COVID-19 Support Groups
A Resource Guide for Behavioral Health Practitioners

SSM Health

LIFESPAN RESEARCH FOUNDATION

"The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience".

—*Judith Herman*

This toolkit was created in response to requests from SSM healthcare workers *(HCWs)* for a scalable intervention to psychologically support staff amidst COVID-19. Our present circumstances are unprecedented and present unique challenges to providing interactive and high-quality support: limited behavioral health capacity, virtual interactions, challenges to basic needs *(e.g., childcare, health)*, and barriers to traditional support *(e.g., family/friends also under stress)*. Given this context, this document offers principles, key considerations, and an example structure for group support. **The primary aim of this toolkit is to distill best practice research into an actionable format to leverage group support capacity.**

This toolkit is not meant to be a shortcut guide on how to run support groups, nor on how to become a group therapist. The closer an intervention approaches individuals' raw and honest emotional experiences, especially under high stress, the more specialized training may be required. This is a primary bottleneck for scalability to emotionally support large populations. Therefore, this toolkit is primarily for trained behavioral health staff with experience running groups. In addition, the focus of this support model is not on 'debriefing' *(e.g., Critical Stress Incident Debriefing)*, as such interventions have mixed findings in the literature, and an overt focus on the details of a stressful event may be too stimulating for the narrator and fellow group members. This toolkit is also not meant to be a structured facilitation training manual, as some of that training is presumed, and behavioral health staff have diverse areas of expertise and styles that should enrich support groups rather than be homogenized. **This model is one of many tools in a multi-tiered approach of staff engagement (Fig. 1), recognizing that employees have diverse emotional responses and needs.** Empirically, there are five essential elements of immediate and mid-term mass trauma interventions that should be promoted: 1) a sense of safety, 2) calming, 3) a sense of self- and community-efficacy, 4) connectedness, and 5) hope. [1]

Groups can be powerful levers to manifest these elements and are most effective if part of a larger organizational network of support. The present model is tuned towards the active phase of COVID-19, but it's principles can be adapted for the post-active phases, in which significant support will also be required. This toolkit includes the following sections: Background *(page 2)*; Clinical Principles *(page 3-6)*; Support Group Logistics and Example *(pages 6-9)*; and Virtual Group Considerations *(pages 9-10)*.

Figure 1. Spectrum of Interpersonal Engagement During a Crisis

Everyone	Large groups	Small Groups	1:1
· System communications · Web content · Memos · Screensavers · Pre-recorded resources	· Virtual town halls · Interactive webinars · Schwarz Rounds	· **Support groups** · Focus groups *(e.g. mindfulness)* · Clinical groups *(PTSD)* · Peer-led social groups *(e.g. childcare at home)* · Rounding *(leaders, chaplains, others)* · Huddles	· Psychological First Aid · Care for the Caregiver · 24/7 hotline · Behavioral Health Staff · Chaplaincy · EAP · Manager check-ins · Peer support · Coaching

Low — Medium — High

Background

Despite present uncertainties, it is important to acknowledge that validated research has carefully considered this context before. COVID-19 is unfamiliar territory, but core principles for approaches and interventions are the same. Formative resources that inform this document are listed in the box, right, and are highly encouraged for further exploration.

Lessons from the prior SARS-1 pandemic are useful to consider. Long-term effects of SARS-1 were common in HCWs, but compared to non-SARS-1 hospitals were predominantly in the range of subsyndromal stress response syndromes – professional burnout *(30 vs. 19%)*, depressive and anxiety symptoms *(45 vs. 30%)*, increased smoking, drinking or problem behavior *(21 vs. 8%)*, and absenteeism *(22 vs. 13%)* [7]. That is, SARS-1 was associated with significant long-term

Key Points

- Experience from SARS-1 suggests that the primary target for intervention in HCWs may be to reduce pandemic-related stress, rather than solely on mental illness *(e.g., depression, PTSD)*.
- SARS-1 revealed unique stressors in HCWs related to pandemic infections disease compared to other conditions they typically treated.

Key Resources

- Essential elements of immediate and mid-term mass trauma intervention [1]
- Framework to promote coping in the face serious illness [2]
- The Psychological First Aid Field Operations Guide [3]
- An evidence-based approach to mitigating stress during the SARS pandemic [4]
- Resilience training in the anticipation of influenza pandemics [5]
- Practice guidelines for group interventions [6]

stress, but not with increased mental illness *(e.g., depression, PTSD)*. This suggested that rather than a model of clinical intervention for mental health problems, reducing pandemic-related stress should utilize a model of adaptation and resilience in psychologically healthy people [4]. Granted, the COVID-19 context will be more intense and longer in duration, so a mix of both models will be required. After SARS-1, chronic stress was lower in HCWs with longer healthcare experience and in those who felt effectively trained and supported by their hospital. Greater chronic stress was reported by workers who coped using strategies of avoidance and self-blame [7]. Aspects emerged from experiences with SARS-1 that distinguish the stress of treating a pandemic infectious disease from other diseases [4,5]:

- **Social isolation** – manifested by infection control procedures, interpersonal distancing and avoidance, stigma *(e.g., HCWs seen as community infectious risks)* and re-assigned to unfamiliar work groups.

- **Psychosocial stress** – family support typically buffers stress, but in SARS-1 it was HCWs with children who experienced higher levels of distress [8]. Presumably due to perceived risk of infecting loved ones, and conflicting views of family members as to whether the HCW should continue to work.

- **Work stress** – fear of getting sick, fear of getting patients and co-workers sick, rapidly changing state of knowledge, and treating ill colleagues was particularly distressing.

Clinical Principles

Efficacy of any group intervention depends on the goals and structure of the particular group and the characteristics of the individuals under consideration. Support groups bring people together with similar experiences to share their feelings, coping strategies, and to support one another amidst the shared context.

For many, support groups fill a much-needed gap between individual psychological treatment and the need for emotional support. **The primary goals of a support group are to help people connect and cope**. Other forms of interpersonal group psychotherapy focus more on change, when a recurring problem affects an individual and the goal is for that problem to shift. Support groups are primarily suited for issues and challenges that cannot be changed *(e.g., medical conditions, bereavement, COVID-19)*. Primary goals for a support group amidst COVID-19 include the following:

1. Provide a psychologically safe environment of mutual support
2. Validate and normalize emotions without overstimulating participants
3. Facilitate connectedness
4. Provide psychoeducation and skills for coping

> **Key Points**
> - The primary goal of a support group is to help people connect and cope.
> - The most important initial therapeutic target for facilitators is 'cohesiveness'.
> - Groups in the COVID-19 context will spend a majority of time in/out of the initial 'formation' stage of group development.
> - Facilitators should be on the lookout for how the 3 primary coping domains show up for group members.
> - Facilitators should avoid a 'debriefing' model for stressful events.

Therapeutic Factors

To achieve these goals, it is imperative to remind ourselves of the well-established therapeutic factors for group treatment [9]. These are the empiric mechanisms for positive change:

Cohesiveness	Gives members a sense of belonging, acceptance, and value, providing both a nurturing and empowering experience. This promotes security within oneself and in relationship to others.
Universality	Members recognize that others share similar feelings, thoughts and problems. Helps move members out of isolation and recognizing that others are willing to support them.
Altruism	Allows members to experience a sense of meaning and significance by helping other members. Recognizing they have something of value to provide fellow group members, they gain self-worth and confidence.
Instillation of hope	Creates a feeling of optimism about one's future and the ability to cope amidst a situation that will always be uncertain.
Imparting information	Educates and empowers group members with knowledge pertaining to their specific situation, whether it be information about a resource, coping skill, or someone's personal story of how they dealt with difficulties and experienced success.
Development of socializing techniques	Encourages and advances relating and social skills such as tolerance, boundaries, and empathy. This helps reduce isolation and promotes connection with others in more meaningful ways, which is generalized over time into one's life outside of the group.
Imitative behavior	Helps group members learn more effective ways of confronting problems and managing relationships by witnessing other members apply new and appropriate methods.
Catharsis	Release of strong feelings brings a sense of relief and allows for significant shifts in one's internal framework and ability to move forward adaptively.
Interpersonal Learning	Provides opportunity for group members to learn about relationships in times of crisis, in effect helping them develop supportive, authentic interpersonal relationships. Within the

	safety of the group space, members can openly share and communicate; in return, they receive support and respectful feedback.
Existential Factors	Involves one's individual journey to find meaning in their life. Includes the process of understanding and accepting the reality of the human condition. With each other's support, members learn to tolerate this reality and live with and through challenges. Recognizing that obstacles are not in the way of the path, but in fact are the path.

Different members benefit from various factors within the same group at different times. Therefore, facilitators should be attuned to recognizing factors and promoting them whenever possible. Of all factors, **'cohesiveness' is considered to be the most crucial in group experience** [10], as it imparts a sense of belonging that is one of the basic needs in Maslow's hierarchy [11]. Cohesiveness is thought to be a gateway for other factors, especially essential factors known to have high impact in groups, and likely amidst COVID-19: **universality, altruism, and instillation of hope**. Given that some support groups may have a 'drop-in' design, facilitators should aim to promote cohesiveness as an early therapeutic target. Evidenced-based techniques to promote cohesiveness are also part of standard group interventions:

- Demonstrate a supportive demeanor *(tone, posture, activity level)* – facilitator provides the initial model for a supportive relationship.

- Establish clear group boundaries and reinforce adaptive behaviors – facilitator "informs" the group about the safety of the setting.

- Respond competently to strong affect – facilitator models that strong affect can be tolerated, clarified, and utilized as a model of what others may be feeling. Competent management of strong affect in the group is a signal to members as to whether the group will continue to feel safe. When stressful events are shared *(e.g., patient death)*, the facilitator can validate and provide space for those feelings, and also redirect away from excessive details to avoid a 'debriefing' model and towards how the group might be able to support the individual.

- Give language to emotional experience – validates and normalizes emotional responses to transform "muddy" emotional experience into accessible language.

- Link group members' feelings or ideas – models the universality of emotions during crisis *(e.g., fear)* even though emotional expression may differ *(e.g., anger, sadness, guilt)*.

- Connect present feelings to common themes or metaphors – offers shared concepts for members to connect through.

- Ask for group input *(attitude of curiosity)* – facilitator models that empathic inquiry is supportive, and that the group is not the facilitator's didactic forum, the space is co-owned by all members.

Initial Stage of Group Development

Entering a group for the first time is anxiety provoking, both for the members and the facilitator. There are various stage models of group development, however under times of crisis *(e.g., COVID-19)*, **groups may likely spend a majority of time in the initial "formation" stage**. Most models agree that this initial stage is marked by themes of dependency and inclusion:

- **Dependence** – members look to the facilitator for approval, acceptance, and answers. They look to the facilitator *(and other members)* to determine how they should proceed, what they should talk about, and what behavior is "good" group behavior. This theme may be more pronounced in virtual groups, where the setting feels even more unfamiliar *(see the section titled "Virtual Group Considerations")*.

- **Inclusion** – the cadence of member participation may feel stilted as members orient themselves to whether this experience will be useful, safe, and inclusive. Ironically, groups may discuss topics of apparently little substantive value in an effort to explore safety and understand other group members. Dipping in and out of topics related to COVID-19 is healthy, a journey of building trust is often necessary before vulnerable information may be revealed.

General Coping Framework [2]

A framework of appraisal and coping with stress is useful for facilitators as they observe and understand individual members' responses. **Having a framework helps to conceptually organize how members are approaching stress in order to link and connect their experiences**. The stress process begins when a person becomes aware of a change or a threatened change in the status of current goals and concerns *(Figure 2)*. Appraisal includes an evaluation of the threat and its personal significance *(primary appraisal)*, as well as a perception of resources for coping *(secondary appraisal)*. Primary appraisal is influenced by the person's beliefs, values, and commitments. Physically entering the hospital amidst COVID-19 may be appraised by some primarily as inevitable harm, by others as a manageable threat, and still by others as a challenge to be overcome. All are valid and may co-exist to different degrees for the same person. Secondary appraisal is the extent to which the threatening situation can be controlled or changed by the individual. This can be influenced by factors such as one's self-care practices, established coping skills, work unit and/or social support, and ability to communicate workplace concerns.

Together, primary and secondary appraisal determine the extent to which a situation is determined as potentially harmful or positively challenging, and directly interacts with coping. **The most distressed members of a group will express significant difficulty with both appraisals.** For example, with the threat of infecting family members, a given HCW's primary appraisal may have high-value significance *(e.g., infecting an elderly household member)* combined with challenging secondary appraisal *(e.g., little social support, compromised self-care, mistrust of workplace leadership)*. Likewise, it is useful for facilitators to identify the primary coping domains members may be using or desiring:

- **Problem-focused**: Aims to remove or mitigate the source of the stress, consequently reducing the negative emotional response. Healthy examples include problem-solving, time management, and seeking information or assistance in handling a situation. Effective problem-focused coping involves a clear understanding of the source of stress and where action can be utilized. For example, an initial stressor of "I'm terrified I'm going to get sick at work" requires clarification, moving perhaps to a specific fear about PPE availability for their next shift they could ask their manager about.

- **Emotion-focused**: Seeks to better manage the emotions associated with the situation, rather than changing the situation itself. Healthy examples include emotional expression *(talking, journaling, art)*, cognitive reappraisal *(e.g., CBT)*, positive thinking *(gratitude, forgiveness)*, healthy self-talk, seeking social support, emotional regulation skills *(e.g., DBT)*, prayer, and meditation.

- **Meaning-focused**: Involves searching for meaning in adversity that draws on a person's beliefs *(e.g., religious, beliefs about justice)*, values, and existential goals *(e.g., purpose in life)* to motivate and sustain coping and well-being during a difficult time. Empiric examples include [12]:

  – **Benefit finding** – the most commonly reported type of meaning-focused coping. It involves seeking new benefits that come from a challenge, whether they be growth in wisdom, competence, better sense of what really matters, or stronger social relationships. Note that the impact of this coping typically occurs after a difficult situation, as an outcome of the experience, not necessarily during it.

  – **Benefit reminding** – individuals remind themselves of the possible benefits stemming from the stressful experience based on their past history. It mostly occurs during the stressful situation.

Figure 2. Coping Framework
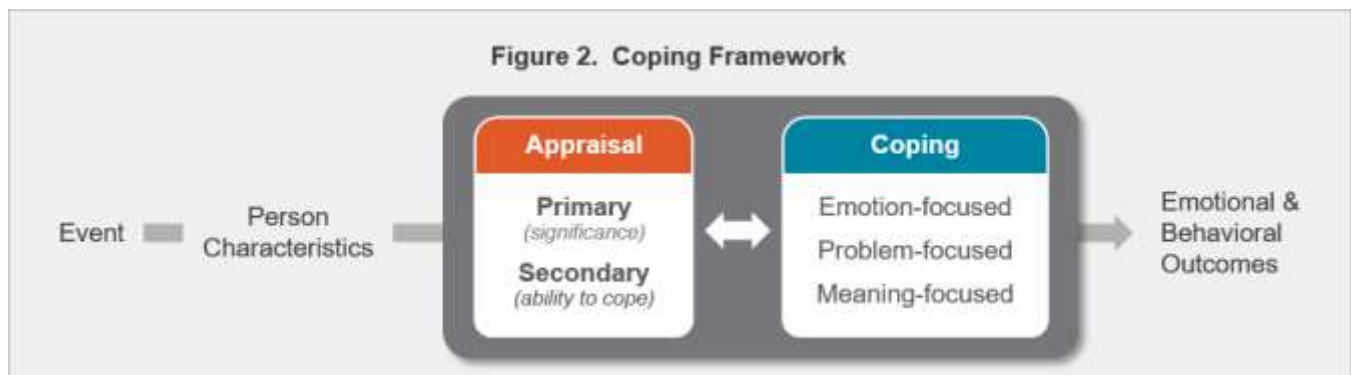
- *Adaptive goal processes* – reappraising goals in light of the circumstances, giving up goals that no longer work *(e.g., I like to grocery shop a few times per week for my family),* and substituting new goals that are valuable to the individual *(e.g., I will still aim feed my family well, but only grocery shop every 2 weeks).*

- *Reordering priorities* – a value-based process, which can be stressful in itself *(e.g., I must find new ways to obtain food). The reordering process can lead to increased coping efficiency by narrowing a person's focus (e.g., I will ask friends for any grocery delivery services that have shorter wait times).*

- *Infusing ordinary events with positive meaning* – re-framing commonly overlooked events to increase positive emotions *(e.g., gratitude, meal with colleagues, a beautiful sunrise).*

Support Group Logistics & Example

It is important to acknowledge that the process of organizing and running such groups will be anxiety-provoking for systems and facilitators. Therefore, networked support, communication, and shared learning are imperative to create a system that feels safe and sustainable. In addition, initializing such an effort requires a dedicated spirit of willingness – we are in largely unknown territory, so the 'right' answer will not always be available; we may have to *(intelligently)* try first.

Frontend Logistics

1. **Establish a network**: determine a local champion *(e.g., senior mental health professional)* to lead weekly facilitator meeting to process experiences, supervise, and share learning.

2. **Scheduling**: determine the times and audiences that will be offered group opportunities depending on the setting. Current experience reveals that lunchtime *(12pm),* near end of shift *(4-5pm),* and at-home after children to bed *(8-9pm)* are the prime opportunities for better attendance. A network of facilitators will have to decide their own mix of virtual drop-in, in-person drop-in, or dedicated closed ongoing groups for their target audiences.

3. **Recruitment**: advertising is everything. Utilize multiple outlets – email, web announcements, team huddle announcements, etc. Some current models have externally publicized these as pre-scheduled virtual 'chat sessions' to decrease stigma and increase accessibility *(see Marketing Example, next page)* [13]. One could also poll HCWs for interest and schedule preferences, and organize virtual group invites around role and schedule.

4. **Referral channels**: determine the accessible resources *(e.g., EAP, individual treaters)* to direct members to that may show concerning signs of depression PTSD, or other worrisome presentations.

5. **Liability & Documentation**: current understanding is that such a group model is not formal psychotherapy nor an interaction with patients. It is currently being practiced as a facilitated opportunity for colleagues to connect and support one another, and therefore doesn't require billing or formal documentation [14]. It should be an established principal that hospital administration is fully supportive of this group model as a means to promote an atmosphere of support and greater safety at the workplace. To that end, it is recommended that each institution should establish a mechanism for communication between hospital administration and group facilitators. This would ideally allow group facilitators to notify hospital administration of prominent themes that are voiced regarding safety concerns without compromising individual confidentiality. In addition, group facilitators will not be obligated to maintain confidentiality if there is a concern that a caregiver may be a danger to his/herself or others and should be

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Key Points

- Establish key 'frontend' logistics before starting a group, especially a networked peer or group supervision model for facilitators to support themselves in the work.

- To the extent possible, it is advantageous to have a more homogenous group by role and/or current clinical context.

- There are many ways to structure a group support session; there is no 'right' way. Facilitators should consider what approach and components resonate most with their style, so that their therapeutic presence can feel most natural and authentic.

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able to seek consultation with hospital administration to secure emergency treatment interventions for a distressed caregiver. If the goal is to run a closed group with specific member selection and screening, this is more in line with a group psychotherapy model, would likely require appropriate billing/documentation, and the group facilitator would assume professional liability as they would in their ordinary clinical practices.

MARKETING EXAMPLE

MD Chat Sessions
Free facilitated sessions to support each other during COVID-19

Please feel free to drop in virtually for noon sessions offered for 1- hour daily Monday-Friday. Stay for a minute or as long as is possible for you and come back as many times as you like. These sessions will be ongoing as long as needed.

All are welcome.

At times such as this we tend to forget about ourselves and focus on all the things we have to do for others. The hope is that by just chatting and sharing information we may do ourselves a bit of good.

This will occur via zoom and is meant to be a safe space to talk about how we are managing our currently stressful context.

We look forward to chatting with you starting **April XX from 12- 1pm**.

Session Facilitator: Dr. First Last name *(a staff psychologist at XXX location)*

Zoom link: https://zoom.us

Group Session Logistics

- **Participants** *(6 - 20 per group):* HCWs, residents, leaders, managers

- **Facilitators**: LCSWs, psychiatrists, psychologists, mental health counselors, etc.

- **Settings**: Virtual platform *(drop-in or closed ongoing group)*, in-person scheduled or drop-in *(e.g., LCSW in ER offers a check-in after change of shift or lunch break in the break room).*

- **Segmentation**: similar or mixed

  – Current understanding is that it may be more effective for groups to be more homogenous by role and with what challenges they are facing [13,14]. For example, in a virtual group combining nurses working on a COVID unit with nurses in an outpatient pediatric setting may not be advisable. The goal is for the shared discussions to be relevant and not too overwhelming for any subgroup.

  – If a particular work unit of mixed roles is already well-bonded, a group for that team may be advisable. Or if an in-person group is being organized on a unit, anyone may be welcome to attend.

Example Drop-In Group Session

Introduction

- **What it *is*** – This is a safe place to bring colleagues together where we can learn from and support one another through this crisis. People can talk as much or as little as they like.

- **What it *is not*** – Group psychotherapy nor a primary forum for administrative feedback. Issues regarding administration and leadership will of course be discussed, and the facilitator will prioritize encouraging group members to voice key concerns to their managers. In the spirit of promoting

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safety, a facilitator may communicate certain larger group concerns to administration while still honoring individual confidentiality and privacy.

- **Ground rules**:
  - *Confidentiality & privacy*: the facilitator doesn't keep any names and people can identify themselves as they wish. To honor those in attendance we ask that group members do not share anything outside the group.
  - *Respect*: In order for this to be a safe place it is important to have an environment of mutual respect, even if members have differing ideas and approaches.

- **Virtual tips**:
  - If running a virtual drop-in group, send an introductory template 'chat' to the group in the beginning, and if a new member arrives late *(see "Virtual Chat Introduction", right)*.
  - Run an initial poll and share the results with the group as a way to begin. Via Zoom, polls can be constructed ahead of time and easily launched *(see "Virtual Poll", right)*.
  - Ask members to 'rename' themselves on their video window if they would like to protect confidentiality and/or simply share how they would like to be called.

Beginning Phase

- Opening the group can take many directions, here are only a few:
  - A validating and normalizing statement of current stress amidst COVID-19, naming a wide range of potential feelings and hardships, and how we are all in a similar boat in this strange new reality.
  - Asking permission to run a brief mindfulness, reflection, or grounding exercise to center the group.
  - Asking the group what interested them in attending
  - Asking the group for anyone to start with how they've been feeling lately or what's life been like for them most recently

Middle Phase

- Facilitators should try to be as responsive as possible to whomever has spoken *(especially if virtual)* and work early to find commonalities between group members to promote connection and facilitate themes for others to further respond.

VIRTUAL CHAT INTRODUCTION

The goal of this group is to develop connection and support. You're welcome to stay as long as you can and speak as little as you wish.

Due to the virtual nature of this drop-in session confidentiality is not guaranteed, say what you feel comfortable saying

We don't keep attendance and all polls are anonymous.

Feel free to write your comments down in the chat box during the group.

Use gallery view on top right corner of your screen to see everyone on the same page or 'speaker view' to see only who is currently speaking.

Please feel free to email me for any feedback: name@email.com

VIRTUAL POLL

What would you like to get out of this group? *(anonymous poll)*

1. Connection with others
2. Share knowledge to help others
3. Learn how to cope better
4. Share a personal experience
5. To see what this group is about
6. None of the above
   (email facilitator or share with the group in the chat)
7. I am a repeat attendee

- You may find members express different feelings and ways of coping. For example, one member may be advocating for a meaning-based coping strategy, whereas another is simply not yet at that stage. This is expected and desired, the facilitator can react by making room for all feelings and differences, noting that it is helpful for people to illustrate the entire spectrum of response and coping to the pandemic.

- Look for and emphasize opportunities for personal control. Ask people to identify any personal strengths or behaviors they have used in the past to get through challenges.

Ending Phase

- Give a time-check warning and politely invite members to express themselves who haven't spoken to feel free to do so.

- Invite members to express any final thoughts, or anything that surprised them or that they learned.

Closing

- Summarize main themes and feelings noted by the group, again with an emphasis on validation, normalization, and commonality in such an uncertain time.

- Options also include a brief mindfulness, reflection, or grounding exercise.

- Inviting people to try anything new for this next week, or for the rest of their shift – connecting with a family member, coping skill, expressing gratitude, etc.

- If the facilitator ever feels it would be appropriate to follow-up with any group member after the session, they should do so. For example, on a digital platform, often a private 'chat' message can be sent to a particular member to request they stay online after others have left the session.

Virtual Group Considerations

1. **Shared control of the setting** – facilitators feel secure when they are in control of the therapeutic setting to ensure a measure of predictable comfort and safety for the group *(e.g., private room, chair arrangement, etc.)*. In the virtual world that control must be shared, the members must also arrange for a quiet room with full privacy and minimal interruptions, and surprises will happen *(e.g., cat jumps on the computer keyboard)*. A fundamental principle is that the facilitator should become very familiar with the digital platform they are using for two reasons:

   Key Points
   - In the virtual realm, facilitators give up some control of the therapeutic setting. We can adapt by thoroughly knowing the digital platform in use.
   - Facilitators will need to be more active in the virtual realm, and aware of the changes in nonverbal communication.

   a. *Full attention* – the group will need your full attention and being distracted with a platform's technology will compromise your therapeutic presence. For example, in Zoom, being able to adeptly switch screen views, mute or unmute participants, know preference settings to trouble shoot audio, and manage chat functions are essential.

   b. *Provide a safe environment* – this also means a technologically safe environment. Easily informing members of their options *(e.g., screen view, re-naming)* models that this unfamiliar virtual environment is safe and predictable to the facilitator, and also can be for the group.

2. **Disembodied environment** – novel aspects of online interaction include the absence of the body and intentional eye contact. In virtual settings, we lose much nonverbal communication and we can't actually tell who is looking at whom. Technically, no one is looking at anyone, since everyone looks at their screen rather than into the camera lens. However, there is more intense focus on faces for the entire group. Some suggestions:

a. *View & lighting* – Facilitators should have the camera at face level, mimicking a normal conversational view, rather than a 'laptop view' of the camera looking up and the facilitator's face 'looming down' on the group.

b. *Activity level* – Virtually, facilitators need to be more active. There is far more distraction *(e.g., background of each member's screen)* and members can't tell if you are nonverbally engaging with them. Therefore, use names often and keep in mind that your face is your primary means for nonverbal communication.

c. *Engage participants* – Ask the group about their experience of meeting virtually. This inquiry can generate interesting discussion around having more or less comfort with emotional expression and/or connectedness.

d. *Screen views* – Invite members to explore which screen view is most comfortable for them. For example, in Zoom, the gallery view is often preferred because one can see the entire group. However, some participants dislike the gallery view as it feels unnatural with a flavor of surveillance. The speaker view is actually more akin to in-person interaction, where you focus only on the face that is speaking.

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