

online counseling as secure were more likely to use it via instant message and video chat. Nowadays, the use of advanced Internet technology expands the variety of online platforms in delivering counseling services, including instant messaging and videoconferencing. Online communication platforms also give clients a sense of security to share sensitive information during counseling sessions.⁵ Young people may be more willing to explore and address topics that they feel ashamed to talk about in real-life settings. It is expected that online counseling can reach a much wider user community, including those who feel uncomfortable meeting in person, for mental illness prevention. Nevertheless, the anonymity and convenience of online counseling, which have been conventionally considered appealing to clients, were not significant factors motivating students to use online counseling services.

Distressed students who perceived their previous counseling experience as effective would be more likely to use online counseling services. Instead of benefits and channels of online counseling, distressed students were more concerned about the effectiveness of counseling, compared to those without mental distress. With a successful counseling experience, distressed students may feel more comfortable to try online services. In fact, some previous studies have shown the effectiveness of online counseling. For instance, it was found that young people who engaged and intervened online had a significant alleviation in emotional distress and social withdrawal symptoms.⁶ Another study has also demonstrated that online counseling reduced suicidal thinking among medical students.⁷ This information may further encourage distressed students to use online counseling services.

While more students are willing to utilize online counseling services, it is meaningful to advocate online counseling so it can be incorporated when developing student-centered support programs.¹ In fact, some non-governmental organizations have pioneered providing online counseling services in Hong Kong.^{5,6,8} Practitioners will inevitably encounter new technological challenges and ethical issues.^{8,9} Further research is needed to consolidate the experience and steer the counseling field in new directions. As the demand of mental health services has been growing in Hong Kong, online counseling will be a new alternative to meeting mental health needs in the future.

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Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1. The methods and results of this study.

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Acute impact of COVID-19 pandemic on phenomenological features in fully or partially remitted patients with obsessive–compulsive disorder

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Recent researches and observations have indicated that during the COVID-19 pandemic, a number of people have exhibited stress- or anxiety-related psychopathological features, including fear of becoming infected, fear of coming into contact with possibly contaminated objects or surfaces, fear of foreigners, fear of the socioeconomic consequences of the pandemic, compulsive hand-washing, checking and reassurance-seeking associated with possible pandemic-related threats, and traumatic stress symptoms about COVID-19 infection (e.g., nightmares, intrusive thoughts).¹ Fear and panic about COVID-19 can also cause an increased risk of developing mental health problems, such as depression.² Moreover, the high levels of fear of COVID-19 may cause irrational and unclear thoughts. In contamination-based obsessive–compulsive disorder (OCD) especially, overestimation of threat may include health-anxiety-based symptoms, such as obsessions with becoming ill or contaminating others.³

Additionally, the explicit recommendations by the health authorities on ways to deal with COVID-19's potential threats (including washing hands frequently and avoiding physical contact with other people and specific surfaces) often overlap in 'appearance' with OCD symptoms.⁴ Indeed, OCD individuals with fear of contamination may spend hours worrying about the possibility of contacting an infectious illness, avoiding potential contaminants (such as not touching certain surfaces or decreasing social contacts), and/or engaging in compulsive washing behaviors of different sorts (such as taking excessively long showers or spending hours washing or disinfecting hands).^{2, 4} Thus, in such a situation, OCD patients, especially those with contamination/washing compulsions, may be most sensitive and vulnerable to COVID-19 fears and at risk of deterioration or recurrence of OCD symptoms.⁴ The possibility has been suggested that OCD patients may change their symptomatic phenotype and the focus of their main preoccupations, or may add obsessions or worries about COVID-19 in addition to having greater hand-washing compounded by increased avoidance.⁴

To clarify the issues, we preliminarily investigated the acute impact of the COVID-19 pandemic on the changes of OCD severity or

symptomatology in 60 fully or partially remitted OCD patients (mean age = 41.5 years [SD = 7.9 years]; sex ratio (M/F), 25/35) consecutively treated for more than 3 years in our OCD clinic. All participants: met the DSM-5 criteria for OCD; had directly visited our clinic from 7 April to 2 May 2020 in the state of emergency in Japan; and provided us with informed consent to participate in this study. Of the subjects, 24 (40%) had fully remitted (FR) OCD (total score on Yale–Brown Obsessive–Compulsive Scale [Y-BOCS] < 8) and 36 subjects (60%) were assessed as partially remitted (PR; $9 < Y\text{-BOCS} < 15$),⁵ and their principle OCD symptoms were categorized according to the symptom dimension typology,⁶ such as contamination/washing ($n = 29$), aggressive/checking ($n = 20$), and symmetry/repeating and ordering ($n = 11$), at the latest assessment before the spread of COVID-19 (before December 2019). Their OCD symptoms were reassessed at the time when they came to our clinic in the state of emergency as described above.

The mean (SD) Y-BOCS total scores before and after the spread of COVID-19 were, respectively, 5.5 (1.4) and 5.7 (1.5) in the FR group and 12.2 (2.2) and 13.0 (2.3) in the PR group. Only four participants (one in the FR group and three in the PR group; 6.7%) exhibited additional or renewed OCD symptoms associated with COVID-19, such as contamination obsessions or washing compulsions, and no subjects exhibited the symptom transition of their principle symptoms. In addition, six of the participants (10%) experienced the deterioration of the symptom severity of OCD as assessed by increase of Y-BOCS total score > 3, especially the ‘time spent performing compulsions’ score rather than the ‘time occupied by obsessive thoughts’ score on the Y-BOCS without any significant differences in the prevalence between the FR (8.3%) and PR (11.1%) groups. All six subjects with deteriorated OCD, except for one assessed as predominantly having symmetry/repeating and ordering symptoms, had principle OCD symptoms associated with contamination/washing. Finally, those subjects with OCD symptoms badly affected by COVID-19 were significantly more likely to have higher trait anxiety, depressive status, higher prevalence of generalized anxiety disorder, and contamination/washing symptoms specifically associated with virus respiratory infection, such as influenza infections, at the assessment before the spread of COVID-19.

In this preliminary study, there were some crucial limitations, such as sample bias (only including subjects who had visited our clinic in the state of emergency), cross-sectional assessment, and low number of subjects. Moreover, determining the diagnostic threshold for OCD along with severity of OCD symptoms especially associated with contamination/washing symptoms should be substantially affected by the attention in the media, because excessive washing behaviors for more than 30 s has been recommended and endorsed by Japanese health agencies.

Nevertheless, at least in the acute phase along with fully or partially remitted samples, there may be some acute impact on the phenomenological features and severity of OCD. These findings seem consistent with the long-term stability of OCD symptom dimensions⁷ and also seem to support the possible inflexibility of symptoms, specifically biological bases of the long-term enduring symptom structure.⁸ Further studies are needed to prospectively clarify the longer-term effect of fear or anxiety regarding COVID-19 on the onset or deterioration of OCD symptoms in a larger number of subjects, including the general population.

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COVID-19-related stigma and its association with mental health of health-care workers after quarantine in Vietnam

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The coronavirus disease 2019 (COVID-19) global pandemic is affecting 210 countries and territories around the world. By the end of March 2020, the total number of infected cases had exceeded 3 000 000 with more than 200 000 deaths.¹ Vietnam is a low-resource country that has had a good response to the outbreak with only 260 cases and no deaths thanks to the highly restricted infection-prevention and control policy.² On 28 March 2020, the government of Hanoi locked down one of largest medical centers in the country, Bach Mai Hospital (BMH), after a large outbreak was detected in staff and linked patients.³ At the Center for Tropical Diseases where the first two cases were identified, all health-care workers (HCW) were quarantined for more than 3 weeks.⁴ The psychological distress of quarantine has been well documented and includes stress, anxiety, confusion, fear, insomnia, and post-quarantine-related stigmatization. This distress might impact HCW more severely than the general population.⁵ We aimed to measure the stigma experienced and its association with mental health problems among HCW after 23 days of quarantine at BMH.

We collected data from HCW between 26 and 29 April 2020. We developed a self-reported instrument that measures COVID-19-related stigma among participants. The questionnaires consisted of 12 questions with response options on a 4-point Likert scale. Responses were summed to calculate a total score; higher scores indicated a higher level of stigma (Table 1). We referred to Berger's HIV Stigma Scale for the wording of terms and phrasing of measurement items.⁶ Details of the methods are reported in Appendix S1. The validity assessment followed the COSMIN Risk of Bias Checklist (Appendix S2).⁷ The study was approved by the Director Board of BMH and all participants provided informed consent.

A total of 61 participants enrolled in the study; 82.0% were female and the median age was 32 years (interquartile range = 29–36 years).