Reflection of Types of Prosocial Behavior During COVID-19 in Collectivistic Asian Countries—India and Indonesia

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Abstract
COVID-19 is an infectious disease that has widened the gap between victims and non-victims in society. Understanding how individuals support and assist COVID-19 sufferers in a pandemic crisis is critical. Thus, this study aims to qualitatively evaluate the prosocial intention and types of prosocial behavior toward COVID-19 victims by low socioeconomic individuals from India and Indonesia’s collectivistic societies. We conducted semi-structured and in-depth interviews during the lockdown from March to May 2020, via phone and in-person, using a purposive selection of respondents (total n = 50). The data were analyzed using the qualitative synthesis method. Five themes were discovered: 1) too scared to help, 2) love to help but scared: moral dilemma, 3) informing authority who knows how to handle, 4) caring, sharing, and supporting, but with a distance, and 5) helping at one’s personal health risk. This study highlights that prosocial intentions range from minor acts of kindness to self-harm and out-of-bounds acts of kindness for COVID-19 victims.

Keywords
COVID-19, prosocial intention, low socioeconomic, collectivistic society

The COVID-19 pandemic that started in 2019 has gripped the whole world, affecting people’s lives. Even though everybody experiences the pandemic, different communities are affected differently depending on their socioeconomic conditions. Representatives of low socioeconomic backgrounds are more exposed to the consequences of the pandemic because of unstable work conditions, limited access to healthcare, financial uncertainties, poor housing condition, and overcrowding (Kantamneni, 2020; Kikuchi et al., 2021). Thus, the severity and uncertainty associated with the pandemic have generated anxiety and stress among people (Dean et al., 2021; Hagger et al., 2020; Pérez-Fuentes et al., 2020). Previous research suggested that perceived threat or stressful situation often triggers defensive mechanism and affects decision-making, psychological health, and prosocial action and intention (Nickels et al., 2017; Vieira, Schellhaas, et al., 2020).

Prosocial Intentions and Actions
The prosocial intention is defined as the willingness to be prosocial, that is, to perform actions that benefit other individuals or groups (Baumsteiger & Siegel, 2019). Research suggests that people’s intentions are direct antecedents of conduct and depend on their attitudes, perceived behavioral control, and subjective norms (Ajzen, 1991). Prosocial actions may be of different forms, such as providing aid, psychological assistance, and monetary help.

Researchers suggest that there are several benefits of indulging in prosocial activities. It facilitates social cohesion and group bonding, increases the feeling of self-enhancement, reduces stress, and increases positive affect and well-being (Grossman et al., 2019; Raposa et al., 2016; Weinstein & Ryan, 2010).

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Prosocial Intentions and Actions: During Crises

In diverse economic and cultural contexts, the inclination to help others may be ingrained in human beings because of the emotional factors it brings out (Aknin et al., 2013). Extant literature supports the idea that emergencies or crises can attenuate or leverage prosocial intentions and actions among individuals. Many competing frameworks suggest different levels (low, moderate, high) of prosociality during crises/emergencies. For example, the vulnerability framework highlights panic and selfishness that arise due to competition for resources (Brancati, 2007). This framework may explain why people engaged in stockpiling behavior during the early phases of the COVID-19 pandemic (Tse et al., 2022). The resilience framework suggests that crises give rise to prosociality and solidarity (Drury et al., 2019; Ntontis et al., 2018). This is because, during a crisis, there is a shift from “me” to “we” and support for each other. This results in self-categorization that potentially leads to prosociality and altruism. However, despite associated prosocial intentions, some actions can be risky during a crisis, causing risk to the helper (e.g., comforting COVID-19 sick friends/family members without wearing a mask or maintaining a distance). There can be two reasons behind these actions. First, this can be caused by intuitive, hot, and system one preferences, as the intuitive model of prosociality (Zaki & Mitchell, 2013) suggests. Second, this extreme prosociality might result from the adopted prosocial behavioral strategies from lower-stake settings in everyday life. This internalized prosociality is, then, sometimes used (overgeneralized) in high-stake situations where it is extremely expensive to help.

Prosocial Intention and Actions: COVID-19 Crises

COVID-19 is a novel, contagious and viral disease for which a vaccine is unavailable (this study was initiated in early 2020). To prevent the spread of infections, people are recommended to follow measures like wearing masks, maintaining physical distance, following hygienic habits, and providing long-distance care to the sick when required. Some countries have even taken extreme measures of complete lockdown (like restraining social movement). These combined restrictions and the fear of catching infection have psychological and economic impacts on individuals (Buheji et al., 2020; Pedrosa et al., 2020). Thus, COVID-19 is associated with a stressful situation. Extant literature found that the time since the pandemic began is associated with a high level of self-reported everyday altruism (such as offering bus/train seats to a stranger). This altruism may be due to the fulfillment of affiliative needs by “tending and befriending” during the imminent threat situation (Vieira, Pierzchajlo et al., 2020).

Many researchers pointed out that complying with the COVID-19 appropriate social behavior can also be seen as unselfish and prosocial (Dinić & Bodroža, 2021). In a trying time when people are advised to maintain physical distancing, researchers suggest that prosocial behavior may help improve bonding and the quality of life. It may also help reduce the impact of stress on emotional functioning. For instance, in a daily diary study from a sample of adults, researchers highlight that prosocial activities increased social satisfaction, positive affect, and well-being among participants on those days when they indulged in prosocial activities (Sin et al., 2021). Similarly, it has been proposed that prosocial behavior can be a promising intervention strategy for improving mental health (Miles et al., 2021).

However, studies during the pandemic either focus on prosocial activities preventing COVID-19 or everyday volunteering activities like donating food, money, or clothes or providing emotional comfort (Aresi et al., 2022; Drury et al., 2021; Mao et al., 2021; Tekin et al., 2021; Templeton et al., 2020). So far, researchers have not explored the prosocial intention among people when they come across a confirmed/suspected COVID-19 patient. Several newspaper reports highlight the stigma and ostracization of such individuals (Bagcchi, 2020). Besides, there is also the news of solidarity among people towards them. Thus, there is a visible paradox in people’s behavior towards COVID-19 patients. On the one hand, helping individuals might reduce their stress. On the other hand, helping may increase the possibility of catching and spreading the infection (if handled inappropriately). If prosocial action/intention is considered a stress reducer, then the inability to help may facilitate emotional load among individuals.

This article aims to explore the prosocial intention of people of low socioeconomic group in a collectivist society toward COVID-19 suspected/confirmed individuals. We also find out the kinds of prosocial actions they take in such a situation.

We have specifically chosen collectivist societies because in a collectivist society, a sense of duty towards one’s group, interdependence with others, and a desire for social harmony and conformity with group norms are essential (Triandis, 2018). Researchers have found that people in a collectivist society are more familiar with helping others, even when the needy are personally responsible for the assistance (Mullen & Skitka, 2009). A cross-cultural study across 63 countries found that collectivism exhibited a higher empathy and prosocial behavior. Researchers argued that this might occur due to the difference in individualist and collectivist values ingrained in the early socialization environment (Chopik et al., 2017). Similarly, it was also found that collectivism is associated with the manifestation of prosocial
behavioral tendencies among Greek young adults (Lampridis & Papastylianou, 2017). Thus, we believe that during COVID-19, irrespective of how individuals get infected, the prosocial intent of people in collectivist societies is an important aspect to capture.

The other factor that influences prosocial behavior is socioeconomic status. Studies on the relationship between socioeconomic status and prosociality are replete with mixed findings. On the one hand, Piff et al. (2010) observe that people from low socioeconomic classes, who experience greater exposure to threats, display prosociality, possibly due to greater egalitarian values and compassion. On the other hand, a series of studies conducted by Komndörfer et al. (2015) found that the low socioeconomic class spent a lower percentage of their income on philanthropy and are less likely to make donations than their counterparts from higher strata. However, recently it has been observed that the relationship between prosociality and socioeconomic status is mediated by a kind of social identity (Wang et al., 2021). It may be argued that people from the low socioeconomic level in a collectivist society during emergencies relate more to their fellow representatives who experience similar adversities (e.g., limited resources) and hence share an emergent identity and support each other for different types of needs in many ways. Thus, in collectivist countries like India and Indonesia, where there is a large population from the low socioeconomic strata, understanding the prosocial intention may be crucial to curb the deleterious consequences of the pandemic. Also, these approaches bring out varied forms of helping, which will be necessary for enhancing social behavior intervention programs.

**Importance of the Study**

Since prosociality during crises can range from low to extreme prosocial behavior, we have limited understanding of individuals’ prosocial intentions and actions towards COVID-19–infected patients in the context of the competing reactions (vulnerable/resilient). Also, most of the research in prosociality focuses on normative groups, either in general environments or in short-term emergencies like an earthquake, and relatively less attention has been paid to studying prosociality among marginalized/minority populations in a country or various countries. This study has bridged this gap by considering prosociality among people from the low socioeconomic level in collectivist countries like India and Indonesia during a long-term crisis like the COVID-19 pandemic. This study’s unique feature is exploring prosociality pertaining to COVID-19–infected (confirmed/suspected) individuals. The present study employed the qualitative method to understand an individual’s prosocial intention and actions towards confirmed/suspected COVID-19 patients. The qualitative approach is particularly suitable for exploring prosocial intention in the ongoing context of the pandemic in a natural setting. With the help of probing questions, qualitative interviews enable the creation of detailed and contextual information about a person’s experience, beliefs, and perceptions at this time. The qualitative findings are supported by data from two different countries, India and Indonesia, displaying common features like collectivism and the presence of a large low socioeconomic group.

**Methodology**

**Aim**

We investigate the prosocial intention of people from the low-income group during the pandemic in the collectivist societies (namely, India and Indonesia) towards confirmed/suspected COVID-19 patients.

**Setting**

This qualitative study is set in the district of Indore in the state of Madhya Pradesh, central India, and in the administrative city of South Jakarta, Indonesia.

In India, restrictions in public gatherings, dining in or non-essential businesses were invoked from mid-march. On March 22, 2020, a 14-hr-curfew was observed, followed by a total lockdown. In Indore, India, all kinds of public gatherings (at shopping malls, places of worshiping, etc.) were prohibited, and a stay-home order was in force. Those traveling outside for an emergency were advised to use masks (preferably reusable so that surgical and N-95 masks can be available to the healthcare professionals, some of whom were also advised to use the personal protective equipment kits), hand sanitizers, and to maintain a distance of 1.5–2 m from each other. Shops for emergency goods (e.g., food and medicine) were open for a restricted duration. Testing, tracing, treating and isolating cases, quarantining contacts, widespread mask wearing, and social distancing were, and still are, the tools for transmission control (Past Events | District Indore, Government Of Madhya Pradesh | India, n.d.).

In the state of Jakarta, a state of emergency was declared from March 20 to April 19, 2020. To prevent spreading the disease at the mass level, the government applied “large-scale social restrictions” (in Indonesia, it is known as Pembatasan Sosial Berskala Besar, PSBB). This restriction stated that all public transportation options must operate with reduced hours and capacity. Non-essential businesses and stores were closed. Restaurants and food stalls were open for takeaway and delivery only. Markets and essential industries could remain open, enforcing social distancing norms. Depending on the area,
private transportations could carry a limited number of passengers, and an obligation to wear masks in the vehicles was in effect. Mass celebrations of festivals were banned too. Masks (preferably reusable so that surgical and N-95 masks can be available to the healthcare professionals) and alcohol-based hand sanitizers/soap were advised to be used to frequently clean hands, and social distancing was highly recommended (Djalante et al., 2020; Mantalean, 2020; Umah, 2020).

Research Team and Reflexivity

The research team comprises two female and one male researcher, all trained in qualitative research. SKM is a Human Resource Management professor who worked and lived in Indore (India) for 11 years at the time of study conduction. SS is a Doctorate in Psychology and works as a research associate with SKM in Indore (India). DA is from Indonesia and did her postgraduate in International Human Rights. She worked as a freelance writer, translator, and social media administrator for many years in Indonesia. At the time of the conduction of the study, all the researchers were located and were familiar with their place, and collected data from the same place.

Sampling and Recruitment

We selected the participants based on pragmatic and convenience criteria (access, feasibility, interest, and time). Before the COVID-19 crisis, all the researchers had regular contact with some participants. security and gatekeeping, food delivery, and bus driving were common professions of these participants.

Due to lockdown restrictions, semi-structured and in-depth interviews were conducted by phone or in person whenever possible at a time appropriate for participants between March 18 and May 31, 2020. In Indonesia, 25 people participated in the research in a one-to-one interview format. Interviewees lived permanently in areas of South Jakarta and had an annual income of less than $3500. Most interviewees lived in a family of 3–4 members. In general, the average population of South Jakarta is 2,367,002 (Males = 50.05%), and nearly 9.12% of the population falls in the age group of 35–39 years (India - C-14: Population in Five Year Age Group by Residence and Sex, Madhya Pradesh - 2011, n.d.). For the demographic profile of participants, refer to Table 1.

The sample size was determined according to the principle of data saturation, which is achieved via information redundancy. When the researchers heard the same comments again and again, and no new information was identified during the data collection procedure, the recruitment of participants for interviews was stopped (Sandelowski, 2008).

Ethical Consideration

This study is a part of a larger study. The Institutional Review Board ethically approved the study. Researchers explained the research goals and the voluntary nature of the research to the participants and obtained verbal consent before face-to-face/telephonic interviews. Confidentiality is ensured by using numbers instead of names (e.g., IND1, IND2, …, for India and INDO1, INDO2… for Indonesia) and removing identifying information from the transcripts. All recordings and transcripts are saved in a password-protected computer, and the obtained data will be disposed off in 5 years after the research and publication procedure is completed.

Material

Respondents’ age, gender, marital status, occupation, and education were recorded before the interview. The following questions were used as a guide during the semi-structured interview: “If you saw someone who seems to have been infected with COVID-19, how do you think you would react? If someone in front of you, like me, needs help but seems to be sick with COVID-19, what would you do? How, in general, would you help someone who is infected with COVID-19?” The verbal structure of the questions was changed according to the language used during the interview. Besides, the order and flow of the interview differed according to the interviewer. Probing statements, such as “Please tell me more about that,” were used to enhance the depth of the discussion.
Data Collection

Before interviewing, we described the study’s goal to each participant and obtained their consent to record the interviews. Interviews were recorded using a Sony digital voice recording device in India and a mobile recording app in Indonesia. Participation in these interviews was voluntary, and no monetary or in-kind remuneration was offered. Participants were assured that their information would be kept private. The information was gathered in their native language. In India, the language used was Hindi. In Indonesia, it was Indonesian. Each interview lasted between 20 and 50 min until there was information saturation. The interviews were initially transcribed verbatim in the participant’s language. Later, it was translated into English. We followed the back-translation process (Brislin, 1980) to translate the transcripts into English. Professional language translators were used for the activity.

Data Analysis

We used the qualitative synthesis method to analyze the data (Troman & Jeffrey, 2007). This method is useful for cross-cultural projects and helps manage and map the data from diverse research teams. The current research aims to find shared prosocial cognition (intention and actions) among people from low socioeconomic levels in collectivist countries. Hence, this method is well adapted for synthesizing ideas and practices across countries. In addition to that, because of the COVID-19 crisis, this strategy is adaptable and well-suited for research teams unable to meet in person. The method requires that each partner data set be considered as data that must be processed, analyzed, interpreted, and then themes/categories are defined. The results are then compared, refined, and distilled in the analysis.

The data sets from partner countries (India and Indonesia) are included in the study data corpus. Each data set includes transcribed interviews (in English), demographic data (age, gender, occupation, and marital status), and reports (memos, observations, and other points) from partner researchers. In the first step, we used the NVivo 11 software to undertake open coding that began with a thorough reading of the data set from partner countries. These codes were referred to as features. The coder was primarily concerned with identifying features in the data set associated with prosocial intents. The same coder then carried out the initial comparison analysis. It entailed two different analytical approaches. To begin, the coder chose all the common features from the data sets and did a collective synthesis. These features were then classified into higher-level categories. Second, in grafted synthesis, the coder selected an idea from a partner’s data set and conducted a search to develop its characteristics from other partners’ data sets. It is possible that the data set of a partner does not contain an absolute concept, but it does have examples of its existence. The categories derived via collective and grafted synthesis were combined to form different themes. Participants’ quotations are presented to illustrate the themes derived from the study. After the thematic report was completed, it was sent to the partners for validation. Research partners examined the themes and their interpretations in detail throughout this procedure. All the arguments about the themes’ validity, inclusion, and analysis were discussed. All inaccuracies were discovered, and an analytical research report was generated, which was evaluated by all the researchers. Finally, the report for the last audit was sent to an anonymous researcher for their opinion. The final report was created after incorporating all the changes. The themes and codes were then presented, and quotes were added to highlight them. Where necessary, edits were made to correct grammar and eliminate redundant words. See Figure 1 for a schematic representation detailing the steps involved in data analysis.

The qualitative methods and corresponding analytical strategy used in this study are not intended to accurately estimate the participants’ actual prosociality prevalence. Due to the nature of the interviews, the content and the amount of time spent exploring the prosocial intentions and actions of each participant differed greatly based on their own salient concerns. So, following the usual research practices, no prevalence figures were computed. The objective of the current study is to produce insight into prosociality, for which qualitative approaches are appropriate. It is worth mentioning that each theme is identified based on its importance and the emphasis given by the participant. Further, each theme is discovered in at least four interviews (2 each from India and Indonesia, except in gender difference sub-theme 2a).

Rigor and Quality Criteria

The trustworthiness of this study was established using the following four-dimension criteria: credibility, transferability, dependability, and conformability (Lincoln & Guba, 1985). Obtaining participants’ approval, describing the studied phenomenon in detail, analyzing the data with the NVivo software, comparing the results with previous research findings, discussing with the research team, and utilizing the experiences of the researchers were all used to achieve credibility. A detailed description of the research sample, setting, and process was provided to ensure transferability. Besides, participants’ intertextual statements were directly quoted. Dependability was ensured through partner researchers’ themes and the validation of categories. Besides, the data corpus, data
collection tools, initial analysis, and final inferences were sent to another researcher not involved in the research. Throughout the project, conformability was maintained by considering each researcher’s reflecting comments and point of view.

Results

The findings of this study are summarized under the themes and categories. We pulled out five broad themes from the data to explain participants’ willingness to become prosocial towards confirmed/suspected COVID-19 patients in India and Indonesia (Refer to Figure 2).

Theme 1. Too Scared to Help

Theme 1 highlights that prosocial intention may be very low during emergencies. In the low socioeconomic group, the fear of catching infection associated with other secondary sources of stress such as unemployment, shortage of daily supplies, and limited access to healthcare may increase the perception of threat, thereby reducing prosociality. This is consistent with the vulnerability framework that reveals that people tend to panic and act selfishly due to stress (e.g., competition for resources). For instance, some participants in the study report pessimism in helping COVID-19 patients or suspected individuals. They believe that no one can help these individuals at this time. Besides, they are afraid of their own health as it is a contagious disease. We further observe that the prosocial behavior of these individuals depends on social approval. That means they may be motivated toward prosocial behavior when they see other people are doing prosocial activities and that society is not ostracizing them.

Contagious disease. IND 13: In the current scenario and situation, I don’t think I will be able to help the patient. It is such a pandemic that no one can help or accompany others with a positive case. 5-year old children are going all alone to hospitals, and no one is accompanying them. IND 15: No, no, I’m scared! Just seeing someone cough, I already feel a phobia. . . Because to deal with infected people we have to wear complete, right. We can’t just touch people. If we touch our face, body, or clothes, it’s dangerous. We never know.

Behavior depends on “social approval”. IND 19: When a person is diagnosed positive, others will keep their distance from him/her. Even if s/he is cured, people will stay away from him. I have read several cases in the newspaper where a COVID-19 survivor was not accepted even by his/her own family. Life will be tough.

INDO 23: (chuckles) It’s kinda scary if somebody collapses because of Corona. What are we gonna do? We have to keep our safety too. We can’t . . . the bystanders would also stop us. . . we can’t.

Theme 2. “Love to Help but Scared”: Moral Dilemma

Under this theme, participants described that they wish to help people but are scared that they might be infected by it. However, not helping people clashes with their moral and religious code of conduct. Here, participants reflect stress in deciding what to choose and display an emotional state of fear mixed with compassion. Thus, participants display prosocial intentions but fear that they cannot exercise them.

IND 11: We shall try to save that person. Will feel sad too. But we will certainly try to save, too. But recently I have heard that we should not touch these persons. So, that is a big problem.

INDO 1: Well, honestly, 1 day, if someone asks for help, I would be torn into two.

I would love to help, but I’m scared . . . Helping others is an obligation. But in this time of Corona, we have to be careful. . . I’m sure that if there’s anybody asking for help but we refuse to help, this is what I learn from my religion, then we are sinful. We have to help (those in need) even if they don’t ask for help.

a. “Love to Help but Scared”: Females’ Concern for Family

Further, a gender difference is observed under this theme, as females felt more scared to help due to their family and home responsibilities. This may reflect their crucial role in the household affairs of the families belonging to the low socioeconomic level in a collectivist society. Females in these families are more, if not solely, responsible for the well-being of children and other family members like older people (as, in many cases, they live in multi-generational households), cooking, other household works, and perceive more threats from an emergency like a pandemic than a male member.

INDO 7: If someone gets affected, there is no point in going in the vicinity. Because the person is going already. If we go nearby to the patient, persons associated with us like husband, children will also get affected.

INDO 6: Well, sometimes I’m worried, I would help but I’m scared since the transmission is through contact. I’m the breadwinner in the family since my husband is not working.

Theme 3. Informing Authority Who Knows How to Handle

In this theme, participants reflect the prosocial intention and intend to help COVID-19 patients by informing
organizations. Participants reported that since COVID-19 is a fatal and contagious disease, they cannot help infected or suspected individuals without training. Instead, they will choose to call medical aids so that the person can be adequately treated, and it will not lead to community spread. In the context of the COVID-19 pandemic, the effort of calling and informing organizations about the COVID-19–infected individuals may be included in the list of prosocial activities. In that sense, our study indicates an extension of the scope of prosocial activities.

IND 10: we won’t go near that person because if we touch him/her, the disease will be spread. We shall keep the person at a distance and will call ‘medical’ aides.

INDO 25: call the medics or the police. They have… or the district government. One thing for sure, we can’t be reckless, because the disease can’t be handled by… you have to wear PPE, you have to call someone who has that.

Theme 4. Caring, Sharing, and Supporting, but with a Distance

Participants under this theme reflected a positive attitude and reported that they would help confirmed/suspected COVID-19 patients by supporting them in various ways. For instance, some suggested providing meals, basic necessities, or even monetary help to the patients and their families. Others reported that they would coordinate with health authorities to help patients visit the hospital. Besides, some suggested supporting individuals by boosting their confidence through verbal support and counseling.

a. Providing Meals, Necessities, or Financial Support

IND 14: If I can do anything about the food and water, I will try to arrange it (like lentils), and whatever is possible I will give him. Rest, only the doctor can do and even his treatment. However, I can help the patient with monetary assistance. I cannot do anything more than that.

INDO 19: I will surely support him/her. This is what I do to a friend at the Mobile Brigade Corps commanding headquarters (Mako Brimob) who has been exposed to Coronavirus by a colleague who had tested positive. Now he is self-isolating at home. Once in a couple of days, I go there to deliver some groceries and basic necessities. I protect myself from being exposed to the virus by following the protocol as advised by the government and the authority (the Mako Brimob). I wore a face mask, and at the entrance, I was sprayed with disinfectant. I put the groceries in front of the house and sent him a message to inform him about it. We never had direct contact; he just checked on me from the window.

b. Helping Individual to Coordinate with Health Authority

IND 8: If something of this happens, we will ask the person to go to the medical center for a check-up. We will also help him in taking him to the hospital by calling the ambulance. If his financial situation is weak, then we will help him.

INDO 6: Since we have some restrictions, the best thing that I can do is suggest going to the referral hospital or helping to coordinate with the local health authority to get him/her picked up by an ambulance. If this person has to do self-isolation at home, I will support him/her by providing meals and basic necessities.

c. Verbal Support and Counseling

IND 9 (1): People will be scared, but there is no need to be afraid of the person. We have to treat the person from a distance. We don’t have to go very close to that person. This way, it won’t spread from one person to another. We should boost his morale by saying, “he should not worry about it; everything will be alright soon”.

INDO 21: I will keep a safe physical distance from this person, but I will give him/her my support. I will pray for him/her, cheer him/her up, and give him/her positive suggestions because I believe that our thoughts can affect our health.

Theme 5. Helping at One’s Personal Health Risk

In this theme, participants reported that they would help confirmed/suspected COVID-19 patients at all costs. They reflect excessive prosocial intention and do not even hesitate to take risky measures to protect the individual. It may be due to the gratitude from experience, the optimistic bias that COVID-19 will not affect them, or the “bad things will not affect good people” attitude. The certainty of helping individuals increases for known persons. This behavior is consistent with the literature, which suggests that during an emergency, sometimes helping leads to impulsive behavior and can put the helper’s life in danger (Rand & Epstein, 2014).

IND 10: AIDS is also a contagious disease. Its virus also spreads. There was a person nearby our house. That person did not have his father. I used to take him to the hospital. It must be 5–6 years back. Nothing happened to me. He was under treatment now. So, I do not have fear. I shall help a COVID patient as well.

INDO 18: It saddens me to see some people’s rejections in helping their neighbor(s) who got infected or died because of Coronavirus. It is not humane to treat others like that; let’s be brave and help them sincerely. For me, if it is not our time, then this virus will not kill us. So, there is
no need to overreact; let’s support and help each other while staying alert. We are all the same in God’s eyes.

**For Known Person**

This theme highlights that the prosocial intention of people increases for those close to them. They also yield to risky prosocial actions to protect their close people. This behavior is consistent with the social identity theory that reveals that during an emergency, individuals overemphasize similarities between themselves and other in-group members and show higher sympathy and prosocial intention. This is also consistent with the theory of kin selection (Burnstein et al., 1994) during emergencies, which assumes that the kindness-to-kin genes make people help those close to them (e.g., choosing brothers over nephews over acquaintances).

IND 11: Certainly, if it is someone of our own family or near or dear ones, it is important to help. We will help and will try to save him/her. If a medicine is to be taken, will do that. Also, just by burning cow dung, the virus gets killed. Similarly, we can filter its ashes and make the sick person drink that. Possibly, this solution can kill the virus from inside.

INDO 9: Yes, I am worried that I will get infected, but I do not want to have negative thoughts. If I know the patient personally, then I will try my best to help him/her.

**Discussion**

In summary, we have studied prosocial intention among individuals toward confirmed/suspected COVID-19 patients from the lower socioeconomic strata in a collectivist society, especially in India and Indonesia. To the best of our knowledge, this is the first study in this direction that uses primary data that has qualitatively been examined. We have found five themes of prosociality, starting with prosocial apathy and gradually moving to risky prosocial intentions.

The first theme manifests prosocial apathy and a feeling of helplessness. This theme reflects a fear of COVID-19 due to its contagious nature. This can be explained by previous studies that highlight that in the context of prosocial behavior, fear, anxiety, and personal distress force individuals to focus on their own emotions and personal losses instead of others’ gains (Paciello et al., 2013). Moreover, we observed that individuals’ intent depended on social approval, primarily while deciding what and how they should help others. This observation aligns with the previous studies, which suggest that during crises or uncertainty, people look for additional information and opinions and observe the behavior of others before taking their actions (Gelfand & Harrington, 2015; Haddow & Haddow, 2014). This theme also highlights high group conformity, so much so that even negative norms are followed if it is popular. Previous studies suggest that collectivism contributed to people’s stigmatizing attitude and behavior towards a person with mental illness (Ran et al., 2021). Hence, descriptive norms during COVID-19 may play an important role in prosocial behavior. From this perspective, policymakers should define and develop group norms that motivate common people to help COVID-19 patients appropriately and prevent apathy.

The second theme demonstrates a moral dilemma of whether to help COVID-19–infected people or not. Research shows that witnessing someone in need evokes empathy, but the dilemma of whether to help or not generates an unpleasant and aversive experience. The adverse psychological outcomes from moral dilemmas can lead to moral distress or frustration (Kälvemark et al., 2004). The current study identifies the negative feelings being reported as indicative of moral distress. Prior research suggests that personal distress may enhance moral disengagement mechanisms that inhibit the propensity to help when a person is in a moral dilemma and facilitate self-centered behavior (Paciello et al., 2013). Their condition may lead to a negative psychological outcome. Future studies may consider understanding the impact of moral dilemma on individual outcomes, in a prosocial context, among bystanders during a health crisis like a pandemic. Further, recent research on COVID-19 suggested that if altruistic individuals are not allowed to help, they may fall prey to negative mental health outcomes (Feng et al., 2020). However, their fear may be due to the lack of awareness about the safer prosocial actions like supplying food and medicines at the doorstep of a sick individual without coming in proximity or informing organizations about their needs. If that is the case, an elevated awareness among these individuals about the prosocial actions that do not lead to the transmission can encourage them to help without fear and save them from a dilemma and stress.

Under this theme, we also observed that women participants reported a dilemma in the form of increased empathy for the patients as well as a fear of helping them because of family responsibilities. Previous researchers (Becker & Eagly, 2004) suggest that there appears to be a “person-by-situation interaction,” such that gender differences show up more strongly in some situations than others. The differences depend not only on the opportunity to help but also on the required type of help. Future works may examine gender differences in prosocial activities and motives during a pandemic in more detail.

The third theme reveals the tendency to help from a distance (like calling organizations to arrange support) because of a fear of physical proximity to patients. Previous studies identify several activities like sharing,
helping, comforting, cooperating, donating blood, donating money to the COVID-19 fund, volunteering and complementing, neighborhood help (e.g., carrying out tasks for older people), taking part in digital public action (e.g., by offering online courses or support), and sewing mask to be prosocial (Rudert & Janke, 2021). The effort of calling and informing organizations about the COVID-19–infected individuals may be included in the list of prosocial activities. In that sense, our study indicates an extension of the scope of prosocial activities. However, future researchers may examine this suggestion further.

In our study, we also identify a theme that suggests that people may ignore COVID-19-related guidelines while helping others. In the absence of a clear guideline for helping (or in the absence of knowledge of its existence), people in a collectivist society may choose a risky method (for instance, coming in close contact with a COVID-19 patient without following safety protocols) to help a person. Though intended to be prosocial, this act could be a bane for society. Helping people when one does not have the required skills may be harmful. Our finding suggests that this tendency to help increases manifold when the target group is known to the benefactor. This might be one
of the reasons why there was a surge of COVID-19 cases in India and Indonesia after a waning number of cases. However, our findings also highlight that people indulge in prosocial activities following prevention strategies during COVID-19. Their safe way of helping ranges from providing food, money, and verbal or emotional comfort to coordinating with health authorities from a distance. We believe that all kinds of prosocial behavior that also consider appropriate safety measures help improve social cohesion and mitigate the adverse effects of the pandemic, like stigma or ostracization. Since this behavior fills individuals with a sense of meaningfulness, the well-being of these individuals will possibly be boosted in the wake of such prosocial acts. However, understanding the beneficacity of some prosocial intentions over others is beyond the scope of this paper. Future researchers may explore whether specific prosocial behaviors (e.g., comforting, providing food, and coordinating with health officials) during a pandemic instill positive changes in mental well-being.

It is apparent from the above discussion that the current study brought to light the interesting point that not all prosocial intentions (like the urge to help without following the COVID-19 safety protocols) will benefit a society during specific situations like a health pandemic. People depend on each other in a collectivist society, and not helping others can create further emotional stress. Hence, policymakers should explain to people the proper and safe ways of helping others. They should develop a framework and a guideline for supporting and promoting the protocols for helping diseased individuals among the common mass. The norms of social responsibility and self-sufficiency should also be clearly informed.

We would like to acknowledge that in this cross-cultural study, the role of researchers was somewhere within the “insider–outsider” continuum. Obtaining a sample is “a complex social process of gaining access into the community itself” (Sixsmith et al., 2003). The complexities associated with the insider–outsider perspective is a continually negotiated relationship where outsiders sometimes occupy insider positions and vice versa (Dwyer & Buckle, 2009). During the different study times, we became the outsiders (i.e., maintained psychological distance) and the insiders (negotiated the relationship) with the respondents. Being an “insider” (from the aspects of ethnicity, language, and familiarity with participants), researchers from India and Indonesia were able to build a good rapport and connect with their respective participants and collected rich data. Also, we positioned ourselves from an “outsider” perspective to bring objectivity and mitigate the biases in our observation and interpretation.

Our study, however, has certain limitations. First, models of helping and allocation behavior developed in collectivist cultures may not adequately capture the variables that affect helping behavior in other cultures. Another limitation of the current study is the mixed use of face-to-face and telephonic interviews. Due to the pandemic, researchers could not perform all the interviews face-to-face due to the risk of exposing participants and themselves. However, we believe that certain data from face-to-face interviews mitigate this limitation and help organize the findings.

To conclude, the COVID-19 pandemic is a situation where concern about the well-being of the self and others is essential. Hence, the findings of this study might be relevant for developing positive psychological

| Table 1. Participants’ Sociodemographic Data—India and Indonesia. |
|---------------------------------------------------------------|
| S. No. Characteristics                                      | Participants India (n = 25) | Participants Indonesia (n = 25) | Total Participants (n = 50) |
|---------------------------------------------------------------|
| 1 Age (mean in years)                                        | 35.88                       | 40.84                       | 38.36 |
| 2 Gender                                                      |                              |                            | 43    |
| • Males                                                       | 21                           | 22                          | 43    |
| • Females                                                     | 4                            | 3                           | 7     |
| 3 Education level (mean years of schooling completed)        | 14.36                        | 14                          | 14.18 |
| 4 Marital status                                             |                              |                            | 35    |
| • Married                                                    | 19                           | 16                          | 35    |
| • Unmarried                                                  | 6                            | 9                           | 15    |
| 5 Occupation                                                  |                              |                            | 9     |
| • Driver                                                     | 3                            | 6                           | 9     |
| • Office staff                                                | 3                            | 3                           | 6     |
| • Security guard                                             | 9                            | 2                           | 11    |
| • Vendor                                                     | 1                            | 8                           | 9     |
| • Janitor                                                    | 6                            | 2                           | 8     |
| • Other                                                       | 3                            | 4                           | 7     |
interventions in the future. We also emphasize that creating a framework highlighting what is prosocial and what is not is essential. In this situation, the media can raise awareness by complimenting and publicizing helpful acts.

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