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Telephone-based psychological crisis intervention: the Portuguese experience with COVID-19

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ABSTRACT

Portugal is one of the European countries that implemented early protective measures in the context of the COVID-19 pandemic. Portugal declared a state of emergency on 18 March, and a set of regional and national preventive public health measures was progressively implemented. Studies on the psychological impact of pandemics show evidence of the negative impact on mental health. Of particular concern are individuals with previous fragility (e.g. personal, family or occupational) and those undergoing life transitions. In this paper, we present a telephone-based psychological crisis intervention that was implemented to provide brief, appropriate, and timely psychological help. This intervention follows standard models of crisis intervention and is structured in five phases and five different intervention modules to take into account the impact of the pandemic on the mental health of specific risk groups. With these support services, we hope to help our community better cope with the immediate impact of the pandemic and to contribute to preventing serious mental health problems in the medium and long term.

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The pandemic in Portugal

In Portugal, the first case of COVID-19 was reported on March 2, and by 25 April, the updated epidemiological situation evidenced 23,392 reported cases and 880 fatalities related to COVID-19 in a population of 10 million (Directorate-General for Health, [DGH], 2020). On the same date, there were 1,040 hospitalized patients and 186 patients in intensive care units, and the mortality rate was approximately 3.8%. The gender distribution showed a higher prevalence of females (59.01%), and most patients were aged above 30 years (>80%).

Portugal declared a state of emergency on 18 March, and a set of regional and national preventive public health measures was progressively implemented. These measures included closing schools, nurseries, educational facilities, public spaces, and nonessential

shops (e.g. cafes, restaurants) and banning public events together with physical distancing measures, stay-at-home recommendations, national movement restrictions and confinement among other measures that aimed to contain the spread of infection (European Centre for Disease Prevention and Control [ECDC], 2020a). While these measures are needed to control the pandemic, they are associated with dramatic psychological, social, and financial costs, especially for more vulnerable people. These negative effects include the presence of fears (e.g. being infected or infecting others, death, helplessness), increased risk of mental and physical deterioration, social stigma and discrimination, all of which may have long-term lasting consequences for communities, families and the most vulnerable individuals (Reference Group on Mental Health and Psychosocial Support in Emergency, 2020). The fact that COVID-19 is an infectious disease, coupled with some suggested strategies for handling the outbreak (e.g. certificates of immunity, smart phone tracking of people) and social discourse centered on the idea that only fragile people become severely ill, may increase the burden of being sick and further contribute to stigmatizing patients. Even without this extra burden, all measures needed to contain the pandemic are highly demanding from a psychological perspective (“cabin fever” is a good metaphor for some of the stress). In addition to these costs, confinement at home increases family stress, and there is a global concern that family violence, as well as marital conflict, will increase, and increased rates of domestic violence are being reported around the world (e.g. China, France, Brazil, Spain, USA) (Campbell, 2020).

Therefore, the promotion of mental health has been considered a central component of the response to COVID-19 as a way to buffer the negative effects of the public management of the pandemic and the exacerbation of psychological suffering. There is also an expectation that good mental health fosters a population’s resilience in maintaining adherence to public health measures and simultaneously prevents psychopathological symptoms and psychological crises (ECDC, 2020b).

The psychological impact of the pandemic

Although preventive infection measures are important to contain the pandemic, they clearly pose common difficulties for all of us, and for already vulnerable people, they may constitute a burden that overcomes their coping abilities. Previous studies have shown that other infectious diseases that led to the imposition of similar social isolation preventive measures, such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), or Ebola outbreaks, were associated with increased anxiety, depression, post-traumatic stress disorder, feelings of anger and sleep disorders (Jeong et al., 2016; Wu, Chan, & Ma, 2005a). Moreover, these negative effects on mental health were observed not only during the outbreaks but also afterward, increasing the burden and the mortality risk of these diseases (Shultz et al., 2016; Wu, Chan, & Ma, 2005b). A recent meta-analysis conducted on the psychological impact of quarantine showed that longer quarantine duration, reduced social contacts, financial loss and stigma are associated with increased psychological distress, such as increased anxiety, depression, irritability, anger and sleep disorders (Brooks et al., 2020).

Several online mental health surveys have been carried out to evaluate the psychological impact of the COVID-19 outbreak across different countries. In China, a study that aimed to assess the psychological impact of COVID-19 on the general population found

that more than half of the respondents (53.8%) rated this outbreak as having a considerable psychological impact, with 16.5% of the sample reporting moderate to severe symptoms of depression and 28.8% reporting moderate to severe symptoms of anxiety. Moreover, symptoms of stress, anxiety and depression were positively and significantly associated with being female, being a student, physical symptoms and poor self-rated health status (Wang et al., 2020). This psychological distress is even more exacerbated when the mental health impact is assessed on samples of healthcare professionals, who face additional stressors. A multicenter study carried out in China with 1,563 medical staff documented a 50.7% prevalence of depression, 44.7% of anxiety, 36.1% of insomnia, and 73.4% of stress-related symptoms (Liu et al., 2020). Other studies addressing the immediate impact of COVID-19 have shown symptoms related to the fear of participating in daily routines (e.g. anxiety related to shopping or community events), feelings of insecurity related to personal health and a decrease in autonomy, and a sense of lack of personal control in daily life, together with uncertainty and concerns about economic and job issues (Zhou et al., 2020). Furthermore, several economic, psychosocial, and health-associated risk factors related to these pandemic scenarios may increase suicidal risk (Reger, Stanley, & Joiner, 2020), with some suicidal cases due to COVID-19 already being reported (Goyal, Chauhan, Chhikara, Gupta, & Singh, 2020).

Overall, this evidence shows the need to adopt universal measures that promote mental health in the face of the expected dramatic increase in psychological suffering and psychopathological symptoms, including persistent depression, anxiety, panic attacks, guilt over the effects of the infection, psychotic symptoms and suicidal ideation (Xiang et al., 2020). The absence of competent and effective psychological responses has proven to increase the risk and burden of psychological distress and severe psychopathology in populations under epidemic scenarios (e.g. Zhang, Wu, Zhao, & Zhang, 2020).

In contrast, some factors may promote resilience and reduce the risk of psychological suffering and psychopathology, and social support is probably one of the most important factors. In fact, meta-analytic evidence makes it clear that objective and subjective social isolation have an effect on physical health similar to well-known biomedical risk factors (e.g. tobacco consumption, lack of physical activity) (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Interestingly, in this meta-analysis, there was no difference between subjective and objective measures of social isolation, which suggests that the perception of social isolation may have the same effect as objective social isolation. Thus, as containment and social distance measures result in separation from others, ensuring some sense of connectedness may act as a protective factor. In addition to social support, other factors, such as the capacity to regulate emotions, to make adaptive appraisals, and to flexibly cope with problems, may also facilitate resilience and protection from the negative impact of stressful life events (e.g. McGiffin, Galatzer-Levy, & Bonanno, 2016; Palinkas, 2012; Palinkas, Petterson, Russell, & Downs, 2004). In particular, access to effective responses to personal, family and community needs as well as the perception of self-control over daily life experiences and adaptation to new life routines contribute to maintaining a feeling of self-continuity, despite the real or threatened discontinuity of immediate or long-term life projects (McGiffin et al., 2016; Palinkas et al., 2004). People with more instability in terms of these protective factors are at higher risk of developing psychological symptoms that, if not addressed, may evolve to more severe

psychopathology. In a pandemic scenario, many people may need psychologically oriented support either to mitigate the impact of risk factors or to enhance the available protective factors.

In sum, studies highlight the need to consider not only the immediate but also the long-term psychological impact of COVID-19 on personal, family and community lives and the urgent need to develop and implement mental health support and services in a timely manner (Courtet, Olié, Debien, & Vaiva, 2020; Xiang et al., 2020; Yang et al., 2020). Several online mental health services were widely implemented during the COVID-19 outbreak in China as essential measures for those in need of psychological support (Liu et al., 2020), with several hotlines and mobile applications being developed. Maintaining and fostering social contact with people who might be isolated and at risk includes developing integrated solutions, such as telephone-based interventions and digital solutions (Reference Group on Mental Health and Psychosocial Support in Emergency, 2020).

Telephone-based psychological intervention: a useful resource in times of pandemic

Communication technologies have been considered a useful resource to enable informal contact and social support, contributing to protection from the onset of psychopathological symptoms but also acting as an available resource for psychological intervention for people with anxiety, depression, post-traumatic stress disorder, and adjustment disorder (Varker et al., 2018).

Studies have supported the efficacy of cognitive-behavioral phone-based interventions for people experiencing anxiety, depression, and obsessive-compulsive disorder (Somer, Tamir, Maguen, & Litz, 2005). Several authors have also highlighted the need to adapt cognitive and behavioral interventions to the needs of the general population during pandemic situations, with a privileged focus on psychoeducational strategies that aim to prevent psychological suffering and promote well-being (e.g. Wang et al., 2020; Zhang, Ho, Fang, Lu, & Ho, 2014). A recent review of studies focused on the efficacy of telepsychology interventions with clinical populations of adults with emotional disorders showed that these interventions are promising (Varker, Brand, Ward, Terhaag, & Phelps, 2018). Different types of interventions using communication technologies have been reported in the literature, evidencing their effectiveness in the provision of mental health services in general and in epidemic situations in particular (Liu et al., 2020; Zhou et al., 2020). Providing synchronous telephone communication with people who are in need contributes to timely and responsive intervention, reducing social isolation and overcoming different types of barriers (e.g. physical, geographic, economic, cultural) (Martin, Millán, & Campbell, 2020). In the pandemic scenario, compliance with restrictive measures on physical and social contact hinders traditional face-to-face psychological services. Moreover, as the acute phase of the pandemic passes, it is very likely that people who are more vulnerable (both biomedically and psychologically) will continue to avoid face-to-face contact.

An SOS telephone-based psychological intervention

Addressing mental health, providing psychological support to the academic community, and maintaining respect for containment measures, on 18 March 2020, the Association of Psychology of the University of Minho launched the first Portuguese university telephone-based SOS psychological support for the COVID-19 outbreak, targeting the university community. This SOS telephone-based line was initially designed to provide immediate and free psychological support to university students who were in psychological distress and had no access to traditional psychological services as a way to help them solve immediate problems related to the psychological and behavioral impact of COVID-19 and to prevent the worsening of this impact in the medium and long term. This initiative was welcomed by the academic community and attracted the attention and interest of civil society. Two weeks after this SOS psychological support for COVID-19 was made available, it became clear that requests for help were motivated mainly by concerns about academic, personal or family stability and security. In addition, we received demonstrations of interest in access to this service from institutions in the surrounding region, which allowed us to open it to the civil community of the two municipalities where the University of Minho is located. A more focused and contextual response was developed in line with the specific needs of the population and with other existing responses from the municipalities (Braga and Guimarães) and following the Reference Group on Mental Health and Psychosocial Support guidelines to build in local care structures (Reference Group on Mental Health and Psychosocial Support in Emergency, 2020).

Over the course of a month, 27 accredited psychologists volunteered to participate in this helpline by offering two to three hours a week of psychological crisis intervention. Psychologists were previously integrated in different teams centered in different intervention domains (e.g. psychotherapy with adults, psychotherapy with children and adolescents, domestic violence intervention, educational and career intervention). Clinical psychologists have a predominantly cognitive-behavior orientation. These psychologists were trained with a manual that elaborated procedures for intervention in psychological crisis under COVID-19 (including the steps described below). There is a weekly supervision meeting with seven senior psychologists with experience in psychological crisis intervention, who have training and specialized practice in different psychological intervention domains. The SOS psychological support for the COVID-19 helpline operates from 9 am to 6 pm, Monday to Friday.

The core intervention of this telephone line follows a funnel structure of psychological crisis management (e.g. Meyer et al., 2005¹³, see [Figure 1](#)). More specifically, the contribution of the psychologists is organized into five different modules to address what could be the main difficulties associated with the pandemic and the current state of containment (see [Figure 1](#) and appendix 1).

We structured the interventions in five different steps personal introduction and establishing a connection; 2) evaluating and identifying problems or difficulties; 3) identifying resources and possible alternative solutions; 4) defining a realistic plan to implement immediately; and 5) terminating the session. In the following section, we describe this structure.

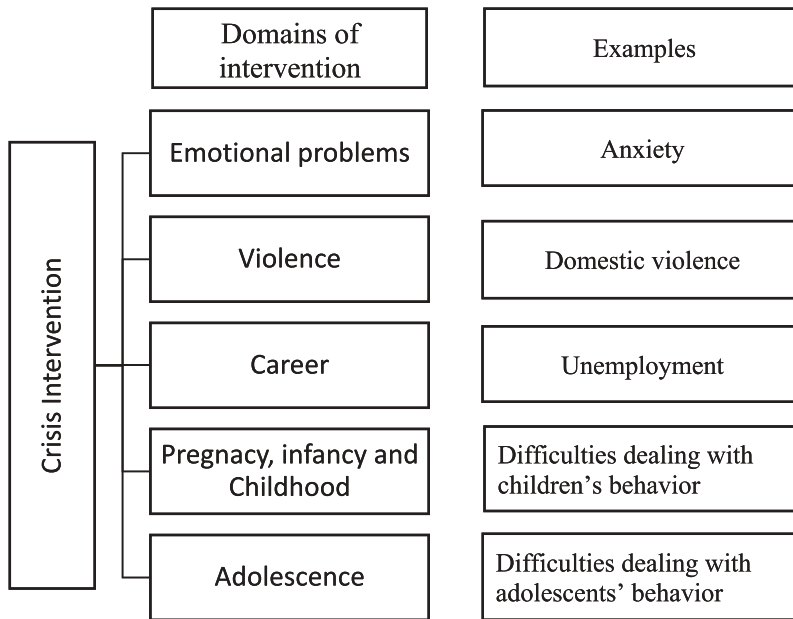


Figure 1. Structure of crisis intervention.

- (1) Personal introduction and establishing a connection: In the first phase of contact, it is vital to assess the client's level of emotional, cognitive and behavioral instability and disorganization. Understanding the person's degree of functioning guides the psychologist's decision regarding a more collaborative or a more directive stance to meet the objectives of crisis intervention. In this first phase, it is essential to establish empathic contact and ensure *presence* by using active listening skills, demonstrating interest in the person, and verbally encouraging the expression of the current difficulties. The main objective is to promote reassurance and help the person communicate calmly and maintain contact. It may be appropriate to stabilize the physiological symptomatology by guiding breathing, for example.
- (2) Evaluating and identifying problems or difficulties: At this stage, it is important to identify the problems that can be identified and with which it is possible to cope realistically in the here and now. For example, the person may be confused about what he or she is feeling physically and emotionally, concerned about whether and how to approach family members and how to protect them, ruminating about the impact of having gone shopping and the possibility of having been infected, or concerned about what will happen in the future in his or her academic or professional activity. At this stage, it is essential to accept, validate and normalize the person's experience. For example, in the case of concerns about his or her academic or professional future, the psychologist may reflect this experience: "I understand that you are feeling confused, with doubts and worries. . . . It is difficult . . . , but it is normal not to know how to deal with all the uncertainty derived from the impact of the COVID-19 pandemic".

- (1) At this time, it may be important to explain the adaptive nature of emotions by providing a brief psychoeducation (e.g. adaptive nature of anxiety).
- (2) Identifying resources and possible alternative solutions: At this stage, it is appropriate to foster hope, promote some sense of control, reinforce the temporary nature of the pandemic situation and focus on the here and now and what it is possible to do in the present (e.g. "We're all doing what we can to get this phase to pass. . . . Do the best we can with what we know now"). It may be appropriate to ask the person about familiar strategies that have worked in the past: "What has helped you in this pandemic situation or in other situations in which you have felt very anxious?"; "Of all these techniques that you usually use to cope with similar difficulties, what do you think is possible to do at this point in time?" and to suggest alternative solutions to the specific problem.
- (3) Defining a realistic plan to implement immediately: defining a plan of action, although simple, will help promote hope and personal organization, thus giving the person some sense of personal control (e.g. developing a plan with a timetable for the next 15 days and organizing personal routines, including academic or work routines, leisure, online meetings (chats) with friends, reading, watching a movie, and setting spaces and times for self-care and relaxation).
- (4) Terminating the session: Before finishing the intervention, it is important to stress the importance of having asked for help, encourage the implementation of the agreed-upon plan, and emphasize the importance of self-care and personal resources. Psychologists should ensure that the person is more stable and underline the availability of the helpline if needed again. Typically, the intervention lasts around twenty minutes.

The following clinical vignette with a fictitious client illustrates the different steps of the intervention. The specific step is marked in brackets and bold. The client was afraid of infecting family members who were dependent on her help, and despite implementing the recommended hygiene guidelines, she had much difficulty dealing with this fear, which had become very stressful, keeping her awake at night and very agitated. She decided to call, expecting to be helped to decide whether to continue visiting her family.

Client (C): Good morning. . . . I just called because I do not know what to do; this is very difficult. . . . I need you to help me decide. . . . I'm lost (the client presents vague and hesitant speech, expressing nervousness).

Psychologist (P) (speaking slowly): Okay, my name is Maria, I'm here with you. I am glad that you decided to call. . . . Can you tell me what's been hard for you right now? [**Personal introduction and establishing contact**].

C: I'm very distressed; I can't even think about it. . . . I'm very confused. . . .

P: Ok, I feel like you're very stressed. . . . Let's try to regulate your breathing so you can feel a little bit calmer. . . . Can you hear me well? [**Establishing connection**].

C: Yes, I can hear you.

P: Ok. . . . Please breathe in and out very slowly, note your diaphragm moving up and down. . . . Please follow my instructions (breathe in . . . , breathe out . . .). Ok . . . take your time. . . . I am here with you. . . . Maybe you can tell me now what is the main concern or problem for which you would like to receive help?

C: I'm afraid to infect my parents. ... They live alone and are dependent on my help. Every time I go to my parents' house, I wonder if I have carried the virus, and I can't sleep, I don't focus on anything. ... But I have to do it. ... They don't have anyone else to help them. ... I don't know what to do.

P: Okay, I understand. ... It is normal to feel some fear in this pandemic situation. ... Although difficult to experience, this fear can have a positive function. ... It is likely that it makes you more alert to protective measures ... to what you should do. ... Can we talk about what you know about the rules of hygiene you've been doing when you go to your parents' house? **[Evaluating and identifying problems or difficulties].**

C: Yes. I've been trying to be careful; we've defined a dirty area at the entrance of the house, and I always wear a mask and gloves. We never get close physically, and I'm there just as long as it takes to disinfect the groceries and tidy up what's needed. ... But then when I leave, I wonder if I did everything right; I mentally review several times everything I've done, and I'm very confused. ...

P: Ok, it looks like you've been doing everything very carefully ... but if I'm getting it right, the need to be sure makes you more insecure and afraid you missed something. ... It is likely that this mental check you mentioned will not help you. ... Do you have any idea what's been helping you get calmer at this point? **[Identifying resources and possible alternative solutions].**

C: I don't know; I think I am getting tired ... I just wish I had peace. ...

P: It is expected that you will get tired, exhausted, because what you are doing is very demanding. ... Maybe you can say something to yourself that recognizes what you are doing, like "I am doing the best I can, following what I know is safe in order to protect them. ..."

C: Yes, because I can't leave them either ... not going there would also be terrible.

P: Yes, this care is important to your parents and to you ... but you can't control everything, and it's expected that if you are sad or anxious, you're more insecure about the way you proceed. ... Maybe we can come up with a simple plan that will help you to better cope with your emotions and your limits. ...

C: Yes, that would be good. ...

P: My suggestion would be to make a plan of your daily routines in which your visit to your parents' home is scheduled at a time that is usually calmer for you. After leaving your parents' house, you should say to yourself, "I did the best I can; it's time to take care of me," and maybe you can do some activity dedicated to you. What do you think it could be? **[Defining a realistic plan to implement immediately]**

C: Maybe playing piano; that's something that relaxes me ... or calling friends to talk a little. ...

P: Great, taking care of yourself. ... Maybe you can define two or three things like this that make you feel calmer, identify which of your friends you would like to talk to. It can be important to regulate your breathing day by day, doing breathing exercises, like what we did at the beginning of our phone call. ... What do you think?

C: It sounds good. ... I can try. ... Yes.

P: Ok. ... How do you feel now? **[Terminating the session]**

C: Calmer, a little bit quieter ... more confident. ...

P: Ok, good. ... Maybe you can keep that feeling with you ... and you can call back whenever you need to. ... Can we finish?

C: Yes, thank you.

Potential and limitations of the intervention

An appraisal of the strengths and limitations of the present intervention invites consideration of a number of intervention and ethical issues. The intervention that we present is in line with the guidelines of psychological organizations (Portuguese Psychological Association and American Psychological Association) for providing appropriate psychological care through remote access, thus overcoming the limitations on face-to-face psychological intervention associated with measures to contain COVID-19 infection. On the other hand, as the line is free of charge, anyone who has a telephone, regardless of his or her financial position, can obtain psychological support when they are in need. This is particularly important if we consider that, due to the effects of mandatory confinement measures on the Portuguese economy, many families are currently facing difficulties in dealing with basic expenses, and these families can be more emotionally affected and benefit the most from crisis intervention.

Despite the empirical evidence that favors the efficacy of psychological intervention by telephone and the relevance of crisis intervention in preventing the onset or worsening of mental health problems, this type of intervention has several limitations.

Our experience, in the context of the SOS psychological support for COVID-19 helpline, shows that it is younger people (e.g. students) or people who already have some experience of psychological help (e.g. psychotherapy) who most often resort to the hotline. Stigma or misinformation associated with psychological help or unfamiliarity with this type of intervention may prevent more vulnerable people from asking for help. Thus, this type of intervention may not reach people who have difficulty asking for help, such as depressed or bereaved people who may experience helplessness and anhedonia that leave them in situations of greater isolation and risk. In addition, in line with recent findings about adherence to Internet-based psychotherapy (e.g. Arndt, Rubel, Berger, & Lutz, 2020; Schröder et al., 2017), we anticipate that negative expectations and attitudes or lack of confidence regarding the use of telephone interventions inhibit requests for help in crisis situations.

Another limitation is the inappropriate use of the line due to either inadequate expectations regarding the provided services or clients' personality characteristics. Clients who have experience with psychotherapy may anticipate that this crisis intervention replaces or follows the structure of help that they are accustomed to; thus, they may have difficulty understanding the psychologists' limited time and availability. On the other hand, knowing that this type of help is available at any time can generate some dependence on the service for emotional management and day-to-day decision-making in certain people. The awareness that they can connect at any time and whenever they need it may be perceived as a guarantee of available unconditional support, but it can inhibit the activation of personal resources and the implementation of agreed-upon action plans. According to our experience, these behaviors of apparent dependence are often associated with other behaviors related to difficulties in understanding and establishing interpersonal limits, sometimes creating an intrusive and inappropriate use of the line (e.g. requiring more time than what is defined).

This phone line is supported by volunteer psychologists who provide a few hours of their week to support it, so when people ask for help more than once, they may not be attended to by the same psychologist. Our experience shows that people who use the helpline more than once would like to be in contact with the same psychologist. Sometimes, due to the presence of severe psychopathological symptomatology or the impossibility of stabilizing clients in the context of crisis intervention, these clients are recommended to a more appropriate type of intervention (e.g. online psychotherapy). However, we find that some of them, even when they are already undergoing a regular therapeutic process, continue to use of the line, which raises ethical questions for the attending psychologist. In these situations, psychologists do not decline the appropriate help, but they should suggest that the person contacts their psychologist, trying not to interfere with the therapy process (e.g. "Ok, I understand that you are in pain now ... and it's been hard to deal with what's happening (...) it is important that you can talk about it with your psychotherapist").

These aspects also highlight the importance of relational bonding despite the brevity of this intervention and the need to take care of relational dynamics and ethical issues.

In our view, crisis intervention by telephone requires from the psychologist the ability to quickly identify the clients' main needs and to respond efficiently in a limited time. One of critical issues is related with acute crisis with the client expressing potential for harm to self or others (e.g. suicidal thoughts) or revealing risk of being abused (e.g. domestic violence). In these situations, the psychologist needs to demonstrate presence, be assertive and assure that at the end of the telephone call the client (or others) is safe and that the appropriate protection procedures will be implemented (e.g. involving significant others, referral to hospital emergency room or victim support office). For example, the psychologist might say "ok, I am here with you, I'm glad you called ..., please tell me where you are ... ?, Is anyone with you ... ?, I need the phone number of (a relative or friend), I must call for the emergency ... please what is your address?". The psychologist should inform the client that they will contact later to make sure he or she is safe. In addition, based on our experience, the supervisors should be available to support psychologists online in these critical situations. Although each module of the intervention manual includes a topic about critical issues and a list of appropriate resources and respective contacts (e.g. telephone number of hospital accident and emergency department), the weekly supervision is also the context to discuss technical strategies and the emotional impact on the psychologists of the acute crisis.

Regardless of the severity of the problem, balancing empathic understanding and responsive guidance or collaborative skills without exceeding the limits of appropriate professional conduct (e.g. not making decisions for the client or ensuring certainties that do not exist) requires competence and ethical responsibility. The psychologists must recognize the limits of the scope of crisis intervention, for example, resisting the impulse to deepen emotions and explore issues of the clients' life history that are not essential at the moment, as they will not have time to deal with the impact of those issues. For example, if the client calls for help after losing a significant person (infected with COVID-19), and says something such as: "I am feeling lonely ..., we always had a problematic relationship ... (crying) but now I don't know what to do ..." the psychologist can reply something such as "I think I understand you ..., this is a hard loss, it's normal to feel confused and sad now ... you're going to need time to give meaning to all of this ..., now

it's time to take care of yourself ... ", focusing on the here and now client's experiences and resisting to explore the history of relationship and the related emotions.

Our experience in the context of the weekly supervision of psychologists who collaborate in the SOS psychological support for COVID-19 has shown the importance of training in crisis intervention strategies as well as regular supervision. All psychologists who volunteered for this helpline attended a workshop on crisis intervention and studied a crisis intervention manual in the COVID-19 context, regardless of whether they had experience with previous psychological or psychotherapeutic interventions. In the supervision meetings, issues of a technical nature are addressed (e.g. discussion of the most appropriate strategies in specific situations, limits of intervention) as well as issues related to the emotional impact on the psychologists (e.g. feelings of helplessness, the limits of possible help, how to cope with situations beyond their control) and ethical issues (e.g. the overlap of psychological aid processes, identifying situations of risk and the need to break confidentiality). Needless to say, the psychologists who volunteer to provide services at SOS COVID-19 are obliged to maintain the privacy and confidentiality of all information to which they have access in the context of this helpline in compliance with the principles that regulate the practice of psychology in Portugal, as defined in the Code of Ethics. We truly believe that therapists' background, the regular supervision and supervisors' availability to support difficult emergent interventions are central issues for promoting adherence and intervention efficacy. We anticipate that other therapists who have a similar training and practice background, working in similar cultural contexts might use this intervention model, taking into account the specifics of people who ask for help and adapting it accordingly. One of the learnings that we draw from our experience in the context of this helpline is that the psychologists need to be aware of the potentialities and limits of this type of intervention, being flexible and responsive, doing the best they can to provide an adequate service, including maintaining access to support and supervision and taking care of themselves.

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Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributor

Eugénia Ribeiro, PhD, is the coordinator of the Psychotherapy and Psychopathology Research Lab of the Research Center in Psychology of University of Minho (UMinho). She is the coordinator of the Psychological Intervention of the Psychological Association (APsi-UMinho). Currently, she is the Master in Psychology's Director at UMinho. She is member of the Society for Psychotherapy Research and the Portuguese Society of Constructivist Psychotherapies. She is member of the editorial committee of international journals, *International Journal of Clinical and Health Psychology and Psychotherapy Research*, and *Associate Editor of Psychotherapy Research*. Her academic career has been dedicated to the study of the relational processes in psychotherapy, both from a macro and micro-analytical perspective. In recent years, its research program has been developed around the phenomenon of therapeutic collaboration and responsiveness, based on the model of therapeutic collaboration and its coding system (Therapeutic Collaboration Coding System) developed by her team.

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Miguel M. Gonçalves is Professor of Psychology at School of Psychology, University of Minho, Portugal. His main research interests focus on narrative and dialogical processes in psychotherapy. He and his team have developed the concept of innovative moment, as events in psychotherapy in which novelties to a previous problematic pattern emerge and contribute to meaningful change. This concept has been inspiring his research projects from the past few years, allowing the study of change, ambivalence to change and resolution of ambivalence. Despite his main research interest on psychotherapy, the concepts and methods his team developed to study the psychotherapy process, have been applied on other related domains, like vocational counseling and academic underachievement.

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