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How to Effectively Break Bad News: The COVID-19 Etiquettes

Bad news is defined as "any information that results in a cognitive, behavioural or emotional deficit in the person receiving the news that persists for some time after the news is received."[1] Effective breaking bad news (BBN) is a complex communication task. This complexity is compounded when less than one-third of clinicians are adequately trained in BBN.[2] In the clinical milieu, BBN not only includes death telling (as per popular perception) but also revealing test results, failure of treatment effects, disease recurrence, major side effects of drugs, and issues pertaining to hospice and resuscitation care.[2] Empathetic, honest, balanced, and unhurried communication (Cunningham's model) and actively involving the significant others while delivering bad news have been associated with healthier clinical outcomes.[2,3]

"How to effectively break bad news?" needs a redressal during the terra incognita COVID-19 pandemic, especially when more than 10.3 lakh victims (with > 26,000 deaths) have suffered in India.[4] Citing the highly infectious nature of the virus, numerous prophylactic measures have been deemed mandatory for health care professionals (HCPs). These measures, the new COVID-19 health care etiquettes, include personal protective equipment (PPE) such as cap, goggle, face mask, gown, and gloves that shield affective display, restrained time of contact, and those mini invisible barricades created by floor marks to maintain adequate safety distance. Surely, these are *barriers* for the ideal setting and skilled communication (e.g., pat on the shoulder) deemed essential by every recommended BBN protocol, be it the ABCDE model,[5] the SPIKES,[2] or the BREAKS.[6] As per the protocols proposed for breaking news of a death in a hospital or emergency set-up,[7–8] meticulous preparation, building a therapeutic relationship, skilled communication, dealing with family reactions (shock, denial, anger, and guilt), and validating emotions are the core strategies to execute BBN effectively.[9] However, the COVID-19 etiquettes pose a tough challenge to these steps. Furthermore, considering the anxiety and stigma around COVID-19, the emotional reactions can be extreme and need sensitive handling by HCPs.

Certainly, there is a need for customized BBN protocols for HCPs, especially of death due to COVID-19. We suggest five "COVID" practical recommendations that can be incorporated into such protocols:

1. ***C***ubicles and minimal PPE: Custom-made double (opposite) entry cubicles with a transparent partition, set up with a two-way audio/microphone-speaker system, may be used specifically for the BBN sessions. Adequate and periodic sanitization of the cubicle will be essential. Proper sanitization will

also allow the HCPs to deliver the BBN sessions by donning just a surgical mask. This will allow for better establishment of rapport and aid in developing optimal empathy. The usual protocol for BBN should be followed during the counseling session. The HCP delivering the BBN session has to be well informed regarding the patient's course of illness and hospitalization. These cubicles, set up at appropriate locations within the COVID-19 facilities, can, in fact, be used for psychological first aid of COVID-19-suspected cases as well.

2. ***O***n-admission: As soon as a patient, either COVID-19-suspect or COVID-19-positive, is admitted to the facility due to any indication, the relatives/caregivers should be counseled regarding the average duration of stay, possible therapeutic procedures to be conducted on their patient, and the prognosis. The contact number of the primary caregiver has to be compulsorily noted, and that person should receive at least 12-hourly updates regarding the patient's status through text messages. This will bring down the caregiver commotion to a large extent. A designated social worker may be posted at the COVID-19 center for this purpose.
3. ***V***ideo chat: The moment the treating team in the COVID-19 isolation-ward/ICU realizes that the patient's condition is critical, they should arrange for a video chat, on the patient's own mobile phone, with the primary caregiver. The two of them—the patient and the caregiver—should be encouraged to have an open conversation; the patient should be encouraged to discuss any pending issues with the caregiver. Utmost care should be taken to maintain privacy in such situations.
4. ***I***nformation or news regarding death: As soon as the death of a particular patient occurs, an immediate text message requesting the caregiver to visit the center urgently has to be sent. Information/news of death has to be given only during the BBN session. This task should be performed by the designated social worker. Alternately, when a personal visit by the caregiver to the center is not possible, the news can be broken through a voice/video call. Although certain suggestions for BBN "remotely" have been put forth,[10] they should be second in preference. For remote BBN, proper attention ought to be paid to the tone of voice. Usage of empathetic language with simple and non-ambiguous words and proper documentation of the conversation should be heeded to.[10] Recently, suggestions for BBN via telemedicine also have been made.[11]
5. ***D***ead body transportation and cremation/burial: As the emotions begin to settle down, towards the end of the BBN session, the procedure for transportation of the dead body and cremation/burial, as per the latest standard guidelines,[12] has to be explained carefully to the caregiver. This process further helps the clients to divert their emotions.

Within the purview of "how to effectively break bad news?" lies another vital question "Who can effectively break bad news?" Psychiatrists, by the virtue of their training in interviewing techniques and psychotherapy, have two significant roles in BBN—delivering the sessions themselves and training the HCPs in delivering the sessions.[13]

- With mental health and psychosocial support services deemed essential for COVID-19 care facilities,[14] COVID support teams have roped in psychiatrists. And pertinently, terming the role of psychiatrists during the pandemic as "crucial," several roles for them have been identified, including "facilitating problem solving" and "empowering families and health care providers."[15] Indeed, both these roles are inherent to the person delivering BBN and therefore make the context of BBN relevant to psychiatrists. Psychiatrists who are part of the COVID support teams can very well take up the role of providing BBN sessions themselves; critical-care teams could call them to provide BBN sessions. If not, and if psychiatrists are not available to the COVID-19 team, a liaison with telepsychiatry services may be undertaken. With a pandemic-prompted, first-ever telemedicine guidelines for India in place,[16] this liaising is practical as well as a logistic possibility.
- Having said this, we, however, believe that liaising with psychiatrists to deliver BBN directly should be considered a stand-by. Beyond doubt, the primary responsibility of BBN should rather lie with the principal critical care treating team. We also believe that the primary HCP teams will be able to deliver BBN more effectively if they undergo targeted training. For training HCPs in BBN, several learning modes and a range of teaching strategies, such as lectures, small-group discussions, and peer role-play, have been recommended.[15] In such training activities, psychiatrists should take the lead and be the principal resource personnel.

Building competence in dealing with such novel yet very challenging situations will enhance the quality of care and, therefore, improve HCPs' professional satisfaction. Currently, COVID-designated hospitals and facilities in our country must attempt to include BBN within their standard operating procedures. We believe that our recommendations will certainly be useful in such attempts.

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Ascending Child Sexual Abuse Statistics in India During COVID-19 Lockdown: A Darker Reality and Alarming Mental Health Concerns

Child sexual abuse (CSA) has been identified as a serious public health concern. This issue has been a global challenge. The World Health Organization (WHO)[1] defines CSA as a coercive act with a child who is unable to comprehend or provide consent, leading to serious physical or psychological damage. CSA includes sexual activities like inappropriate touching of private parts or indulging the child in touching the private parts of the perpetrator, molestation, sodomy, exhibitionism, pornography, and cybersexual acts.[2] It is considered offensive in every culture.

Prevalence rates of CSA range from 8% to 31% for females and 3% to 17% for males.[3] The highest rates have been reported for boys (<18 years) in Africa, i.e., 19.3% and for girls, in Australia, i.e., 21.5%. Asia has the lowest rates both 11.2% for girls and 4.1% for boys.[4]

CSA is linked with an adverse impact on the child's normal development and maturation.[5] It also affects neurobiological systems and endocrinological profiles. Such trauma experienced during the abuse has lifetime ramifications. The CSA survivors are at greater risk of developing psychiatric disorders, such as personality disorders. Moreover, the most common sequelae for adult survivors include developing into perpetrators and increased risk for relational violence.[5] About 37% of India's population comprises children under 18, with a large proportion of them lacking basic nutrition, education, and access to health services. Around 53% of Indian children reported experiencing different kinds of abuse, which included being forced to nude photography, assault, inappropriate touching, and sexual abuse.[6]

CSA During the Lockdown: Challenges and Possible Solutions

The pandemic situation is moving fast toward "an emerging social crisis." According to the American Psychological Association, there has been a spike in cases of intimate partner violence and child abuse in the USA during this "lockdown." The key risk factors include overstressed caregivers becoming violent or abusive due to economic crisis and children's restricted mobility as the schools are closed. The children are struggling to cope with an alternative lifestyle and the trauma ex-