?*
- *Have you seen anybody else dealing with a similar situation?*
- *If tomorrow morning you were to wake up and a miracle had happened and the problem was solved, what would be different? What will you notice around you that let you know that the miracle had happened? What will you see? What will you hear? What will you feel inside yourself? What would you be doing differently?*
- *On a scale of 1 to 10, how much difficulty is the problem causing for you currently? (e.g. client says 6) To change the difficulty level from a 6 to 5, what would need to happen? What could you do to make this happen?*

3.3.4 Behavioural Interventions

Help clients manage information overload. This is discussed in detail in Chapter 2 (Section 3). Briefly, we can support clients in developing personalized strategies to reduce information overload e.g., setting alarms to limit social media scrolling, using boundaries such as 'I will use my phone till I am on my desk, when I shift to my bed, I will keep it aside'.

Structuring the day and using anchoring rituals. When an external structure to our lives has disappeared, it can help to organize aspects of our lives we do have control over. We can ask clients, *'Would it help if we could plan your days in some way?'* We can provide examples of why structure is important; at schools, at religious places of worship, at work, there is a certain agenda and structure to the day. *'Could you tell me about your current routine? What are the predictable parts of your day? What could be made more predictable? How could we make it predictable?'* Another way of doing this is to use certain anchoring rituals throughout the day, *'Is there a ritual you can do at a predictable time in the day that will bring you peace and calmness? It could be something as small as making a cup of coffee every morning before starting the day or giving a hug to your kids and spending 5 minutes talking to them before starting work'.*

Support clients to engage in physical activity. Physical activity can help us feel a sense of agency as we are actively moving our bodies (Van der Kolk, 2020). We can gently ask about and encourage physical activity, *'What is your preferred form of physical activity?* Would you like to try it out?' It is important to not push a client to implement behavioural changes as these can often offer the greatest amount of resistance.

Practice relaxation techniques. When suggesting regular practice of relaxation techniques to a client, it is important to offer a rationale for the same (i.e. anxiety is held in our bodies and in our muscles, hence relaxing our bodies and muscles can reduce anxiety). We can also support clients in planning how they might incorporate relaxation techniques in their daily life, *'At what time could you do the exercises daily?' 'What might be certain barriers to doing so?'*

Practice mindfulness exercises. Mindfulness exercises generally involve the use of an anchor to refocus the mind to the present (Kabat-Zinn, 2018). The anchor could be one's own breathing or certain external sensory aspects of the environment such as sounds or visuals. Mindfulness exercises can also involve teaching oneself to see one's own thoughts and feelings as mental events and not get entangled with them. We can use metaphors such as *'Our thoughts or feelings are like clouds passing by, waves on a beach, bags on a conveyor belt, or like leaves falling from a tree'* to explain this idea. *'We can notice each one but don't need to act on it or every thought/feeling does not represent reality.'* Some examples of mindfulness exercises include:

- Grounding
- Mindful eating e.g., choosing a small piece of fruit and eating is slowly, focusing on its looks, smell, taste, feel

- Mindful walking
- Mindfully doing routine chores
- Simply paying attention to one's own breathing

Sleep hygiene. If clients mention sleep disturbance as a major concern, we can educate clients about sleep hygiene:

- Explain about circadian rhythm i.e., it is not just the amount of sleep we get that matters but also the time at which we sleep. Our body is primed to wake up with the sun and sleep when the sun sets.
- Limit use of substances before sleep (caffeine/ alcohol)
- Try to use bed only for sleeping and not for other activities
- Limit time spent in bed trying to sleep (we can explain that '*the more you try to sleep, the more anxious you may feel*')
- If the client can't sleep for 15-20 minutes, they can get up and do some sedentary activity (e.g. reading), only returning to their bed when they feel very sleepy
- Mindfulness techniques can help if the client has a tendency to ruminate while sleeping

Let's Avoid…

Giving false, generic reassurances e.g., *'Everything will be alright' 'The vaccine will come soon'*

Inadvertently conveying that anxiety is an abnormal emotion to feel e.g., *'I will show you some strategies to get rid of anxiety'*. 'Getting rid of anxiety' is probably neither possible nor desirable.

Rushing into problem-solving or discussing solutions as this can sometimes heighten anxiety, by giving the impression that the counsellor, too, thinks the problem needs to be solved immediately. The counsellor acting as a container for the anxiety and tolerating the anxiety is what can help the client in turn tolerate the anxiety. Let's keep a watch on our own arousal and ensure that we are calm ourselves when working with an anxious client.

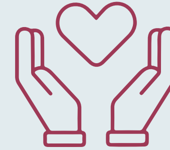
4. How do we reflect on our work?

Supervision

Physiological interventions can seem easy to implement when we read them but are often much trickier in practice with a client experiencing high distress. Hence it may be helpful for us to practise the interventions ourselves before implementing them in the session.

Would you like to take turns in peer supervision trying different techniques such as grounding, breathing techniques and imagery with clients at different levels of distress? After the exercise, the group could reflect on:

- Which are easier techniques to use?
    - Which techniques require more client engagement?
    - How would working on the telephone affect the use of these techniques?
    - Do you find yourself to be more personally comfortable with a certain technique?



Self-Care Exercise

Anxiety is one of the most common emotions we are likely to face during the pandemic. As mental health professionals, we may not be immune to the experience of anxiety. We can reflect on our own anxieties and the strategies we use to manage it.

- What are some aspects you are personally anxious about in the pandemic?
- This chapter discusses various ways we can help our clients manage anxiety. How can we practice what we preach? Do you currently use any relaxation or mindfulness techniques for yourself?
- If not, would you like to try using one right now? [You can refer to the chapter above, if needed].
- Would you like to incorporate this practice into your daily routine in some manner?

References

Borkovec, T. D., Alcaine, O. M., & Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In: R. Heimberg, C. Turk, & D. Mennin (Eds.), *Generalized anxiety disorder: advances in research and practice* (pp. 77–108). New York, NY, US: Guilford Press.

Clark, D. M. (1989). Anxiety States. In K. Hawton, P. M. Salkovskis, J. Kirk., & D. M. Clark (Eds.), *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide* (pp. 52-96). Oxford, New York, Tokyo: Oxford University Press.

Chatterjee, S. (2020, July 6). Pregnant woman says Bengaluru hospital refused to treat her because she got COVID-19. *The News Minute.* https://www.thenewsminute.com/article/pregnant-woman-says-bengaluru-hospital-refused-treat-her-because-she-got-covid-19-128080

Deng, J., Zhou, F., Hou, W., Silver, Z., Wong, C. Y., Chang, O., Huang, E., & Zuo, Q. K. (2020). The prevalence of depression, anxiety, and sleep disturbances in COVID-19 patients: a meta-analysis. *Annals of the New York Academy of Sciences*, 1–22. https://doi.org/10.1111/nyas.14506

Dugas, M. J., & Koerner, N. (2005). Cognitive-behavioral treatment for generalized anxiety disorder: current status and future directions. *Journal of Cognitive Psychotherapy, 19, 61–68.*

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78(1), 107–126.* https://doi.org/10.1037/h0031360

Frost, R. O., & DiBartolo, P. M. (2002). Perfectionism, anxiety, and obsessive-compulsive disorder. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (p. 341–371). American Psychological Association.

Grover, S., Sahoo, S., Mehra, A., Avasthi, A., Tripathi, A., Subramanyan, A., Pattojoshi, A., Rao, G., Saha, G., Mishra, K., Chakraborty, K., Rao, N., Vaishnav, M., Singh, O., Dalal, P., Chadda, R., Gupta, R., Gautam, S., Sarkar, S., … Janardran Reddy, Y. (2020). Psychological impact of COVID-19 lockdown: An online survey from India. *Indian Journal of Psychiatry, 62(4),* 354–362. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_427_20

Hao, F., Tam, W., Hu, X., Tan, W., Jiang, L., Jiang, X., Zhang, L., Zhao, X., Zou, Y., Hu, Y., Luo, X., McIntyre, R. S., Quek, T., Tran, B. X., Zhang, Z., Pham, H. Q., Ho, C. S. H., & Ho, R. C. M. (2020). A quantitative and qualitative study on the neuropsychiatric sequelae of acutely ill COVID-19 inpatients in isolation facilities. *Translational Psychiatry, 10(1).* https://doi.org/10.1038/s41398-020-01039-2

Kabat-Zinn, J. (2018). Falling Awake: *How to Practice Mindfulness in Everyday Life.* New York: Hachette Book Group, Inc.

Kotov, R., Gamez, W., Schmidt, F., & Watson, D. (2010). Linking "Big" personality traits to anxiety, depressive, and substance use disorders: A meta-analysis. *Psychological Bulletin, 136(5*), 768–821. https://doi.org/10.1037/a0020327

McGonigal, K. [NICABM]. (2020, March 18). A 3-step Awwpproach To Manage Uncertainty [Video]. *YouTube.* https://www.youtube.com/watch?v=AM-g5wOGDc8

Padesky, C. [NICABM]. (2020, March 21). *Helping Clients Tolerate Uncertainty During The COVID-19 Pandemic [Video]*. YouTube. https://www.youtube.com/watch?v=sC5mp3AbCt8

Roy, D., Tripathy, S., Kar, S. K., Sharma, N., Verma, S. K., & Kaushal, V. (2020). Study of knowledge, attitude, anxiety & perceived mental healthcare need in Indian population during COVID-19

pandemic. *Asian Journal of Psychiatry, 51*(102083). https://doi.org/10.1016/j.ajp.2020.102083

Salkovskis, P., Richards, H., & Forrester, E. (1995). The Relationship Between Obsessional Problems and Intrusive Thoughts. *Behavioural and Cognitive Psychotherapy, 23(3)*, 281-299. https://doi/org/10.1017/S1352465800015885

Siegel, R. [NICABM]. (2020, March 21). *Working with Anxiety During the COVID-19 Pandemic* [Video]. YouTube. https://www.youtube.com/watch?v=Vf5BRK9kVX0

Van der Kolk, B. [NICABM]. (2020, March 28). *When the COVID-19 Pandemic Leaves Us Feeling Helpless* [Video]. YouTube. https://www.youtube.com/watch?v=fVOt_KOT8Zk

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends.* New York, London: W. W. Norton & Company

5 Responding to low mood

The COVID-19 pandemic has led to widespread lifestyle disruptions for people around the world, including drastic changes in daily routines and decrease in social contact. A study conducted in the US found a three-fold increase in symptoms of depression reported by adults during the pandemic as compared to before the pandemic (Ettman et al., 2020). In India, too, an online survey study conducted in March 2020 found that 10.5% of the 1685 participants, from across different states in India, reported symptoms of depression (Grover et al., 2020).

Social distancing protocols, quarantine and self-isolation have led to decrease in opportunities for in-person social contact, leading to loneliness (Groarke et al., 2020). Quarantine has also been a major source of boredom and feelings of isolation for people (Brooks et al., 2020). Data from a survey conducted in the UK showed that risk factors for loneliness during the COVID-19 pandemic included younger age, being separated/divorced, having prior mental health problems and poor quality of sleep (Groarke et al., 2020). However, older adults, too, may be particularly at risk for loneliness, compounded by the fact that they are likely to be following more stringent protocols around social distancing (Luchetti et al., 2020). Protective factors included being married or co-habiting with a partner, living with a higher number of people and high social support (Groarke et al., 2020).

Lifestyle disruptions as a result of lockdowns have also been associated with mood disturbances (Ingram et al., 2020; Shanahan et al., 2020). Lifestyle changes in COVID-19 have included changes in diet, sleep, level of physical activity, screen-time and overall changes to daily routines (Ingram et al., 2020; Shanahan et al., 2020; Zhang et al., 2020). In one study, negative changes in diet, sleep and physical activity had the strongest link to negative mood states (Ingram et al., 2020). The authors also found that lockdown conditions were associated with higher negative mood and that once lockdown conditions eased, there were improvements in negative mood states (Ingram et al., 2020). In another study conducted in China, such lifestyle disruptions, especially the reduction in physical activity and outdoor recreation time, were shown to be linked to negative mood states such as depression, tension, fatigue, anger and confusion for children and adolescents (Zhang et al., 2020). Interestingly, Shanahan et al. (2020) also found that some young adults reported feeling better during than before the pandemic; these participants appreciated the opportunity to decelerate their life.

1. What is our role as a mental health professional?

Ms. Sneha is a 73 year old widowed woman currently self-isolating at home. When the counsellor calls her, she reports feeling physically healthy but sad and lonely. She replies in a low voice and the counsellor has to ask her to repeat herself several times in order to hear her. After some time, she tells the counsellor that she is missing her daughter and her daughter's family who live in another city and are unable to come and visit her due to COVID-19. She tells the counsellor, 'My daughter is the only person I have left in the world now...I don't have a husband, I don't have any sons...My daughter tries to take care of me but she is also busy with her work...she tells me to talk to them on video but I don't like all this video. In my time, there were no videos...' She further says, 'Never in my entire long life have I encountered such a situation...this is the first

that I am not able to go to the temple, it is very upsetting for me.' Her pension, too, has not been coming on time since the past few months and she is concerned about the same. She tells the counsellor that she is no longer young and that she does not have the energy to run from pillar to post to get it as she once could. 'And anyway,' she says, 'what is the point? It's not like there is anything to use it for…'

Working with low mood and emotions such as sadness, hopelessness and loneliness is an important aspect of our role as mental health professionals in the pandemic. In this respect, our role can involve:

- Identifying persistent low mood as an area of concern for clients.
- Supporting clients to explore what might be contributing to low mood
- Understanding their feelings and validating them.
- Supporting and motivating clients to exercise more agency in their lives
- Supporting and motivating clients to challenge cognitions and behaviours that maintain low mood outside of the session.

Reflective Exercise

'Liberation psychologies throughout the world ask that one forsake the safety of the narrowly construed "psychological"[...] allowing one to see the interconnections between the psychological, the historical, the socioeconomic, and the spiritual.' (Watkins & Shulman, 2008, p. 62)

- Which of these factors can you identify as contributing to Sneha's low mood in the vignette above?
    - Biological?
    - Psychological?
    - Social?
    - Cultural?
    - Historical?
    - Economic?
    - Spiritual?
- Would you say that low mood or 'depression' is located inside a person or can it also be a legitimate response to outside circumstances?

2. What key concepts and ideas can inform our practice?

The general principles for working with emotions apply to working with low mood as well. Relevant specific concepts include:

2.1 Behavioural factors

Ferster (1973) proposed that due to reduced motivation, the individual who is experiencing low mood ends up engaging in activities that inadvertently lead to continued avoidance and escape from life situations (e.g., lying down in bed for the entire day). This decreases the opportunity for experiencing positive reinforcement and pleasure, thus reinforcing the low mood and leading to a vicious cycle. Hence, intervention for low mood often involves encouraging the client to approach rather than avoid activities, even if they lack motivation for the same, to help increase their experiences of positive reinforcement (Lejeuz et al., 2001).

2.2 Cognitive Factors

Beck et al.'s (1979) influential cognitive model of depression posits that individuals who are

experiencing low mood may have certain cognitive distortions in their thinking and may have an unrealistically negative view of themselves, the world and their future. Hence, cognitive interventions target these thought processes and aim to guide individuals to a more realistic (and hence, positive) appraisal of their circumstances.

Further, when uncontrollable negative events occur repeatedly, it may lead to 'learned helplessness' (Peterson & Seligman, 1983) when the individual expects any action taken be futile and hence ceases to respond. Acquiring COVID-19 (and the associated consequences, such as loss of income, loss of employment) is one such uncontrollable negative event which may lead to a phenomena of learned helplessness. Hence, interventions may involve helping the client to be more agentic in their lives and building hope that future responding may not be futile.

2.3 Interpersonal factors

Interpersonal theory (Klerman et al., 1984; Stuart & Robinson, 2012) posits that an individual's low mood is directly related to their interpersonal relationships. Specifically, an acute interpersonal crisis or the non-availability of social support, in the background of biopsychosocial, cultural and spiritual vulnerabilities, can lead to low mood. Hence, interventions for low mood often involve helping the client enhance their social support and interpersonal connectedness.

2.3 Contextual factors

The role of contextual factors (social, political, economic, cultural) in influencing low mood is more relevant than ever in the pandemic. The lockdown has significant economic implications, such as increasing rates of unemployment and financial stress (Ray & Subramanian, 2020; Agarwal, 2020). In this background, historical factors such as gender inequality, religious and caste inequalities, ableism and discrimination against the LGBTQ community may become even more pronounced. Low mood and hopelessness can be seen as a legitimate and understandable, rather than a pathological, response to such a situation. As per these ideas, interventions need to be carried out at individual as well as systemic levels e.g., prevention programs at local, district/state and national levels (Ormel et al., 2019).

3. How do we assess and intervene?

3.1 Preparing to intervene

We can prepare to intervene by:

Creating a list of various activities that can be engaged in during the lockdown. This will be helpful when we are brainstorming with clients the different activities they can do as part of behavioural activation.

Talking to someone we know who has been in quarantine or self-isolation. If this is possible, this can help us to understand the experience of being isolated better and therefore understand our client's feelings.

Being aware of various mindfulness, distraction and self-soothing strategies.
This may be helpful when we need to give certain suggestions to our clients.

Being aware of our own mood. In the lockdown, we too, may be experiencing feelings of boredom, loneliness and even sadness. Affect is often communicable. Hence, it is important that we be aware of our mood as it may in turn affect the client's mood and vice versa.

3.2 Identifying the concern

Certain verbal indicators for low mood include:

- Expressing boredom and apathy e.g., *'I don't really care' 'It's all the same'*
- Talking in extremes, e.g., *'I will always be like*

this' 'There's nothing to do, what's the point of all this? This will never get over'

- Expressing low motivation or an inability to be active e.g., *'I don't feel like doing anything'*
- Expressing isolation and loneliness e.g., *'I feel very alone' 'There's nobody to help me'*
- Feelings of numbness e.g., *'I don't feel anything'*
- *Feelings of derealization and depersonalization 'Everything feels unreal' 'I feel as if I'm out of my body'*

To understand more about the client's emotions, we can ask, *'Can you describe this feeling more?'* We can also ask scaling questions to understand the intensity of the distress described in Chapter 3 (Section 3).

Certain non-verbal indicators for this spectrum of emotions include:

- A low tone of voice and/or slow speech
- Decreased amount of speech, replying in monosyllables or the bare minimum
- A tearful voice or crying

Another indicator is a **change** in daily routines, levels of social interaction, work functioning and leisure functioning. We can explore this by asking, *'Have you noticed any change in your day-to-day functioning / in how you are functioning at work etc.?'* **Changes in sleep and appetite** (both an increase and decrease) can also be an indicator of low mood.

Since low mood is often linked to the lack of fulfilling **interpersonal interactions,** it is important to ask about these factors, using questions such as:

- Who is currently supporting you?
- How is your social life currently?
- Is there anyone you can share your feelings with?
- Are you able to interact with your family and friends?

Finally, at times, there may be particular **precipitating factors** for the client's current mood. We can check for this by asking: *'Since when have you noticed feeling like this?' 'Was there a particular trigger for your feelings?' 'Did something happen that bothered you?'*

3.3 Providing Interventions

3.3.1 Physiological Interventions

Although low mood generally tends to be accompanied by low physiological arousal, some clients may present in high distress, such as crying or sobbing. Grounding techniques and breathing techniques can be used in session if required to help regulate the client's distress described in Chapter 4 (Section 3).

If a client is very low in arousal or energy, there are some techniques that may temporarily and immediately increase arousal. Before engaging in these techniques, it is important to ask for permission, *'Can I suggest doing something that may help you feel a bit more energetic and then we can continue this call?'* If the client agrees, we can choose one of the following suggestions:

- Asking the client to stand up and engage in brief physical activity for around 2-5 minutes *('Can you move your neck up and down?' 'Can you rotate your shoulders?' 'Can you put out your arms in a swimming motion?' We can move from head to toe in this manner)*. It is important that we modulate our instructions to feedback we receive from the client and that we do not exhaust/push the client.
- Asking the client if they would like to eat something that has a sharp taste (e.g., something spicy, something sour, a piece of chocolate), something that is crunchy or chewy (e.g., crisps) or drink cold water.
- Asking the client if they would like to listen to some music with a fast beat or an energizing rhythm and then continue the call.

3.3.2 Emotion-focused Interventions

Labelling and validating. When a client reports

feeling 'low' or 'upset', it can refer to various different emotions: feeling sad, feeling bored, feeling apathetic, feeling frustrated and hopeless etc. Hence, it is important to identify and reflect the client's specific emotion and use a 'feeling word' that resonates with the client. Linking the emotion to possible influencing factors or triggers can also help the client understand their emotions better e.g. '*I'm hearing that in quarantine, there has been simply nothing to do and you are not feeling connected with your family at all…could that be a major reason why you may be feeling low?*' This is validating in itself as the counsellor is giving reason to the client's emotions.

Psychoeducating clients about low mood. We can also psychoeducate clients about certain aspects of low mood:

- *'Feeling low/bored/lonely is an understandable response to quarantine or self-isolation, such emotions have been reported by many people who are in quarantine/self-isolation '*
- *'What we think is linked to what we feel, hence if we think that we are not being productive enough or that our future is going to be bad, we may feel low'*
- *'It is not your fault, you are not causing your low mood or making yourself feel like this'*
- *'Feeling low doesn't mean that you are weak or that you are too sensitive or vulnerable'*
- *'Emotions are like waves, they peak and then subside…when we are feeling an intense emotion, we feel that this emotion will never change, but it does' (This helps to address affective forecasting: when we are feeling low, we 'forecast' that we will keep feeling low forever, which in turn, can maintain the low mood)*

3.3.3 Behavioural Interventions

Keeping a mood diary. We can ask the client to scale from 1 to 10 how they were feeling at different times of the day (*How were you feeling today morning? In the afternoon? After lunch? Was there a time when you felt neutral or a positive emotion, even for a few seconds?*) The rationale is to help clients recognize that even within a space of 'feeling low', their mood does undergo changes (even if minor), thus providing hope that mood can change and this state will not last forever. This can be accompanied by psychoeducation, as described above.

Behavioural Activation (Lejuez et al., 2001). This can be especially helpful for clients who report inactivity, boredom or low motivation. We can ask the client about their current daily routine. Then we can explain the rationale to the client that our emotions are often linked to our behaviour. What we do affects how we feel and vice versa. Sometimes, even if we don't feel like doing something, starting to do it can make us feel better. Explaining that the goal is not to increase productivity but to break the monotony of the day can also offer a helpful frame for clients.

Behavioural activation generally starts off with helping the client brainstorm activities of pleasure (what can give them a sense of pleasure/enjoyment in their day? e.g. playing some music, ordering dinner, playing a game with a sibling). As far as possible, supporting a client to engage in something active (e.g., creating a video) is likely to be more beneficial than engaging in something passive (e.g. watching a movie).

Then we can support clients to brainstorm activities of mastery (what can give them a sense of competence in their day? E.g. learning something using an app, reading a pending book, doing some work for a family member). It is important to start small. Since the client's motivation is likely to be low, planning too many or complicated activities can be off-putting and lead to feelings of failure at not being able to accomplish what was desired. In such a situation, we can help clients break a task down into small, achievable chunks and encourage them to attempt just one sub-goal at a time.

It is also important to remind clients to acknowledge/appreciate themselves for making micro-gains, as the smallest of activities can be

challenging when we are feeling low. We can plan with the client how they can incorporate small changes in their day. We can also ask, '*How long do you think you could play the game for?*' to increase the concreteness of the plan and reassure them that even doing something for 10 minutes is okay.

For clients in quarantine, structuring of the day and anchoring rituals described in Chapter 4 (Section 3) can be especially helpful, as they can act to counter the sense of timelessness. We can also support clients in quarantine to do or learn something new with the time on their hands, engage in one piece of physical activity or collaborate with someone on a project (through phone/online methods). Let's remember not to push, but rather invite suggestions from clients themselves and collaborate with them to engage in activities that work for them.

Support social connection (Dana, 2020). This can be helpful for clients who report feeling lonely, isolated or a decrease in social interaction. We can say, *'Everyone has different preferences for their levels of social connection they want'*. We can ask the client to draw or imagine a line from being very connected to being lonely. The following questions may be used to support the client to reflect:

- Where do you see yourself on that line?
- In which direction would you like to go?
- What is one step you could take to move in that direction?
- Which people in your life do you feel connected to?
- What can you do together to maintain that connection?
- Is there anyone you would like to invite into connection?
- What can you do to nourish connection to yourself?

Clients can mark on the line every day where their body feels like it is on that day and where it wants to be. We can explain that knowing where we are helps us to know what we need to do. We may need to be creative and help the client brainstorm ways to connect socially in times of physical distancing, for example, through use of phone calls or reconnecting through writing letters or making cards.

Practicing mindfulness exercises.
Mindfulness exercises described in Chapter 4 (Section 3) can be helpful for those clients who report ruminative thinking. Rumination is a repetitive thought on a theme related to unresolved personal concerns, which can be constructive or unconstructive (Watkins, 2016). In the context of low mood, it can often be unconstructive as it does not lead to a decision or plan. They can also be helpful for clients who are over-identifying with negative thoughts and emotions ('I will always be sad' 'Nothing good will ever happen in the future' 'I am a sad person').

Distraction and self-soothing techniques. These can be useful if the client is experiencing phases of very painful and overwhelming sadness. Some ideas for distraction strategies include (McKay et al., 2007):

- **Distraction using pleasurable activities** (Listening to favourite music; cooking a favourite dish, watching a funny movie)
- **Doing something for someone else** (Calling a relative/friend and ask if they need help doing something)
- **Taking attention off oneself** (Just sit and watch other people or walk around among them. Watch what they do.Observe how they dress. Listen to their conversations. Count the number of buttons they're wearing on their shirts. Observe as many details about these other people as possible)Distraction using tasks and chores (Organize books, wash plates/ clothes, clean the house)
- **Distraction using counting** (Count breaths, count sounds one can hear, count the vehicles passing by)

Some ideas for self-soothing strategies include (McKay et al., 2007):

- **Self-soothing using smell:** burn scented candles; bake pleasing food or cook food that smells soothing; buy fresh-cut flowers and smell them; hug someone whose smell brings feelings of calmness
- **Self-soothing using vision**: draw or paint a picture that is pleasing; carry a photograph of someone we love or admire
- Self-soothing using hearing: listen to soothing music; listen to audiobooks; listen to a recording of nature sounds or sounds of the sea
- **Self-soothing using taste**: eat a soothing food, like ice-cream, chocolate or pudding; buy a piece of ripe and juicy fresh fruit and eat it slowly
- **Self-soothing using touch:** carry something soft or velvety in your pocket; take a hot or cold shower; play with an animal.
- Clients can also be encouraged to make a physical 'self-soothing box' that they can turn to at times when they need it.

3.3.4 Cognitive Interventions

Helping the client evaluate cognitions. Clients may be making certain assumptions in their thinking, such as 'I need to be extremely productive in the lockdown, otherwise I am a failure' or 'If I can't cope with a few days of self-isolation, it means I am so weak'. When we identify a particular assumption (e.g., the client says *'I am not doing anything in quarantine, I am such a failure*'), we can bring it to the client's notice by saying, *'So I'm hearing the assumption here is that if you are not productive, you are a failure?'* Then we can help them evaluate these assumptions, by asking, *'In what way is this assumption realistic?* In what way is it unrealistic? *Does this assumption reflect the reality of human experience? Is this assumption helpful or unhelpful? Where did this assumption come from? What could be a more moderate alternative assumption that would be more helpful?'* (Fennell, 1989).

Problem-solving. For clients whose emotional distress stems from specific and concrete problems (e.g., being unemployed, financial distress), we can use problem-solving interventions, as described in Chapter 4 (Section 3).

3.3.5 Interventions aimed at building hope

> **Caution:** While these strategies may not be appropriate for use with everyone, certain clients such as those who are experiencing less distress may benefit from hope-building

Working with hopelessness. When clients are feeling hopeless, we can first empathize and validate their emotions. Then we can help the client visualize the immediate future by asking, *'What are your plans after you get out of quarantine/hospital stay? What is the first thing you will do? What is something you're really looking forward to doing after you get out?'*

Exploring hope-related themes in clients' lives. If appropriate, we can help the client think about the long-term, *'What are your hopes, dreams and wishes for your life? How have you developed these hopes? How have you managed to sustain these hopes in difficult times? What keeps you from giving up? Who has supported you in your hopes and dreams? How have they done so?'* We can also help clients to interpret the past events in their lives from a hopeful perspective by asking about how the client generated goals in the past, what was their motivation to reach goals, how attainable/realistic their goals were, what the biggest barriers to reach goals and how did they overcome barriers (Lopez et al., 2000). Another useful question is, *'How have you motivated yourself in the past?'* The idea of exploring the past is to help clients reflect on what they have learnt from the past, as they project themselves into the future (Lopez et al., 2000).

Brainstorming ways to reach a goal (Lopez et al., 2000). Generally, people find it easier to

identify a goal rather than identifying how to reach a goal. As counsellors, we can help clients break down their goals into a series of small steps they need to take to reach a goal. For example, 'You have mentioned that you would like to search for a new job. What do you think will be the first step in doing so?'

Silver Lining (Lopez et al., 2000). Sometimes, it is difficult for clients to identify anything hopeful about their stories. In such cases, we need to be careful that we are not imposing a 'forced positivity' stance on clients. Rather we can help in exploring their stories for finding situations in which there were glimpses of hope. One way in which we can gently introduce a hopeful frame with clients is to ask them if they can identify just one positive element of all the different situations that occurred in the day. This will help the clients to realise that we are not asking them to find the silver linings in all situations. This may seem invalidating to the client's difficulties. Rather, we are emphasizing that there might be one instance of silver lining in their day. We can ask them to write down these instances as tangible reminders of these silver linings. Another way of doing so is maintaining a gratitude journal (Wood et al., 2010). We can ask clients to write three things that they were grateful for throughout the day. It is possible that these may help the client identify the silver linings.

Hope-writing (Lopez et al., 2000). Some clients may be interested in and may benefit from writing about their hopes and dreams. For example, clients can write for 20 minutes about a domain-specific goal (e.g., managing symptoms of illness) and how they dealt with it at various points in their lives. Such an exercise can help clients to reflect on their changing perspectives and can emphasize the various methods they have found to reach their goals in the past.

3.3.5 Advocacy-based interventions

These interventions support clients to empower themselves and to advocate for themselves.

Narrative approaches (White & Epston, 1990). The idea behind the narrative approach is to think of clients' problems as stories that are in the process of development. Narrative approaches can help clients develop more agency towards problems in the face of which they feel powerless. These interventions are described further in Chapter 11 (Section 3.)

Self-advocacy. When low mood is rooted in oppressive circumstances, self-advocacy, i.e., speaking up for what we want or need, can be helpful. For example, some individuals who were in financial distress during the pandemic shared their story on social media and used crowdfunding platforms to obtain financial support for themselves. Self-advocacy can occur at different levels and must not be imposed on the client. These interventions are described further in Chapter 10 (Section 3).

Referral to other organizations. Referring a client to other organizations or specialized services that can help them fulfill basic needs, legal needs or other needs can also be an intervention in its own right. These interventions are described further in Chapter 1 (Section 3)

Let's Avoid…

Diagnosing or labelling 'depression'. Our aim is not to diagnose clients and nor are we conducting a full assessment. We can refer the client to specialized help if we feel that the client has clinical depression.

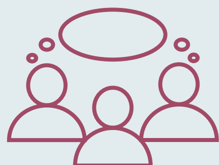
Intervening without understanding the client's emotions. As discussed,

'feeling low' can comprise various different emotions such as sadness, boredom, apathy, hopelessness etc. The more nuanced an understanding we have about the client's emotions, the more validated they are likely to feel.

Trivializing the client's problems. Let's avoid making statements that convey implicitly or explicitly, *'Many people have problems, it is all about how we see it'*

Forcing platitudes and excessive positivity e.g.,'Everything happens for the best', *'Let's try to see the positive side of the situation',*

4. How do we reflect on our work?

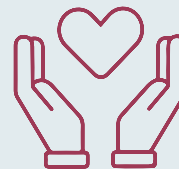


Supervision

Our own beliefs about ourselves, the world and the future can influence how we interact with clients who are experiencing low mood. With our supervisors, we can reflect on these beliefs:

- What are your views about the future, the 'world' and of yourself?
- How have these beliefs developed?
- How has the pandemic/lockdown influenced these beliefs? How do they change when you feel low?

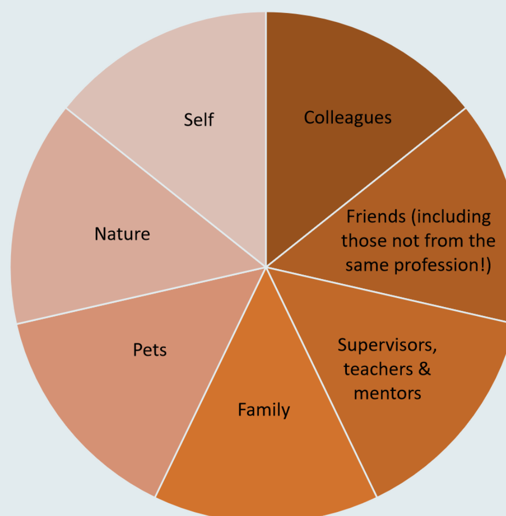
How do you think these beliefs influence your work with clients?



Self-Care Exercise

As counsellors, we spend a lot of time building and sustaining interpersonal relationships. Yet, counselling can be a lonely profession. After a day filled with talking, many clinicians may prefer to retreat into a cocoon and spend time by themselves (Norcross & VandenBos, 2018) However, nurturing our own meaningful and intimate relationships is important to ensure that we ourselves do not feel isolated and can maintain our spontaneity and vitality. You can use the circle below to reflect on:

- Which of your relationships sustain you?
- Who may be witnesses to your struggles and triumphs?
- Whom would you like to share your success stories with?
- Who would be able to appreciate you?
- How could you nurture these important relationships in your life?



References

Ackerman, C. E. (2020, September 1). 19 *Narrative Therapy Techniques, Interventions + Worksheets* [Blogpost]. https://positivepsychology.com/narrative-therapy/

Agarwal, K. (2020, May 1). COVID-19 Lockdown: In April, MGNREGA Work Crashed to Lowest in 7 Years. *The Wire.* https://thewire.in/labor/covid-19-lockdown-mgnrega/

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

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. *Lancet, 395*(10227), 912–920. https://doi.org/10.1016/S0140-6736(20)30460-8

Choi, E. P. H., Hui, B. P. H., & Wan, E. Y. F. (2020). Depression and Anxiety in Hong Kong during COVID-19. *International Journal of Environmental Research and Public Health*, 17(3740). https://doi.org/10.3390/ijerph17103740

Dana, D. [NICABM]. (2020, April 25). *How to Befriend Your Nervous System During Quarantine [Video]*. YouTube. https://www.youtube.com/watch?v=2To9TDl-7mQ

Ettman, C. K., Abdalla, S. M., Cohen, G. H., Sampson, L., Vivier, P. M., & Galea, S. (2020). Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. *JAMA Network Open, 3(9)*, e2019686. https://doi.org/10.1001/jamanetworkopen.2020.19686

Fennell, M. J. V. (1989). Depression. In K. Hawton, P. M. Salkovskis, J. Kirk., & D. M. Clark (Eds.), *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide* (pp. 169-234). Oxford, New York, Tokyo: Oxford University Press.

Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, 28, 857-870.

Groarke, J. M., Berry, E., Graham-Wisener, L., McKenna-Plumley, P. E., McGlinchey, E., & Armour, C. (2020). Loneliness in the UK during the COVID-19 pandemic: Cross-sectional results from the COVID-19 Psychological Wellbeing Study. PLoS ONE, 15(9), e0239698. https://doi.org/10.1371/journal.pone.0239698

Grover, S., Sahoo, S., Mehra, A., Avasthi, A., Tripathi, A., Subramanyan, A., Pattojoshi, A., Rao, G., Saha, G., Mishra, K., Chakraborty, K., Rao, N., Vaishnav, M., Singh, O., Dalal, P., Chadda, R., Gupta, R., Gautam, S., Sarkar, S., … Janardran Reddy, Y. (2020). Psychological impact of COVID-19 lockdown: An online survey from India. *Indian Journal of Psychiatry, 62(4)*, 354–362. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_427_20

Hyland, P., Shevlin, M., McBride, O., Murphy, J., Karatzias, T., Bentall, R. P., Martinez, A., & Vallières, F. (2020). Anxiety and depression in the Republic of Ireland during the COVID-19 pandemic. *Acta Psychiatrica Scandinavica, 142(3)*, 249–256. https://doi.org/10.1111/acps.13219

Ingram, J., Maciejewski, G., & Hand, C. J. (2020). Changes in Diet, Sleep, and Physical Activity Are Associated With Differences in Negative Mood During COVID-19 Lockdown. *Frontiers in Psychology, 11*, 588604. https://doi.org/10.3389/fpsyg.2020.588604

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. (1984). *Interpersonal psychotherapy of depression.* Basic Books: New York.

Lejuez, C. W., Hopko, D. R., & Hopko, S. D. (2001). A brief behavioral activation treatment for depression: Treatment manual. *Behavior Modification, 25*, 255-286.

Lopez, S. J., Floyd, R. K., Ulven, J. C., & Snyder, C. R. (2000). Hope therapy: Helping clients build a house of hope. *Handbook of Hope: Theory, Measures, and Applications,* 123–150.

Luchetti, M., Lee, J. H., Aschwanden, D., Sesker, A., Strickhouser, J. E., Terracciano, A., & Sutin, A. R. (2020). The trajectory of loneliness in response to COVID-19. *American Psychologist, 75(7), 897–908*. https://doi.org/10.1037/amp0000690

McKay, M., Wood, J. C., & Brantley, J. (2007). The *Dialectical Behaviour Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation & Distress Tolerance.* Oakland, CA: New Harbinger Publications.

Norcross, J. C., & VandenBos, G. R. (2018). *Leaving It at the Office: A Guide to Psychotherapist Self-Care (2nd ed.)*. New York: The Guilford Press.

Ormel, J., Cuijpers, P., Jorm, A. F., & Schoevers, R. (2019). Prevention of depression will only succeed when it is structurally embedded and targets big determinants. *World Psychiatry, 18(1)*, 111–112. https://doi.org/10.1002/wps.20580

Peterson, C., & Seligman, M. E. P. (1983). Learned Helplessness and Victimization. *Journal of Social Issues, 39(2),* 103–116.
https://doi.org/10.1111/j.1540-4560.1983.tb00143.x

Ray, D., & Subramanian, S. (2020). India's lockdown: An Interim Report. *NBER Working Paper Series* (No. 27282). http://www.nber.org/papers/w27282

Shanahan, L., Steinhoff, A., Bechtiger, L., Murray, A. L., Nivette, A., Hepp, U., Ribeaud, D., & Eisner, M. (2020). Emotional Distress in Young Adults during the COVID-19 Pandemic: Evidence of Risk and Resilience from a Longitudinal Cohort Study. Psychological Medicine. https://doi.org/10.1017/S003329172000241X

Stuart, S., & Robertson, M. (2012). *Interpersonal Psychotherapy: a clinician's guide* (2nd ed.). Boca Raton: Taylor & Francis Group, LLC.

Watkins, E. R. (2016). *Rumination-focused cognitive-behavioural therapy for depression*. New York: The Guilford Press.

Watkins, M., & Shulman, H. (2008). *Towards Psychologies of Liberation* (Critical Theory and Practice in Psychology and the Human Sciences Series). Hampshire, New York: Palgrave Macmillan

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends.* New York, London: W. W. Norton & Company.

Wood, A. M., Froh, J. J., & Geraghty, A. W. (2010). Gratitude and well-being: A review and theoretical integration. *Clinical psychology review, 30(7),* 890-905.

Zhang, X., Zhu, W., Kang, S., Qiu, L., Lu, Z., & Sun, Y. (2020). Association between physical activity and mood states of children and adolescents in social isolation during the COVID-19 epidemic. *International Journal of Environmental Research and Public Health, 17(20)*, 1–12. https://doi.org/10.3390/ijerph17207666

6 Regulating Anger

The COVID-19 pandemic has seen widespread expressions of anger, so much so that new terms such as 'pangry' ('pandemic angry') and 'corona rage' have been coined in popular culture (Anand, 2021; Borresen, 2021). 'Pangry', for example, refers to the anger felt by a person when they see the risky behaviour of friends, family and others who are not taking appropriate precautions in the pandemic and enjoying experiences that they are missing out on (Borresen, 2021). A study published in July 2020 reported that global sentiments towards COVID-19 shifted from fear (dominant at the start of the outbreak) to anger (as fatigue from social isolation set in) (Lwin et al., 2020).

Spread of misinformation has also been linked to increased anger. One study conducted in the UK found that belief in 5G conspiracy theories about COVID-19 was positively correlated with anger, which in turn was linked to a greater justification of violent behaviours (Jolley & Paterson, 2020). Frequent news-seeking and accessing information from social media have also been associated with increased anger in multiple studies (Shanahan et al., 2020; Smith et al., 2020). Conspiracy theories are widespread on social media and news sites and endorsement of conspiracy theories has been associated with increased confrontation behaviours (Smith et al., 2020).

Experiences of anger in the pandemic can be thought of as situational or institutional. Situational anger is triggered by specific circumstances that are perceived as frustrating or unfair. In a study conducted in India, individuals diagnosed with COVID-19 and their family members reported various instances of being angry due to perceived unethical or inefficient medical treatment, being denied testing or other medical facilities, perceived unfair circumstances (e.g., being posted for COVID-19 duty despite requesting superiors for a pardon) and so on (Duggal et al., 2020). Individuals also reported anger at invasions of their privacy due to being repeatedly contacted for tracing (Duggal et al., 2020).

In the pandemic, anger may also be directed at institutions, systems or circumstances in general. Those who are disproportionately and unequally affected by the pandemic and the lockdown are more likely to be angry e.g., those who are less able to work from home, those who have a higher likelihood of facing financial difficulties (Smith et al., 2020). Anger is also linked to a low level of trust in governments and their response to the pandemic (Smith et al., 2020). Globally, increased xenophobic tweets were noted after the imposition of the lockdown (Lwin et al., 2020). In India, hostility against marginalized communities has been on the rise, with reports of violent attacks by mobs on individuals from particular communities (Naqvi & Trivedi, 2020). This led Smith et al. (2020) to conclude that, in the pandemic, we may be moving from therapeutic communities (that are characterised by high levels of cohesion) to corrosive communities (which are characterised by division and conflict).

Hence, anger in the pandemic must be understood from both perspectives of individual anger at specific situations and collective anger at institutions and circumstances.

1. What is our role as a mental health professional?

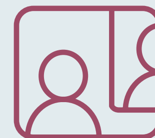
Sheela is a trans woman who has got tested positive for COVID-19. She was forced to get admitted in a 'male' ward in the hospital as that is her assigned sex at birth. Although the medical staff overtly do not say anything to her, they continuously refer to her by 'he'

and 'him' which distresses her a lot. She also notices that the staff avoid touching her and they try to exchange shifts so they don't have to interact with her. She overheard a person in a nearby bed whisper to his family about her 'You know, she is a [slur used against trans people]'. When the counsellor calls her, Sheela is furious and blames the counsellor saying, 'You medical people are all the same! People like you will never know how it feels to be people like us.'

Anger is one of the most commonly encountered emotions by helpline counsellors during COVID-19 (Duggal et al., 2020). At times, clients may directly share their felt experiences of injustice, frustration and anger with us. At other times, we may become the target of clients' anger because the anger may be towards a nameless, faceless entity perpetuating injustice (COVID-19, authorities, an unfair world) and we are a concrete agent that represents these entities in the eyes of the client. On our part, anger can be a difficult emotion to contain and manage, as it can be threatening and demeaning.

When supporting clients who are feeling distressed in the context of anger, our role can involve:

- De-escalation through containing and validating the anger
- Acknowledging the felt injustice and helping clients identify reasons or triggers for their anger
- Supporting clients to regulate themselves so that they can address the need underlying anger in a productive manner
- Helping clients to problem-solve ways to address the reasons behind the anger or alternately, to decide to accept an unchangeable/ uncontrollable situation Equipping clients with tools and strategies to manage anger outside of the session



Reflective Exercise

- Consider the case vignette. Apart from anger, what other emotions might Sheela be feeling?
- Try to do this thought experiment: If you identify as a woman, imagine that you are forced to be admitted in the 'male ward' of a hospital and are constantly referred to as 'he' or 'him' by all the nurses and doctors. Similarly, if you identify as a man, imagine that you are admitted to the 'female ward' of a hospital with other patients who identify as women and are constantly called 'she' or 'her'. How would it feel to you?

2. What key concepts and ideas can inform our practice?

2.1 Physiological, cognitive and behavioural dimensions of anger

Anger is generally manifested through physiological symptoms (e.g., increased muscle tension, increased heart-rate and breathing rate), cognitions (e.g., thoughts of revenge and hostile thoughts) and behaviour (e.g., verbal or physical violence) (American Psychological Association [APA], 2012).

2.2 Anger as a primary and secondary emotion

Anger can be both a primary and secondary emotion. When anger is a primary emotion, it is the core emotion in that situation. It may be a valid response to perceived injustice or to the client's legitimate goals being blocked. In this case, interventions might be aimed at helping the client take action to correct the injustice, stand up for themselves or achieve their goals.

When anger is a secondary emotion, it may merely be the 'tip of the iceberg'. In this context, anger may be protecting the person from their rawer, more difficult to tolerate feelings. For example, anger may be a response to perceived rejection and hurt. In this case, interventions might include helping the client to understand the emotions and needs underlying the anger and supporting them to address those emotions.

2.3 Anger as adaptive and non-adaptive

Evolutionarily, anger has a self-protective function as well as an alerting function (APA, 2012). It helps us to stand up for our rights and alerts others to our needs. For example, various protest movements around the world use anger and indignation as a way of motivating participation, increasing solidarity and guiding strategic choices (Jasper, 2014).
However, anger can also lead to perpetration of violence and injustice against others. It can have

Anger Iceberg : By Drs. John and Julie Gottman, The Gottman Institute

negative consequences in the form of interpersonal conflicts, occupational maladjustment, increased risk of physical health consequences and even criminal behaviour (APA, 2012).

Anger expression styles is another concept through which we can understand adaptive versus maladaptive anger. This is essentially the idea that anger can be expressed or manifested in different ways. Various researchers have classified various anger expression styles (Wolf & Foshee, 2003):

- 'Anger-out' style i.e., directing anger towards others
- 'Anger-in' style i.e., suppressing anger
- 'Anger control' style i.e., controlling feelings of anger regardless of their direction
- 'Anger discuss' style i.e., talking about anger to other people or discussing the problem with others

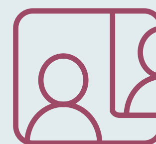
Anger expression can also be conceptualized through the well-known framework of 'constructive and destructive' anger (Holt, 1970). Constructive anger is expressing and resolving anger in a way that more than one person can 'win'. Destructive anger might involve behaving aggressively towards another person without leading to a resolution or suppressing one's anger, thereby increasing distress in the long-term.

Hence, interventions for anger focus on expressing anger in a healthy manner that does not cause harm to ourselves or others. We do not want to get rid of anger, but rather, harness it for our benefit rather than to our detriment.

2.4 Socio-cultural and collective dimensions of anger

There are socio-cultural influences on the expression of anger. Historically, gender socialization norms have constructed anger as an inappropriate emotion for women and normalized the expression of anger for men (Lerner, 1977). This has been shown to play a role in the perpetration of intimate partner violence (Copenhaver et al., 2000). Feminist movements have particularly worked to battle norms that dictate that women should not express anger (Jasper, 2014). Hence, interventions for anger must take into account the particular socio-cultural dimensions of anger in the context we are working in.

Collective emotions are emotions that can be attributed to entire groups that may be linked through a common identity (e.g., collective pride in one's country) (Sullivan, 2020). Social media is one avenue through which such emotions are spread. For example, an influential study after the Paris terror attacks in 2015 showed that tweets about the attacks led to 'emotion-sharing feedback loops' at a scale that would not have been possible through in-person conversation alone (Garcia & Rimé, 2019). Similarly, perceived collective anger can influence individuals' feelings of anger and subsequently influence behaviour (Kim, 2015). A recent study in China showed that anger spreads faster than joy, sadness or disgust on social media (Fan et al., 2014). Hence, when intervening with a client who is experiencing anger, it is important to keep in mind the possible influence of collective anger on their emotions.



Reflective Exercise

Consider the situation below:
[phone rings]
Counsellor: Hello, I am so and so, you are calling the X helpline.
Client: Hello, [inaudible]
Counsellor: Sorry, I couldn't hear that, could you speak a little louder please?

Client: [audible now] How can I speak loudly when there is no food in my stomach since the past 2 days? [mutters to himself] Speak loudly, they tell me. All you government people are the same.

- How do you feel at this point in the call?
  - Do you feel embarrassed?
  - Do you feel confused?
  - Do you feel sympathetic?
  - Do you feel offended?
- *How do you feel like responding? Do you feel tempted to defend yourself or the government? Do you feel like continuing the call?*
- *What information do you already have about the client's situation that you can use to make sense of the client's feelings?*
- *Taking this into account, how would you want to respond?*

3. How do we assess and intervene?

3.1 Preparing to intervene

Before we start intervening to support clients who are experiencing anger, we can:

Be aware of various circumstances in the pandemic that can create feelings of anger. This can help us to be more understanding of the difficulties faced by our clients.

Be aware of our own physical and emotional state. Are we feeling hot, tired or hungry before going into the call? Physical discomfort can increase the likelihood of an anger reaction. Are we feeling emotionally drained or frustrated? This, too, can reduce our tolerance for accepting clients' angry feelings. If we identify ourselves to be in a space of emotional and physical vulnerability, we can spend some time to regulate ourselves to ensure that we are able to safely contain our clients' angry feelings.

Examine our own beliefs about anger. If we believe that anger is not an appropriate emotion to feel or express, we may find it difficult to validate someone else's anger. Hence, we may benefit from examining our own beliefs about anger.

3.2 Identifying the concern

Certain verbal indicators of anger include:

- Being irritable e.g., a question about how they're feeling elicits a response *'Isn't it obvious?'*
- Expressing a sense of unfairness e.g., 'It is not fair' *'This is not okay' 'Why did this happen to me?'*
- Withdrawal e.g., *'I don't want to speak anymore' 'I don't want to discuss anything'*
- Using shoulds e.g., *'The doctors should not have behaved like this!' 'My father should have told me'*
- Being dismissive of the counsellor e.g., *'Nothing can help' 'What will you do?'*
- Equating the counsellor with a system/organization/group of people e.g., *'You are all like this'*

Certain non-verbal indicators of anger include:

- A loud voice or shouting
- A curt or sharp tone of voice
- Responding in monosyllables can also sometimes be an indicator of anger

When we identify that the client is angry, we can explore further by asking for specifics of the situation that has upset them, *'When you say 'The hospital was horrible', what do you mean?'* We can also look out for any triggers, *'So when the line in which you had been waiting for for 3 hours suddenly just closed down, that was the last straw?'*

3.3 Providing Interventions

3.3.1 De-escalation: Physiological and emotional interventions

Containing anger. Ejected anger needs a safe and accepting container, a person who will tolerate, hold and survive these difficult feelings for the client. Hence, let's try to listen as well as we can without interrupting the client.

Monitoring our own responses. It is important that we are aware of how our bodies are reacting to the client's anger. What is the primary emotion we are feeling? What do we need to do for ourselves to contain our own and our clients' feelings? We may need to take a deep breath, ground ourselves using an anchor or remind ourselves *'This anger is not just about me'*.

Reflecting and validating the anger. If the anger has not been triggered by us, we can name and acknowledge the feeling of anger as well as that it is justified, '*I hear you, you are feeling really angry right now', 'I cannot argue with that', 'I see your point'*. We try to match the intensity of the client's emotion, '*You felt angry….you felt furious...you felt completely enraged'*. If anger has been triggered by something we have said, we can say *'I can see I've upset you in some way, I am sorry, I didn't mean to do that, could you please help me understand how I've upset you?'* Such a statement takes responsibility for triggering the anger while at the same time, establishes that the intention was not to anger the client. Some triggers may be logistical issues, such as long waiting times on helplines or being transferred. In this case, we can acknowledge and apologize for the client's experience e.g., *'I am sorry that you had to wait for a long time for your call to be answered, I can understand that it is very frustrating'*.

Giving a choice. Some people have reported feeling angry at being repeatedly called for contact-tracing in the pandemic (e.g., Duggal, et al., 2020). If we are doing outreach work, we may encounter a client who is angry at being called itself. Proactively asking, 'Do I have your permission to continue this call?' can help reduce the client's irritation. If the client says they do not want to speak, we need to respect this decision.

Helping the client to self-regulate. Before helping the client to regulate themselves, it is important to ask for permission and offer an explanation, *'I am here to help you and understand what we can do to address this problem. I understand anger is a very justified feeling given all that you have gone through. I'm concerned that I may not be of much help to you unless we can reduce your distress. I would like to make sure you are feeling a little calmer, is that okay?'* Such an elaborate explanation can help because suggesting regulation or 'calming down' can be triggering in itself when someone is angry. Once we have received permission, we can proceed with physiological interventions aimed at reducing arousal:

- Would you like to have a glass of water and then continue?
- Could I help you take some deep breaths? [Guide client through paced breathing]
- Grounding techniques

Establishing boundaries. When clients' anger is directed towards us, it is important to set limits when they cross certain personal boundaries we have. Sometimes, when a client is angry, establishing boundaries can be perceived as invalidating by them. Hence, it is important to accompany setting limits with validation, *'I can understand you are angry and I want to understand it so I can help you. But I'm going to have to request you to stop abusing me so I can help'*. If the client does not stop, then we can escalate the warning, *'I can understand that you are really, really frustrated and I want to help. But if you continue to abuse me, I will be forced to end this call.'* If we have to hang-up, we can say, *'I am ending the call now. You are welcome to call the helpline in the future if you need help'*. We can make sure to use a calm tone of voice when limit-setting. It is important to be

consistent about boundaries and not to relax them, as the client may get a signal that it is okay to cross those boundaries for any future calls.

Complex reflection and validation. This can be done after the client is a little calmer. For example, we may reflect, *'It sounds like you felt really unjustly treated'* or '*It sounds like you are really angry at how unfair it was'*. We can also reflect any underlying emotions, *'I'm also hearing that you felt really disrespected…you felt hurt…you felt trapped and scared'*. We can further validate the anger by statements such as, *'It is understandable that you feel furious at being treated so unfairly' 'Anybody would feel angry in such a situation'*. When we use specific statements, the client feels more understood, *'What really made you angry was not the rudeness, but the indifference with which the doctors were treating you. It felt as if they just didn't care?'* We can also acknowledge the client's wish or desire to change what has happened, *'You really wish this hadn't happened to you'*.

Explored client's preferred direction in the session. This can help us to find a focus for the session collaboratively with the client. We can use more open-ended statements such as, '*All of this can be a lot to deal with. What is it that you hope from our conversation today?' 'What would be most helpful to you in this conversation?' More change-focused questions include, 'What is it that you would like to see change about how you are feeling right now?' 'What needs to change in order for you to feel less angry about this situation?'*

Psychoeducating the client about anger. After de-escalation, the client may be ready to discuss anger and its implications. Psychoeducation about anger generally involves framing anger as a natural and useful emotion, when employed productively. We can say:

- *'Everybody feels angry, it is okay to feel angry'*
- *'Anger is a normal emotion that shows to us that our goals are being blocked in some way' 'Anger is self-protective'*
- *'Sometimes intense anger can cloud our judgment. It's usually better to let the anger decrease and then think about the action we want to take'*
- *'Anger can sometimes hide other emotions' 'Anger protects us from our deeper, more* difficult feelings sometimes'

Addressing secondary emotions. Clients may have certain beliefs about anger itself, such as 'It is bad to feel angry' 'I should never feel angry' 'I am an angry person' (seeing anger as a fixed trait rather than a transient emotion that everyone feels) 'Anger is always unhelpful' 'If I get angry, I will do something bad' and so on. We can identify and reflect back these emotions to the client, 'I'm hearing that you feel guilty about feeling angry, is that right?' Then we can explore further, *'What do you think is not okay about feeling angry?'* The realization that anger is often self-protective can help the client to see their anger objectively rather than as a 'bad emotion'. Further, the second arrow metaphor described in Chapter 3 (Section 3) can be used to help the client realize the cost of secondary emotions.

3.3.3 Cognitive Interventions

Some clients may be ready to work at a cognitive level with their anger. This is usually possible only when the acute distress and arousal has reduced.

Increasing insight about triggers and vulnerability factors. This involves helping the client analyze their triggers and vulnerability factors. We can ask, *'What are the main triggers around you that might bring your anger back?'* 'Were you already in an emotionally vulnerable space when the trigger happened?' *'What made you emotionally vulnerable?' 'Were you in any physical or mental discomfort?' 'What generally tends to make you angry?'*

Cognitive reframing. Only after sufficient discussion of what went wrong, we can attempt to help the client examine if there is another side to the situation, '*Despite everything that went wrong, is there something that you feel went in your favour*

and prevented things from getting worse?' 'Do you see anything positive about the situation?'

Practicing radical acceptance.
Here, acceptance does not mean support or agreement. We are not encouraging clients to agree to injustice, but we are encouraging them to accept the reality that the injustice occurred. This can mobilize them to do something about it. For example, we can say '*We cannot change the past, even though we may really wish to…how could you accept what happened?* If you were to accept what happened, what would you want to do next?' '*Acceptance doesn't mean you have to like or be okay with what happened, but accepting what happened means accepting it did happen. Then you can do something about it if you wish'*. To encourage agency, we can say, *'Is there any action you would like to take to prevent this from happening again?'*

Problem-solving. These strategies are described in Chapter 4 (section 3). They can be used when the client's anger is stemming from a particular goal that has been blocked e.g., the client is angry because they have not been able to get medical information from the hospital about their family member's health status. Problem-solving can then be focused on how they can obtain the medical information.

Strengths-based approach. These strategies are described in Chapter 11 (Section 3). They can also be used when the client's anger is stemming from a particular goal that has been blocked.

3.3.4 Behavioural Interventions

Time-out and distraction. We can share with the client that taking a time-out and distracting themselves can be helpful when they are feeling very angry. A time-out is when we temporarily leave a situation (e.g., a fight) in order to prevent escalation. We can distract ourselves in the time-out to reduce our arousal and regain our calm so that we are not making decisions in the heat of the moment.

Practicing self-regulation strategies. When the client feels that they would like to learn to manage anger, we can teach them mindfulness strategies and breathing techniques described in Chapter 3 (Section 3). This should not be imposed by us out of our belief that they should control their anger. Usually, modelling the suggested strategy in session is helpful. Then we can ask, *'How did you find this experience?' 'Would you want to try practicing it outside of session?' 'When would you want to practice?' 'How would you practice?' 'What might be some barriers to practicing?'*

Using anger to advocate. We can support the client in advocating for themselves or others through social media or other public avenues, for example, the client may want to describe their negative experiences in a social media post. There have been numerous examples of how expressing anger on a public platform have led to reparative actions (See Grégoire et al., 2015 for examples). These avenues can also be used to express anger (e.g. through art/creative writing), even when nothing can be done to change the situation. When a felt injustice is expressed, even if the past cannot be fixed, there is a sense of acknowledgement and validation. Such actions may also help in expressing collective anger and mobilizing social movements that aim to bring about systemic change, as different individuals with similar experiences may come together.

Mobilizing social support. When anger is a result of feeling helpless/frustrated as some goals are not being achieved, we can assist the client to seek support to achieve those goals, *'Might you benefit from someone else's help in this situation?' 'Do you have anyone in mind who could help?' 'How could you reach out to them?'*

Planning communication. If anger is arising in an interpersonal context, the client may need help to communicate their anger to somebody in an appropriate way such that their needs can be met. We can help them plan their communication by asking, *'How could you communicate what you are feeling to them in a way that they will understand?'*

'What would you say?' We can help them think of different aspects of communication, *'Would you want to ask them for a specific time when they are free?' 'Would you want to go into a private room?' 'Through which medium would you want to communicate - writing / speaking / texting?' 'What would you want to avoid doing? How could you manage yourself so that you don't do that?'*

Let's Avoid...

Arguing with the client e.g., 'It is government policy, what can be done?' 'You should not have reached late'

Being defensive e.g., 'I am not responsible for your situation' 'I am just a counsellor, not a part of the government'

Making interpretations e.g., 'I can see that you are really angry at the government which you are targeting towards me' 'I think you may be angry because you are hungry'

Invalidating the anger itself e.g., 'I can understand you have suffered a lot, but getting angry is not the solution'

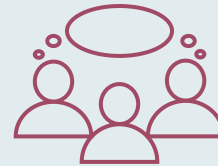
Setting limits overzealously e.g., 'Please speak in a lower tone of voice' 'Please speak calmly so I can understand'. There will probably be some increase in the amount of speech/tone of voice/hostility in tone when somebody is angry. Hence, balancing the client's right to express their anger with our personal boundaries is important.

Threatening the client e.g., 'This will be reported or complained about' 'If you do this, your number will be blocked' unless in special cases that this is the protocol decided for a repeat caller or the client is abusive towards us.

Using an angry tone of voice. No matter what the client's tone of voice, we should remain calm, even while setting boundaries.

Putting the client on hold or hanging up *without warning.*

4. How do we reflect on our work?



Supervision

Anger is an emotion that we have all felt and expressed in some way or the other. We all have our personal beliefs and responses around anger. You could use the following prompts to reflect in supervision about:

- How does it feel when somebody is angry at you? How does your body respond? Does it bring back any memories?
- Do you notice any similarities between how you and your family members deal with anger?
- One framework for various responses to anger includes (Walker, 2013):
  - Fight :We fight back and respond angrily in turn
  - Flight :We want to run away and escape the situation
  - Freeze : We freeze in place and are unable to do anything
  - Fawn : We try to please and appease

the person in order to reduce their anger

Which of these responses do you tend towards in your daily life? Would that be different from how you would want to respond to a client's anger?

Self-Care Exercise

- In this chapter, anger has been conceptualized as one of the emotions that mobilizes us to stand up for our rights. Standing up for our rights can be an act of self-care.
- Are there any rights you would want to stand up for…
  - In your personal context?
  - In your organizational context?
  - In your societal context?
- Setting boundaries is another way to stand up for our rights. Take a few minutes to reflect on your current boundaries with work, friends and family:
  - Financial boundaries?
  - Physical boundaries?
  - Time boundaries?
  - Emotional boundaries?
  - Social boundaries?

References

American Psychological Association. (2012, January 1). *How to recognize and deal with anger.* https://www.apa.org/topics/anger/recognize

Anand, S. (2021, January 10). What is 'corona rage'? *India Today.* https://www.indiatoday.in/india-today-insight/story/what-is-corona-rage-1757704-2021-01-10

Borresen, K. (2021, January 25). How To Deal With The Anger You Feel Over People Ignoring COVID-19. *Huffpost.* https://www.huffpost.com/entry/deal-anger-ignoring-covid-19_l_6009cbbec5b6df63a91e4197?guccounter=1

Copenhaver, M. M., Lash, S. J., & Eisler, R. M. (2000). Masculine Gender-Role Stress, Anger, and Male Intimate Abusiveness: Implications for Men's Relationships. *Sex Roles, 42*(5/6), 405–414. https://doi.org/10.1023/A:1007050305387

Fan, R., Zhao, J., Chen, Y., & Xu, K. (2014). Anger Is More Influential than Joy: Sentiment Correlation in Weibo. *PLoS ONE, 9*(10), e110184. https://doi.org/10.1371/journal.pone.0110184

Garcia, D., & Rimé, B. (2019). Collective emotions and social resilience in the Digital Traces after a Terrorist Attack, *Psychological Science, 30*(4) 617-628.

Grégoire, Y., Salle, A., & Tripp, T. M. (2015). Managing social media crises with your customers: The good, the bad, and the ugly. Business Horizons, 58(2), 173–182. https://doi.org/10.1016/j.bushor.2014.11.001

Holt, R. (1970). On the interpersonal and intrapersonal consequences of expressing or not expressing anger. *Journal of Consulting and Clinical Psychology, 35(1)*, 8–12. https://doi.org/10.1037/h0029609

Jasper, J. M. (2014). Constructing indignation: Anger dynamics in protest movements. *Emotion Review, 6(*3), 208–213. https://doi.org/10.1177/1754073914522863

Jolley, D., & Paterson, J. L. (2020). Pylons ablaze: Examining the role of 5G COVID-19 conspiracy beliefs and support for violence. *British Journal of Social Psychology, 59(3)*, 628–640. https://doi.org/10.1111/bjso.12394

Kim, J. (2015). The effects of collective anger and fear on policy support in response to terrorist attacks. *Journal of Social Psychology, 156(5*), 455–468. https://doi.org/10.1080/00224545.2015.1119669

Lerner, H. (1977). The taboos against female anger. *Menninger Perspective.* 5–11.

Lwin, M. O., Lu, J., Sheldenkar, A., Schulz, P. J., Shin, W., Gupta, R., & Yang, Y. (2020). Global Sentiments Surrounding the COVID-19 Pandemic on Twitter: Analysis of Twitter Trends. *JMIR Public Health Surveillance, 6*(2), e19447. https://doi.org/10.2196/19447

Naqvi, M., & Trivedi, U. (2020, April 24). A New Wave of Anti-Muslim Anger Threatens India's Virus Fight. *Bloomberg.* https://www.bloomberg.com/news/articles/2020-04-23/a-new-wave-of-anti-muslim-anger-threatens-india-s-virus-fight

Shanahan, L., Steinhoff, A., Bechtiger, L., Murray, A. L., Nivette, A., Hepp, U., Ribeaud, D., & Eisner, M. (2020). Emotional Distress in Young Adults during the COVID-19 Pandemic: Evidence of Risk and Resilience from a Longitudinal Cohort Study. *Psychological Medicine.* https://doi.org/10.1017/S003329172000241X

Smith, L. E., Duffy, B., Moxham-Hall, V., Strang, L., Wessely, S., & Rubin, G. J. (2020). Anger and confrontation during the COVID-19 pandemic: a national cross-sectional survey in the UK. *Journal of the Royal Society of Medicine, 0(August)*, 1–14.

https://doi.org/10.1177/0141076820962068

Sullivan, G. B. (2020, September 2). Collective emotions and Covid-19. https://thepsychologist.bps.org.uk/collective-emotions-and-covid-19

Walker, P. (2013). Complex PTSD: *From Surviving to Thriving. Lafayette*, CA: Azure Coyote Publishing.

Wolf, K. A., & Foshee, V. A. (2003). Family Violence, Anger Expression Styles, and Adolescent Dating Violence. *Journal of Family Violence, 18*(6), 309–316. https://doi.org/10.1023/A:1026237914406

7 Assuaging guilt

During the COVID-19 pandemic, people are being exposed to various heart-breaking and ethically difficult scenarios. They may be forced to make or accept decisions that are not in keeping with their personal ideals or moral values, for example, being unable to tend to a loved one who is suffering (Haller et al., 2020). Such situations may precipitate guilt, regret and shame reactions.

One group of people identified as particularly vulnerable to such reactions in the pandemic are individuals who have acquired COVID-19 and their family members (Cavalera, 2020; Haller et al., 2020). The prolonged situation of being 'on alert' for COVID-19 can create a context where people are vulnerable to feeling hyper-responsible for transmission of COVID-19 to loved ones (Cavalera, 2020). Social media exposure may lead to information (and misinformation) overload that can amplify such feelings of hyper-responsibility for contracting COVID-19 or passing it on to others (Cavalera, 2020). This can lead to feelings of guilt for even minor actions that are seen as threatening to safety. Given that it is very difficult to trace the exact source of a particular infection and that even asymptomatic people can be carriers, it is tough to prove or disprove whether someone has been the carrier, thus the guilt may not really have an 'answer' (Cavalera, 2020). Guilt may be especially high if a healthy person suspects themselves of having passed on the virus to somebody much more vulnerable, such as their elderly parents or their newborn child (e.g., Sahoo et al., 2020).

Guilt and regret can be strong emotions for people infected by COVID-19 themselves, even if they are not concerned about infecting others. Conditions of loneliness in quarantine accompanied by a fear of death may lead to regret ('I didn't pay enough attention to safety measures') and guilt ('I am causing my family so much inconvenience') (Cavalera, 2020). Further, the internalized stigma of being a 'COVID-19 patient' can also lead to feelings of shame, exacerbated by rejection from family, friends and neighbours (Brooks et al., 2020; Ransing et al., 2020)

Healthcare professionals are another group of people vulnerable to guilt, regret and shame reactions. Healthcare professionals must often make life-and-death decisions over allocation of scant resources under critical and stressful situations (Greenberg et al., 2020). In such situations, they may experience intense shame, guilt and disgust if they feel that they have violated personal ethical or moral codes (*'I was not as caring with that patient as I could have been')*. Health care professionals can also experience 'sideline guilt', the feeling that they are not doing enough in the pandemic as they are not on the frontline, engaged in direct care of individuals diagnosed with COVID-19 (Reuben, 2020).

Guilt is also a commonly experienced emotion in the aftermath of bereavement (Worden, 2018). In COVID-19, bereaved individuals may feel survivor guilt, a sense of discomfort that they were spared some adversity their loved ones were not (Goveas & Shear, 2020). Bereaved individuals may also feel guilty for not being there by their loved one's side as they suffer or die or not being able to perform or attend traditional rituals after death (Goveas & Shear, 2020; Sun et al., 2020). They may imagine alternative scenarios where their loved ones might not have died (Goveas & Shear, 2020), perhaps imagining that they could have made better medical decisions, such as consulting a doctor sooner, finding the right hospital or giving consent to certain medical procedures. Parents or caregivers who lose a child are highly vulnerable to guilt that is focused on their helplessness to stop the child from feeling pain or dying (Worden, 2018). Such strong feelings of guilt can increase the risk for complicated grief reactions (Shear, 2012).

Finally, the general public may also experience guilt related to the resources, happiness or enjoyment they have in the pandemic, e.g.,'I am getting time to spend with my family, but so many people are suffering' (Chivers et al., 2020).

1. What is our role as mental health professionals?

The counsellor calls up John, a 45 year old police personnel. He says that he maintained all precautions to not get affected by COVID-19. As he was a front-line worker, he was not affected till November and he feels proud about that. But during Diwali, he somehow relaxed and enjoyed freely with his family and then he got diagnosed with COVID-19. Now, he feels extremely guilty and is worried about his family getting the infection from him. He feels that he has not done his duty properly and as a policeman, his responsibility is to protect society which he has failed at.

Guilt can be a subtle and often ignored source of emotional distress. Due to its association with shame and self-reproach, clients may be hesitant to directly bring it up as a concern. However, guilt can be a significant source of distress to the client. Hence, as mental health professionals, our role involves:

- Picking up on subtle indicators of guilt and focusing on guilt as a source of distress for the client, if appropriate Creating an accepting and non-judgmental space for the client so that they
- feel safe to bring up guilt and shame concerns
- Helping the client reduce immediate distress related to guilt
- Helping the client to cognitively appraise or 'reality-test' their guilt
- Equipping them with certain tools and strategies to manage guilt outside of the session

2. What key concepts and ideas can inform our practice?

The basic framework for working with emotions described in Chapter 3 (Section 3) applies to handling guilt. Specific concepts for working with guilt include:

2.1 Guilt, regret and shame

Guilt and regret are emotions felt in situations where we perceive our actions or inactions as negative such as thinking that we did something bad (Kubany & Watson, 2003). The distinction between guilt and regret is subtle. One distinction is that guilt applies to situations in which harm is caused to someone else, whereas regret is used when the harm is caused to self (Berndsen et al., 2004). Traditionally, regret is also defined as a negative emotion that occurs when one compares the outcome of a decision to what might have been ('*If only I had made a different decision...*'; Bell, 1982). In another study, the authors concluded that guilt was a self-focused and aversive emotion whereas regret was a less aversive, more empathic emotion focused on taking a victim's perspective (Imhoff et al., 2012). However, some researchers do not distinguish between guilt and regret; and consider both these emotions to occur together (Zeelenberg & Breugelmans, 2008). Further, these emotions may not be clearly distinguished in language; people may use the words 'regret' and 'guilt' interchangeably (Zeelenberg & Breugelmans, 2008).

Shame occurs when guilt is considered to be a part of the person and generalized to the the person as a whole ('*I am bad*'; Tangney et al., 2007). Guilt does not directly affect one's self-concept, whereas shame does (Tangney et al., 1996). Another difference between guilt and shame is that guilt is thought to be a more private emotion that is the result of one's internalized conscience and can be felt when alone. However, shame is a more public

emotion that involves a perception of judgment or disapproval from other people (Tangney et al., 1996).

2.2 Guilt can be adaptive or maladaptive.

Guilt can be adaptive and constructive when it leads to actions aimed at reparation and encourages prosocial behaviour (Cryder et al., 2012; Donohue & Tully, 2019; Haller et al., 2020). Guilt can become maladaptive when:

- It is exaggerated or 'free-floating' i.e., the intensity of the guilt is disproportionate to the reality of the situation.
- It is internalized to the whole person.
- It does not lead to reparative action or a renewed commitment to act differently, but instead becomes directed at self in the form of excessive rumination or self-criticism.

Hence, we do not aim to erase guilt completely from a client's life. We want to reduce maladaptive guilt and support adaptive guilt that can lead to reparation and prosocial actions, in accordance with the client's values.

2.3 Common cognitions in guilt

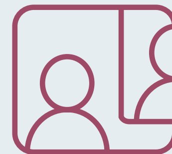
This is adapted from Norman et al.'s (2014) model of trauma-informed guilt reduction therapy, which in turn is based on the work of Kubany and Watson (2003). They identified four common cognitions around guilt.

Hindsight bias: Believing the outcome was known at the time of the action e.g., somebody whose family member has got COVID-19 believes that they 'knew' they were ill and did not quarantine on time (when in reality, they did not have symptoms)

Lack of justification: Believing that there was no justification for the course of action one chose to take e.g., somebody who made a decision to not go to the hospital and their relative passed away believes there was no justification to their action.

Exaggerated responsibility: Believing that one is solely or mostly responsible for the outcome e.g., somebody who believes that it is completely their fault that their family member has been infected by COVID-19.

Wrongdoing bias: Believing that one purposely did something that was wrong or violated moral values e.g., a healthcare professional believing that they did not do all they could to help a patient.
Norman et al.'s model (2014) involves psychoeducating clients about guilt and appraising these four cognitions. The second part of the model involves helping clients identify important values and ways to live a life in integrity with these values.



Reflective Exercise

- How is right/wrong seen in your culture? How is/was it seen in your family-of-origin?
- How were you supposed to feel when you have done something 'wrong'? How were you supposed to act?
- According to you, when does guilt become problematic?

3. How do we assess and intervene?

3.1 Preparing to intervene

Guilt is a major theme in the pandemic, however it is an emotion that may not be easily or directly discussed with us. Before intervening with guilt, it may be helpful to:

Familiarize ourselves with the role of guilt in the pandemic. This will help us tune in and identify signs of guilt in our clients, even when they are not able to explicitly verbalize these emotions.

Examining the personal meanings of guilt for us. Reflecting on the personal relevance of guilt for us, our beliefs about guilt and how we tend to react to this emotion in other people may help us to work more sensitively with such concerns.

3.2 Identifying the concern

Guilt may be a subtle emotion that may not always be obvious as an area of focus in our work. Hence, we may need to be observant to certain indicators of guilt expressed by clients such as:

- Using 'should' statements about past actions or inactions e.g., *'I shouldn't have yelled at him' 'I should have worked harder'*
- Continuously speaking about past action or inaction
- Talking negatively about oneself e.g., *'I am a bad person' 'I am not a good doctor' 'It is all my fault' 'I have done a lot of mistakes'*
- Reacting defensively/with anger to seemingly neutral questions that imply the client's role in the event e.g., *'Were you there when this happened?'*

When we identify a possible indicator of guilt, we can focus on it and ask the client *'Could you tell me more about this feeling?'* if we suspect the client may be feeling guilty but has not verbalized it yet, we can sensitively explore the same by normalizing guilt first and then asking if the client is feeling similarly, *'When we find ourselves in such situations, it is quite common for people to wonder if they did anything wrong, have you ever felt like that?'*

Once we have identified guilt, we can proceed to identifying the **source of guilt**. This may be different from what we have assumed. For example, a client who initially presents with feeling guilty about passing on COVID-19 to a friend whom she went to meet may clarify that she is feeling guilty mainly because she went to meet a friend with the intention of enjoying herself and not that she went to meet a friend in itself. Hence, the source of the guilt is the intention and not the action and if our intervention was directed at the action, it might not work.

We can ask scaling questions to assess the **intensity of guilt,** *'On a scale of 1 to 10, how responsible do you feel for passing on COVID-19 to XYZ?'* 'On a scale of 1 to 10, how convinced are you that you have done something wrong?'

It is also important to identify **the context of any action** or decision that is the source of guilt. For example, we could ask, *'What was the situation around you when you decided to seek out some form of enjoyment?'* If the client has made a critical decision, we can ask, *'Was anybody else present to help you/support you when you made this decision? Were there any other supports available?'* If the source of guilt is work-related, we can ask *'Did your organization have any protocols on situations like this? Did you feel prepared for this/were there any supports in place to make such decisions? Did you have supervisors who could guide you?'* As we can see, these questions, although technically part of assessment, can themselves be therapeutic as they help the client to reflect on the context of their actions and perhaps help them realize that they may have done the best they could, given the circumstances.

We can also assess the **reactions from significant others,** which can play a significant role in guilt and shame reactions, especially those related to the

stigma of being a 'COVID-19 patient'. Questions we can ask include: *'How are other people around you treating you? How did the hospital staff treat you? Is anybody behaving differently towards you?'* Even if the guilt is not related to internalized stigma, it may still be helpful to check for reactions from others, '*What do your family/friends/neighbours say about this? Did anybody say or do something that made you feel worse/better?'* Social media may be another important domain that could have played a role in the client's feelings, *'Are you on social media? How is social media influencing your feelings? Did you come across anything that increased/decreased your distress?'*

3.3 Providing Interventions

In keeping with the levels of intervention framework described in Chapter 3 (Section 3), we will describe different interventions that can be used with guilt.

3.3.1 Physiological Interventions

If the client is extremely distressed in the session, we can use similar interventions to those described in Chapter 3 (Section 3) to reduce their distress (grounding and breathing techniques).

3.3.2 Emotion-focused Interventions

Labelling guilt. Often, clients may not have a word for the feeling they are experiencing. We can use the specific word 'guilty' or some other close feeling word to describe the client's experience and check with the client if that feels appropriate. This can be therapeutic in itself.

Containing and validating guilt. Guilt is a difficult emotion to tolerate. We feel tempted to rush in and reassure the client that they have done nothing wrong. However, this can feel inauthentic and false. Instead, it is important to stick with and explore the feeling of guilt, by using reflection of feeling, sensitive questions and appropriate pauses. Once we have understood the nuances of the client's emotions, we can verbalize that guilt is a difficult emotion to feel, *'It's not easy to feel so responsible for what happened'*. We can also validate the pain of guilt (*'I can understand that you feel guilty because you think that you should have been there but weren't'*) while being careful at the same time not to inadvertently justify it (*'You weren't there, so you feel guilty'*).

Psychoeducating the client and normalizing guilt. We can educate clients about certain aspects of guilt. This in turn may help to normalize guilt and to understand that feeling guilty does not necessarily mean we have done something wrong. Examples of statements we can make include:

- *'Many people who have lost a loved one feel guilty...it is common to feel that we could have done something to prevent this loss' Feeling guilty does not necessarily mean that we have done something wrong'*
- *'We feel guilty because we care, because something matters'*
- *'When we lose somebody close, our mind searches for reasons for why it happened...guilt is one of the ways in which we can give it a reason'*
- *'It is part of being human to make mistakes'*
- *'Some amount of guilt can be healthy and can help us to improve our relationships and actions, but if guilt becomes too much, it can hinder us and interrupt our lives'*
- *'Guilt that is unexamined can fester and the more guilt we feel, the more certain we feel that we have done something wrong. We become trapped in circular thinking'*

We can also give specific examples of common sources of guilt during COVID-19, *'Many people experience guilt because they think they have passed on COVID-19 to someone, many people also experience guilt about not being able to care for a loved one due to being separated from them in quarantine'*. Let's remember that when we are trying to normalize guilt in this way, we are not dismissing it because it is common, but rather, we are attempting to convey to the client that their experience is understandable

and to help them feel less alone.

3.3.3 Cognitive Interventions

Appraising distorted cognitions related to guilt. Norman et al.'s (2014) framework which was described above is a useful resource in understanding and appraising these cognitions. The objective is to help clients to evaluate their cognitions more realistically and reach a reasoned conclusion about the circumstances that have produced guilt. However, it is important that we do not push clients to do this or ask leading questions about these cognitions. By doing so, we may incur the risk of increasing rumination. We can use this intervention if clients themselves bring up specific cognitive distortions (*'I had a feeling I was positive, so I should have known! I still went to the party, I'm such a horrible person' indicator of hindsight bias*). Once we have identified certain cognitive distortions in the client's words, we can ask targeted questions to help the client realistically evaluate their cognitions for themselves.

A **foreseeability appraisal** can help clients who have a hindsight bias. We can explain hindsight bias in terms of the *'I knew it all along effect*'. We can give examples of hindsight bias (when studying for an exam, many students may feel *'I already know this'* when they read something even if they did not know that new information; doctors tend to feel they always knew what a patient's outcome would have been when they actually did not). Then, we can ask the client, *'What information did you actually have for sure at the time of the event? What did you come to know after the event?' 'What did you actually know about your health status when you went to the party? When did you actually get to know that you are ill'?*

A **justification analysis** can help clients who think there is no justification for the decisions they made. We can help the client evaluate the different potential choices available to the client at that time, (e.g., go out for duty, stay home or leave station unstaffed) and what were the pros and cons of each choice. This generally leads to the realization that there were no 'good' options; all options had some negative trade-offs.

A **responsibility appraisal** can help clients who are exaggerating their sense of responsibility. The client can be asked to rate the extent to which they believe they are responsible for the outcome. Then we can use a metaphor such as asking the client *'How are we able to speak right now even though we are far away from each other?'* The client may reply, 'Because of the phones'. We can say, *'Yes and also because there are phone lines, electricity to charge the phone, invention of wireless networks etc'*. Then we can ask, *'In the same way, what other factors may have contributed to the outcome in your case?'* In the case of a loved one getting COVID-19, this could be the loved one themselves not taking proper precautions, chance, unforeseen exposure etc.

A **wrongdoing appraisal** can help clients who have a wrongdoing bias as explained previously in the chapter. This involves helping the client evaluate whether there is a difference between intentionally doing something and something bad unfolding unintentionally e.g., *'What was your intention when you did that?' 'Did you mean to cause harm to your father?'*

Value-based work. Often, clients may feel guilty because they perceive that a personal value they have has not been adhered to (Norman et al., 2014). We can ask them, '*Which of your personal values felt violated in this situation?'* Then we can help clients identify alternative ways to express values, rather than through guilt and shame. Some clients may say *'If I don't feel guilty, it means I don't care enough!'* In this case, the client can be helped to consider how they can express this value of caring in different, adaptive ways going forward e.g., *'How would you like to express this important value of caring going forward in your life?' 'In which domains of your life would you like to express it?' 'What might be a short-term goal that would show you that you have acted consistently with this value?' 'If you were to go to sleep tomorrow knowing that you have been a caring person, what would you be doing*

differently in the day?'

Identifying the function of guilt. This is an important intervention for clients who are not able to dispute or reason with their guilt. This essentially supports clients to reflect on, *'What purpose does the guilt serve in your life?' 'What might it mean to lead a life of less guilt?'*

Some clients may believe that guilt leads them to be good people. This is not completely untrue, guilt is adaptive to some extent! Validating the function of guilt while also pointing out, *'Is there a cost to too much guilt? Is the guilt currently adding to your life or subtracting from it or both?'* can help clients reflect and reconsider the role of guilt in their lives.

Working with different identities and roles of the client (Lanius, 2020). This essentially involves helping the client explore and accept the many 'hats' they wear in different situations. Each hat represents a part of their identity and the roles they play while wearing different hats. People can thus behave differently depending on the demands of the situation and role they are in, while still preserving aspects of their identity. For example, a healthcare worker may feel guilty about not heeding to a dying patient's last request for speaking to their parents on the phone. We can help the person explore the circumstances of the situation and identify the pressures that she was acting under. Perhaps she was so focused on trying to save his life that the doctor 'hat' or identity took precedence over other demands of the situation during the crisis. This does not mean that the client is not an 'empathic person'. We can help the client differentiate between labelling the self vs. labelling the behaviour i.e., gently encouraging the healthcare worker to understand that while she may not have behaved empathetically in that moment, that does not mean she is not an empathic person.

3.3.4 Behavioural Interventions

Self-soothing. When clients are overwhelmed by guilt-related rumination that they are not able to cognitively dispute or reason with, self-soothing strategies may help. One strategy comes from a self-compassionate approach (Gilbert & Procter, 2006). We can say to the client, *'I'm going to ask you to imagine what is your ideal of caring*. Try to think of such an image now that would represent the best way of care for you. Try to make it have the qualities of wisdom, strength, warmth and acceptance. *How would you like your ideal caring– compassionate image to look (visual qualities)? What would it sound like (e.g., voice tone)? What other sensory qualities can you give to it? Would you want your image to feel/look/seem old or young; male or female (or non-human looking, e.g., an animal, sea or light)? What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement?* The image should not be suggested by the therapist and it should be as personal and warm as possible. When clients find it difficult to generate alternative thoughts or feelings to their self-attacking they can focus on 'feeling the presence' of their compassionate image. This strategy usually works well with clients who are comfortable with imagery.

Clients can also use any distraction or self-soothing strategies described in Chapter 3 (Section 3) when guilt-related rumination becomes overwhelming.

Expressive techniques. Clients can write themselves compassionate letters or forgiveness letters ('Dear X, I was sad to hear that you have been beating yourself up again for doing X. I want you to know that….'). Clients can also express themselves through art. We can prompt this by asking, '*What would your balanced frame of mind want to say to your guilty frame of mind? Would you want to draw what it would say?'* Because such techniques involve creating a tangible and more permanent representation of one's thoughts and feelings, they can help consolidate verbal interventions.

Reparative Action. Guilt can prompt a desire to take reparative action or make amends (Cryder et al., 2012). For example, if a client feels guilty about

not being there in the hospital for a loved one, they may wish to help them out after they return home (e.g., by preparing meals for them, doing their household chores). Taking such reparative actions has been shown to alleviate guilt (Donohue & Tully, 2019). Hence, if the client expresses interest in doing so, we can support them to make a plan for reparation. This may involve discussing concrete aspects of the plan, such as when, where and how they will take reparative action. It may also involve setting realistic expectations for the outcome of reparative action and considering whether the wronged parties are likely to accept the gesture (*'Is there a possibility that they may not accept your help? How would that make you feel? How would you like to proceed then?'*).

Encouraging prosocial behaviour. If the client expresses interest in doing so, we can support them to find ways to express kindness and compassion, e.g., checking in on an elderly neighbour, messaging somebody who is in quarantine, combating misinformation online, sharing positive news in WhatsApp groups.

Let's Avoid…

Rushing to reassure the client e.g., 'You didn't do anything wrong' 'You are a good person'

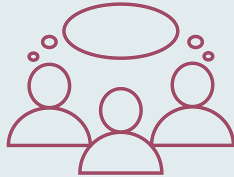
Feeling pressurized to label guilt as adaptive or nonadaptive. It can be both - follow the client's preferred direction!

Pushing the client to recall the traumatic event. Feelings of guilt can be worked with without needing to know exactly what happened.

Pushing the client to take any reparative action. If the client has not initiated the discussion of reparative action, this can increase feelings of guilt by suggesting to the client that the counsellor thinks they need to take reparative action.

Arguing against the client's values. If the client's value is to be a selfless person, it won't be helpful to try to argue them out of it.

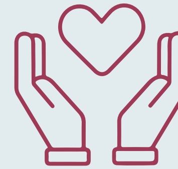
4. How do we reflect on our work?



Supervision

India is sometimes called a shame-based culture, as opposed to a guilt-based culture (Patel, 2018). In a guilt-based culture, individuals' behaviour is based on their individual morality, whereas in a shame-based culture, it is a fear of getting caught or perceived honour that determines actions. Some of our cultural practices may reinforce shame. This may have an impact on our work. Would you like to discuss this in supervision? We could explore the following themes in supervision:

- How might being a part of a culture of shame impact the lens through which we view shame?
- Since we are also a part of the culture, might we inadvertently normalize it?
- How can we safeguard ourselves against such a possibility of normalizing shame?



Self-care Exercise

As healthcare professionals working in the pandemic, we, too, may be vulnerable to feelings of guilt. We may find it difficult to 'say no'. We will have to remember that even superheroes need a break. One of the ways of doing so is to ensure that we maintain boundaries and try to keep some time to ourselves to replenish. But it may be important for us to reflect on our attitude towards boundaries. Some questions that we can ask ourselves are:

- What are your views about out of session contact with clients?
- What are your views about refusing requests from clients?
- What about when clients call during emergencies but outside of working hours?

We may feel bad about refusing the clients in any of these situations. But being available all the time may also not be an option. Thus, we will have to find a balance between saying yes and risk burnout and saying no and feeling guilty. Would you like to use any of the methods described in this chapter to support yourself when feeling guilt?

References

Bell, D. E. (1982). Regret in decision making under certainty. *Operations Research, 30*, 961-981.

Berndsen, M., Van der Pligt, J., Doosje, B., & Manstead, A. S. R. (2004). Guilt and regret: The determining role of interpersonal and intrapersonal harm. *Cognition and Emotion, 18*, 55–70.

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. *Lancet, 395*(10227), 912–920. https://doi.org/10.1016/S0140-6736(20)30460-8

Cavalera, C. (2020). COVID-19 Psychological Implications: The Role of Shame and Guilt. *Frontiers in Psychology, 11,* 571828. https://doi.org/10.3389/fpsyg.2020.571828

Chivers, B. R., Garad, R. M., Boyle, J. A., Skouteris, H., Teede, H. J., & Harrison, C. L. (2020). Perinatal Distress During COVID-19: Thematic Analysis of an Online Parenting Forum. *Journal of Medical Internet Research, 22(9)*, e22002. https://doi.org/10.2196/22002

Cryder, C. E., Springer, S., & Morewedge, C. K. (2012). Guilty Feelings, Targeted Actions. *Personality and Social Psychology Bulletin, 38(5)*, 607–618. https://doi.org/10.1177/0146167211435796

Donohue, M. R., & Tully, E. C. (2019). Reparative Prosocial Behaviours Alleviate Children's Guilt. *Developmental Psychology, 55(10),* 2102–2113. https://doi.org/10.1037/dev0000788

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach. *Clinical Psychology and Psychotherapy, 13,* 353–379. https://doi.org/10.1002/cpp.507

Goveas, J. S., & Shear, M. K. (2020). Grief and the COVID-19 Pandemic in Older Adults. *American Journal of Geriatric Psychiatry, 28(10),* 1119–1125. https://doi.org/10.1016/j.jagp.2020.06.021

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *British Medical Journal, 368,* m1211. https://doi.org/10.1136/bmj.m1211

Haller, M., Norman, S. B., Davis, B. C., Capone, C., Browne, K., & Allard, C. B. (2020). A Model for Treating COVID-19-Related Guilt, Shame, and Moral Injury. *Psychological Trauma: Theory, Research, Practice, and Policy, 12(S1),* 174–176. https://doi.org/10.1037/tra0000742

Imhoff, R., Bilewicz, M., & Erb, H. (2012). Collective regret versus collective guilt: Different emotional reactions to historical atrocities. *European Journal of Social Psychology, 42,* 729–742.

Kubany, E. S., & Watson, S. B. (2003). Guilt: Elaboration of a multidimensional model. *Psychological Record, 53,* 51–90.

Lanius, R. [NICABM]. (2020, November 3). *Treating Trauma: How to Work With the Shame of Moral Injury with Ruth Lanius, PhD* [Video]. YouTube. https://www.youtube.com/watch?v=eJYViIdklxY

Norman, S. B., Wilkins, K. C., Myers, U. S., & Allard, C. B. (2014). Trauma Informed Guilt Reduction Therapy With Combat Veterans. *Cognitive Behavioural Practice, 21(1),* 78–88. https://doi.org/10.1016/j.cbpra.2013.08.001

Patel, P. J. (2018). Shame and Guilt in India: Declining Social Control and The Role Of Education. *South Asia Research, 38*(3), 287-306.

https://doi.org/10.1177/0262728018796283

Ransing, R., Ramalho, R., de Filippis, R., Ojeahere, M. I., Karaliuniene, R., Orsolini, L., Pinto da Costa, M., Ullah, I., Grandinetti, P., Gashi Bytyçi, D., Grigo, O., Mhamunkar, A., El Hayek, S., Essam, L., Larnaout, A., Shalbafan, M., Nofal, M., Soler-Vidal, J., Pereira-Sanchez, V., & Adiukwu, F. (2020). Infectious disease outbreak related stigma and discrimination during the COVID-19 pandemic: Drivers, facilitators, manifestations, and outcomes across the world. *Brain, Behavior, and Immunity, 89*, 555–558. https://doi.org/10.1016/j.bbi.2020.07.033

Reuben, D. B. (2020). Sideline Guilt. *JAMA Internal Medicine, 180*(9), 1150–1151. https://doi.org/10.1001/ jamainternmed.2020.2746

Sahoo, S., Mehra, A., Suri, V., Malhotra, P., Yaddanapudi, L. N., Puri, G. D., Grover, S., & Grover, S. (2020). Lived experiences of the corona survivors (patients admitted in COVID wards): A narrative real-life documented summaries of internalized guilt, shame, stigma, anger. *Asian Journal of Psychiatry, 53*, 102187. https://doi.org/10.1016/j.ajp.2020.102187

Shear, M. K. (2012). Grief and mourning gone awry: pathway and course of complicated grief. *Dialogues in Clinical Neuroscience, 14(2)*, 119–128.

Skovholt, T. M., & Trotter-Mathison, M. (2016). *The Resilient Practitioner: Burnout and Compassion Fatigue Prevention and Self-Care Strategies for the Helping Professions* (3rd ed.). Oxon, New York: Routledge.

Sun, Y., Bao, Y., & Lu, L. (2020). Addressing mental health care for the bereaved during the COVID-19 pandemic. *Psychiatry and Clinical Neurosciences, 74*(7), 406–407. https://doi.org/10.1111/pcn.13008

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are Shame, Guilt, and Embarrassment Distinct Emotions? *Journal of Personality and Social Psychology, 70*(6), 1256–1269. https://doi.org/10.1037/0022-3514.70.6.1256

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*, 345–372. http://dx.doi.org/10.1146/annurev.psych.56.091103.070145

Worden, W. J. (2018). Grief Counseling and *Grief Therapy: A Handbook for the Mental Health Practitioner (5th edition)*. New York: Springer Publishing Company, LLC.

Zeelenberg, M., & Breugelmans, S. M. (2008). The Role of Interpersonal Harm in Distinguishing Regret From Guilt. *Emotion, 8*(5), 589–596. https://doi.org/10.1037/a0012894

8 Working with grief

Grief is a universal human experience. Leo Tolstoy famously said, 'Only people who are capable of loving strongly can also feel great sorrow, but this same necessity of loving serves to counteract their grief and heals them.'

The COVID-19 pandemic has exposed us to a close encounter with loss and death. The global death toll from the pandemic crossed two million in January 2021 (Law, 2021). According to the Ministry of Health and Family Welfare (MoHFW, 2021), as of 17th January, 2021, more than 152,000 deaths had occured in India directly due to COVID-19. Further, it is estimated that there may be a significant indirect death toll, as people with serious illnesses may be unable or unwilling to visit hospitals and receive adequate healthcare (Khanna, 2020). In an Interim Report on India's Lockdown, Ray and Subramanian (2020) argued that several 'invisible' deaths will and have occurred due to the lockdown creating circumstances of starvation, violence, financial indebtedness and extreme physical and psychological stress in the Indian population.

The fear of death due to acquiring COVID-19 is a major fear in the pandemic amongst individuals diagnosed with COVID-19 (Duggal, et al., 2020). In India, 12% of all people who lost their lives due to COVID-19 were under the age of 45, whereas 88% were over the age of 45 (Kaul, 2020). Hence, while the death rate is significantly higher for older individuals and those with comorbidities, COVID-19 is also leading to unexpected deaths amongst healthy and young individuals. When bereavement is sudden, grief can be amplified and lead to increased psychiatric morbidity (Lundin, 1984).

In many ways, grief in the pandemic is also disenfranchised (Doka, 2002). Social distancing protocols and quarantine rules interfere with natural mourning processes (Wallace et al., 2020) and make social support, one of the most important factors in processing grief, difficult to access (Klerman et al., 1984; Stuart & Robertson, 2012). The proper expression of grief is curtailed (Ramadas & Vijayakumar, 2020). Misconceptions and fear surrounding the virus can lead to traumatic and difficult experiences for bereaved individuals. For example, a doctor's burial rituals were interrupted by violent protests due to locals' fears of getting infected (Josephine M, 2020). Hence, advertently or inadvertently, the dignity and ethics of bereaved individuals may be breached (Ramadas & Vijayakumar, 2020). Further, in India, where many people fight for their daily existence, grief may be 'a thing of privilege' and the lives of people from less dominant socio-economic positions may be less valued or acknowledged by society (Ghosh, 2020). This has been heartbreakingly illustrated in the casual deaths of migrant workers sleeping on railway tracks in India (Banerjee & Mahale, 2020).

Such inhibited and disenfranchised grief can increase the risk for mental and physical health difficulties in those who are bereaved (Ramadas & Vijayakumar, 2020). In addition, the focus on the number of collective deaths in the pandemic can reduce the recognition of each individual's death; the death of elderly people may be minimized (as they are viewed as most susceptible to the pandemic) and the death of health-care workers may be glorified as noble sacrifices (Kokou-Kpolou et al., 2020).

As Maddrell writes (2020, p. 110), 'COVID-19 is producing new geographies of death and deathscapes are being writ large in regions and communities unprepared for the effects and affects of a pandemic'. In this sobering background, mental health professionals will be one of the frontline workers to support people who are grieving a loss.

1. What is our role as a mental health professional ?

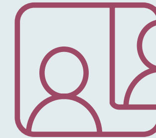
Mr. Rashesh, a 32 year old man, is diagnosed with COVID-19 and admitted in a hospital. Upon being called up by the counsellor, he reports that he has a cough but the severity has come down. The counsellor asks about his family members. He says, 'My brother and father also got infected and they have recovered'. The counsellor asks how they got infected and Mr. Rashesh says 'My mother underwent a heart surgery at a hospital and developed COVID-19. Then we all got infected'. The counsellor asks, 'How is your mother doing now?' He says, in a flat tone of voice, 'We lost her and now all of us are positive and we are unable to grieve her death or carry out any of the rites properly.'

Reaching out to grieving individuals is an important part of our work as mental health professionals in the pandemic. In the context of brief telephonic intervention, our role can involve:

- Actively reaching out to bereaved individuals
- Supporting bereaved individuals with their grief, by bearing witness to their pain, containing their emotions and helping them resume daily functioning
- Identifying those bereaved individuals who may need more specialized help and referring them appropriately

Working with a bereaved individual can be difficult for us as counsellors. Sometimes, we might connect with clients within the first 24-48 hours after a loss, when the client may be too overwhelmed to speak to us. Logistical concerns such as arranging for the funeral and informing relatives of the death may dominate their mindspace. Even a few weeks after the death, it may still be too soon to start coming to terms with the loss.

Given the nature of brief and remote psychosocial support, it is also important that we do not overstep our role. The nature of our intervention will be primarily supportive and we may not be able to provide 'grief therapy' or facilitate clients' movement through the process of mourning in the duration of one or two
phone calls.



Reflective Exercise

"Pain is inevitable in such a case and cannot be avoided. It stems from the awareness of both parties that neither can give the other what he wants. The helper cannot bring back the person who's dead, and the bereaved person cannot gratify the helper by seeming helped." (Parkes, 1972, p. 175)

When a client is in grief, we bear witness to an intensely painful experience in the face of which we are helpless.

- Do you think that anything you say or do can take away the client's pain at this time?
- What might it be like for you to know that you cannot take away the client's pain or make them feel better?
- Might you feel tempted to move away from the topic of grief or to cut short the call?
- According to you, what is the value of bearing witness to someone's grief?
- How do you think the disenfranchisement of grief in the pandemic impacts the value of bearing witness to someone's grief?

2. What key concepts or ideas can inform our practice?

In this section, we will discuss what the process of mourning looks like and well-known theories of grief.

2.1 Grief is normative

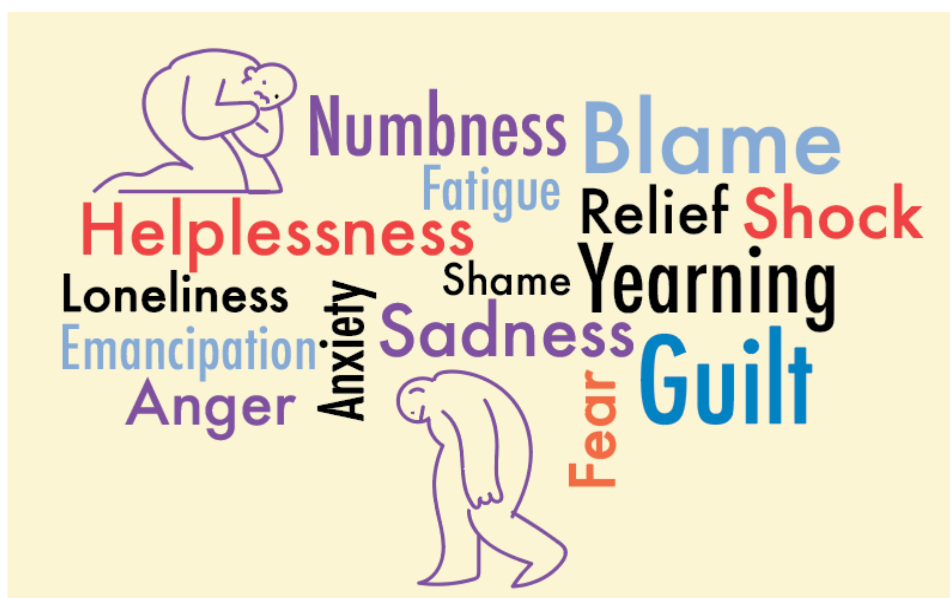
Grief is universal. It is not abnormal to grieve and grief should not be medicalized or considered a disorder. Certain important points to note about the experience of grief include:

There is no one correct way to grieve. According to Worden (2018, p. 22), 'each person's grief is like all other people's grief; each person's grief is like some other person's grief; and each person's grief is like no other person's grief'. As this quote beautifully illustrates, each individual's grief is unique. Some people may prefer to grieve alone, some people may prefer to re-engage with social connections that help them grieve. Some people may show their grief overtly though crying, others may grieve silently.

Grief is a natural process. Grief is a process that occurs over time, facilitated by traditional customs and social processes. Not all grieving people require therapeutic intervention. Sometimes, counselling or therapy can help facilitate the process of grief, but it can't speed it up; mourning takes the time it takes.

Grief is a complex emotional experience. The experience of grief does not involve merely the emotion of sadness, but can involve myriad emotions (See Figure 6.1).

In COVID-19, bereavement is especially likely to be sudden and unexpected. Hence, the sense of disbelief about the loss might be heightened. People may also experience feelings of guilt ('If only we had put him on the ventilator earlier'), helplessness ('How could this happen to me?') and anger ('This is unfair!'). This anger may become directed at hospital personnel or at governmental agencies and the bereaved may wish to pursue legal or official means to get justice. If the death is unexpected, there can also be a sense of unfinished business: that they did not get to say or do many things they wished to do with the deceased.



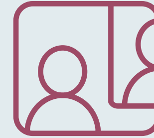
Common feelings in grief. None of these are abnormal or pathological (Worden, 2018)

2.2 Types of grief in COVID-19

In the COVID-19 pandemic, there are multiple topographies to grief that we need to keep in mind.

Bereavement, grief and mourning. Bereavement refers to the experience of losing a loved one. Grief is a broader term that can refer to losses other than the loss of a person. Mourning refers to the process of adaptation to a death or loss (Worden, 2018). **Traumatic bereavement** refers to bereavement where the death itself and its circumstances have been traumatic or the person's relationship with the deceased individual has been such that it gives rise to trauma symptoms (Worden, 2018). **Complicated grief** (also called prolonged grief/ chronic grief/unresolved grief) refers to grief that has persisted for an atypically long period of time (at least more than 6 months) and clearly exceeds the socio-cultural and religious norms for the individual's context (American Psychological Association, 2013; WHO, 2018). While uncomplicated or 'natural' grief generally does not require intervention, complicated grief can benefit from intervention. COVID-19 increases the risk for complicated grief due to social distancing protocols interfering with natural grief processes and the suddenness of the death (Wallace et al., 2020). **Pre-loss or anticipatory grief** is the experience of grief prior to the loss of a loved one, as someone struggles to make sense of a potential or imminent loss (Nielsen et al., 2016). In COVID-19, several factors such as limited communication between family members and medical staff, misinformation about COVID-19 and decreased social support can increase the risk for pre-loss grief (Singer et al., 2020). Anticipatory grief can also occur due to around-the-clock coverage about COVID-19, which can lead to people anticipating the spread of the virus to their household and community (Bertuccio & Runion, 2020).

Bereavement Overload. Sadly, in COVID-19, there have also been accounts and news reports of families that have faced multiple losses. There are families that have seen an entire generation obliterated (Sedensky & Santana, 2020). When families have faced multiple losses due to the pandemic, the bereaved individual may be literally 'overloaded' or overwhelmed. Healthcare personnel may also experience bereavement overload in a professional context in the pandemic.



Reflective Exercise

A "good death" in COVID-19

Trigger Warning: This exercise may be triggering if you have personal experience of bereavement in the pandemic.

In their report, Bear et al. (2020) ask the question: What does a 'good death' look like for people across faiths and vulnerable groups?

In many ways, COVID-19 affords no dignity even in death. Think of these moments in the process of the death, to consider how COVID-19 may worsen the suffering of grief:

- **Pre-admission to a hospital:** How do communities prepare for death and how has COVID-19 affected this?
- **Hospital admission**: How have isolation protocols affected how people can be present by their loved one's side when they are ill? How might it feel to have a loved one die alone in a hospital? How does COVID-19 affect how relatives can be present to support the loved ones or to assist in practical tasks? What about individuals who die because they could not get the hospital care they needed?

- **Disposal and release of the body**: How might families be affected by uncertainty and constant change in government policies around the release of bodies? How might people be affected by not getting to see the body of their loved ones and it being disposed of by the hospital? What if crematoriums and burial grounds refuse to take bodies as it is a 'COVID-19 case' and one has to run from place to place trying to find an appropriate resting place?
- **Funerals:** How might people be affected by not getting to see/touch the body from up close? From not being allowed to perform rituals or take as much time as they want? How might people respond to being unable to gather at funerals? To not engage in social mourning or collective prayers?
- **Bereavement:** How might the bereaved manage grief while socially distancing?

How might restrictions on use of religious spaces (e.g. temples, mosques) impact grief for those who turn to faith for help?

It is almost as if the bereaved suffer two losses: the loss of the person and the loss of a 'good death'. Such circumstances can lead to a higher risk for complicated grief in COVID-19.

2.3 Theories of Grief

Grief can be theorized in various ways. Elizabeth Kübler-Ross was a Swiss-American psychiatrist who worked with terminally-ill and dying patients. Through interviews with her patients, she famously proposed that there are five stages of normal grieving: Denial, Anger, Bargaining, Depression and Acceptance (Kübler-Ross, 1969). Initially, the person may deny the loss, as a temporary defense against facing the reality and immense pain of the loss. Then, the person may feel angry and search for whom to blame for the loss ('Why did this happen to me? Why did God do this to me?'). Bargaining involves the hope that the loss can somehow be postponed or negotiated ('Please, God, if you heal my husband, I will never smoke or drink again'). The next stage, depression, involves experiencing intense sorrow and hopelessness as the reality of the loss sets in. In the final stage, the person begins to come to terms with the loss and adjusts to their changed life with the loss.

Kübler-Ross's model was critiqued for consisting of prescriptive stages of grief that may not apply to all bereaved individuals. Worden (1982; 2018) proposed a different model based on four 'tasks of grief' that are less prescriptive and linear. The first task is to accept the reality of the loss. This means to face the reality that the person is gone and will not return. The second task is to process the pain of grief. The essence of this task is that the pain associated with loss needs to be processed in some way and not avoided or short-circuited. The third task involves adjusting to a world without the deceased. These include internal adjustments (how death affects the sense of self), external adjustments (how death affects day-to-day life and functioning) as well as spiritual adjustments (how it affects beliefs about the world, life, faith in God). The fourth task involves finding a way to remember the deceased while embarking on the rest of one's journey through life. This model is praised for being more flexible and has stood the test of time (Martin, 2019).

After Worden, Stroebe and Schut in 1999 introduced the dual process model of grief. This model posits that the mourner oscillates between two states: confrontation of the loss (e.g., processing emotions related to the loss) and avoiding the loss (e.g., resuming their life activities, not talking to family members about the loss). According to the researchers, such oscillation is not only normative, but also necessary for grieving adaptively.

Reflective Exercise

In the pandemic, many are facing losses such as the loss of a home, the loss of a job, the loss of career or educational opportunities, the loss of cultural events, the loss of travel, the loss of personal independence and so on. Further, there can be a sense of ambiguous loss as many are left wondering if they will ever return to 'life as they knew it' (Bertuccio & Runion, 2020).

Do you think such non-bereavement losses can be seen similarly to bereavement losses? Why or why not?

Let's consider the vignette below:

Client: *Even though I've got out of COVID-19, I feel so bad, I don't know why. I keep thinking that I was always so healthy, I never had any illness, and now I still feel breathless at times, I have aches and pains and I am not as energetic as I used to be. I just feel like my perfect health has been ruined and I will never get it back.*

- What is the primary emotion that comes through for you from the client's narrative?
- How would you want to acknowledge this emotion?
- Would you want to explore this emotion further with the client? What questions could you ask or what kind of statements could you make that would facilitate this process?

3. How do we assess and intervene?

3.1 Preparing to intervene

Before we start supporting clients with grief, we can take certain steps to prepare ourselves:

Being aware of the natural process of grief (as described previously in this chapter). This is important so that we do not pathologize clients' grief and so that we can identify those who may need more specialized help.

Being aware of our own emotions in the context of grief. Grief work may bring up memories of our personal loss. Before we launch into grief work, it may be helpful to consider what could be our personal triggers and how we may handle them. It is also important to set up our self-care and support systems proactively; this is discussed in more detail in the last section of this chapter.

Having a database of resources we can refer clients to if needed, e.g., therapists who have experience in grief work, support groups for bereaved individuals.

3.2 Identifying the concern

Common phenomena seen in grief include (Worden, 2018):

- Physical sensations (Hollowness in the stomach, tightness in the chest etc)
- Disbelief ('There must be some mistake, he can't be dead')
- Depersonalization ('Nothing seems real')
- Confusion and absent-mindedness ('I can't pay attention')
- Sense of presence i.e., feeling that the deceased is still there somewhere in the present time and space ('I could feel him in the kitchen, watching over me')

- Hallucinations, both visual and auditory ('I can hear her voice')
- Social withdrawal ('I don't want to talk to anyone')
- Sleep and eating disturbances
- Dreams of the deceased individual
- Avoiding reminders of the deceased individual
- Seeking reminders of the deceased individual (Visiting places/carrying objects related to the person)

All of these are normal and expected responses to loss. They do not require 'intervention'. However, we expect some differences in how grief manifests between clients who are very recently bereaved (e.g., the death has occurred a few days ago) and those who have been bereaved some months ago. As time passes, the intensity of emotions (e.g. disbelief, depersonalization, shock) gradually reduces. The circumstances of the death are processed and accepted. Phenomena such as hallucinations and sense of presence reduce. Work and daily functioning is resumed, along with some amount of social functioning. Essentially, the bereaved individual begins the task of adjusting to a life without the deceased.

3.3 Providing Interventions

The boundary between 'recent' and an 'earlier' bereavement is arbitrary; there is no time-limit to grief. However, for the purposes of this manual, there are differences in the way in which we might support a client who has lost a loved one a few months ago as compared to a client who has suffered a loss just days ago. Hence, after we have identified where the client is in their process of mourning, we can intervene accordingly.

3.3.1 When the client is recently bereaved

If the client has suffered a loss mere days or a week ago, we can:

Acknowledge the pain of the loss and express condolences for the loss. When a client brings up a recent bereavement (even in passing or in a seemingly casual way), we need to acknowledge it.

Examples of what we can say to acknowledge the pain include:

- *I am so sorry for your loss.*
- *This must be so painful for you.*
- *I feel at a loss of words to express how sorry I am.*
- *It must be so painful to feel like you could not do anything to help them.*
- *When someone passes away so suddenly, it can be quite difficult to accept it as real.*
- *You spent a lifetime together, I cannot imagine what this is like for you.*

Be aware of our own feelings. Death and grief bring up difficult emotions. We may feel discomfort, awkwardness, shock, pity, helplessness and so on. Overwhelmed by our own emotions, our tone of voice and our demeanour may change. Let's take a deep breath to regulate ourselves and try to remain calm, speaking gently and slowly.

Ask permission to continue the call. Respect the client's right to not continue the call and not to talk or share: *'I imagine it is not easy to talk about this. It is totally up to you whether you would like to speak to me or not. If you want to speak, I am here. If you do not want to speak, that is totally fine.'*

Follow the client's lead in what they want to discuss. Some clients may want to discuss the circumstances of the death whereas other clients may find it traumatizing. It is generally better to not ask pointed questions or details of what happened ('How did he die? Then what did you do?') as there is no way to predict whom it might be helpful for and whom it might harm. Instead, we can give a gentle invitation to share, that allows the client to lead the conversation in whichever direction they prefer, e.g., 'I can't imagine what that must have been like for you' 'That sounds so painful'. If the client does share spontaneously the details

of the death, we can listen well. This may be an indication that the client does want to discuss and process the circumstances of the death.

Acknowledge and validate feelings of anger and helplessness. In the above example of Mr. Rashesh, we can listen to his anger at the medical negligence and validate it, 'It is completely understandable that you feel so frustrated and angry at this situation' 'It is very frustrating to be so helpless and feel like you're unable to do anything'. It is important that we not focus on the facts (was there negligence or was there not?) but rather focus on the client's felt sense of being wronged and wanting to do something about it. If calling from a governmental organization, we need to be prepared to answer sensitively to requests such as, 'This hospital has committed a lot of wrong-doing. Can you bring this to the notice of the authorities?' Clients who are in quarantine or unable to say goodbye to their loved ones may feel especially frustrated, powerless and desperate. Validating the unfairness of the situation ('I agree, it is not fair') and of their desire to be with the loved one *('You really wish you were able to be there with them', 'I can't imagine how frustrating it is to be stuck in quarantine when you really want to be with them') is important without getting tangled in the 'truth' or 'facts' of the events leading up to the death.*

Normalize their feelings of grief. We can normalize grieving clients' emotions, thoughts and behaviours. It is common for people to feel like they are going 'crazy', especially if they have not suffered a loss before. In the present, we can reassure grieving individuals that what they are experiencing is understandable and expectable. We can accept complex emotions such as anger, yearning, guilt if they are shared. From our specific knowledge about common grief phenomena, we can normalize these experiences.

We can also gently share some information with clients on what they can expect for some time to come: 'There may be times you feel very sad and times that you're okay, this kind of oscillation is normal in grief', 'Even after a few months, there may be times you still can't believe the person is gone'. It is important to not overload the client with information (See Chapter 2, Section 3, Information Overload). We can also attempt to match our sharing of information to the intensity and form of grief they are experiencing. For example, if somebody is experiencing numbness, then our statement 'It is common to feel very sad' can make them feel guilty about not feeling sad. In this case, we might be better off saying *'It's common to feel numb after experiences like this been like for you' 'That sounds so painful'*. If the client does share spontaneously the details of the death, we can listen well. This may be an indication that the client does want to discuss and process the circumstances of the death.

Discussing practical needs (e.g., need for information the client may have). Clients may have a lot of confusion because of the changing policies and procedures in COVID-19 ('Is it allowed to hold a small funeral service of around 20 people?' 'How do we get the insurance?') We can acknowledge the extreme frustration and anxiety that this can create. We can give the client the information we are aware of and direct the client to appropriate sources to get other information (See Chapter 2, Section 3). We can also help the client find ways of holding online memorials, streaming prayer services or other ways of involving their relatives/ friends if they desire.

Listen to clients' reminiscence about the deceased, if the client initiates the topic. Some clients may want to reminisce about the deceased or talk aloud about their relationship with them. We can listen well and through reflection of content and feeling, help them feel heard and understood. We can discuss ways to remember the deceased in times of COVID-19, e.g., creating an online memorial page on Facebook where people who knew the deceased can post messages, making a scrapbook or collage containing memories of the deceased etc.

Respect religious and spiritual concerns. For example, clients may be unhappy that certain rituals are not possible during COVID-19 and may be concerned about the implications for the deceased ('Will they go to heaven, do you think?'). It is important for us to respond sensitively and engage with these conversations to the extent we can, regardless of our personal beliefs and orientations.

Conduct a brief risk assessment, as suicidal thoughts can occur in the wake of a death, especially of a partner or close loved one. (See Chapter 9 Section 3, for more information on how to do a risk assessment). At this stage, it is generally too soon to refer a client for specialized services or to conclude that grief is complicated or prolonged. However, a referral is needed if the person expresses active suicidal ideation or other forms of risk (e.g., is currently self-harming).

3.3.2 When the bereavement has occurred a few months earlier

When the bereavement has occurred a few months before we make contact with the client, the client may still be in the mourning process. However, at this point, we can do a little more, such as encouraging the client to resume tasks of daily living and encourage social connection, if the client is not already doing so.

The first few steps would be similar to the ones described above. These include expressing condolences, responding with empathy, asking permission to continue the call and being aware of our own feelings. Apart from this, we can:

Let the client lead the conversation. The breadth of the conversation may expand as compared to the client in acute grief. The client may or may not wish to directly speak about the bereavement. Some clients may still want to discuss the circumstances of the death; others may want to discuss other aspects, such as their jobs or a shift in their philosophical stance on life. Whatever the client wants to discuss, we can pick up on that thread and follow.

Check on the client's self-care. By this time, we expect that if the natural process of mourning is occuring, the client would have resumed daily tasks such as eating, personal hygiene, work and so on. Not being able to do these tasks might be an indicator of a serious concern. We can ask, 'How are you taking care of yourself at this time?', 'How is your sleep?', 'How is your eating?', 'What does a typical day look like for you right now?' 'What is your current routine?'

Normalize that everyone has a unique way of grieving and that there is no one 'correct way' to grieve. Some clients may be concerned that they are not grieving properly or that they have not 'cried enough' (well-meaning relatives and friends might often say 'You need to cry and let it all out'). It is important for us to reassure the client that everybody grieves differently and that's okay. Some clients may be worried about others who are grieving differently, for example, a parent may be concerned that one of their children is not grieving in a healthy way. Here, it is important to ask about and validate their concerns but at the same time, not pathologize different ways of grieving. Helping the parent see that different children may have different relationships with the deceased person and thus grieve differently, might be useful.

Gently ask about and encourage social connection. Grief is often isolating and it is through resuming social connection that we heal. We can get a sense of our clients' current social support and connection, *'Who is supporting you at this time?'* '*Many people feel lonely and isolated when they are grieving, is something like that happening for you as well?' 'In COVID-19 times especially, we can end up feeling very isolated as there are few ways to connect to others. How are you feeling?'* Although we can understand our clients' need to withdraw socially, we can also gently ask some questions that may help our clients reflect on whether they would want to increase their social connection, *'What kind of support would you like*

from others?' 'What have you shared with others about your experience of loss?' 'Grief can be a very lonely experience, how are you helping yourself feel connected at this time?'

Provide referrals if required. We may decide to refer some clients to other services. We can refer clients to a local support group we know of and have vetted. During the pandemic, several support groups aimed at supporting those bereaved by COVID-19 have been started. We can keep a track of such support groups in the location we are working in. We can also refer clients to specialized counselling or therapy services. Let's avoid pathologizing grief when making a referral ('You are suffering from grief disorder' 'You have symptoms of grief'). Instead, we can explain that 'Some people find therapy to be useful in helping facilitate the process of grief when they are having difficulties, that is why I would like to give you a referral.'

Indicators for referral

(if occurring after 5-6 months of the bereavement)

- The client is eating/sleeping poorly and is finding it difficult to do daily activities such as bathing/brushing
- Work functioning is seriously affected
- Suicidal ideation, self-harm or risky impulses and activities e.g., reckless driving, excess drinking
- Client is extremely isolated and socially withdrawn or client expresses a lack of social support
- Client expresses intense or persistent longing or pining for the deceased
- Persistent feeling of disbelief or inability to accept the death
- Frequently hearing voices or seeing the dead person to the extent it interferes with their functioning
- Intense feelings of guilt/shame/anger or constant rumination over the circumstances of the death
- Recurrent nightmares or flashbacks
- Excessive preoccupation with the deceased excessively avoidings reminders of the deceased
- Inability to speak of the deceased
- The circumstances of the death (e.g., death by suicide, traumatic deaths) may also play a role in our decision to refer the client to specialized services.

Let's consider the below vignette:

The counsellor is speaking on the phone with a 17 year old girl living in a semi-urban area. Her girlfriend had passed away due to COVID-19, five months ago. Their relationship was a secret due to the stigma around same-sex relationships and nobody, not even her family, knew the nature of her relationship with this person. They all feel she was a close friend.

She tells you that she feels numb and in shock all the time and only eats her first meal of the day at 5 pm. She is unable to speak to anyone about it as she can't tell anyone about the romantic nature of their relationship. Her exams have been postponed due to COVID-19, but she is sure that she will fail when they occur as she is not able to concentrate on studying at all. She says, 'I can't even cry because no one knows how important she was to me.'

This vignette has several factors that would make us suggest a referral to specialized services for this client:

- Her daily functioning and self-care is highly affected.
- She reports intense feelings of numbness and shock, even five months after the bereavement,

suggesting that she may still be having difficulty accepting the death.

- Her grief is disenfranchised as it is socially unspeakable; she has no avenues in which she can freely express her grief.

Note that since she is a minor, we may speak to parents while making a referral. However, we cannot reveal details of her sexuality or romantic relationship to them without her consent.

Let's avoid...

Making the client see the positive side of the death e.g., 'It was probably for the best/He is better off now', 'At least he went quickly and did not suffer' 'It's good that you are alive' 'It's good that no one else died' 'It could be worse; you still have a brother/sister/mother'

Explicitly or implicitly pressurizing the client to 'get over it' or 'be strong' e.g. 'You should work towards getting over this', 'You are strong enough to deal with this', 'That which doesn't kill us makes us stronger' 'You need to be strong now for your family' [to a child] 'You are the man/woman of the house now, be a brave boy/girl!'

Explicitly or implicitly pressurizing the client to grieve in a certain way e.g., You need to cry

Referring to fate or destiny e.g., 'It was her time to go', 'Everything happens for the best according to a higher plan'

Casually self-disclosing a similar loss e.g., 'I also suffered a loss, it was very tough but I got over it'

Giving generic reassurances e.g., 'You'll feel better soon/You will be fine', 'You did everything you could'

Ending the session without containing distress. Experiences of grief and loss can bring up strong, intense emotions that can be scary for both clients and counsellors. It is important that we support clients to contain high levels of distress before closing a session and not leave clients grappling with intense, raw emotions. We can help the client regulate before we end the session by using some techniques described in Chapter 3, section 3.

4. How do we reflect on our work?

Reflective Exercise

"A body that has little meaning, how meaningful is their death? How non-existent is their grief? How long can they weep before they already starve." (Ghosh, 2020)

- Whose grief is privileged and whose grief is invisibilized?
- What about a famous celebrity who loses their life after acquiring COVID-19?
- What about a person from the Dalit community who loses their life due to indirect effects of the pandemic?
- What about a labourer who loses their life in a road accident in the lockdown?

Read the following excerpts from news articles:

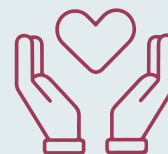
'Forty-one-year-old Pinky, a sex worker in Mumbai's Kamathipura, does not have the money to buy her medication...Pinky said, "When men need sex, they come to us, but now when we need them, no one will even care if we are alive or dead."' (Kajal, 2020; IndiaSpend)

"Some nights I only had sugar and water; from where will I get medicines in this lockdown?" she asks. "I only understand my work. That also has become impossible as it is said that the virus spreads due to physical contact. I will die from hunger. There is no food and I don't know where I will get the medicines from. The system doesn't care who lives and who dies."' (Mishra, 2020; Firstpost; translated from Hindi).

- How do you feel when you come across such a story in a news article?
- Are we tempted to stifle the discomfort we feel and move on?
- Sex workers are a community that are marginalized in several ways. They often do not have official documents such as Aadhaar cards, they are stigmatized because of their profession and they are vulnerable to extreme levels of violence and poverty. They have little legal recourse. They are especially vulnerable to acquiring COVID-19 because of the physical contact involved in their work. How do you think society will respond to the death of a person from a community that is already marginalized in so many ways?
- What could be certain actions through which you could advocate for people from marginalized communities who have experienced disproportionate loss in the pandemic?

Supervision

- Working with loss can also bring forth anxiety and fear of potential losses in our lives. This can be especially so if we perceive certain clients as similar to us in terms of age, gender and other demographics. Further, in the pandemic, we are also dealing with the threat of untimely mortality just like the clients.
- Can you recount any personal experience of loss? Was it in the past or more recent?
- If you are comfortable, exploring your own history of loss, the resources you drew upon and your personal coping style (can be useful for us to reflect on.)



Self-Care Exercise

Healthcare professionals are experiencing bereavement overload in the pandemic. When we work with grief repeatedly, we may feel overwhelmed with it. We may then begin to ask ourselves about how to sustain our efforts in this field. When we face such a situation, we may want to focus on what can be some of the rewards of being in the profession:

- What were your reasons for entering this profession in the first place? This may serve as a means of refreshing our sense of calling and professional fulfilment related to the career.
- What are some of the journeys that you have undertaken with your clients which have been fruitful and fulfilling? Sometimes, thinking of clients whom we have been able to help reminds us of the unique and rich rewards that the profession provides to us.
- What blessings do you currently have in your life? If you want, you could write a gratitude journal when you get a chance.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Banerjee, S., & Mahale, A. (2020, May 8). 16 migrant workers run over by goods train near Aurangabad in Maharashtra. *The Hindu.* https://www.thehindu.com/news/national/other-states/16-migrant-workers-run-over-by-goods-train-near-aurangabad-in-maharashtra/article31531352.ece

Bear, L., Simpson, N., Angland, M., Bhogal, J. K., Bowers, R., Cannell, F., Gardner, K., Lohiya, Anishka, James, Deborah, Jivraj, Naseem, Koch, Insa, Laws, Megan, Lipton, Jonah, … Zidaru-Barbulescu, T. (2020). *"A good death" during the Covid-19 pandemic in the UK: a report on key findings and recommendations.* http://eprints.lse.ac.uk/104143/

Bertuccio, R. F., & Runion, M. C. (2020). Considering Grief in Mental Health Outcomes of COVID-19. Psychological Trauma: Theory, Research, Practice, and Policy, 12, 87–89. https://doi.org/10.1037/tra0000723

Doka, K. (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice. Champaign*, IL: Research Press.

Ghosh, S. (2020, April 27). COVID-19: Grief is A Thing of Privilege. *Feminism in India.* https://feminisminindia.com/2020/04/27/covid-19-grief-thing-privilege/

https://www.hindustantimes.com/india-news/88-of-covid-fatalities-40-of-cases-in-45-age-group-govt-data/story-0RvZ2kT1CXMRonZjl6pGlL.html

Josephine M, S. (2020, April 20). In Chennai, doctor's burial marred by protests, attacks. *The Hindu.* https://www.thehindu.com/news/cities/chennai/in-chennai-doctors-burial-marred-by-protests-attacks/article31386195.ece

Kajal, K. (2020, April 17). Sex Workers, High-Risk for COVID-19, Seek Government Help. *IndiaSpend.* https://www.indiaspend.com/sex-workers-high-risk-for-covid-19-seek-government-help/

Kaul, R. (2020, December 19). 88% of Covid-19 fatalities, 40% of cases in 45+ age group: Govt data. *Hindustan Times.* https://www.hindustantimes.com/india-news/88-of-covid-fatalities-40-of-cases-in-45-age-group-govt-data/story-0RvZ2kT1CXMRonZjl6pGlL.html

Khanna, S. (2020, July 2). Other deaths spike in indian city ravaged by coronavirus. *Reuters.* https://www.reuters.com/article/us-health-coronavirus-india-casualties/other-deaths-spike-in-indian-city-ravaged-by-coronavirus-idUSKBN24311A

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. (1984). *Interpersonal psychotherapy of depression.* Basic Books: New York.

Kokou-Kpolou, C. K., Fernández-Alcántara, M., & Cénat, J. M. (2020). Prolonged Grief Related to COVID-19 Deaths: Do We Have to Fear a Steep Rise in Traumatic and Disenfranchised Griefs? Psychological Trauma: Theory, Research, Practice, and Policy, 12(S1), S94-95. https://doi.org/10.1037/tra0000798

Kübler-Ross, E. (1969). On death and dying. New York, NY: Macmillan.

Law, T. (2021, January 15). 2 Million People Have Died From COVID-19 Worldwide. Time. https://time.com/5930111/2-million-covid-19-deaths/

Lundin, T. (1984). Morbidity following sudden and unexpected bereavement. *The British Journal of Psychiatry, 144,* 84-88. https://doi/org/10.1192/bjp.144.1.84.

Maddrell, A. (2020). Bereavement, grief, and consolation: Emotional-affective geographies of loss during COVID-19. *Dialogues in Human Geography, 10(2),* 107–111. https://doi.org/10.1177/2043820620934947

Ministry of Health and Family Welfare [MoHFW]. (n.d.). *Home.* Retrieved 17th January, 2021 from https://www.mohfw.gov.in/

Mishra, S. K. (2020, July 21). No income, no food, no government relief: Sex workers of Kamathipura pushed to the brink. *Firstpost.* https://www.firstpost.com/india/coronavirus-outbreak-no-income-no-food-no-government-relief-sex-workers-of-kamathipura-pushed-to-the-brink-8623201.html

Nielsen, M. K., Neergaard, M. A., Jensen, A. B., Bro, F., & Guldin, M. B. (2016). Psychological distress, health, and socio-economic factors in caregivers of terminally ill patients: A nationwide population-based cohort study. *Supportive Care in Cancer, 24,* 3057–3067. http://dx.doi.org/10.1007/s00520-016-3120-7

Parkes, C. M. (1972). *Bereavement: Studies of grief in adult life.* New York, NY: International Universities Press.

Ramadas, S., & Vijayakumar, S. (2020). Disenfranchised grief and Covid-19: How do we make it less painful? *Indian Journal of Medical Ethics.* https://doi.org/10.20529/ijme.2020.128

Ray, D., & Subramanian, S. (2020). India's lockdown: An Interim Report. NBER Working Paper Series (No. 27282). http://www.nber.org/papers/w27282

Sedensky, M., & Santana, R. (2020, June 11). 'Grief overload': Families absorb multiple virus deaths. Associated Press News. https://apnews.com/article/647ddf5a592177e16a33d5e8adf4a55e

Singer, J., Spiegel, J. A., & Papa, A. (2020). Preloss Grief in Family Members of COVID-19 Patients: Recommendations for Clinicians and Researchers. *Psychological Trauma:* Theory, Research, Practice, and Policy, 12, 90–93. https://doi.org/10.1037/tra0000876

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. Death Studies, 23, 197–224. https://doi.org/10.1080/074811899201046

Stuart, S., & Robertson, M. (2012). *Interpersonal Psychotherapy: a clinician's guide (2nd ed.).* Boca Raton: Taylor & Francis Group, LLC.

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief During the COVID-19 Pandemic: Considerations for Palliative Care Providers. *Journal of Pain and Symptom Management, 60(1)*, e70–e76. https://doi.org/10.1016/j.jpainsymman.2020.04.012

Worden, W. J. (2018). G*rief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner* (5th edition). New York: Springer Publishing Company, LLC.

World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics* (11th Revision). https://icd.who.int/browse11/l-m/en

9 Managing risk for suicide

Risk can be understood as the probability of an adverse event or outcome. In the context of our work, it can be understood as a situation involving danger to the client or others. For example, our clients may be at risk for self-harm, suicide or experiencing abuse or violence. On the other hand, if a client harms someone else, it is also a situation of risk but in this case, the risk is to others. For the purpose of this chapter, we will focus on clients who are at risk for suicide.

Suicide is an intentional, self-inflicted act that results in death. It is a complex and multifactorial phenomenon which has biological, psychological and social underpinnings. While the focus was earlier on identifying biological and psychological factors contributing to suicide, the emphasis has shifted to examining the ways in which history, contexts, policies, discourses, and structures contribute to vulnerability, hopelessness, and distress (Hoffman, 2000).

The pandemic and the lockdown period were associated with an unprecedented increase in incidents of suicide around the world (Reger et al., 2020). There were several factors associated with this such as an increase in mental health concerns in the general population (Pierce et al., 2020), increase in reporting of thoughts and behaviours of self-harm among those diagnosed with COVID-19 (Iob et al., 2020) and difficulties in accessing mental health services (Iob et al., 2020).

A similar trend was noted in India as well. The WHO had reported that India had the highest rate of suicide in South-East Asia (WHO, 2017) prior to the pandemic. During the pandemic, suicide ranked as the second most common cause of death in India, after COVID-19 infections (Kapilan, 2020). Other researchers reported that there was a 67.7% increase in online news media reports of suicidal behaviour during the pandemic as compared to previous year (Pathare et al., 2020). The most common factor associated with this increase was the fear of the diagnosis of COVID-19 itself (D'Souza et al., 2020). Some other factors which have been identified include undergoing a financial crisis, feeling a sense of loneliness, being at the receiving end of social boycott and facing pressure to be quarantined, loss of employment , inability to go back to loved ones due to lockdown and unavailability of addictive substances during the lockdown (D'Souza et al., 2020).

1. What is our role as mental health professionals?

Ms. Bela called a helpline and reported that the lockdown had been terrible for her. She said, "First, when the work from home started, I was unable to get a stable internet connection. Because of this, I was unable to attend important meetings as I couldn't hear properly. My performance suffered because of this. My company was laying off individuals and I was so scared that I started working harder and spending all my time either working or worrying about it. My partner broke up with me because of my inability to give time to the relationship. While still reeling with this shock, I got the notice that my company was shutting down my branch completely. I was then diagnosed with COVID-19 yesterday. In a way I am glad. I will hopefully die of COVID-19 and my parents will never come to know what a failure I am. In the worst-case scenario where this disease will not kill me, I will just overdose in the hospital and my parents will never have to know."

Reflective exercise

- What do you make of Bela's situation? What kind of opinions did you find yourself forming about her problem and her emotional response, as you were reading her story?
- Would there be a difference in how you would respond to Bela if you were her friend, and how you would respond if you were her counsellor?

The mental health system has been recognised as one of the primary sources of support for people at risk for suicide (Shield, et al., 2003). By offering timely and immediate support during a crisis, mental health professionals can mitigate risk of suicide by helping clients contain transient feelings of extreme distress.

In the context of the pandemic, vulnerabilities that increase the risk for suicide were exacerbated. On the other hand, resources available for support became less accessible. For example, social support, a key factor which helps in prevention of suicide was not easily available for most. The pandemic created a unique context which made recognition of mental health concerns imminent and critical.

We will have to consider the limitations to our role as mental health professionals especially in the context of providing remote psychosocial care during the pandemic. For one, we might be the first point of contact for people at risk but we may not be able to support them with long-term interventions. A key competency for us might therefore be sensitively and accurately identifying risk and referring the client to more specialised care when required. High-risk situations can be overwhelming for us to manage as mental health professionals and often require a set of structured guidelines that can be relied upon during emergencies. Thus, another competency may be awareness of crisis management protocols and implementing them appropriately.

2. What key concepts and ideas can inform our practice?

This section will help us in understanding the key terms that are used in suicide risk assessment. We discuss the contextual factors that may increase or decrease the risk for suicide.

2.1 Key terms in risk assessment

- **Suicide**: Death which is because of injurious behavior undertaken by the person themselves with intention to die as a result of the behavior (Centre for Disease Control and Prevention, 2017).
- **Risk factors:** Factors which operate at the biological, psychological, family, community, or cultural level that precede and are associated with more probability of occurrence of negative outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).
- **Warning signs:** Symptoms or stressors observed during the last few day(s) before the advent of an event (in our case, suicide) (Rudd et al., 2006).
- **Suicide attempt:** An act possessing the following characteristics (a) self-initiated, potentially injurious behavior; (b) presence of intent to die; and (c) nonfatal outcome (Apter, 2010).
- **Suicidal Ideation:** Thinking about, considering, or planning suicide (Klonsky et al., 2016). It exists on a continuum ranging from having fleeting thoughts to detailed plans for suicide. Having a death wish is thinking about

not wanting to live or imagining being dead whereas active suicidal ideation is thinking about different ways to die or forming a plan to die (Kumar, 2017, p. 269).

The ideation pattern can be understood using markers of frequency (how frequently the client has these thoughts, contingencies (under what conditions these thoughts increase or decrease), duration (how long these thoughts last), intensity (how intensely clients experience these thoughts) and control (how much control clients' perceive they have on these thoughts).

- **Intent:** The seriousness or intensity of the client's wish to terminate their life (Beck et al., 1974). The intent shows that the purpose of the behaviour is to die.
- **Lethality:** The inherent danger and the potential for death which is associated with the suicidal act (Berman et al., 2003). It is often a measure of the means or method of death by suicide.
- **Ambivalence:** It is the ambiguity between wanting to live but wishing to die (World Health Organization, 2000). This ambivalence is useful for planning intervention as we will aim to increase this ambivalence and thereby collude with the part of the client that wants to live.
- **Protective factors:** Factors that are linked to lesser probability of negative outcomes or those which mitigate the impact of a risk factor (SAMHSA, 2019). These factors contribute to each person's unique 'reasons for living' and can inform and anchor our interventions with each client.

2.2 Contextual factors

Research has shown that there are certain factors whose presence may increase or decrease the likelihood of suicide. A summary of these factors will be discussed in this subsection.

2.2.1 Risk factors and warning signs

Research has identified certain risk factors associated with suicide.

- **Previous attempt of suicide** is the strongest predictor for future suicide risk (Yoshimasu et al., 2008)
- **Hopelessness** is one of the strongest warning signs of suicide (WHO, 2014)
- **Presence of psychiatric disorders** such as mood disorders, schizophrenia, substance use disorders, personality disorders and eating disorders (Arsenault-Lapierre, et al., 2004).
- **Lack of social support** may make the client feel isolated serves as a risk factor for suicide (Casiano et al., 2013). Strengthening social support for the individual might be an important intervention (WHO, 2014).
- A **recent crisis** might serve as a stressor which may be responsible for the client feeling overwhelmed and attempting to solve a problem in unhelpful ways. Suicide can be one of the solutions that the client may be considering (Mann et al., 1999).
- **Death by suicide by a family member** can heighten risk for suicide by desensitizing the person to suicide, changing family dynamics, disrupting social support and making help-seeking difficult for the client (Jordan & McIntosh, 2011).
- Having **adverse and traumatic experiences** in the past may increase the risk of suicide (Dube et al., 2001).
- The **clients' view of themselves** is also an important consideration. If the client feels that they are a burden on others, they may feel intense shame, feel unworthy of being alive and not be accepting of help (Rassmusen et al., 2018).

2.2.2 Protective factors

Some of the protective factors identified across research include:

- **Having healthy close relationships** might increase individual resilience and act as a protective factor against the risk of suicide (WHO, 2014). Significant others may be supportive in times of crisis and act as an important source of social, emotional and financial support, buffering the impact of external stressors (Sarchiapone et al., 2011).
- **Having good self-esteem**, self-efficacy and effective problem solving-skills, which include the ability to seek help when needed, can mitigate the impact of stressors reduce the possibility of suicide.Having a **career** which is satisfying might serve as a protective factor for clients as they may mitigate financial distress or provide meaning to their lives (Stuckler & Basu, 2011).
- **Presence of certain cultural and religious beliefs** that discourage suicide and support instincts for self-preservation might serve as important protective factors (Centre for Disease Control and Prevention, 2017).
- Having **effective care for mental, physical, and substance abuse difficulties** and **easy access** to these facilities can serve as an important protective factor (Centre for Disease Control and Protection, 2017).
- **Presence of a strong therapeutic relationship** might help to decrease suicidal ideation (Dunster-Page et al., 2017).

Epidemiology of Suicide in India

India had 17.8% of the global population in 2016, but accounted for **36.6% of the global deaths by suicide** among **women and 24.3%** among **men** (WHO, 2016).

- **Age**
  Suicide was the leading cause of death in India in 2016 for those aged 15–39 years (Global Burden of Disease [GBD], 2018)

- **Gender**
  - World over, more women attempt suicide, more men complete suicide (WHO, 2014)
  - In contrast to trends of marriage being a protective factor for suicide across the world, marriage is a risk factor for women in India. This may be attributed to arranged and early marriage, motherhood at a younger age, lower social status, high rates of interpersonal violence and lack of economic independence for women (Dondana et al., 2018).

- **Geographical Region**
  - More economically developed states report 3 to 4 times higher rates than less economically developed states. A probable reason can be better registration of suicide cases in these states. Southern states of Andhra Pradesh, Karnataka, Tamil Nadu, and Telangana ranked highest whereas Bihar and UP ranked the lowest (Arya et al., 2018).
  - States which had more people employed in agriculture, higher rates of male unemployment and higher literacy rates had higher risks of suicide (Arya et al., 2018).

- **Methods of suicide**
  - Pesticides, firearms, hanging, self-immolation, jumping off bridges and in front of trains are reported as the most commonly used methods of suicide in the country (WHO, 2014).

- **Caste** There might be underreporting

of suicides in Dalit community where the number are likely to be much higher than National Crime Rate Bureau (NCRB) data shows (Arya et al., 2019).

- **LGBTQ+ community**
- Research evidence for isolation and discrimination that LGBTQ+ individuals face places them at a greater risk for suicide (Virupaksha et al., 2016; Wandrekar & Nirudkar, 2020)

3. How do we assess and intervene?

3.1 Preparing to intervene

The first step before intervening may be to understand our own beliefs about suicide. Our values and philosophical beliefs about suicide will enter our work with clients who are suicidal. It is important to be mindful of the role we thrust ourselves in and the value frameworks that inform our approach. We may experience multiple, overlapping and even contradictory values and perspectives towards suicide. Thus, awareness of the same may help us to choose how we wish to integrate our values in our work. Let us undertake a reflective exercise to understand our values and beliefs about suicide.

Reflective exercise

What are my beliefs and stance on suicide? (Tick as many statements that apply to you)

1. Suicide is caused by mental illness. Mental illness is treatable, and hence suicide is preventable
2. Humans have a right to choose whether they want to live or die. Suicide is a choice. It is not my role to force anyone to live if they have decided not to.
3. The wish to end one's life is indicative of a wish to end unbearable pain, often due to psychological distress. If the distress can be treated, suicide is preventable.
4. Some suicides are impulsive, not thought through and happen due to trivial reasons
5. Once a person has decided to end their life, nothing can really be done about it
6. Suicide is a sin, it is wrong and immoral
7. Suicide devastates families, the person contemplating ending their life should think of the impact their permanent decision can have
8. Not being able to stop a client from completing a suicide is reflective of inadequate skills on my part as a mental health professional
9. Suicide is a complex issue. It goes beyond mental illness. It is caused by a mix of social, economic, biological and psychological factors
10. My role as a clinician in suicide prevention is limited until systemic and structural factors such as poverty, patriarchy, class and caste discrimination is addressed on a large scale.

We may want to explore options of supervision and personal therapy as helpful ways to continue reflecting on our stance and how our self enters into our work while we navigate the distress that clients who may be at risk for suicide.

As a way for preparing to intervene with clients at risk, we may want to explore the **option of obtaining adequate training** in working with risk and trauma. For further training, we could try to assess the following resources

- QPR Suicide Prevention Gatekeeper Training
- ASIST (Applied Suicide Intervention Skills Training)

3.2 Identifying concerns

3.2.1 Principles of risk assessment

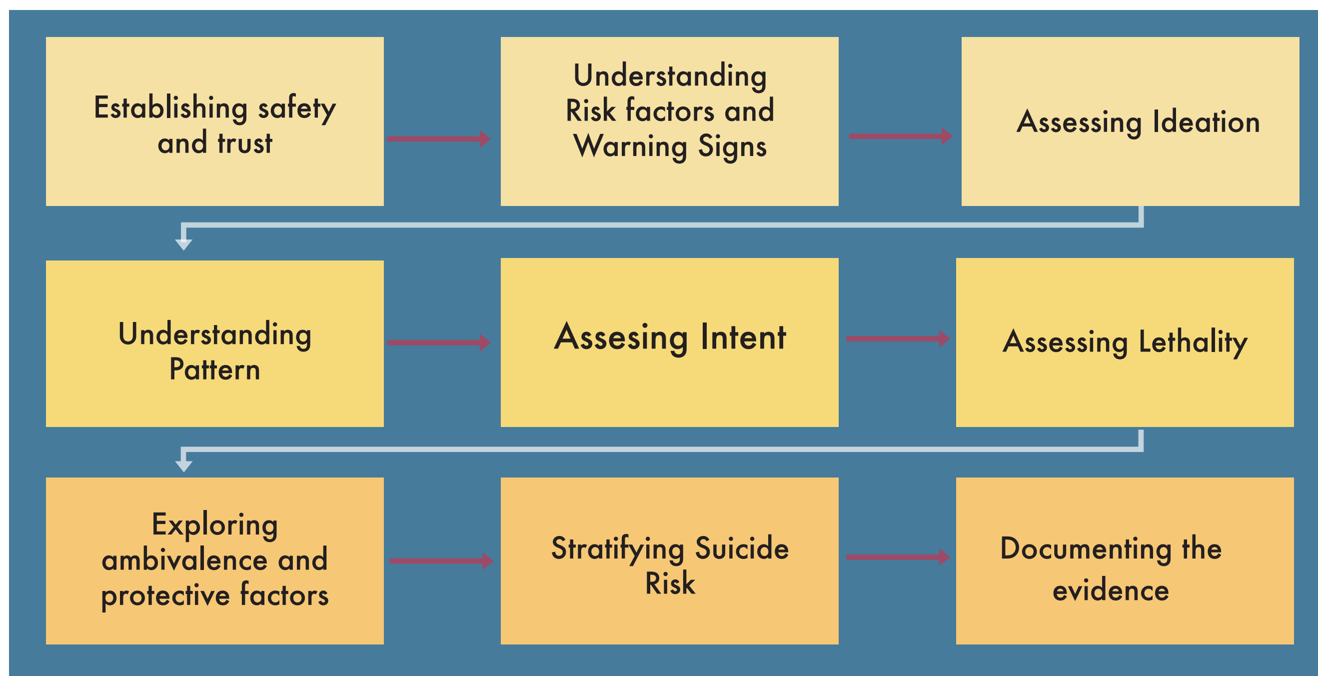
Risk assessment can be understood as a way of estimating how likely it is that a particular adverse event will occur under the specific conditions within a predefined period of time.

Certain principles of conducting a risk assessment to be kept in mind are:

- **Respect for agency and autonomy of the client:** Even when a client is at risk, respect for client's agency and autonomy is paramount. This is not an interrogation, but a compassionate inquiry into their story. It is important to remember that the client is more than a cluster of symptoms.
- **Collaborative:** The assessment as well as management of risk needs to be a collaborative partnership with the client at every step. This is to ensure that the process does not become authoritarian or disempowering for the client who is already distressed.
- **Dynamic:** The assessment of risk is a dynamic process and requires regular review to track changing levels of risk for the client.
- **Reliance on clinical judgement:** Risk assessment is informed by interactions with the client as well as information of the client's previous history.
- **Assessment as therapeutic:** The process of the risk assessment itself could be a therapeutic process for clients, helping them feel that their story can be heard in a safe and confidential environment.

3.2.2 Pathway to risk assessment

A comprehensive risk assessment can be understood under the domains described in the figure.



Pathway to risk assessment

3.2.2.1 Establishing safety and trust

The starting point of suicide assessment is creating a safe therapeutic space which allows the client to trust us to be able to share their struggles. The client may be apprehensive about sharing their struggles with someone who may judge them. They may be wondering if we will be able to tolerate the depth of their pain. Thus, we will have to convey our stance of unconditional acceptance and empathy throughout the session. We will have to genuinely try to understand why suicide feels like the only way out for them and empathise with this distress.

An important component of creating a trusting relationship is using our skill of talking to the client about painful emotional states without immediately trying to '*fix*' the problem and without giving too many reassurances at first. This may prove to be difficult as many of us may feel anxious and would like to do something right away to allay our own anxiety. But rushing in with premature solutions may convey to the client that we are impatient or unable to tolerate their pain. We can refer to the chapter on 'working with clients in distress and other chapters related to emotions like anger, anxiety and sadness' to help us understand and manage our emotional states.

We may see warning signs as tangible evidence that the client is at heightened risk of suicide in the short term. These factors may be present even in the absence of potentiating risk factors. But when the combination of warning signs and risk factors is present, it may increase the risk of suicide (Rudd et al., 2006).Instead of launching into problem-solving, we can endeavour to listen empathetically to the person at risk and use a calm tone of voice in conversation. This may help in de-escalating the situation and model the behaviour that the client may use when in crisis. We can also start by establishing a context for the call and asking them how they would want to be addressed. We can then provide them with an explanation of our role and the purpose of the assessment. This may help to minimize feelings of uncertainty and anxiety that the client may be experiencing. The focus of the assessment will be to help the clients see their own strengths, validate their feelings, and help them to regain control.

3.2.2.2 Understanding risk factors and warning signs

Risk factors may be associated with vulnerabilites that increase a client's risk for suicide over the long term, whereas warning signs are those factors that are indicative of the possibilty of suicide in the immediate future (i.e., minutes and days), (Rudd, 2008). Warning signs indicate the person's level of risk, while risk factors present areas of focus for interventions.

3.2.2.2.1 Risk Factors

Risk Factors	Sample questions
Diagnosis of depression or other psychiatric disorder	• Asking about the presence of the disorders *("Have you ever received a diagnosis of a psychiatric illness?")* • *Previous psychiatric treatment ("Have you ever sought psychiatric help?")* • *Predominant mood ("How do you feel these days? Since when have you been having these feelings?")*

Risk Factors	Sample questions
Diagnosis of depression or other psychiatric disorder	• Energy levels *("Could you tell me about your energy levels?; Have you noticed a change in your energy levels recently?, If yes, could you tell me about it?")* • Activities of daily living such as bathing, brushing, to name a few *("Are you able to manage your daily activities independently such as eating, brushing, bathing, dressing on your own?")* • Whether they feel like engaging in activities that previously made them happy *("What did you do to make yourself feel happy earlier?; do you still feel like doing that?")* • Sleep or appetite changes *("Have you noticed any changes in your sleep or eating habits recently?")* • Substance use *(using close-ended questions such as Do you consume alcohol? Cigarettes? Beedi? Or anything similar?)*
Hopelessness	• Asking about thoughts about the future *("How do you see your future?"; "What are your plans for the future?"; "what are your expectations of the future?")*
Inadequate social support	• Asking questions such as, *"Whom do you live with?; Whom can you trust?; whom can you contact in emergencies?; Who do you think you can talk about this to? / Do you have anyone who you think can understand you? / Can you think of someone who would be able to help you right now?"*
Recent crisis and loss (interpersonal, debt, unemployment etc.)	• This could include questions like, *"Is there something bothering you? Have you had any recent experiences which were difficult? Would you be open to sharing those with me?"*
History of family member dying by suicide	Asking a direct question such as, *"Has anyone in your family died by suicide?"*
History of trauma	• Asking questions related to trauma in a matter-of-fact and supportive way may be helpful. • This would involve questions such as *"Have you been hurt in the past?", if the client is confused, then questions would become more specific such as, "Has someone has hurt you physically? What about sexually?"*
Feeling like a burden	• Feelings and thoughts related to self: *"Could you tell me about your thoughts and feelings towards yourself?"; How do you think others in your life see you?"*

Table: Assessing Risk factors

In case of a prior history of attempted suicide, it is critical to probe the attempt gently and in detail. Clients may be asked to tell their personal stories about how they had reached the point of wanting to kill themselves, and how they went about it. The aim of the assessment is to reach a client-centred understanding of the individual mechanisms leading to psychological pain and suicidal behaviour, and to elicit specific vulnerability factors and trigger events. Some of the questions that we can consider asking are

"Can you please tell me how you came to the point of harming yourself?"

"I would like to hear the story behind the suicidal crisis"

Some of the components that we will assess when exploring previous suicidal attempts are grouped under the categories of what was happening before the attempt, during the attempt and after

Before the Attempt

- What was happening before the event? Can you describe in some details?
- Was this attempt planned or impulsive?
- What were some preparatory steps that the client has undertaken? (We can probe for writing their will, suicide note etc)
- What were some precautions that they might have taken to prevent discovery?
- Were any substance used at that time?

During the Attempt

- What methods were used by the client?
- Where were they at the time of attempt?
- What was going through their mind ?
- How were they feeling at that time?
- What did they do immediately after the attempt?

After the Attempt

- Did they call anyone?
- How did others react to their attempt?
- If medical treatment was required, who did they reach out for help?
- How did they feel when help arrived?
- How do they feel about being 'saved'?
- If they were to feel like this again, what would they do differently?

Some questions related to before, during and after the attempt.

3.2.2.2.2 Warning signs

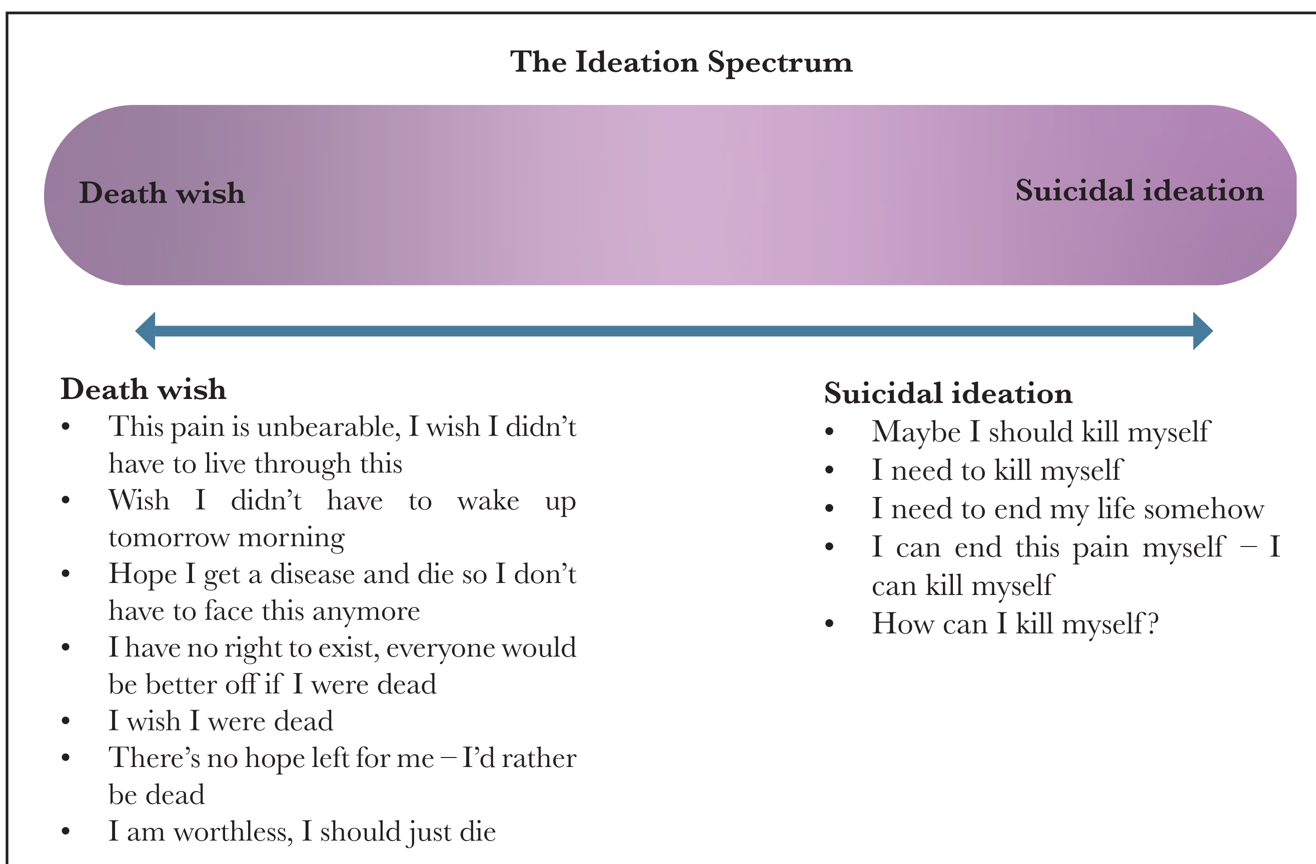
We can try to observe the warning signs during the assessment process. A mnemonic that can be used for this process is the ISPATHWARM which is described in the figure below.

IS PATH WARM : Mnemonic for Recognizing Warning Signs

Ideation: Suicidal statements or other communications
Substance use: Increased use of drugs or alchol
Purposelessness: Feeling of meaninglessness, no purpose in life
Anxiety: Agitation
Trapped: Feeling sense of entrapment:noway out
Hopelessness: Feeling no sense of hone
Withdrawal: Nethdrawing from f Mends, family, employment, society
Anger: Rage, uncontrollable anger, revenge-seeking
Recklessness: Risk-taking, reckless behaviors,seemingly without thinking
Mood changes: Dramatic changes in mood

3.2.2.3 Assessing Ideation

Ideation exists on a continuum ranging from death wishes to suicidal ideation.



We can use the funnel technique which follows the continuum from death wishes to suicidal ideas. The questions range from being general to more specific as the client answers.

We can start by exploring the presence of death wishes. We can ask them, *"Have you thought of death?"* followed by asking about the specifics of these wishes. We can then understand what can be the client's reasons for living. Some of the questions that we can ask include *"Do you ever go to sleep and wish that you did not have to wake up?; Have you felt that life is not worth living?"*

This can be followed up with specific questions regarding suicidal ideation. This includes, *"Is death something that you have considered recently?"*

We then move on to questions that assess specific aspects of suicidal thoughts, plans and behaviours. Examples of these questions include "*Since when have you had these thoughts? What events led to these thoughts?; How often do you have these thoughts?; Have you ever felt close to acting on these thoughts?; How likely are you to act on these thoughts in the future?; What do you think will happen if you acted on these thoughts?"*

These are just examples of some questions. We can have a repertoire of such questions with us that we will feel comfortable in asking in our own language.

3.2.2.4 Understanding Pattern

We can understand the pattern using markers of frequency, contingencies, duration, intensity and control.

Marker	Questions
Frequency	• *How often do these thoughts come to your mind?* • *How many times a day do these thoughts come?* • *Is it during specific time of the day? At night or evening?*
Contigencies	• *Are there times when these thoughts are most intense?* • *Is there any change in the patterns of these thoughts when you are alone or with people?* • *Are there specific places or people or situations that trigger these thoughts?* • *Is there anything that makes them better? If yes, can you tell me about the same?*
Duration	• *When these thoughts come,how long do they last?* • *Can you explain in terms of minutes or hours?*
Intensity	• *How often do these thoughts come to your mind?* • *How many times a day do these thoughts come?* • *Is it during specific time of the day? At night or evening?*
Control	• *To what extent are you able to control, or deal with these thoughts?* • *Do you try to distract yourself from these thoughts? How successful are you in this endeavour?* • *Can you describe this to me on a scale of 0-10 where 10 signifies that you have absolute control over these thoughts?*

Understanding patterns

3.2.2.5 Assessing Intent

Some questions that may help us in assessing intent are given below.

- *"Have you made a decision already?*
- *Have you been exploring ideas for how to carry out the act?*
- *Have you made a plan as to how you will kill yourself?*

When the client explains their plan, we can explore how detailed it is, what is the method that they have chosen and the reason behind choosing that particular method. We will also have to consider whether clients have access to means that will execute the plan (like having rope, knife, medications to name a few).

Another domain of assessment is to understand the preparation that the client has made when they have been contemplating suicide. Certain 'red flags' include the client mentioning that they have prepared a suicide note have decided to give away their belongings or taken precautions against being discovered. A key consideration in determining a person's motive and level of intent is to ask questions related to the client's future orientation. For example, asking about whether the person has plans for education, employment, entertainment, or social outings in coming days and weeks may help identify to what extent the person is at immediate risk of ending their own life.

3.2.2.6 Assessing Lethality

Lethality refers to the likelihood of the chosen method resulting in death. Some of the methods high on lethality include:

- Shooting
- Hanging
- Self-immolation
- Jumping from a height
- Ingestion of pesticide/poison
- Specific kinds of drug overdose

3.2.2.7 Exploring ambivalence and protective factors

3.2.2.7.1 Ambivalence

Ambivalence refers to the balance between the wish to die and the will to live. We can try to understand if the client feels there is anything to remain alive for. The part that wants to stay alive is the part that we will collaborate with during the process of intervention.

3.2.2.7.2 Protective factors

The identification of protective factors is a necessary component of suicide risk assessment in order to identify potential strengths and resiliency that can be used to buffer suicide risk. Recognizing protective factors can be a means to encourage hope among clients contemplating suicide. However, the protective nature of some factors may be temporary (e.g., a person may not attempt suicide while their children are still living at home). Thus, protective factors should never supersede

evidence of warning signs when assessing risk. The presence of protective factors does not reduce the risk associated with the presence of severe warning signs. Some of the questions that can be considered when assessing protective factors are listed below.

Protective factors	**Sample questions**
Presence of children, pets or close and strong relationships	Asking about other members of the family or significant others would be helpful with questions such as "*Who all are there in your family? / Who are your significant others? / Can you tell me about your friends?" / "Is there anyone who you think will be able to help you?"; "Could you tell me about the person who is closest to you?"*
Fulfilling sense of purpose	General enquiries into this domain such as *"What do you think is the purpose of your life? / What do you think gives meaning to your life" might be helpful.*
Access to treatment	In an adverse situation, the person might not be able to access help. Asking about the nearest medical facility, or mental health centre might be a useful reminder for the same.
Therapeutic relationship	Having a strong therapeutic relationship with a therapist might be helpful. General enquiries into previous psychiatric or psychological help may yield information about this
Survival and coping beliefs	A gentle inquiry about clients' personal beliefs and values about life, death, and thoughts about how one should face the adversities can be helpful. A dialogue of this nature can also bring up responses which might serve as a ray of hope. Questions such as *"What could be your reason for living? / What do you think is the purpose of your life?" I*t is important not to preach to the client about the value of life, rather to help them gently reflect on their own beliefs.
Problem-solving abilities	Lastly, framing the difficulties as 'problems that can be solved' and linking them to how problems have been solved by the client in the past can also be helpful. Activating problem-solving abilities also serves as a reminder that the client was able to survive a similar situation in the past. Questions could be framed as *"Have you ever encountered a similar difficulty before? How did you deal with it at that time? Or in the past, when you have faced difficulties, what did you do?"*

3.2.2.8 Stratifying Suicide Risk

After the process of assessment is complete, we try to understand where we can place the client on the continuum of suicide risk. This will help us in making decisions about the intervention.

Level of Risk	Sample questions
Very Low Risk	• Thinking about death casually, wondering about it but not thinking about it excessively *("having thoughts such as, What would happen when I die?; I wonder when that would happen?")* • Such thoughts are occasional and the client is not preoccupied with them • Does not express that it would be better if s/he is dead. **No intervention needed**
Mild Risk	• Thoughts about death and dying are present (expressing thoughts such as 'My life is not worth living; It would be better if I was dead or I really hope that God takes me away) but these thoughts are of limited frequency, intensity or duration. The client can exercise control over them and does not wish to act on them. • Has not thought of any method of harm or is not expressing any intention to harm self. • Reports having good self-control and demonstrates the ability to solve problems during stressful times • Emotional state may be sad, irritable, crying, or even be expressing mild emotional hurt • Presence of protective factors such as feeling cared for by family members, peers or significant others, has plans for the future, is hopeful about it. **Requires intervention such as psychoeducation, increasing the coping skills, suggesting a referral to a therapist or a helpline in their community and planning a follow-up call.**
Moderate Risk	• Suicidal ideation is frequent • The intensity and duration of these thoughts are limited. These thoughts do not occur all the time and the client is able to manage the urge to act on these thoughts on their own. • Has considered methods of taking their life but has not decided on a specific, detailed plan to be carried out. • Acknowledges the presence of reasons for living • Can exercise impulse control and possesses problem solving abilities as evident from past experiences of dealing with stress • Their support system may be fragile and not always accessible • They may have a history of prior attempt of suicide **Requires immediate support, safety planning and referral to a mental health professional in their community**

High Risk	• Expresses ideas of hopelessness and sees future as meaningless and empty • Reports that suicidal ideations are frequent, intense, persistent and difficult to exercise control over • Reports a specific, detailed plan which they want to carry out, have access to lethal methods for carrying out the plan and intend to carry it out on a specific day (e.g. I plan to go to the balcony tomorrow when mom and dad leave for their morning walk and my sister is sleeping. At that time, my neighbors are also busy, then I will jump off the balcony.) • The client's control over impulses may not be strong (I may not be able to control myself; I feel so overwhelmed that I don't think I can stop myself.) • They may be emotionally numb or in high emotional turmoil (anxiety, anger, agitation). They may also be in unbearable emotional pain expressed as distress or despair. • Multiple risk factors (such as previous attempts) and few protective factors are present. They may feel isolated, neglected or have intense conflicts with significant others. **Stay on the call and arrange for a referral as soon as possible. Collaborate with the client to involve a trusted relative/friend until the risk passes.**

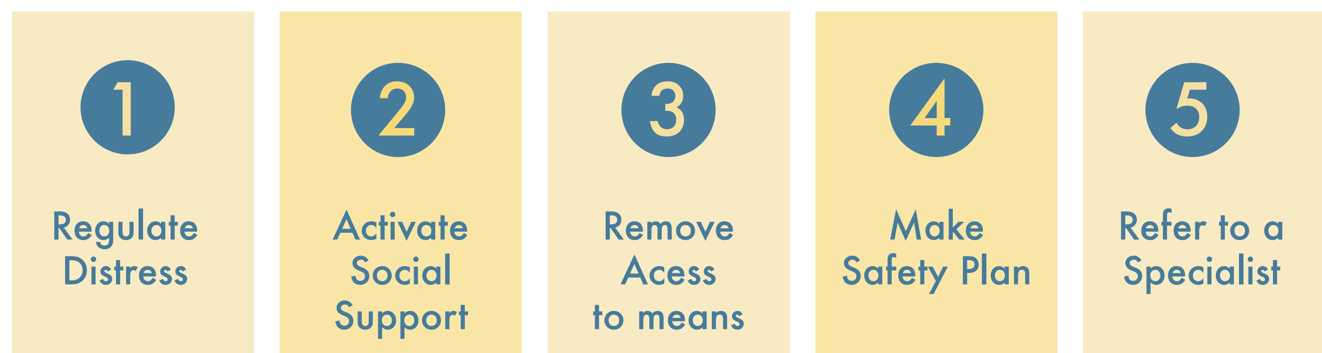
Table: Assessing Protective factors

3.2.2.9 Documenting the evidence

The level of risk needs to be clearly documented along with evidence for our clinical judgement. The documentation would encompass all the domains discussed before during risk assessment. Documentation is considered part of professional and ethical practice as it is evidence of the fact that a methodical and step by step process was followed in accurately assessing risk. In case of referral to other professionals, documentation also ensures clarity of communication and continuity of care.

3.3 Providing interventions

After a comprehensive evaluation, the next step is to plan intervention. This manual will help in understanding a step-by-step intervention plan which is suitable for telephonic intervention. The steps in intervention include:



3.3.1 Regulating distress

The role of the mental health professional is to regulate their own emotions as well as regulating the emotions of the client. It is imperative that techniques discussed in the chapter on 'Working with Clients In Distress' be used for the benefit of the client and the mental health professionals as well. These include deep breathing, slowing down, grounding, self-soothing etc In addition we can ensure the following :

- Try to listen to the client attentively and without interruption
- Ask one question at a time
- Give appropriate time to respond
- Repeat to the client what you have understood
- Reassure that you are listening to them
- In case you are not able to understand, ask for clarifications (e.g. *could you tell me more about it? / I am afraid I might not have understood this correctly. Can you explain it to me further?)*
- Validate the client's distress, be sure to be empathic and convey the empathy (e.g. it seems like such a difficult situation / it must have been so hard)
- Reframe suicide as a way of coping with unbearable pain (e.g. It seems that it was so hard that you felt maybe dying would be the only way to end the pain)
- Convey the nature of suicidal thought as 'waves'. Consider using statements like *"Suicidal urges are like waves in that they rise in intensity, peak and eventually crash. These thoughts are like most other thoughts. They ebb and flow in their intensity. If we do not act on them or do anything to aggravate them further, they subside in time"*. The wave metaphor also ensures that we can emphasise on "riding these waves." For example, we can help the client to use their breath as an effective way to ride these waves. We can say, *"Let's use our breath to help ride out the waves like a surfboard. Simply observe each breath as we ride out each wave. If we want, we can comfort ourselves or distract ourselves with anything that is pleasant."*
- Organize the client's distress into specific domains. This helps to make helplessness more manageable by reframing a mountain of overwhelming distress into specific and solvable problems. This organization can also increase the sense of control that they might perceive over the situations and encourage problem-solving actions. For example, we may say, *"It seems that a lot has been going on and making sense of all these difficulties at the same time may feel overwhelming. I am hearing that you are facing a, b, c and d difficulties right now. Is that correct? Would you like to add something to this list?"* After the client feels satisfied with the list, we may continue, "*I wonder if we could go over them one at a time. Which seems to be the most pressing concern for you right now? What about the others? Can we organise these in order of priority for you?"* The client may then feel ready to then start working on these one by one. We can facilitate this process by saying, *"You have organized the concerns in the list of priorities. Can we go through them one by one? (after gaining their assent) Have you experienced such a difficulty in the past? What did you do at that time?"*

Certain techniques that can be used when working with suicide as a crisis are:

- Understanding how the client views suicide. Exploring the personal meaning associated with ending one's life and understanding the imagined consequences of completing suicide (e.g. *What do you think is the purpose of suicide in your situation? How do you feel suicide will help at this point?)*
- Reframing suicide as an attempt to solve a seemingly unsolvable set of problems. Helping the client differentiate between the desire to end the pain and desire to end life itself.
- Accept the reality of the client's pain. At the same time, encourage the client to identify ways

which may reduce the pain a little. Finding examples with the client where a small change has led to a noticeable difference

- Working with them to consider alternatives to suicidal behaviour which can make the difficulties more manageable.
- Using the 'Miracle Question' (e.g. *Imagine that after this call ends, you feel very tired and decide to go off to sleep. After you wake up, you realise that suddenly your problem is gone! What would your day look like then? What will you be doing?)* This exercise can be used to shift the focus of the client from the problem to a goal.
- Seek exceptions to feelings of hopelessness. E.g. *Were there times when you did not feel so hopeless? Could you tell me more about them?*
- Remind the clients about their success in the past when they had weathered an emotional storm. Exploring their coping skills in those contexts may serve as a reminder to them to access these in current circumstances.
- Identify their reasons to live but in a non-blaming way. (e.g. Instead of saying *"have you thought about what will happen to you children if you die? Ask them "can you think of any reasons to stay alive?")*

3.3.2 Activating social support

The process of activating social support starts with asking the client about who can be involved in the process of supporting them. However, it does not end with us connecting the client to this social support. It is important to work with the concerned family member as well.

The family member may be shocked and in disbelief, and may get distressed and overwhelmed with feelings of despair, helplessness, and failure. They may respond with anger at their loved ones for "being selfish". They may respond with apparent indifference especially if the client has a history of suicidal attempts.

Regardless of their response, we must be non-judgmental, empathic, and supportive towards them. Some ways in which we can help the family members include:

- Providing education about suicide risk, warning signs of depression and the possible challenge that they may face.
- Helping them recognise signs of low mood, identifying questions that they will need to ask, collaborating on safety planning and giving numbers of helplines that can be contacted during crisis.
- Helping them to manage their own distress during this time. We can offer strategies such as sharing the responsibility of caring with others, activities which they can engage in which they find soothing, and seeking help for themselves. It can be overwhelming to help a client who is facing difficulties. Acknowledging this may help the family member feel validated.

3.3.3 Removing the access to means of harm

This can be done in collaboration with the family members. This would involve ensuring that the clients do not have access to implements such as knives, razors, scissors, medications or any other way in which they can be harmed. We will make sure that we convey to the clients about the importance of these steps in ensuring safety before we start with this process.

3.3.4 Safety planning

Safety plans are proactive strategies collaboratively developed by the mental health professional and the person at risk. Safety planning is done before a crisis, and has clear instructions and indications about what the client will do and who the client will contact when faced with suicidal urges. This process can be used as an opportunity to rehearse problem-solving and forming coping strategies. This is done in the session and can be a key take-away for the client.

Safety plans include specific steps that can be taken to ensure physical and emotional safety. Physical safety refers to an environment where the individual has a limited chance of being harmed. Ensuring physical safety over a telephonic conversation may be difficult. However, we can help the client identify a space where they may feel safe. This could be a place where others are available (a place of family gathering), or where methods of harm are absent (e.g. avoiding the kitchen or bedroom if it has triggers for harm). Ensuring emotional safety involves identifying places, people or ideas which give a sense of grounding to the individual. This can be done with the help of the coping kit that can be made during safety planning. A successful safety plan has the following components:

- **Identify high risk moments and triggers** and keep them handy. These can be memories or thoughts which remind the client of the distress, or places which are reminders of these painful memories or thoughts. Knowing these in advance can help prepare for the situations or moments where the client may be at risk.
- **Develop a coping plan**
    - Activities that help (either for calming down self)
    - Accessing a coping tool box (photos, lyrics, poetry, messages that help)
    - List of reasons for living
    - Distraction techniques to ride the wave until the suicidal urge passes
- **Keep the contacts of friends and family members accessible.** This includes a list with their names, telephone numbers and addresses. We can keep them in a list of priority (that is, who to contact first and then list out further names) and have back-ups. This would also involve people who can be available at a short notice, in case there is an emergency.
- **Maintain a resource book of health care professionals who can be contacted**
    - Crisis helpline numbers
    - Therapist, psychiatrist
    - Emergency services

3.3.5 Referring to a specialist

Certain groundwork that needs to happen before making a referral includes:

Do the background work : Check the client's availability for the session, their motivation and socio-demographic details

Recommend professionals who are verified, qualified and professionally recommended: Be sure to make a referral to a person who has the required expertise

Are currently taking new clients: It is important to coordinate with the professionals to check if they have slots available.

Language and cultural background : Check the compatibility of the client and the professional backgrounds such that there are limited barriers for rapport building

Budget : Referring a professional who may be unaffordable to the client may cause both the client and the professional to feel that their time was not valued

Let's Avoid...

Interrupting or judging the client while the client speaks

Interrogating the client

Saying that we understand, when we do not. It might be more helpful to clarify than go ahead with our assumptions.

Rushing into premature problem-solving. For example, using a statement like, "I think the difficulty that you are facing is of emotional regulation. We could try to use a technique such as deep breathing" after only listening to the client for 5 minutes might not be helpful.

Forcing positivity or giving platitudes. For example, we may find that statements like, "Don't worry, everything will be fine, let us look at the positive side to this" might make the client feel unheard or invalidated.

Being overwhelmed by our emotions and still continuing. We can try to take a break if we are feeling overwhelmed. Being overwhelmed is a natural response and we must take care not to overextend ourselves in order to help the clients.

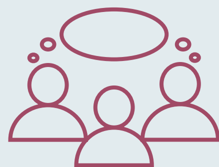
Taking full responsibility for the client's well-being. We are a part of the process of help but the client is in-charge of their lives. The final decision rests with the client always.

Creating a no-suicide contract. A no-suicide contract is an agreement between the client and the mental health professional, whereby the client is asked to pledge not to harm themselves (McMyler & Pryjmachuk, 2008). Research has shown that they have limited applicability in preventing suicide (Kelly et al., 2000). It is possible that these contracts merely take a promise that the client will not die by suicide without giving them steps to manage their urges (Lewis, 2007).

4. How do we reflect on our work?

The other side of the continuum is understanding the impact of working with clients at risk of suicide for the mental health professionals. It is important to take care of ourselves as well as the client. Our reactions to clients' stories of suicide and their difficulties can trigger feelings that range from numbness to rage, helplessness to excessive control, and trying to keep ourselves separate from the narrative of the client. This may lead to a blurring of therapeutic boundaries, where we may start relying on advice-giving and self-disclosure. We will have to be watchful against these probabilities and learn to take care of ourselves.

Some of the ways of doing so is taking care of ourselves and seeking supervision.



Supervision

Unfortunately, it is also a reality that we may lose a client to suicide. When a client dies by suicide, it is important for the clinician to acknowledge the death. The following questions may assist with reflecting on and coping with this loss which can be taken up in supervision:What was your initial response to losing your client to death by suicide?

- What was your initial response to losing your client to death by suicide?
- How did the experience impact you professionally?
- What was helpful to you at the time of the suicide? What was helpful to you in the weeks and months after the suicide?
- How has this experience impacted the way you work with your clients?
- What have you learned from this experience? (Source: American Association of Suicidology, 2001)

Self-care Exercise

Calls in which clients may be at risk for suicide can be very distressing for us. During and after such calls, it is important for us to be self-compassionate towards ourselves. We can consider how we can care for and comfort ourselves in these moments.

- How can you help yourself feel calm after such sessions? What acts of kindness can you do for yourself?
- How can you realistically evaluate your responsibility? The client's life and decisions are their own. We can help as much as possible but beyond a point, there would be things outside of our control.
- Such sessions can leave us feeling overwhelmed and inadequate. How would you like to manage your emotions at such a time? What could you say to yourself after such a session?
- How could you recognize your shared humanity at these times, i.e., suffering and personal inadequacy is part of the human experience?
- How can you take a balanced approach to your emotions and neither suppress nor exaggerate them?

Other forms of risk

There are many risks that clients may face during this time, and suicide is just one of them. It is possible that some clients may directly disclose to us that they are at risk of being harmed by someone else. Some clients may not directly share this information with us, but may indicate risk and distress in subtle ways. We may have to be alert for signs and red flags which necessitate a risk assessment. These include:

- We notice bruises or injury marks on video call
- We notice that the client seems to be in pain or discomfort
- We hear screaming/yelling on the phone
- The client may not be able to find time or place for the call which they consider private or safe
- Client mentions they are scared for their safety
- Client is a minor and shares that they are scared of a parent or an elder

Keeping these points in mind, we will have to be cautious about not putting the client further at risk. Thus, before conducting a situational risk assessment for harm from others, we can ask the client:

- If they are safe right now and feel comfortable sharing more information
- If they want to move to a safer more private space or reschedule the call for later

When conducting a risk assessment when a client is at harm, we will have to seek permission by describing the purpose of the call (May I ask you a few questions to understand what has been going on right now?; Is this a good time for us to talk about the difficulties that you might be facing?). We can then explore with them:

- Who is the risk from?
- What is the nature of risk? (it can be physical, emotional or sexual abuse or it can include neglect like the client's basic needs are withheld or denied)
- How severe is the risk? (This will be helpful in understanding whether immediate physical or medical care is required by the client)
- How frequent is the threatening behaviour?
- What are the sources of safety for the client? (This may include people or places where the client may feel safe)
- What kind of help do the clients think they need?
- What have they tried earlier? What do they think worked? What has not worked for them?
- Is there anything they fear will make the situation worse?

Once the assessment process is complete, the steps in intervention follow a framework that includes providing immediate emotional support, and planning for their safety. Validating the client's distress is important. We may be one of the few individuals who are the witness to their difficulties and abuse. Using supportive and validating statements can be helpful (We can refer to basic counselling skills and the chapters on regulating emotions and the previous section of this chapter to get an overview).

- One of the most important interventions that we can undertake is focusing on the blame and guilt that the client might be feeling and helping them to understand

that the blame lies only with the person who decides to be violent, abusive or neglectful. Considering the high incidence of intimate partner violence and patriarchal nature of our society, it is possible that the client may feel as if they are at fault for their difficulties. We might be one of the few individuals who may take a stand against this. One of the ways of doing this is to clearly state our position on violence. Simple phrases such as, *"It is not ok for someone to hurt you, no matter what you did" may serve to be powerful reminders for the clients that they do not deserve to be treated in an inhuman way"*.

- We can make a safety plan with the person experiencing violence. At the outset, this would include identifying triggers for others who may be abusing the client. It is important to emphasize that while the client is not responsible for abuse that s/he is undergoing, it is possible to identify the situations where abuse is likely to occur. Thus, a plan can be made to either circumvent the situation or put protective measures in place, in advance. For example, if it is clear that the client's partner hits after consuming alcohol, we can identify the early signs of drinking (staggered steps, alcohol on the breath, slurred speech, just to name a few). Then the client can minimize contact with the partner by either staying inside a locked room, trying to minimize engagements with the partner, and keeping someone informed of the threat they may be under.
- The safety plan would also include identifying physical spaces where people who could potentially harm the client are absent (e.g. having a room in which the door can be locked or shut completely), people they can contact for help such as family members or friends who may be able to calm the other person down or physically separate the client from the abuser, check in on the client to make sure they are safe, places that are safe to go to (such as a safe house where they can stay), a bag that they can keep ready for leaving (carrying government ID, some money, a spare set of clothes), helpline numbers such as helpline for National Commission for Women, Childline, and police. We can also offer a follow-up call from our side.
- Referral to a specialised care centre that might be in the best position to help the client remain safe is our next step.
- Lastly, documentation for the calls is very important. There might be certain guidelines that we will have to follow as per the policy of the organization that we may be working with. These documentations may serve an important function of evidence when the reporting happens. Certain laws, for example, the Protection of Children against Sexual Offenses (POCSO), mandates that if as an adult, we come across any incident of a child (below the age of 18 years) experiencing any form of sexual violence, we must report it to the police. In such a scenario, our documentation will serve an important function.

References

Apter, A. (2010). Clinical aspects of suicidal behavior relevant to genetics. *European Psychiatry, 25(5)*, 257-259.

Arsenault-Lapierre, G., Kim, C., & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: a meta-analysis. *BMC psychiatry*, 4(1), 37.

Arya, V., Page, A., Dandona, R., Vijayakumar, L., Mayer, P., & Armstrong, G. (2019). The geographic heterogeneity of suicide rates in India by religion, caste, tribe, and other backward classes. *Crisis: The Journal of Crisis Intervention and Suicide Prevention.*

Arya, V., Page, A., River, J., Armstrong, G., & Mayer, P. (2018). Trends and socio-economic determinants of suicide in India: 2001–2013. *Social psychiatry and psychiatric epidemiology, 53(3)*, 269-278.

Beck, A. T., Schuyler, D., & Herman, I. (1974). *Development of suicidal intent scales. Charles Press Publishers.*

Casiano, H., Katz, L. Y., Globerman, D., & Sareen, J. (2013). Suicide and deliberate self-injurious behavior in juvenile correctional facilities: A review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 22(2)*, 118.

Dandona, R., Kumar, G. A., Dhaliwal, R. S., Naghavi, M., Vos, T., Shukla, D. K., ... & Dandona, L. (2018). Gender differentials and state variations in suicide deaths in India: the Global Burden of Disease Study 1990–2016. *The Lancet Public Health, 3(10)*, e478-e489.

Dsouza, D. D., Quadros, S., Hyderabadwala, Z. J., & Mamun, M. A. (2020). Aggregated COVID-19 suicide incidences in India: Fear of COVID-19 infection is the prominent causative factor. *Psychiatry Research, 113145.*

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *Jama, 286(24)*, 3089-3096.

Dunster-Page, C., Haddock, G., Wainwright, L., & Berry, K. (2017). The relationship between therapeutic alliance and patient's suicidal thoughts, self-harming behaviours and suicide attempts: A systematic review. *Journal of affective disorders, 223, 165-174.*

Hoffman, M. A. (2000). Suicide and hastened death: A biopsychosocial perspective. *The Counseling Psychologist, 28(4)*, 561-572.

Iob, E., Steptoe, A., & Fancourt, D. (2020). Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic. *The British Journal of Psychiatry, 217(4)*, 543-546.

Jordan, J. R., & McIntosh, J. L. (Eds.). (2011). *Grief after suicide: Understanding the consequences and caring for the survivors. Routledge.*

Kapilan, N. (2020). Suicides cases among nurses in India due to COVID-19 and possible prevention strategies. *Asian journal of psychiatry, 54,* 102434.

Kelly, K. T., & Knudson, M. P. (2000). Are no-suicide contracts effective in preventing suicide in suicidal patients seen by primary care physicians?. *Archives of Family Medicine, 9(10)*, 1119.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual review of clinical psychology, 12.*

Kumar, U. (Ed.). (2017). *Handbook of suicidal behaviour.* Springer Singapore.

Lewis, L. M. (2007). No-harm contracts: A review of what we know. *Suicide and Life-Threatening Behavior, 37(1)*, 50-57.

Mann, J. J., Waternaux, C., Haas, G. L., & Malone,

K. M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *American journal of Psychiatry, 156(2)*, 181-189.

McMyler, C., & Pryjmachuk, S. (2008). Do 'no-suicide'contracts work?. *Journal of psychiatric and mental health nursing, 15(6)*, 512-522.

Pathare, S., Vijayakumar, L., Fernandes, T. N., Shastri, M., Kapoor, A., Pandit, D., ... & Korde, P. (2020). Analysis of news media reports of suicides and attempted suicides during the COVID-19 lockdown in India. *International journal of mental health systems, 14(1)*, 1-9.

Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., ... & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. *The Lancet Psychiatry, 7(10)*, 883-892.

Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *The Lancet*, *360*(9340), 1126-1130.

Rasmussen, M. L., Hjelmeland, H., & Dieserud, G. (2018). Barriers toward help-seeking among young men prior to suicide. *Death studies, 42(2)*, 96-103.

Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019—a perfect storm?. *JAMA psychiatry*. doi:10.1001/jamapsychiatry.2020.1060

Rudd, M. D. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports, 10(1)*, 87-90.

Rudd, M. D., Berman, A. L., Joiner Jr, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., ... & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36(3)*, 255-262.

Rudd, M. D., Berman, A. L., Joiner Jr, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., ... & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36(3)*, 255-262.

Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., & Roy, A. (2011). Controlling access to suicide means. *International Journal of Environmental Research and Public Health, 8(12)*, 4550-4562.

Shield, T., Campbell, S., Rogers, A., Worrall, A., Chew-Graham, C., & Gask, L. (2003). Quality indicators for primary care mental health services. *BMJ Quality & Safety, 12(2)*, 100-106.

Stone, D. M., Holland, K. M., Bartholow, B. N., Crosby, A. E., Davis, S. P., & Wilkins, N. (2017). Preventing suicide: A technical package of policies, programs, and practice.

Stuckler, D., & Basu, S. (2013). The Body Economic: *Eight experiments in economic recovery, from Iceland to Greece.* Penguin UK.

Substance Abuse and Mental Health Services Administration. (2019). Risk and protective factors. https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). *The interpersonal theory of suicide. Psychological review, 117(2)*, 575.

Virupaksha, H. G., Muralidhar, D., & Ramakrishna, J. (2016). Suicide and suicidal behavior among transgender persons. *Indian Journal of Psychological Medicine, 38(6)*, 505.

Wandrekar, J. R., & Nigudkar, A. S. (2020). What Do We Know About LGBTQIA+ Mental Health in India? A Review of Research From 2009 to 2019. *Journal of Psychosexual Health, 2(1)*, 26-36.

World Health Organization. (2014). Preventing

suicide: A global imperative.

World Health Organization. (2017). Depression and other common mental disorders: global health estimates (No. WHO/MSD/MER/2017.2). World Health Organization.

Yoshimasu, K., Kiyohara, C., Miyashita, K., & Stress Research Group of the Japanese Society for Hygiene. (2008). Suicidal risk factors and completed suicide: meta-analyses based on psychological autopsy studies. *Environmental health and preventive medicine, 13(5)*, 243-256.

Zortea, T. C., Brenna, C. T., Joyce, M., McClelland, H., Tippett, M., Tran, M. M., ... & Platt, S. (2020). The impact of infectious disease-related public health emergencies on suicide, suicidal behavior, and suicidal thoughts. *Crisis*, 1-14

10 Mitigating stigma

Stigma can be understood as negative views which get attributed to a person or groups of people on the basis of characteristics considered to be different from or inferior to norms prevalent in society (Dudley, 2000). It can be defined as "an attribute that is deeply discrediting" which can diminish a person from being "whole and usual to a tainted, discounted one" (Goffman, 1963; p. 3). Stigma is present when trivializing, labeling, and segregation processes all occur together at the same time, creating in-groups and out-groups on the basis of certain characteristics (e.g., caste, illness symptoms) (Link & Phelan, 2001). This means that when people stigmatize others, it may lead to an "us versus them" dichotomy where 'out-groups' become devaluated, and targetted through socially undesirable labels, verbal discrimination or even violence (Corrigan, 2004; Parker & Aggleton, 2003).

Historically, we have seen examples of how illnesses have been associated with stigma. When the person who is ill is considered to be the 'other', people can feel safe in the knowledge that this person is different from them. People with leprosy, AIDS, tuberculosis and mental illness have faced discrimination and social isolation as a result of stigma. The outbreak of bubonic plague in Africa was accompanied by high polarization, racism, and blame against certain ethnicities (Davtyan et al., 2014). Similarly, during the Ebola outbreak in the Democratic Republic of Congo in 2019, misinformation about Ebola became associated with violence, mistrust, social disturbances, and targeted attacks on healthcare providers (WHO, 2019). The healthcare providers did not belong to the community and were considered as outsiders who had brought Ebola to Congo. The people from the community showed distrust towards them as they believed that the outbreak was fabricated for outsiders' political or economic benefit, or to further destabilise the region (WHO, 2019). Thus, healthcare providers due to their association with the disease became targets of violence.

Unknown information about illness generates fear and rumours, thus fueling stigmatising beliefs and discriminatory practices. The fear of being stigmatised may also lead to delay in help seeking and under-detection of disease which may increase community transmission (Turan et al., 2017). Stigma is, thus, recognised as a major mental health and public health issue (Link & Phelan, 2006). Prejudice can have adverse mental health consequences including isolation, loss of employment, and shame. Isolation and discrimination have also been linked to increase in suicides (Kapilan, 2020). Furthermore, isolation, stigma from facing boycotting and religious discrimination can also lead to an increase in the risk of loneliness and self-harm (Corrigan, 2012).

The outbreak of COVID-19 resulted in widespread stigmatizing behaviours and prejudices (Misra et al., 2020). Such was the impact of stigma during the times of the pandemic that the Director-General of WHO remarked "Stigma, to be honest, is more dangerous than the [corona]virus itself" (Ghebreyesus, 2020).

The stigma associated with the COVID-19 has provoked discriminatory practices towards certain ethinc groups and people who were thought to have any contact with the disease such as healthcare workers, people diagnosed with the virus and their family members. For example, healthcare workers in India reported that they were not allowed to enter their rented accommodations, refused houses on rent, not allowed to use public transport and were attacked while on duty (Bagcchi, 2020). There were also reports of how airline crew members who were involved in rescue missions of bringing back Indians from other countries faced discrimination in the form of boycott by their

neighbors after being quarantined (Bhattacharya et al., 2020). It was also reported that stigmatizing attitudes of the communities created difficulties for arranging for last rites of people who had lost their lives to COVID-19.

The WHO (2020) has proposed that widespread prevalence of stigma may be because disease is still new and there are a lot of unknowns associated with it. Since people are often afraid of the unknown; it becomes easy to associate that fear with 'others'. Thus, it is understandable that the pandemic has created a lot of confusion, anxiety, and fear. Added to this aspect were reports of rumors, and conspiracy theories connected to it which further fueled a number of harmful stereotypes. This is dangerous in the current context as stigma associated with COVID-19 can undermine social cohesion and prompt possible social isolation of groups, which might contribute to a situation where the virus is more, not less, likely to spread.

Reflective exercise

- Do you recall if you or someone you know who experienced stigma related to COVID-19?
- If yes, what was the impact of the stigma on you / them experiencing it?
- How did you / them make sense of the stigma?
- What action did you or they take in this regard?
- What were the obstacles to taking desired action?

1. What is our role as mental health professionals?

Titli and her husband had tested positive for COVID-19 two weeks ago. They were advised to get admitted in the hospital as they were experiencing some respiratory distress. They recovered from COVID-19 after testing negative, came back from the hospital and wanted tor esume their life at home. They wanted to go for walks around their gated society with precautions as they had felt very restricted in the hospital. However, they were in for a rude shock. Their house had a board highlighting their diagnostic status. Their neighbours avoided them. They found that the services that they had taken for granted such as someone collecting garbage from their house was not available to them anymore. Provisions such as bread and milk which the society had promised to deliver at their doorstep were not given to them. When they stepped out to get these themselves, they were shouted at or simply refused by the society members. In fact, their family members also started getting ostracised. Her elderly mother was not invited to the early morning prayers, a ritual that she always participated in earlier. When they asked why the others were doing this, they were told that if people like them were not being careful, then someone else would have to be. Even after they complained, they were not given help. They felt betrayed and even more isolated than when they were at the hospital.

Reflective exercise

- What were some of the thoughts that came to your mind while reading the example?
- Were you able to relate to the neighbours or the couple?
- Neighbours may feel that they are justified in wanting to keep themselves safe and prevent the spread of COVID-19. But does this translate into actions that seem to be denying people their dignity?

Experience of stigma has important implications for management of the pandemic. Globally, stigma has been recognised as a major deterrent to help-seeking behaviours, engagement in treatment and adherence (Stangl et al., 2019). Stigma contributes to poorer health outcomes by worsening, undermining, or impeding positive health related behaviours (Hatzenbuehler et al., 2013). Thus, working with stigma may be an important step in helping clients with physical and mental health concerns. This will help address the barriers to help-seeking, encourage healthy behaviours as well as mitigate the harmful impact of stigma on mental health as described previously. Addressing stigma is considered to be fundamental in delivering quality healthcare (Nyblade et al., 2019).

Our work as mental health professionals may involve mitigating stigma at individual level by encouraging client-directed interventions such as developing coping resources, working with emotions that are accompanied by stigmatization, encouraging self-advocacy and empowering the clients. We can also intervene at the community level by taking up roles of advocacy, organizational changes, and participation in social movements ourselves and encouraging clients to do the same. We can use our expertise to help educate people by spreading correct information to the general public.

There will be clear limitations to our role as well. We may not be able to stop the stigma that the client might be experiencing. We can only help and work with the aftermath of the experience. Socially, we may not be able to stop the stigmatizing behaviours. Despite the awareness of the detrimental impact that stigma has on the health of the individuals, it is possible that our efforts may not yield immediate and far-reaching effects. However, despite these limitations, our work with stigma is crucial as we might be one of the few people who acknowledge stigma as an important part of clients' experience and validate the same for them.

2. What key concepts and ideas can inform our practice?

This section describes the components and impact of stigma. The process of how stigma develops will be explored. We will also understand the role of intersectionality in the context of COVID-19 pandemic. The section will conclude with discussion on a model for stigma mitigation that informs the process of intervention.

2.1 Components of Stigma: Stigma consists of three components:

2.1.1 Stereotypes: The American Psychological Association defines stereotypes as "a set of cognitive generalizations (e.g., beliefs, expectations) about the qualities and characteristics of the members of a group or social category" (APA, 2007). The importance of stereotypes is that they use cognitive heuristics (mental shortcuts).

This helps to reduce cognitive load and process information faster. Stereotyping is "efficient" because it allows an individual to form quick impressions and expectations of individuals from the stereotyped community (Hamilton & Sherman, 1994). Stereotypes become "social" when they are used to make judgements about the groups of persons which other people agree upon. They can be positive (for example, 'all doctors are kind and helpful'). Unfortunately, it is the negative stereotypes which get further propagated. An example of a negative stereotype is believing that people who have mental health concerns are "weak".

2.1.2 Prejudice: Prejudice can be any preconceived attitude or view. It can be understood as a negative attitude toward others (individuals or groups) without any prior experience with them (APA, 2007). Prejudices have an affective component (e.g. feeling nervous when being in a community dominated by people from other religions) a cognitive component (e.g having assumptions, beliefs or stereotypes about certain groups, such as, "people who are differently abled are paying for the sins of their past lives"), and a behavioral component (e.g. discrimination and violence).

2.1.3 Discrimination: It refers to the differential treatment meted out to members of different groups based on ethnicity, religion, nationality, etc (APA, 2007). It can be understood as the manifestation of prejudice in terms of behaviours.

In times of COVID-19, discrimination can take many forms such as:

- Not talking to a person
- Spreading rumors about unconfirmed diagnosis
- Speculating about identity of the individuals
- Speculating about cause of how the infection was acquired
- Excluding from social groups (virtual and offline)
- Avoiding or rejecting them at social functions, office, building
- Denying healthcare, education, housing, or employment
- Verbal abuse
- Physical violence

All components of stigma contribute to marginalization which then contributes to social inequities and inequalities.

2.2 Impact of Stigma: The impact of stigma is understood in terms of two reactions- the first is the way in which the general population reacts to the person who is stigmatised, that is public stigma; and the other in which the person who is stigmatized views themselves, that is, self-stigma (Corrigan & Watson, 2002).

Components	Public stigma	Self-stigma
Stereotype	Having negative beliefs about a group or others "They are dangerous; There are weak"	Having negative beliefs about the person herself/himself "I am dangerous; I am weak"
Prejudice	Agreeing with belief such that a negative emotional reaction is present (fear, anger) "I am afraid of them because they are dangerous"	Agreeing with the belief such that the person has a negative emotional reaction to self (low self-esteem, less confidence in self) "I am dangerous and I cannot control myself."

Components	Public stigma	Self-stigma
Discrimination	Behaving in accordance to the prejudice (avoiding people, withholding opportunities like employment, help). Discrimination may take the following forms: withholding help, avoidance, coercive treatment, and segregated institutions. "I will not allow this couple to stay in my society because they are both COVID positive".	Behaving in accordance to the prejudice (not following up on the opportunities) "I don't deserve to get the help for my health conditions as I am responsible for infecting my family"

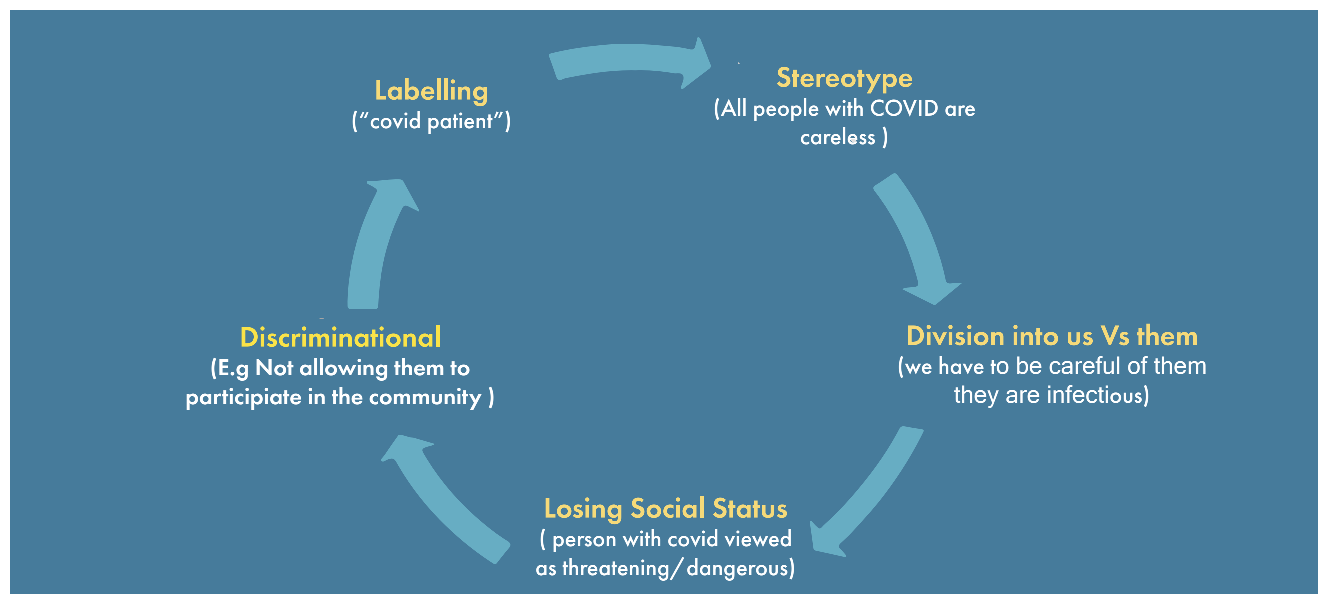
Impact of stigma

2.3 Process of stigmatizing

The intersection of contextual factors, 'othering' and characteristics of illness contribute to the process of stigma. In our society, stigma is based on historical and cultural differences of caste, class and religious divisions. In this background, we see that presence of fear of illness and the eventual suffering from it promotes "othering" towards those diagnosed with it. People may exhibit discriminatory behaviours towards them in order to manage their anxieties and fears. These behaviours may then get maintained by this fear of the illness and the lack of credible information associated with it.

We can see a similar process happening in the context of COVID-19. If we keep the previous example of Titli in mind, we can see a cycle playing out such as the one described below.

Thus, we see that when we start stereotyping against people, we start ascribing certain labels to them. These labels create certain identities and highlight the undesirable characteristics that we



Process of stigmatizing

associate with the identity. An example is given below:

Ascribing Identity— *"A COVID-19 patient"*: The entire identity focuses on a diagnosis

Ascribing Intent— *"They deliberately did not disclose and put others at danger"*: The intention of the person is questioned.

Ascribing Danger — *"Living in the same building they will infect all of us"* : The person is ascribed an undesirable attribute

Ascribing Permanence — *"If they tested positive once, they will always be a risk to others"*: The attribute is considered to be unchangeable

2.4 Intersectionality and COVID-19

Viruses do not discriminate and neither should we! But do viruses affect everyone in the same way? Probably not. An important consideration is intersectionality.

Take the following example.

Kim, an 18-year-old, originally from Manipur was studying in a university in a metropolitan city in the college hostel when the WHO declared the pandemic. She was very stressed as they were asked to vacate and go home. Figuring out the ways to go home was difficult. But the worst part was going out in the city. Whenever she would go to college, people on the road would shout derogatory terms, calling her "Chinese" and saying that she was trying to bring in the virus in the city. At first, she would answer them saying that she was an Indian but she would then be asked to prove it by speaking in Hindi which she could not do. She stopped replying to them but she then faced harassment all the way to the college. When she complained to the guards, they said she could try to dress in the way other girls in the region were dressing and she should really make an effort to learn Hindi. She could not wait to go home. She started contemplating not coming back to finish her education. This upset her because she had worked so hard to clear the cut-off for this college and she could still remember the pride that her family members had felt on her admission.

This is unfortunately not an isolated event. Certain groups such as people from the North-East part of the country, those with travel history, healthcare workers, medical practitioners, police personnel and nurses (just to name a few) have faced more discrimination than others. For example, many of them were asked to leave their neighborhoods and even faced threats to their family members.

Certain people are more vulnerable to stigma and prejudice due to their membership in social groups. The plight of the migrant workers was seen when visions of them trying to get home came to the attention. Reports of them facing problems like being singled out, sneered at or harassed by their community members surfaced. Even after completing their mandatory quarantine, they were still mistreated. Another example was the linking of an increase in the number of incidents to a religious gathering in the capital. The social media unfortunately was overcome with

provocative and condemning messages towards a particular community. The Government of India had to issue an advisory on April 8, 2020 to stop stigmatizing communities and asked people to act more responsibly.

2.5 Model for mitigating stigma

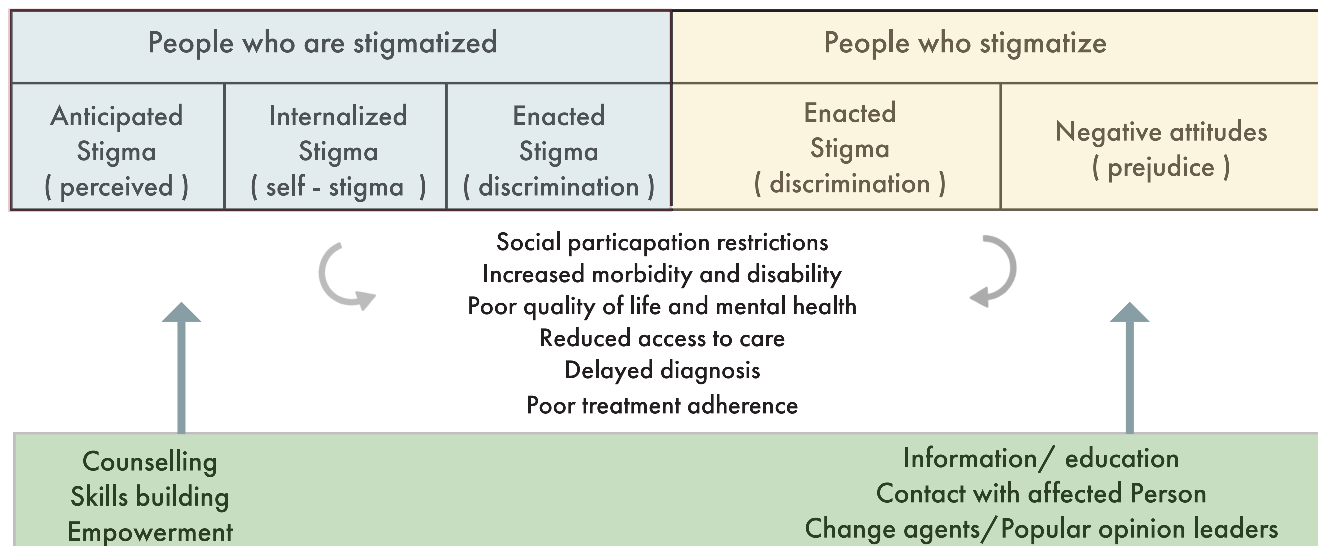
The model below is proposed by van Brakel et al. (2019) for specifically understanding health-related stigma.

This model outlines two pathways through which stigma may show up as a concern in public health contexts. Here, stigma refers both to the experience of people who face stigmatization, as well as those who engage in the process of stigmatization. The consequences of stigma for those who experience it are seen in health-related outcomes such as reduced access to care, delayed diagnosis, poor adherence to treatment to name a few.

We can direct our interventions at both pathways. The first pathway, targeted at people who are experiencing stigma, involves using counselling skills such as listening, psychoeducation and problem-solving (Augustine et al., 2011), strategies for skill building like helping them to engage in community initiatives, finding resources with clients so that they can become more economically independent and encouraging participation in social functions (Dadun et al., 2017, Ebenso & Ayuba, 2010) may be beneficial. These initiatives aim to improve self-esteem and feelings of self-worth. At the same time, being able to contribute to families and communities may help them in regaining their identity and respect (Van Brakel et al., 2019).

For addressing the sources of stigma, some of the research-based interventions include spreading information and knowledge for reducing negative attitudes and perceived stigma (Thornicrof et al., 2008), increasing contact with the individuals who have been affected by a health condition to disconfirm negative attitudes and stereotypes (Uys et al., 2009) and using change agents or popular opinion leaders for leading change campaigns (Young et al., 2011). These leaders can be selected and trained to act as models for spreading non-stigmatizing behaviours and fighting discrimination.

3. How do we assess and intervene?



3.1 Preparing to intervene

It is important to ask, 'who really stigmatizes'?. For many people, the answer would be others! Let us undertake a reflective exercise to understand who the agents of stigma might be.

Reflective exercise

How do we become unknowing carriers of stigma?

- When I first heard of someone in my physical vicinity being diagnosed with COVID-19, I felt…………………………….
- When I hear about celebrities and other people who don't disclose travel histories and put others at risk I feel………..
- When I see someone coughing or sneezing in a public place now, I ……
- Specific groups of people whom I think are less particular about hygiene and self-protection………..
- If the person next door to me was affected by COVID-19 and recovered, and I met them in the staircase or common area I would feel…..….
- If I felt unsafe around someone who I thought was ill, how might I respond?
- Could my self-protective behaviours be seen as a form of discrimination? For example, Would I avoid the person? neighbour?

It is important to ask, 'who really stigmatizes'?. For many people, the answer would be others! Let us undertake a reflective exercise to understand who the agents of stigma might be.

The activity serves to highlight how we are ALL capable of bias!

One of the ways in which these bias manifests is **microaggressions**. These are "the brief and commonplace daily verbal, behavioral or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative attitudes toward stigmatized or culturally marginalized groups" (Sue, 2020; p.16). Some examples could be-

- An Indian abroad being told "You speak great English"
- Not including a woman in a discussion about sports
- Asking a young boy "Why did YOU choose humanities?"
- Not acknowledging the person who picks up garbage from the building every day
- Having separate utensils for domestic helpers
- Calling someone a 'Feminazi'

Thus, we can see that all of us can also have our biases, prejudices and stereotypes. An important step before intervening is to reflect and work on these. Reflecting and working on our biases can help us in providing a non-judgemental atmosphere to the clients while at the same time, also modeling to them that biases and prejudices can be changed. We can keep some of these reminders in our mind which may help us in reflecting.

- Being constantly vigilant of our own biases and fears.
- Seeking out interaction with people who differ from us (in terms of caste, gender, sexual orientation, race, culture, ethnicity, and other attributes)
- Seeking feedback
- Not being defensive about our biases
- Being open to discussing our own attitudes and

biases and how they might have an impact on others.
- Acknowledging and apologising if we have used words or actions towards others or in some sense revealed bias on our part which may have hurt them.

3.2 Identifying concerns

We will first have to identify stigma as a concern and focus on understanding its emotional impact for the client. It might be helpful for us to remember some of the following points:

- We as mental health professionals can bring up stigma for discussion **proactively**. We may start by checking-in with the clients, asking questions like *"I was wondering how you are doing with respect to people around you and their reaction to you?*; *How have you experienced the reactions of your community, family, neighbours, professional space?"*
- When a client makes reference to having experienced stigma, it is important for the counsellor to take a strong stance against the practice of stigmatizing. Using statements like, *"People all over the world are facing discrimination after being diagnosed with COVID-19. It is an unfortunate reality. But just because a lot of people are facing it, it is still not okay"* might be helpful
- After taking such a stance we can **validate their experience** by exploring the emotional impact stigma has had on them and proceeding to help them feel understood through empathic statements. For example, we can say, *"It seems like people calling you irresponsible really hurt. It must have been so tough to hear that."*
- It is possible that we may be one of the first people to consider stigma as a topic that may need to be addressed. It is only after they feel validated, that people may be ready to discuss the emotional impact of stigma. A thorough assessment can then be helpful to understand the extent and impact of stigma for the client.

Some **domains of assessment** can be:
  - **Who might they be experiencing the stigma from?** Family members, professional contacts, community, social media
  - **How are they experiencing it?** Is it in the form of verbal or physical violence? Are they facing exclusion?
  - **When did this experience occur?** Is it at the time of diagnosis or was it even after recovery?

- An important domain is to **explore the way in which people make meaning of their experiences**. This helps in exploring the client's own understanding and attribution of stigma. A question such as *"what is your understanding of/ how have you made sense of why people are behaving this way?"* may help us understand this experience better. For example, does the person believe that people are stigmatizing them because they feel unsafe and afraid or do they attribute stigma to the inherent "traits"of people of those who are stigmatizing against them (e.g "they targeted me because they are bad people")? Exploring the person's own meaning-making process can be an important ally in planning s proactively trategies for intervention. If the individual believes that others discriminate because of fear of getting the disease or lack of information, the conversation can move towards exploring how this may not be a 'personal attack' and can be addressed through agency and awareness. If on the other hand, their understanding is rooted in trait-based explanations, they may perceive the situation to be hopeless and our interventions may first have to be directed towards building hope and facilitating a sense of agency.
- Assessment **of internalized or self stigma** is another important consideration for intervention**.** People may start identifying with the traits that others have bestowed on them. These traits may have an impact on how they view themselves. We can check for **attitudes**

towards the self, using statements like *"Do you think this experience of stigma has changed you as a person? Has it had a permanent impact on you?"* Questions such as these may allow them to reflect on their experiences and help in making sense of their experiences.

- We may also explore the **impact of stigmatization on their own sense of agency.** It is important for us to be on the lookout for learned helplessness. This translates into actively searching for phrases like "I can't change anything", "why try?" "I'm helpless", "I can't trust anyone" etc. Statements such as these have an impact on the mental health of the person. The presence of such beliefs may contribute to depression or anxiety that the person may be experiencing.

3.3 Providing intervention

A unique aspect of intervening for stigma is that it can be done on multiple levels. We can focus on providing interventions at an individual level for clients who are facing stigma as well as intervening at the community level to address the root of stigma.

3.3.1 Interventions for supporting people who are facing stigma

3.3.1.1 Building hope

It is possible that clients may feel that there is nothing that they can do about the stigmatizing behaviours. Thus, we may try to explore what makes them think so.

3.3.1.1.1 Assumption 1: Others are responsible for stigma: Clients may feel that others are attacking them personally. We can intervene by:

Checking if assumption is a feeling or a fact: In such a situation, we may begin by exploring if this inference is a feeling that they have, or is it a fact. Clients may think that it is a feeling as they have no evidence for the same. They may feel better knowing that while the stigmatizing behaviour exists, and they feel bad about it, others may not be deliberately trying to make them feel in this way.

If it is a fact, then checking for the evidence: Clients may believe that the thought that others are deliberately attacking them is a fact then, we can explore the possible evidence for the same.

If the evidence exists, then checking for alternate explanations: We can help the clients reflect on what could be some alternate explanations for the same.

If there are no alternate explanations, then checking for control: We can ask the clients if they have control to change this behaviour. If yes, then we explore about the ways in which the client may wish to do the same. For example, they want to bring evidence for the fact that the others' accusations towards the clients are incorrect.

If things are not under their control, then checking for the costs and benefits of continuing with the thinking process: It is possible that they may recognise that while the stigmatizing process is unfortunate and unfair, it is not in their control to stop it. We may explore with the client what could be the costs of continuing to engage in this thought process and the benefits of the same. This may help the client decide if this process is helpful for them.

3.3.1.1.1 Assumption 2: I am responsible for stigma: Clients may believe that the reason for the stigmatizing behaviour is located within themselves or their surroundings. We can intervene by:

- **Checking the attributions for these behaviours:** If the clients attribute the behaviours to something in their situations, then we may be able to psychoeducate them

about what parts of the situation may have contributed to the behaviour and how we can prepare for such situations in the future. For example, if the client realises that they may have been exposed to the virus because while they were out while shaking someone's hands, they can plan to be careful in shaking hands in the future.

- **If the attribution is internal, checking for whether the causes can be changed:** If the client attributes the behaviour to themselves, we may wish to explore whether these can be changed. If these are changeable, we can discuss with the clients the ways in which they can bring about these changes. For example, if the client believes that they are careless because they tend to forget to sanitize the groceries, we can try to keep the sanitizers near the main door through which the groceries come.
- **If the client attributes it to unchangeable internal causes, challenging these beliefs:** We can use the above mentioned techniques such as asking for evidence, alternate explanation and cost-benefit analysis. In addition to this, we may also try to:
  - Identify other people or situations who can share the responsibility for the event: We may say, "You were mentioning that you feel people are right when they say you are careless. Forgetting to sanitize groceries may seem like an example of this carelessness. I was wondering whether someone else was there who saw that you had not sanitized the groceries but also forgot to comment on it?"
  - Promote a more compassionate stance by asking if they would have the same attitude towards a friend in a similar situation: We can ask them, "If you heard a friend calling themselves careless because they had not sanitised the groceries one day, what would you say to them?"
  - Identifying situations when they have behaved differently: We can ask, *"Can you tell me about a situation where you were not careless?"* Exploring such an example may help the clients to identify certain alternate circumstances where they have been successful in avoiding these labels. We can then build on this by asking them what could be some of the reasons for their behaviours in these situations. This will help in building internal attributions for success.

3.3.1.2 Working with internalised stigma

Clients may have internalised stigma to an extent that they find it difficult to separate their experience of stigma as an external reality from their view of themselves as people who deserve to be stigmatised. We can intervene using the following strategies:

- We can **discuss the impact of stigma on the client's view of themselves.** If the clients start **believing the stigmatizing views** that others hold about them, they may develop a negative view of themselves. However, as we saw earlier, the roots of stigma are more social in nature and arise from various myths and misconceptions. Highlighting the effect of social origin of these beliefs about self may help with mitigating the emotional impact of stigma.
- We can help the clients **understand the connection between their external and internal world.** Being attuned to and exploring ways in which cultures and societies inform the client's psychological experiences and emotional life is an important consideration in working with an issue like stigma (Adames et al., 2018). **We can explore their histories of discrimination, or harassment and try to understand how they have impacted the client.** This in itself is an important intervention (Herek, 1996). Having this awareness about the origins of these negative messages may help them **label these experiences as being different from their**

own, lived experience (Lin & Israel, 2012) and ultimately allow them to **challenge some of their negative self-evaluations.**

- We can also discuss the ways in which societal structures and systems contribute to and maintain the power differences and hierarchy. This may help clients recognise the effect of these on their conceptions of themselves (Moradi & Grzanka, 2017). Reframing experiences in a way that stigma becomes a result of others' biases, rather than an individual's internal experience may help to reduce the impact of stigma on the client's sense of self (Mizock & Mueser, 2014). Some techniques that we can use are:
  - Asking the client to have a **dialogue with themselves** as if they were talking to someone sitting on a chair next to them. They could share with themselves, how the words spoken to them may not be their own words and rather views that others hold about them. This may allow them to distinguish their own experiences from the voices of others (Hardtke, et al., 2010).
  - Asking them to **write down their personal stories** detailing their understanding of the origin and development of their internalized stigma (Russell, 2007). We can encourage them to reflect on how the larger societal influences as well as family, workplace or peer groups may have contributed to this.
  - Asking them to **examine the evidence for the negative view** that they hold on to (Safren & Rogers, 2001). The clients may come up with certain evidence where they recount how others either directly or indirectly said something to them to make them believe their stigmatizing views. We can observe and highlight to the clients how some of these statements may have explicit external influence.
- After acknowledging the role of external experiences, it is important to understand how to **work with these emotions**. It is possible that the client **may feel guilty for agreeing with the external voices.** Thus, we will have to be extremely sensitive in taking a non-blaming stance when bringing this up. We can use statements like, "There's a lot of discrimination and so many marginalizing messages out there, and over time it's hard not to start believing them yourself even though they're not true."
- We may also help them to **engage in a process of creating an alternative story** which highlights how at times in the face of oppressive stigmatizing voices, they may have stood their ground against the internalised stigma by standing up for their rights or resisting implications from others that are stigmatizing (Kaufka, 2009). We may say to them, *"I realize the hardships you've faced because of your experiences with being discriminated against and marginalized, and yet you keep going forward. I don't think you give yourself credit for that. Maybe it's time for us to focus on helping you begin to affirm and celebrate yourself a bit more."*
- A part of working with stigma would involve asking questions for **re-iterating "identity beyond illness".** Understanding "Who am I besides COVID?" may be an important intervention for mitigating self-stigma. Statements like, "Let us get you to know a little bit about you. What are your goals in life? What gives meaning to your life?" may help clients to reestablish their identity beyond and before the illness. This may then help reclaim their identity. An example of such a process is when people move from being labelled as an "irresponsible COVID-19 patient" to re-entering into the imagination of the general public by becoming a "responsible" member of the community as plasma donor or public health ambassador.
- We may also teach some **coping strategies** for mitigating the emotional impact of stigma. This includes teaching them relaxation skills,

asking them to stay physically active and other such activities described in Chapter 3 (Section 3).

- As mental health professionals, we may have the power to engage in perpetuating social marginalization or to challenge it (Prilleltensky, 2008). We can thus be careful and reflective of our own personal identities, social statuses, and experiences of privilege and oppression. We can be attuned to their influence on ways of understanding and responding to our clients in the relationship that we share with them (Brown, 2009). We can communicate that we are **receptive to thoughts, feelings, or concerns** clients may have regarding the significance of similarities and/or differences in our social identities and statuses **by having a valuing, respectful, and empathic relational stance.**
- We can also work with their sense of agency by exploring their preferred options, that is, understanding what they would like to do about their experience of stigma. Statements such as *"You have been experiencing stigma. Would you like to do something about this? If yes, what would you like to do? Have you tried anything? " might help in assessing such beliefs. The aim of this exercise is to reveal the answer to the question, "Do they feel ready to be self-advocates?"*
- We can **try to explore the client's readiness to engage in different levels of self-advocacy**, provided they are ready for engaging in it. Self-advocacy can be exercised on a continuum that spans interpersonal, community, organizational and national levels. People may be ready to become self-advocates at one, all, or none of these levels. We will try to understand the level at which they are ready, people that they may want to target and media that they want to use.

3.3.1.3 Empowering through self-advocacy

Self-advocacy is simply "the ability to speak up for what we want and need" (Schreiner, 2007; p. 300). In the context of COVID-19, self-advocacy may include people who have recovered from COVID-19 sharing their experiences, trials and triumphs on behalf of themselves and their family members. Their stories may be useful in understanding how others can influence narratives negatively (through stigmatization) as well as positively (by offering help and hope). These stories could also be helpful reminders that people have identities beyond their diagnoses and are just like others.

It is always the client's decision whether or not to become a self-advocate. Our role is to introduce self advocacy as a tool to deal with stigma, and help people explore if that is a suitable option for them without forcing it upon them. A useful starting point is to share the rationale of self-advocacy in simple terms . Some statements that can be useful in this endeavour may be:

- *"People across the world after recovering from the illness are taking an active role in talking about their diagnosis and their experiences. They are doing this by interacting with their communities, through their social media platforms to give others a glimpse into the lived experience of the illness and clear myths and misconceptions.*
- *This helps the world, community and family get better information and correct their perceptions."*
- *" Self advocacy can mean standing up for oneself and taking on the role of a change agent by spreading first-hand information, and challenging myths. Through this we also become ambassadors of public health."*

When we share the rationale for self-advocacy, it is equally important to explore the costs and benefits of being a self advocate . It is only after the client is aware of all aspects of the decision, can they make an informed decision and go ahead with the plan. Some of the statements highlighting the costs of self-advocacy can be as follows

Level	Target	Medium
Interpersonal	Immediate social network including family members, extended family and friends	Using phone conversations, letter, voice-notes over social media platforms
Community	Neighbours, Resident Welfare Association (RWA), or other colony members as well as those residing in the immediate vicinity	Using posters in the community, street theatre, letters to the RWA or other officials responsible for the community
Organizational	Colleagues and authority figures	Using phone calls, open letter, emails to Human Resource Department or superiors or even addressed to the organizations at large
National	Public at large	Using the social media platforms, making public posts, writing open letters to newspapers and other mass media agencies

Table: Levels, target and medium of stigma intervention

- *Being a self advocate has its advantages and disadvantages. We will have to keep in mind that by disclosing our identity and speaking about our experiences publicly, we could be at further risk for discrimination."*
- *"It is true that stigma cannot be completely eradicated. This attempt will be a small step, but may not wide-spread changes or overhaul the process of stigma. We may not be able to reach out to or change everyone's perceptions or opinions"*

If the client is ready to take the step towards self-advocacy, we can introduce them to the various levels or platforms at which they could be self advocates. We can use the following table for helping the clients in making this decision

When a client decides to become a self advocate they may consider including the following themes in their communication to people in the community

- Acknowledging that those who stigmatize may have fears that are very real, even if the underlying assumption is false.
- Correcting misconceptions that people may have
- Helping and educating others by promoting the importance of prevention, lifesaving actions, early screening and treatment that the client may have found helpful. For example, through their lived experiences, they may have found certain treatment centers where the staff may be more helpful or waiting lines may be smaller or a telephonic service that others may not know about. They can spread information about the same.

Dear,

I hope you are taking care of yourselves at this difficult time. As you nay,have heard, I was diagnosed with coronavirus last month. It was a difficult time and I am lucky to have survivec this deadly disea-seI want to take this opportunity to share my own experience and make sure others are able to pro-tect themselves from this disease. Here are a list of tips, myths and facts I think may help you keep yourself safe Although COVID-19 is a highly contagious disease which spreads fast and can infect any one of us, we can protect ourselves through social distancing, washing our hands regularly and following sneezing / coughing etiquettes. Despite all precautions, if anybody catches the infection, it is not their fault. In situation of distress, the patient and the family need support and cooperation. It must be noted that the condition is curable and most people recover from it. The easiest way to get a Covid test is to… The easiest way to prevent Covid is to ..

3.3.1.4 Participating in Community initiatives

Besides taking on stigma in their own immediate social environment, clients can also consider joining or leading community initiatives aimed at reducing stigma. This may be empowering for those who wish to mobilize change and engage with a larger audience. Clients can organize community events to amplify the voices and stories of those whose recovery was made easier with the support of their loved ones. This may help people to understand how crucial their support can be to the person who is going through a trying time in their lives. We can also help them implement a local "hero" campaign which honours caretakers and healthcare workers. They can also help detect, assess, and respond to rumors, stigma, and conspiracy theories. They could also be engaged in monitoring social media platforms and online newspapers for misinformation and then using these to dispel rumors, stigma, and conspiracy theories.

Organizing a community initiative has the advantage that it helps us remember that we are not alone. Neither in fighting the virus nor in spreading awareness. Linking up with other people who are addressing stigma and stereotyping can help create movements and develop a positive environment promoting empathy and care for all.

An example of community initiative

The residents of a small town in Italy called Trinità d'Agultu e Vignola, took matters in their own hands to address misinformation and social stigma. They sought to increase the health education of the local population by organizing live online events for the community with the help of experts like epidemiologists and health professionals. They tried to create interactive programmes where the experts would explain the key features of the COVID-19 epidemic (natural history of the infection, detection of vulnerable groups in the community, personal protective equipment, contagiousness, risk of social stigma and discrimination) to change or prevent dangerous behaviours and attitudes. This would be followed by a question and answer session where every citizen could participate with their questions and issues. These sessions were organised on two consecutive Saturday afternoons in March and April 2020. They promoted the events using official and social media channels.

Let's Avoid...

- **It is important not to push clients into self-advocacy.** We can try to avoid statements like *"Why don't you try to become self-advocates for mitigating stigma? This will help." Or "Many people are following this route and get help. Why don't you try to do this so that you might also feel better?"*
- **Let us not try to be cheerleaders for the clients.** Instead, we can gently explore the experiences of stigma and follow the client's lead.
- **Assuming that everyone will be equally motivated to play the role of self-advocates.** As mentioned before, there can be pitfalls of engaging in self-advocacy due to which people may not be ready. We must keep aside our own biases about how people should respond to stigma.
- **Assuming that everyone will be excited about organizing or participating about community initiatives.**People may have their personal and situational
- **Assuming that everyone will be excited about organizing or participating about community initiatives**. People may have their personal and situational reservations about engaging in community participation. We will have to respect the client's positions and decisions regarding
- **Calling out client's stigmatizing attitudes insensitively.** It is possible that clients may also show stigmatizing attitudes towards others. We can try to understand their beliefs and clarify their myths, misinformation and other sources of stereotypes.

3.3.2 Interventions targeting the source of stigma: Mental health professionals as change agents

Research suggests that change strategies for addressing public stigma can be categorised into three approaches: protest, education, and contact (Corrigan & Penn, 1999). **We as mental health professionals may be in a unique position to contribute to these strategies by taking on an advocacy role ourselves** while at the same time encouraging clients to do the same.

3.3.2.1 Protest

We can protest against the inaccurate and stigmatizing representation by the media by educating ourselves and creating awareness about the same. Using social media platforms, we can try to send a message to the media to STOP reporting inaccurate material and to the public to STOP believing in these. This means that we can use our social media platforms to highlight the inaccuracies in their content, directing them towards more reliable sources of information and use our position and knowledge as experts in the field to highlight the detrimental effect of these representations. But we also need to understand that protest is simply a reactive strategy; it does not take into account how positive information can be given. For this purpose, we may want to combine this strategy with other strategies.

3.3.2.2 Education

In this strategy we provide accurate information to allow others to make informed decisions. We as mental health practitioners can be in a unique position to promote this strategy by not only spreading accurate information but also quoting research evidence as to why having accurate information helps. This may help the clients be more informed and updated about information related to stigma-based interventions. We can quote from research in our field, for example, where it has been found that persons who have a good understanding of mental health difficulties tend to be less likely to support stigma (Brockington et al., 1993). Several other studies have shown that people who had participated in the education programs focusing on mental illnesses tend to have more positive attitudes towards persons facing these difficulties (Corrigan et al., 2001). Clients can further quote these examples.

We can follow and spread the messages for the general population as given by reputed organizations. Some do's and don'ts that can be followed when talking about the stigma are:

No.	Do's	Dont's
1	Start conversations about the new coronavirus disease (COVID-19)	Attach locations or ethnicity to the disease. The WHO (2020) reports that the choice for the official name for the disease was done keeping in mind the need to avoid propagating stigma. They explain this process as "the "co" stands for Corona, "vi" for virus and "d" for disease, 19 is because the disease emerged in 2019."
2	Use terminologies like "people who have COVID-19", "people who are being treated for COVID-19", "people who are recovering from COVID-19" or "people who died after contracting COVID-19"	Call people with the disease as "COVID-19 cases" or "victims"
3	Use phrases such as "people who may have COVID-19" or "people who are presumptive for COVID-19"	Using phrases like "COVID-19 suspects" or "suspected cases".
4	Discuss about people "acquiring" or "contracting" COVID-19	Saying things like "transmitting COVID-19" "infecting others" or "spreading the virus". This may imply intent, and allot blame. Using terms which indicate criminal intent or have a dehumanising effect

No.	Do's	Dont's
4		may give the impression that people with the disease have done something wrong or are less human than the rest of us. This leads to stigmatization and presents empathy. As discussed previously, this may translate into reluctance to seek treatment or take preventive actions.
5	Use terminologies like "people who have COVID-19", "people who are being treated for COVID-19", "people who are recovering from COVID-19" or "people who died after contracting COVID-19"	Spread unconfirmed rumours, or language that generates fear.
6	Spread positive messages and highlight how preventive and curative measures are effective. We have all come across stories of people who have overcome this disease. Sharing narratives, or stories that humanize the experiences and struggles of individuals or groups affected by COVID-19 which is done in an empathic manner.	Spread or worry about the negative, or messages of threat. The need of the hour is to ensure safety for all especially the most vulnerable.
7	Spread messages of the importance of prevention, screening, testing and treatmentfortheCOVID-19pandemic.	

(adapted from the UNICEF and WHO guide for preventing and addressing social stigma)

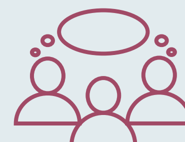
3.3.2.3 Contact

Stigma reduces when people come in contact with those against whom they hold stereotypes. This allows people to appreciate individual differences. Once again, we as mental health practitioners can draw on research from our field to supplement this statement when discussing these concerns with the clients. For example, we may share that research indicates that people who have contact with individuals with mental health concerns tend to endorse less stigma attitudes towards them (Corrigan et al., 2001). Using contact as strategy may be difficult to use in times of COVID-19. We can thus use strategies by keeping people in virtual contact with people diagnosed with COVID-19. We can arrange for live-streams of them sharing their experiences, organizing question and answer rounds for them, and programs showcasing clients interacting virtually in their communities to increase the contact.

4. How do we reflect on our work?

Reflective exercise

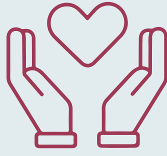
- This chapter has outlined some stigma mitigation strategies for intervention with clients and some that mental health professionals can themselves carry out in their community.
- How do you feel about using your voice to be an advocate against stigma in your community?
- Can you identify one small change that you can make that reflects your commitment to addressing COVID-19 related stigma?



Supervision

Sometimes, other people such as colleagues from allied disciplines may have prejudices against us because of our gender, religion, language or other aspects of our identities. We can explore these themes in the supervision process such as:

- Can we take a stance of advocacy for ourselves? How can we do so?
- Would you like to talk about this experience (our feelings, or the ways in which we responded) in peer supervision?
- Can we brainstorm as a group about some of the ways in which we can advocate about the presence of such experiences of stigmatizing behaviour and ways to mitigate these in organizations that we are part of?



Self-Care Exercise

As mental health professionals, we, too, may experience mental health concerns. There can be both societal stigma and internalized stigma about mental health professionals seeking help for their own concerns. Let's examine and reflect on our personal views and beliefs about seeking help for mental health difficulties.

- Have you previously or are currently participating in personal therapy? How easy or difficult was it for you to start this process?
- Did you disclose this to other people who were close to you? Why or why not?
- What might be some of your hesitations to engage in personal therapy?
- What do you think can be the benefits of engaging in personal therapy? What might be the costs?

References

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatina queer immigrant. *Psychotherapy, 55(1)*, 73–79.

Augustine, V., Warne, K., Ramakrishna, J., Mbwambo, J., Singh, S., Yosep, A., & Longmore, M. (2011). Counselling to reduce stigma. *First. London/Amsterdam: International Federation of Anti-Leprosy Associations (ILEP) and Netherlands Leprosy Relief (NLR)*.

Bagcchi, S. (2020). Stigma during the COVID-19 pandemic. *The Lancet*. Infectious Diseases, 20(7), 782.

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.

Brockington, I. F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *The British Journal of Psychiatry, 162(1)*, 93-99.

Brown, L. S. (2009). Cultural competence: A new way of thinking about integration in therapy. *Journal of Psychotherapy Integration, 19(4)*, 340–353.

Corrigan P.W. & Penn D. L. (1999) Lessons from social psychology on discrediting psychiatric stigma. American Psychologist 54, 765-76.

Corrigan, P. (2004). How stigma interferes with mental health care. *American psychologist, 59(7)*, 614.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry, 1(1)*, 16.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., ... & Kubiak, M. A. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia bulletin*, 27(2), 187-195.

Dadun, D., Van Brakel, W. H., Peters, R. M., Lusli, M., Zweekhorst, M., & Bunders, J. G. (2017). Impact of socio-economic development, contact and peer counselling on stigma against persons affected by leprosy in Cirebon, Indonesia–a randomised controlled trial. *Leprosy Review, 88(1)*, 2-22.

Davtyan, M., Brown, B., & Folayan, M. O. (2014). Addressing Ebola-related stigma: lessons learned from HIV/AIDS. *Global health action, 7(1),* 26058.

Dudley, J. R. (2000). Confronting stigma within the services system. *Social Work, 45(5*), 449.

Ebenso, B., & Ayuba, M. (2010). 'Money is the vehicle of interaction': insight into social integration of people affected by leprosy in northern Nigeria. *Leprosy review, 81(2),* 99.

Goffman E. Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs NJ: Prentice Hall; 1963.

Hamilton, D. L., & Sherman, J. W. (1994). Stereotypes. In R. S. Wyer, Jr., & T. K. Srull (Eds.), Handbook of social cognition (2nd ed., Vol. 2, pp. 1-68). Hillsdale, NJ: Lawrence Erlbaum.

Hardtke, K. K., Armstrong, M. S., & Johnson, S. (2010). Emotionally focused couple therapy: A full-treatment model well-suited to the specific needs of lesbian couples. *Journal of Couple & Relationship Therapy, 9,* 312–326

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American journal of public health, 103(5)*, 813-821.

Herek, G. M. (1996). Heterosexism and homophobia. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health (pp. 101–113)*. Washington, DC: American Psychiatric

Press, Inc

Kapilan, N. (2020). Suicides cases among nurses in India due to COVID-19 and possible prevention strategies. A*sian journal of psychiatry, 54*, 102434.

Kaufka, B. (2009). The shadows within: Internalized racism and reflective writing. *Reflective Practice, 10,* 137–148

Lin, Y., & Israel, T. (2012). A computer-based intervention to reduce internalized heterosexism in men. *Journal of Counseling Psychology, 59, 458– 464.*

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology, 27(1),* 363-385.

Misra, S., Le, P. D., Goldmann, E., & Yang, L. H. (2020). Psychological impact of anti-Asian stigma due to the COVID-19 pandemic: A call for research, practice, and policy responses. *Psychological Trauma: Theory, Research, Practice, and Policy.*

Mizock, L., & Mueser, J. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. Psychology of Sexual Orientation and Gender Diversity, 1, 146–158.

Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. J*ournal of Counseling Psychology, 64(5)*, 500–513

Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Mc Lean, R., ... & Wouters, E. (2019). Stigma in health facilities: why it matters and how we can change it. BMC medicine, 17(1), 1-15.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Social science & medicine, 57(1), 13-24.

Prilleltensky, I. (2008). The role of power in wellness, oppression, and liberation: The promise of psychopolitical validity. *Journal of Community Psychology, 36,* 116–136.

Regan, P., Hudson, N., & McRory, B. (2011). Patient participation in public elections: a literature review: Paul Regan and colleagues look at the role of nurses, their employers and policy makers in ensuring that patients can exercise their right to vote. *Nursing Management (Harrow), 17(10),* 32-37.

Russell, G. M. (2007). Internalized homophobia: Lessons from the mobius strip. In C. Brown & T. Augusta-Scott (Eds.) *Narrative therapy: Making meaning, making lives (pp. 151*–176). Thousand Oaks, CA: Sage.

Safren, S. A., & Rogers, T. (2001). Cognitive-behavioral therapy with gay, lesbian, and bisexual clients. *JCLP*/In *Session: Psychotherapy in Practice, 57*, 629–643.

Schreiner, M. (2007) Effective self-advocacy: What students and special educators need to know. *Intervention in School and Clinic 42(5*), 300-304

Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., Simbayi, L. C., Barré, I., & Dovidio, J. F. (2019). The health stigma and discrimination framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC medicine, 17(1)*, 1-13.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation. John Wiley & Sons.*

Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International journal of mental health systems, 2(1), 1-7.*

Turan, B., Hatcher, A. M., Weiser, S. D., Johnson, M. O., Rice, W. S., & Turan, J. M. (2017). Framing mechanisms linking HIV-related stigma, adherence to treatment, and health outcomes. *American journal of public health*, *107(6)*, 863-869.

Uys, L., Chirwa, M., Kohi, T., Greeff, M., Naidoo, J., Makoae, L., ... & Holzemer, W. L. (2009). Evaluation of a health setting-based stigma intervention in five African countries. *AIDS patient care and STDs, 23(12)*, 1059-1066.

Van Brakel, W. H., Cataldo, J., Grover, S., Kohrt, B. A., Nyblade, L., Stockton, M., ... & Yang, L. H. (2019). Out of the silos: identifying cross-cutting features of health-related stigma to advance measurement and intervention. *BMC medicine*, *17(1)*, 1-17.

VandenBos, G. R. (Ed.). (2007). *APA Dictionary of Psychology.* American Psychological Association

World Health Organization. (2003). Advocacy for mental health.

Young, S. D., Konda, K., Caceres, C., Galea, J., Sung-Jae, L., Salazar, X., & Coates, T. (2011). Effect of a community popular opinion leader HIV/STI intervention on stigma in urban, coastal Peru. *AIDS and Behavior, 15(5)*, 930-937.

11 Nurturing narratives of resilience

The COVID-19 pandemic has had an unprecedented impact on the life of people and functioning of communities. However, despite the struggles and challenges, individuals, families and communities have been able to find ways to stay resilient during the pandemic (Rosenberg, 2020).

Almost one in five young adults from a study in Switzerland reported that they made use of the opportunity the pandemic provided them to decelerate their life and were able to spend more time with loved ones or engage in hobbies (Shanahan et al., 2020). Strategies such as maintaining a healthy lifestyle, maintaining social connection, acceptance of anxiety and negative emotions, and possessing knowledge of where to seek treatment emerged as buffers against emotional distress in the pandemic (Petzold et al., 2020). In the Indian context, six major themes of coping and resilience in the pandemic were identified: making meaning of the pandemic (e.g., through considering it God's will), looking for positive ways forward (e.g., appreciating greater time to play games with children), actively seeking social support (e.g., increased frequency and duration of phone conversations), prosocial behaviour (e.g., helping elderly neighbours), engaging with the natural world (e.g., appreciating pollution-free blue skies) and innovating with new practices (e.g. writing poetry) (Mathias et al., 2020).

At the community level, resilience can be seen in how people have come together in the pandemic. All over the world, the morale of frontline workers has been boosted by social media memes, political satire, singing, games and collective expressions of appreciation (Maddrell, 2020). Vast amounts of research are being made open-access and transnational funding initiatives are being launched (Maddrell, 2020). Many citizens came forward to provide monetary help to others in need (Sheoran, 2020). In the Indian context, women's self-help groups came together to manufacture masks in the pandemic as well as feed their communities (World Bank, 2020). Religious organizations have come forward to promote the idea of 'humanity over hate' and partnered with organizations to supply food to those in need (Sheoran, 2020). Mental health professionals, too, contributed to the efforts by trying to mitigate the psychological distress associated with the pandemic by volunteering in helplines and offering pro-bono services (Balaji & Patel, 2020).

This is in line with previous literature that suggests that accessing social support and connection with loved ones, using distraction to find space for fun and laughter in our lives, maintaining family cohesion, achieving a balance between accessing adequate information and information overload and supporting community cohesion and altruism may be important factors that contribute to resilience in disaster contexts (Chen & Bonanno, 2020).

1. What is our role as a mental health professional ?

Rani is a sanitation worker living in a small state in India. When the COVID-19 pandemic and the lockdown started, the situation was very dire. People in Rani's community did not have work to sustain themselves. They were running out of access to basic necessities such as food and medicine. If they were diagnosed with COVID-19, they had no way to self-isolate or pay for medical treatment. At this point, she was put in touch with Fathima, a mental health professional who leads an non-governmental organization in her state that works towards helping vulnerable groups such as sex workers, construction workers,

fruit and vegetable sellers and sanitation workers. The organization was struggling to help everyone though, so the community itself came together to help themselves. Some women from the area organized a community initiative to provide cooked food every day to the families. The fruit and vegetable sellers procured supplies at cheaper prices for the community. Fathima reached out to her entire network and many citizen groups came forward to donate money. Rani, motivated by her talks with Fathima, created some videos with Fathima's help on how to properly dispose off masks after use. Her videos went viral on social media and were even shared by some celebrities. This led to a noticeable shift in the entire community of how masks were disposed and reduced the clogging of drains and risk of infection due to improper disposal of masks. When asked about her efforts, Rani said, 'First I thought I had no power to do anything. I am just a simple sanitation worker. But then Fathima ma'am showed me that I know some things that others don't and I, too, can contribute to society in a positive way in the pandemic. This has made me very happy and now, some people on YouTube are asking me to create more videos and I will get paid as well!'

As mental health professionals, our focus is often on distress and concerns. However, in disaster settings, most people's concerns are an understandable, rather than pathological, response to the circumstances (Halpern & Vermeulen, 2017). In fact, research related to the disaster context suggests that the majority of people respond to such circumstances with stories of resilience and recovery (Galatzer-Levy et al., 2018; Pietrzak et al., 2014). Hence, acknowledging, thickening and celebrating clients' stories of resilience is also a part of our role. In this context, our role can involve:

- Actively listening for stories of resilience
- Actively identifying clients' strengths and resources in a sensitive manner
- Helping clients' expand and develop their stories of resilience
- Finding ways of nurturing family-based, organization-based and community-based resilience

Reflective Exercise

- Consider the vignette above. Can only individuals be resilient or can organizations, communities or systems be resilient, too?
- Was Rani's resilience only an 'inner trait'? What different factors can you identify that contributed to Rani's resilience?
    - Individual factors
    - Social factors
    - Community factors
    - Systemic factors (e.g., mass media, cultures, government policies)

2. What key concepts and ideas can inform our practice?

2.1 Resilience

Resilience can be defined as 'good outcomes in spite of serious threat to adaptation' (Masten, 2001, p. 228) and 'a dynamic process encompassing positive adaptation within the context of significant adversity' (Luthar, Cicchetti & Becker, 2000, p. 543). Certain key concepts about resilience include:

Resilience is ubiquitous. Trajectories of resilience were the most frequent responses to trauma and adversity in a review of 54 research studies that examined how people respond to

major life stressors (Galatzer-Levy et al., 2018). Hence, resilience is a common, rather than infrequent, response to difficult circumstances. In the COVID-19 pandemic as well, we have seen that individuals, families and communities have displayed resilience in different ways such as by increasing compassion towards other members of the community, showing empathy, altruism, and applauding the efforts of frontline workers.

Resilience is dynamic (Luthar et al., 2000). Resilience is not an all or none phenomenon. It does not mean that people who show resilience do not have bad days or weeks. Instead, they can be resilient some days and not so resilient on the others. Resilience can also vary across time. It may not necessarily follow a linear road which culminates in a static goal of mental health or happiness.

Resilience is determined by the interaction of individual and environmental factors. Newer perspectives on resilience show a gradual movement in the field; from locating resilience as a trait in the individual, we are moving towards a more ecological definition of resilience. It is now recognised as a set of dynamic processes that are facilitated by the environment (Hart et al., 2014; Masten, 2014; Southwick et al., 2014). In fact, Ungar (2008, p. 225) defines resilience as the 'capacity of individuals to navigate their way to health-sustaining resources…and a condition of the individual's family, community and culture to provide these health resources…in culturally meaningful ways'.

Ungar (2011) has described the social ecological approach to resilience and its four principles:

- Decentrality: shifting focus from the individual to the context
- Complexity: exerting caution before generalizing because of the highly complex pathways through which resilience occurs
- Atypicality: the notion that resilience may manifest even in socially-unacceptable ways
- Cultural relativity: processes that promote resilience are culturally-embedded; what may promote resilience in one culture may not promote resilience in another.

Hence, interventions aimed at supporting resilience cannot be conceptualized only at an individual level, but must also include family, community and systemic interventions. Such interventions must also be contextually and culturally meaningful; resilience cannot be conceptualized independent of the context it occurs in.

2.2 Strengths-based approaches

Strengths-based approaches focus on recognizing the many skills, competencies, resources and abilities that people already have. Some specific concepts we can keep in mind, adapted from narrative approaches (White & Epston, 1990), include:

Externalizing. Externalizing is an approach to counselling that aims to separate the person from their problems. It encourages persons to objectify and/or personify their problems so that problems can be thought of as a separate entity from the person whom they are affecting. This allows problems to be rendered less fixed, less restrictive and less internalized. Language is the primary mechanism through which we can externalize problems. For example, consider the difference between saying, *'Mr. Ram is a negative person who is not able to cope with quarantine'* and *'Sometimes, negative thoughts come into Mr. Ram*'s mind and trouble him in quarantine!' The latter probably sounds more manageable and less blaming to Mr. Ram and makes the 'negative thoughts' an external problem that he can work to reduce.

Mapping the problem-saturated story. Generally, clients come to us with a story about their lives that is primarily focussed on problems. This is called a problem-saturated story. At this point, this is the dominant story that the client has about their lives. Initially, it is important to thoroughly understand and explore the problem-

saturated story of the clients' lives. We can do this through asking about the effects of the problem on various domains of clients' lives, helping them to evaluate the effects of the problem and exploring their values to understand why they might be taking a particular position on a problem (Ackerman, 2019).

Counter-storying. The client may initially have a dominant story about their life that is problem-saturated. However, narrative approaches suggest that people's lives are multi-storied; there are always multiple stories that can be told about somebody's life. Our role is to search for these alternative stories about the client's life and to deepen these stories by bringing them into focus and expanding on them. This generally involves identifying unique outcomes i.e., those times when the client was free of the effects of the problem and how they managed these.

3. How do we assess and intervene?

3.1 Preparing to intervene

We can prepare ourselves by:

Being aware of sources of difficulties and sources of resilience in the pandemic. This can help us to be more understanding of the difficulties faced by our clients and not minimise them. At the same time, we need to also understand that people are more than their difficulties. Being aware of the sources of resilience may make us more cognizant and help us recognize these in the client's narratives.

Being aware of our stories of resilience help ourselves? Are we able to share our narratives of resilience with significant others? If we can acknowledge and appreciate the struggles of our lives, our lived realities, our efforts and successes, we can then listen for these in the narratives of our clients as well. Believing in our stories may enhance our capacity to listen to and encourage narratives of resilience for others.

Examining our own beliefs about resilience. It is important to examine our own beliefs about the concept of resilience. If we believe that resilience is a dynamic process, we may then be able to identify sources of resilience in stories which may seem to be problem saturated. If on the other hand, we believe that resilience is static, we may make certain assumptions or miss opportunities to highlight alternative stories.

3.2 Identifying strengths

Listening for the alternative story. One way to identify strengths is to listen carefully for threads of the alternative story in clients' words. For example, let's consider the statement below from an 8 year old child:

I am not able to do my homework properly in the lockdown. I don't like online classes and I am not able to pay attention to them. I just can't do it. I am worried that the teacher will scold me.

This is the problem-saturated story. Let's imagine that after a while in the conversation, the child says:

My father always tells me that I am very brave and can do anything I put my mind to. That is why I won so many prizes for running very fast!

Here, we have the beginnings of an alternative story in which the child frames themselves as someone 'who can do anything they can put their mind to' which might counter the dominant story of 'I just can't do it''.

Strengths-based questioning. This is based on Ivey, Ivey and Zalaquett's (2009) framework. We can also directly explore clients' strengths by asking questions. However, these questions need to be framed sensitively and timed appropriately. We need to be cautious that our attempts to elicit strengths do not lead clients to feel that we are ignoring their problems and only wanting to focus on the positive aspects of their lives. One of the

ways of doing so would be to ask strength-based questions only after problems and concerns have been sufficiently explored.

We can ask about strengths using certain open-ended and broad questions such as:

- What are some things you have been proud of in the past?
- What do you do well/others say you do well?
- Was there a point in the past when someone supported you? What did they do?

Myers and Sweeney (2004) have developed an evidence-based model of wellness called 'The Indivisible Self'. This 'indivisible self' can be thought of as consisting of five different parts that work together to create a whole self. We can use these domains to ask clients about specific areas of strengths. These questions are adapted from Ivey, Ivey and Zalaquett (2009).

The Essential Self

- What strengths and support do you gain from your spiritual and religious orientations?
- What strengths do you draw on from your gender identity and sexual orientation?
- What strengths do you derive from your cultural background?
- Who are your heroes or role models?

The Social Self

- Can you give examples of friendships you value?
- Who are some family members or intimate relationships from whom/which you gain support?

The Coping Self

- What leisure activities do you enjoy doing? What was the last time you took time out for these and how did you feel?
- What do you do when you encounter stress? What have you found that works for you? How do you remember to use these strategies?

The Creative Self

- When have you problem-solved effectively in the past?
- When have you expressed your emotions effectively in the past?
- When have you been able to control challenging situations in a positive way?
- What work habits do you have that you are proud of?

The Physical Self

- What strengths do you have in taking care of your body?
- What have you learnt about your physical activity routine/eating habits/sleep habits?
- What works for you in these areas?

It is rare that we will get an opportunity to ask all of these questions to an individual client and we do not need to ask them all as well. Additionally, these questions are not designed to be asked in a checklist format. Instead, we need to wait for an opportunity to present itself (e.g., a client is talking about their physical health), to ask the relevant strengths-based question ('What strengths do you have in taking care of your body?')

3.3 Providing interventions

3.3.1 Strategies for individuals

3.3.1.1 Strengths-based approaches

The following strategies are derived from narrative approaches (White & Epston, 1990).

People are more than their problems. Beyond every problem is a story of courage, strength and perseverance waiting to be shared. If we look at people and only see their problems, we will only be looking at half the picture. We will be missing opportunities to unravel the hidden capacities within people. This can be reflected in the kind of questions that we ask. Asking about problems is important. But equally important is to also ask about the person who is facing these problems. We can ask, *'Can you tell me how would the person who is closest to you, describe you? What would they want to tell me about you?'* 'What would I

come to appreciate about you if I got to know you better?'

Acknowledging and respecting the person as the expert on their lives. We can demonstrate this by reminding ourselves that while we may be more trained in our field, the client is living the reality of their lives. At no point, can we assume that we could know more or better than them. Asking questions instead of assuming the answers might be helpful for understanding this aspect. For example, if the client wishes to talk about how difficult and unfair the lockdown has been we may want to ask, *'How would you like me to help you?'* instead of using statements like, *'Let me tell you how to deal with this. Just stop thinking about all this. Going down this path is not going to be helpful to you'*.

Recognizing and identifying strengths, internal resources and capacity to cope. While people are struggling, it is difficult to sometimes recognize that they are trying hard and that they have internal resources such as resourcefulness, patience, perseverance, social skills and so on. Listening for and highlighting resources may help them acknowledge these parts of their identity. For example, we can make specific statements such as, *'Despite 3 of your neighbours refusing to help, you persisted with the effort and asked the fourth one. This tenacity paid off and you managed to get the bottle of milk for your daughter. It is so inspirational to hear about this' or using affirmative statements such as*, *'That must have been tough. I can see how doing … was helpful. It must have been hard but I think it took tremendous strength to do it'*.

Looking for 'unique outcomes'. This refers to searching for instances or situations wherein people have managed to escape the problem or resolve the problem, even if only for a few minutes. We could say, *'This is such a difficult situation that you have been facing for some time now. Could you tell me about a time you managed to get free of the problem for a few minutes?'* This question can allow clients to see themselves as people who have resources to fight their problems and the fact that they have been trying. This also lays down the groundwork for generating solutions and highlights the sense of agency that they have.

Listening for people's preferred realities rather than imposing our own solutions. Another aspect of acknowledging the expert position of the client is to deliberately let the client take the lead in solving their problems. We can convey this to the clients by using statements such as, *'I would like to hear what you think is important'* or we can say, *'I think you may have some important insights about how to manage anxiety, since you have been managing it for the past 5 years. We can try to explore how we can use similar strategies during the lockdown as well.'*

Empowering people to initiate their own solutions and mobilize resources. Generating solutions with the client, rather than offering our own, is the goal of our process . In the long run, it will be more helpful if the client can be empowered to work on their difficulties and mobilize resources. Empowering clients ensures that they are able to use their own resourcefulness, and thus has a positive impact on their self-efficacy. It may also serve as a model for problem-solving in the future. For example, we can say, *'Just as you were describing how you helped your cousin by encouraging her to file a complaint against the local miscreants, I was impressed with your quick-thinking in the situation. I was wondering if we were to use this quick-thinking right now, what would it suggest?'*

3.3.1.2 Supporting individual resilience

Moony and Padesky (2012) have suggested a model for building resilience, based on strengths-based cognitive behavioural strategies. The steps of the model are:

Searching for strengths: This would entail identifying strengths as described in the previous section. Preferably, we can choose to focus on

the strengths identified in one activity during this time. This activity can then serve as a key point for constructing the personal model of resilience.

Constructing a personal model of resilience: We can help the client with constructing their own personal model of resilience: a personal blueprint which they can use to understand the sources and acts of their resilience. This is done on the basis of the strengths identified and noted down during the first phase. For example, the client identifies writing poetry during the pandemic as a way for them to express themselves. We can introduce this process by saying, *'You might wonder why I've been curious about your poetry. In listening to you talk about this, I feel that you are quite resilient. Do you know what I mean?'* We can use this opportunity to discuss the concept of resilience and the client's understanding of the same. We can then continue by saying, *"It is possible that if we write down the process of what you do to help you in continuing to write poetry, despite facing challenges such as time constraints, lack of privacy and high workload, we might be able to translate this persistence in other areas of your life.'* We can then proceed to write down these processes in their own words and use their imagery and metaphors to make it more memorable. We may ask about the relevant emotions and beliefs that they hold deeply when talking about these resilient narratives. We can ask the clients to write or draw this plan out.

Applying this personal model of resilience to different life problems: Once this model is created, we can discuss how this may be helpful to maintain resilience in different areas of life where they may be facing difficulties. These challenges and problems are considered and written down. The model may be reviewed to brainstorm about how it can help in persisting their efforts in the face of obstacles. Sometimes, the ideas and metaphors in the model may also help them to consider accepting certain aspects of the situation that they may not be able to change. We may say, *"Can you identify any area of your life where you might be having difficulties and we can consider using this model?"* Once the client is able to identify it, we may say, *"What are the challenges, if any, that you can anticipate in using this model in this context? How will the metaphor of … that we have identified be modified to stay resilient here?"* The final step of the model, practicing resilience, may be outside the purview of our work in brief, telephonic counselling. However, we may assign this as homework. Clients may be asked to conduct experiments where the feasibility or utility of the model may be understood. We can ask the clients for a follow-up call to discuss this further.

3.3.2 Strategies for families

According to Walsh (2020), family belief systems can be a powerful source of resilience in the pandemic. Family belief systems are shared beliefs that a family has, rooted in their multigenerational and sociocultural context, which come to the fore in times of crisis.

In our interventions with clients and their families, we may first acknowledge and contextualize the difficulties they have faced as a family in the pandemic, by framing them as understandable. We may highlight that there are no easy solutions to the challenges that families may be facing. If we feel that the families are doing the best they can, we may want to bring this fact to their attention. In fact, we may be one of the few individuals to recognise, highlight and appreciate their efforts.

Family resilience can be further supported through (Walsh, 2020):

Making shared meaning of the pandemic experience. We can support clients to reflect on how their families are making meaning of the pandemic. For example, a particular family may have a shared story that *'The pandemic is occurring because of God's will'* and this narrative may help them cope. To explore shared meaning, we can ask, *'How is your family making sense of the pandemic? What is the story that is told about the pandemic in your family? What common beliefs do you and your family members share about the pandemic?*

What changes has the pandemic brought to the lives of people in your family? As a family, what new experiences have you had in the pandemic? What have you learnt in the pandemic?'

Supporting cultural and spiritual connections. Cultural and spiritual practices are valuable sources of support for many families in the pandemic. If clients mention cultural or spiritual practices that have helped their families, we can try to engage with these conversations instead of ignoring them. We can ask questions such as, *'Generally, when there is a time of great crisis or difficulty, how does your family seek solace? How has this practice helped your family in the pandemic? What meaning does this have for you and your family?'*

Supporting innovation. We can help clients find creative ways to celebrate important events with their families and loved ones that may have got interrupted by the pandemic. For example, we can brainstorm with clients how they can plan a birthday party or even a wedding ceremony that has gotten interrupted by the pandemic in a way that is meaningful for them. Innovation can also be supported in planning family gatherings. For example, in the pandemic, many families started playing games over online platforms.

Reflecting on time lost and found. In some ways, the pandemic has sharpened our awareness of the fragility of life and has reminded us to not take time with loved ones for granted. If appropriate, clients can be supported to reconnect with the past (e.g., reminiscing with family members over childhood memories, old photos, making keepsakes, recording life stories of family elders, tracing family history) and re-envision the future (e.g., Going forward, how would clients like to spend time with their loved ones? Is there something that, before the pandemic seemed unimportant, but seems important now?).

3.3.3 Strategies for communities

As mental health professionals, we can support resilience within our community as well. Thus, the intervention strategies in this section target our own communities. These have been adapted from Rosenberg (2020):

Shared discovery of resilience. We can make active efforts such as scheduling a dedicated time to meet as a community to discuss ways of coping in the pandemic. Such a meeting can be used to identify the sources of resilience for the community. Some questions that we may like to ask ourselves include, 'What do we do when things get hard?', 'What or who helps us when we face hard times?' and 'What would this experience mean to us when it ends?' We can identify personal or group characteristics that make us resilient, such as cooperation or creativity. We can also look at certain skills that we would want to learn from each other such as setting goals as a team, managing stress together, practising mindfulness together. The community could also co-create certain shared documents or written material together. For example, we can create a crowd-sourced bank of resources or we may choose to document our experiences in the form of a narrative that describes how we overcame this adversity as a community.

Cultivating a sense of community. Within our local communities, we can cultivate a sense of shared community by dedicating a short period of time to check in with other members, even if we may not know them very well. We can ask about the personal difficulties or successes our neighbours and friends experienced, even asking about how the new normal seems to be working for them. This may help in maintaining connections with other people in our communities. We can also try to develop and cultivate new relationships, such as becoming a part of volunteer groups or social clubs, through which we can connect with people who share common interests and purposes. Social media can be an important resource through which we can build connection in times of social distancing.

Let's Avoid...

Indiscriminately suggesting the same strategies with all clients. We may want to tailor our strategies for the clients instead of using the same ones for all. Some unhelpful statements which may be avoided are, "I have seen that deep breathing makes most people calmer. Let us try this for your anxiety. It worked even for me!".

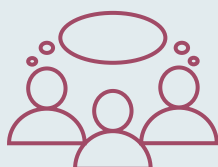
Making ourselves the author of the client's story. We may want to privilege some parts of the story while not wanting to focus on other parts. However, let's remember that we are co-authors, that is, we are writing the story with clients (following their lead, privileging their concerns, finding their voice) instead of writing for them (keeping our concerns at forefront, choosing the topics we want to work with, imposing our values and voice on them). We can avoid using statements like, "People all over the world are suffering currently. Instead of complaining about what you don't have, try to focus on what you have. I think that is more important at this time."

Expressing our enthusiasm inappropriately. Sometimes, looking at the client's efforts and strengths we may feel extremely excited and start gushing over the clients. This may make their stories of strength stand out in a way that they may not be comfortable with. They may also feel that we only wish to discuss positive aspects of their lives. Let's remember that we are mental health professionals, not cheerleaders or coaches!

Pointing out positives in a generic manner. We can build on the client's acknowledgement of their own strengths instead of simply pointing it out to them. Rather than giving generic compliments such as 'Good job!', we can highlight specific aspects, 'I noticed that you tried several different ways of getting the information you wanted and didn't give up.'

Jumping into developing the alternative story before the problem-saturated story has been explored sufficiently. Let's remember that it is only after hearing clients' problem-saturated stories can we authentically highlight what we felt were pockets of resilience that they displayed and expand on these experiences.

4. How do we reflect on our work?



Supervision

This chapter has highlighted how there are multiple ways of recognising and supporting resilience. It can be cultivated at the individual, family, community, organizational and systemic levels. As mental health professionals, we can also play an important role in cultivating resilience in the organizations that we are a part of. Peer supervision may be an avenue for discussing this:

- How can you initiate conversations about resilience in your workplace or with your colleagues?
- What is a small action that you could take to enhance resilience for yourself and other people you work with?
- What concrete steps could you present to organizational authorities to foster resilience that can be implemented in the short-term and in the long-term?

Self-Care Exercise

In the pandemic, many of us may have had experiences of loss, trauma and suffering. Sometimes, these problem-saturated stories can become the dominant stories of our lives. In this exercise, we are going to explore the alternative story of our lives in the pandemic that is not problem-saturated. To do this, we can think of writing a letter to ourselves documenting our experience of the pandemic. We may want to address this letter to our younger self who is yet to embark on this journey of the pandemic. Some prompts that may be useful for us may be:

- What were some of the challenges that we faced in the pandemic?
- What did we learn from this experience?
- Was there anything surprising/ unexpected?
- What were some of our skills that helped us during this time?
- What would we like to do differently?
- What were we grateful for during this time?
- Any special message that we would like to give to our younger self?

References

American Psychological Association. (2014). *The road to resilience.* Washington, DC: American Psychological Association. http://www.apa.org/helpcenter/road-resilience.aspx.

Balaji, M., & Patel, V. (2020, July 29). Mental Health and COVID-19 in India. *India Development Review.* https://idronline.org/mental-health-and-covid-19-in-india/

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.

Galatzer-Levy, I. R., Huang, S. H., & Bonanno, G. A. (2018). Trajectories of resilience and dysfunction following potential trauma: A review and statistical evaluation. *Clinical Psychology Review, 63,* 41–55. https://doi.org/10.1016/j.cpr.2018.05.008

Halpern, J., & Vermeulen, K. (2017). *Disaster Mental Health Interventions: Core Principles and Practices.* New York, Oxon: Routledge.

Hart, A., Heaver, B., & Eryigit-Madzwamuse, S. (2014). Resilience measures for children and young people: *A review for practitioners and community-based researchers.* University of Brighton, England.

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2009). *Intentional Interviewing and Counseling: Facilitating Client Development in a Multicultural Society* (2nd edition). Belmont, CA: Cengage Learning.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543–562. https://doi.org/10.1111/1467-8624.00164

Maddrell, A. (2020). Bereavement, grief, and consolation: Emotional-affective geographies of loss during COVID-19. *Dialogues in Human Geography, 10(2)*, 107-111.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56(3)*, 227–238. https://doi.org/10.1037//0003-066X.56.3.227

Masten, A. S. (2014). Global perspectives on resilience in children and youth. *Child Development, 85*(1), 6–20. https://doi.org/10.1111/cdev.12205

Mathias, K., Rawat, M., Philip, S., & Grills, N. (2020). We've got through hard times before: acute mental distress and coping among disadvantaged groups during COVID-19 lockdown in North India-a qualitative study. *International journal for equity in health, 19*(1), 1-12.

Padesky, C. A., & Mooney, K. A. (2012). Strengths-based cognitive–behavioural therapy: A four-step model to build resilience. *Clinical psychology & psychotherapy, 19* (4), 283-290.

Myers, J. E., & Sweeney, T. J. (2004). The Indivisible Self: An Evidence-Based Model of Wellness. *The Journal of Individual Psychology, 60*(3), 234–244.

Petzold, M. B., Bendau, A., Plag, J., Pyrkosch, L., Mascarell Maricic, L., Betzler, F., ... & Ströhle, A. (2020). Risk, resilience, psychological distress, and anxiety at the beginning of the COVID-19 pandemic in Germany. *Brain and behavior, 10*(9), e17-e45.

Pietrzak, R. H., Feder, A., Singh, R., Schechter, C. B., Bromet, E. J., Katz, C. L., ... Southwick, S. M. (2014). Trajectories of PTSD risk and resilience in World Trade Center responders: An 8-year prospective cohort study. *Psychological Medicine, 44*(01), 205–219. http://dx.doi.org/10.1017/S0033291713000597.

resilience during the coronavirus disease 2019 pandemic. *JAMA pediatrics, 174*(9), 817-818.

Shanahan, L., Steinhoff, A., Bechtiger, L., Murray, A. L., Nivette, A., Hepp, U., ... & Eisner, M. (2020). Emotional distress in young adults during the COVID-19 pandemic: Evidence of risk and resilience from a longitudinal cohort study. *Psychological medicine,* 1-10.

Sheoran, S. (2020, August 4). COVID Pandemic: Resilience holding the Indian community together in adversity. *Voices of Youth.* https://www.voicesofyouth.org/blog/covid-pandemic-resilience-holding-indian-community-together-adversity

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives. *European Journal of Psychotraumatology, 5.* https://doi.org/10.3402/ejpt.v5.25338

Ungar, M. (2008). Resilience across cultures. B*ritish Journal of Social Work, 38,* 218–235. https://doi.org/10.1093/bjsw/bcl343.

Ungar, M. (2011). The Social Ecology of Resilience: Addressing Contextual and Cultural Ambiguity of a Nascent Construct. *American Journal of Orthopsychiatry, 81*(1), 1–17. https://doi.org/10.1111/j.1939-0025.2010.01067.x

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process, 35*, 261–281.

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends.* New York, London: W. W. Norton & Company.

World Bank. (2020, April 11). In India, women's self-help groups combat the COVID-19 (Coronavirus) pandemic. https://www.worldbank.org/en/news/feature/2020/04/11/women-self-help-groups-combat-covid19-coronavirus-pandemic-india