The Psychodynamic Psychiatrist and Psychiatric Care in the Era of COVID-19

Douglas H. Ingram and Kimberly Best

Abstract: Near the beginning of the COVID-19 pandemic, on April 13, 2020, about 50 members of the American Academy of Psychodynamic Psychiatry and Psychoanalysis convened through Zoom to talk about the impact of the pandemic on their practices, their patients, and themselves.* They offer their reflections through oral and written comments. Participants were encouraged to organize their contributions around the dimensions of administrative psychiatry, the structure of clinical care, the content of clinical care, the patients' reported personal experiences, and the psychiatrists' reported personal experiences. Themes identified and discussed are paradoxical separateness, seeking an optimal interpersonal distance, finding new idioms, reality and symbolism, and loss, mourning, and isolation. The views are noted to touch on only one point early in the arc of the pandemic. A significant body of personal commentary provides an understanding of the roots of themes likely to evolve as the pandemic progresses.

Keywords: COVID-19, telehealth, Zoom, pandemic, psychotherapy

Under the auspices of the Psychiatrist Wellbeing Project of the American Academy of Psychodynamic Psychiatry and Psychoanalysis, a virtual session of about 50 member psychiatrists and non-member colleagues was convened on April 13, 2020, to consider the impact of the COVID-19 pandemic on our clinical work, our patients, and on the participating psychiatrists themselves. Introduced by Gerald P. Perman, president of the Academy, the meeting was co-chaired by the authors. This report summarizes solicited written comments of the meeting's participants and comments from a transcript of the virtual meeting.

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For the purposes of organizing this report, we will consider the matter in five dimensions, noting that each dimension necessarily includes aspects of the others. We acknowledge that in some measure the separation is arbitrary. We will consider the impact of the COVID-19 pandemic (1) from the psychiatric administrator's point of view; (2) on the structure of clinical care; (3) on the content of clinical care; (4) on the patients' reported personal experiences; and (5) on the psychiatrists' reported personal experiences.

A further caveat: We recognize that the experiences reported reflect a point in the trajectory of the pandemic. It cannot capture experiences adequately before this date and certainly not beyond it. The first case of COVID-19 in the United States was reported by the third week of January, and the first local transmission was not reported for another month. Initial efforts were centered on containment of transmission from known individual cases. The pace of change increased in March. By March 16, 2020, the White House announced social distancing guidelines, including work and school from home when possible, avoidance of groups larger than 10, and avoidance of restaurants and bars. Reports of mounting hospital admissions and deaths hammered customary structures of patient care. Those in dense populations—notably New York—considered whether to leave the city or hunker down; telepsychiatry became increasingly the mode through which psychiatric care was provided.

By the following month, the date of the Academy-sponsored meeting, the initial bewilderment, uncertainty, and rising terror had shifted—and have continued to shift. Administrative psychiatrists had adapted somewhat to the necessity of personnel restructurings. Office-based psychiatrists had adapted more or less to telepsychiatry. The immediate and challenging questions, What to do now and How will it work, had shifted to, How long will this continue and How will this change things. Hence, the observations that follow represent psychiatrists' experience when these latter questions and concerns had supplanted those more urgent earlier questions and fears.

THE PSYCHIATRIC ADMINISTRATOR

What was the impact of the COVID-19 on the tasks of the psychiatric administrator, director of residency training, or active supervisor of psychiatric residents?

Timothy Sullivan, who is Chair of the Department of Psychiatry and Behavioral Sciences at Staten Island University Hospital, part of Northwell Health, reports that as the COVID-19 crisis evolved, he and his administration were faced with many challenges: determining how

to allocate initially limited personal protective equipment (PPE) and ration testing; making recommendations to physicians and other health care providers regarding their personal risk; managing the logistics of hospital and clinic functions as the crisis unfolded, and so forth. These efforts led to the issuance of a series of guidelines over several weeks, which were based on available though incomplete information, many of which in retrospect were inaccurate, as we came to learn. Initial recommendations from the CDC and other bodies indicated that pregnant women did not appear to be at increased risk of complications, which now appears not to be true; and that it was reasonable to ration masks in clinic settings and not require patients to be masked, a practice that has now changed dramatically. As of mid-April, Sullivan's department, despite the high prevalence of COVID-19 in the community, was finally getting N95 masks, which until then were reserved for workers in critical care areas and emergency rooms. The delays in obtaining some PPE had led to considerable staff anxiety, which needed to be addressed.

The hospital psychiatric inpatient unit of about 35 beds was almost evacuated at the time the stay-at-home order was issued. This was not because patients were discharged, but instead because people just did not come in, perhaps giving us pause to reflect on what it tells us about the state of psychiatric illness in the community and our patients' capacities, given exigencies, to call upon personal resources to help them adapt to risk. The inpatient census in the beginning fell to about one quarter of the customary level. In the following month, a slight increase was noted due to admissions for substance abuse and suicidal ideation.

Consultation liaison services across the Northwell group had seen markedly decreased rates of activity. Whereas the department would ordinarily get a dozen consults a day, at this time it was getting one or two. On April 13, about half of the 800 beds on the two hospital campuses were occupied with COVID-19–related patients. Hence, the underutilized psychiatric staff was largely unoccupied. Also, outpatients were slow to utilize telepsychiatry as a modality for care.

While psychiatric inpatient, outpatient, and consultation activity were decreased, the epidemic brought new needs that the Department of Psychiatry was well positioned to serve. Sullivan reported that his department cooperated with the Department of Medicine to create discharge planning and communication teams. These support teams enabled other medical practitioners to do more intensive specialist work. The teams consisted of psychiatry attendings and some including residents. After being briefed on each patient, a psychiatric staff member would call each family to share information with them, receive family members' questions, share those with the team, and interact as needed with the family. The staff member would then write

a note about the interaction each day. That approach was found to be extremely helpful to the families and the medical staff. A common concern early on was that families were unwilling to receive their convalescing family members back home because of fear of infection. Much education and support were needed to overcome that reluctance.

Joana Chambers (2020), who is active in the training of residents at the University of Indiana, both in clinic and in didactics, reports that both classes and clinical care were moved to virtual experiences after the lockdown in Indianapolis. The hospital clinics contacted patients by phone as many of them lacked the technology needed for virtual visualization. Whereas she had previously attended resident sessions with patients, reliance on phone sessions rendered that practice too cumbersome and redundant. It was necessary to forgo the training benefit of the supervisor's sitting in the session to help the resident better integrate psychodynamic concepts. Although there was some loss in the standard of care and in learning opportunities for the residents, this change in procedure permitted greater independence on the part of the resident and may have facilitated more sense of connection to the patient.

The teaching of a weekly psychodynamic psychotherapy elective to residents, Chambers reported, moved to a Zoom platform. Unfamiliar with the experience, residents were initially reserved. At the outset, active participation was challenging. Whereas previously she could directly address a resident in the classroom, she needed a different approach with Zoom. The first Zoom session, she noted, included about 30 minutes of discussion about the lockdown and how residents were affected. They were unnerved by the experience and were grateful for the chance to openly discuss their anxieties and concerns. A month later, there was a sense of adjustment to a new normal, and many residents expressed pleasure in being able to work from home. Their anxiety had decreased, and they have been better able to focus on the material of the class. Some of the residents are married and have families. She believed it was easier for them as they were less isolated. For residents who are single, the isolation may have been more challenging. The graduating residents also faced the prospect of an uncertain world and the need to take on a new job, possibly in a new city or in a new system. Additionally, they mourned the inability to have family join them or even convene for graduation, an event they had been anticipating for many years.

Kimberly Best, a training director and associate chair, describes her experience:

> By mid-March my department was holding several hour-long conferences calls each day to plan for the expected surge in COVID-19 positive

patients. The outpatient department made a rapid transition to tele-psychiatry. Almost overnight, residents who had only a basic understanding of the treatment frame needed to make radical changes in that frame. The inpatient departments began to make plans for how they could handle a simultaneous surge in COVID-19 positive patients and diminished staffing due to staff being ill. Emails were flying at a dizzying pace, outlining policies for quarantining staff, COVID-19 testing, use of scarce personal protective equipment, and more.

In personal conversations, we talked about how we could protect our families in case we were carrying the virus. Those in the outpatient department moved to full-time tele-psychiatry. Most of us who were coming to work began to wear scrubs. We removed our shoes and scrubs immediately upon returning home. We promptly showered and tossed our scrubs into the laundry. Many of us who had adolescent or adult family members stayed 6 feet away from them. Those with younger children made sure the children understood that they needed to stay away from their mamas and papas until after the decontamination process.

The residents were understandably anxious about what was happening. This was especially so if policies at our affiliate institutions varied from policies at our home institution. As a training director, I felt an intense sense of responsibility for the young physicians under my direction. On the one hand, I needed to protect and advocate for them. On the other hand, I needed to help them develop as doctors, continuing to care for highly vulnerable mentally ill individuals while also fighting the COVID-19 pandemic in ways that could be unprecedented and quite dangerous.

The number of COVID-19 positive cases in our institution has plateaued at a high but manageable level. We have sensible policies for various contingencies. I am proud of what we have accomplished. However, I also understand that we have had good luck and have so far been spared some of the worst outcomes of the epidemic. We continue to live in some surreal blend of mastery and heightened vulnerability.

THE STRUCTURE OF CLINICAL CARE

Whereas outpatient psychiatric care had been delivered only occasionally by telephone and even less often by face-to-face virtual viewing, the advent of the COVID-19 pandemic led to the almost immediate restructuring of clinical care. With few exceptions, "telepsychiatry" became the mode for the delivery of psychiatric care. Reliance on telephone, FaceTime, Zoom, and other platforms has met with mixed acceptance. Minna Fyer notes,

All my treatments are remote now. Some phone, others video—depending on patient preference. Two issues I can comment on. One is that I rely

> heavily on non-verbal communication to understand my patients' experiences and that is very much diminished with remote treatment. This includes the kind of "energy" that fills the room that is not scientifically understood at present. Second is that many treatments have shifted drastically towards practical considerations—especially for patients who are ill or have relatives who are ill.

Jeffrey Rubin concurs, noting the illusion of normalcy imposed by virtual viewing. He cites Gianpiero Petriglieri, who emphasized the "plausible deniability of everyone's absence. Our minds are tricked into the idea of being together when our bodies feel we're not. Dissonance is exhausting. It's easier being in each other's presence, or each other's absence, than in the constant presence of each other's absence."

Douglas Ingram believes that the fatigue reported with virtual meetings reflects an intermediate state, a necessary grief for lost customary structures. We will adapt to video sessions. Once we adapt, the fatigue will fade. The qualifier "virtual" will disappear. When we speak on the phone, we speak to each other. Nothing is experienced as virtual there.

Sherry Katz-Bearnot likewise reports on the taxing aspect of teletherapy. Whereas most patients appear to care about managing anxiety, help-rejecting complainers reject all efforts at reassurance. Telepsychiatry seems to exacerbate this problem. Her own desire for calm, she notes, leads her to feeling more burdened than she would in a person-to-person setting.

While the general sentiment among psychiatrists is that a return to in-person sessions is preferable, Michael Blumenfield (www.psychiatrytalk.com, 4/22/20) emphasizes that in the epoch of COVID-19, returning to in-person sessions may be an error:

> Many practitioners who have tried remote therapy believe that remote sessions are inferior to in-person sessions and feel an ethical obligation to resume in-person face-to-face meetings as soon as possible. In my opinion, this is a serious mistake. I believe that a careful consideration of all the factors will make a strong case for the maintenance of remote therapy sessions at this time and for this foreseeable future as long as there is the possibility of this deadly epidemic being present and perhaps beyond it.

The advent of Zoom and related technology as a means to meet with patients creates interesting epistomological, ethical, and clinical questions. The Zoom application, and perhaps others as well, permit the therapist to appear before a virtual background, such as the Golden Gate Bridge or the Aurora Borealis. Gary Kanter writes:

> What does it mean then if, while using telemedicine technology, we have a virtual, false background installed behind our image? Is the therapeutic framework and structure, already under digital assault, now further undermined by the untruth of the virtual background? Do we collude with the patient in the untruth of their pathology and the disorientation of the world's current reality? Do we foster a denial in order for us to defend against our own and our patients fears? . . . These may seem like frivolous questions in today's pandemic, but I would argue that truth is the bedrock of trust upon which therapy is based and as such this issue requires thoughtful and deep discourse so that we might be intentional in our decisions about this technology.

In a subsequent colloquy in the Zoom conference, Ingram and Kantor considered that perhaps the phrase, "digital assault," might be facile, even histrionic. With certain patients, aspects of the digital online work, including the use of a virtual background, may serve as a kind of play between therapist and patient and, much like dreams, allow play that locates its vehicle on a literal dynamic screen.

Clarice Kestenbaum reports that the background is not of special interest. In her own work as a child psychiatrist and supervisor, she had incorporated telemedicine as a means to both treat patients and provide supervision. Children, she found, were entirely comfortable. Their parents often were not, at least not at the outset.

Not all clinicians turned to virtual sessions. David Lopez, also a child psychiatrist who reports that his early life was in a third-world tropical country, continues to see patients in person. He writes:

> Once in medical school, my future wife and I rotated for a month in the tuberculosis ward at the General Hospital of Mexico, yet we both remained PPD negative. One needs to learn how to recognize and manage danger when living in a third-world country. . .
>
> I adapted my office: a) removed all the magazines from the waiting room; b) changed the fabric chairs to vinyl ones; c) removed all toys, markers, and snacks from my play room; d) set my chair from the sofa seven to eight feet apart e) hired someone to clean my waiting room every hour and clean the sofa between patients; f) found ways to prevent patients from touching door knobs; and g) offered patients the option to meet in person, by Skype, Zoom, or telephone.
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> As an essential community provider, I maintained an average of 50 hours of patient sessions in the first week, with at least half in person. My message to patients has been that: 1) we need to live with this germ in new ways that allow us to survive it; 2) patients can avoid meeting in person if they are sick, have a sick family member, or are too anxious; and 3) video and telephone sessions are not as good for psychodynamic work. By week three (last week), about 40 out of my 50 weekly sessions were in person.

This message has decreased anxiety by providing a sense of control, and promoted adaptation to our new reality.

THE CONTENT OF CLINICAL CARE

The advent of the pandemic has upended the content of patients' concerns and responses that therapists, including psychodynamic psychiatrists, have needed to adopt. Ahron Friedberg writes:

> Among my patients, I have never seen such a sudden access of single-minded fear. All their usual, kaleidoscopic concerns—office politics, children, extramarital affairs—have snapped into abeyance behind one overriding worry: everything feels out of control. What comes out when we talk is a kind of hyped-up banality, a sense that quotidian tasks are potential inflection points along the road to their only goal: not getting sick. They ask about where to walk the dog, when to buy groceries.

David Forrest notes that as a general therapeutic intervention, the therapist should "find a way to be useful, have agency rather than passivity, be the helper and less a part of the problem." Silvia Olarte details this approach in her work with patients:

> [In the week of March 9] with no exception, sessions were opened with a review of the health status of the patient, their loved ones, myself and my loved ones. It moved to a discussion of what was real and what was exaggeration about the COVID-19 pandemic. I found myself imparting medical knowledge and responding factually to the questions with the information I had. It then moved to the reviewing of safety measures to protect oneself, others and one's environment. Discussions were concrete, based on the physical and geographical reality of each patient (reality of food shortage, planning of meals for a week at a time, how to dress to go out, how to handle gear when returning home, how to make sanitizers when they had not been able to procure enough, cleaning supplies and their use to sanitize the home, etc.). It followed by those on medication discussing ways to secure enough medication in case of "shortage." Throughout these conversations I found myself reverting to my extensive experience using "crisis intervention therapy" and "reality testing therapy" during my years in the New York City hospital system. The content of the session was driven by the real needs of the patient. The process was an evaluation on my part of the defense mechanisms activated during the crisis in each patient, their capacity to shift between different defenses when needed and if the symptoms reported (anxiety, initial night insomnia, nightmares, middle insomnia with obsessive catastrophic thinking) were appropriate to each of their circumstances or have become pathological in intensity.

Technically I validated the defense mechanisms that increased their capacity to cope, even if exaggerated in their presentation, and challenged the distorted thinking that fueled their anxious and/or depressed symptomatology. Both techniques were based in the present and not in their past experiences. Universalization of the experience was extremely helpful to "normalize" what was so foreign and frightening to most. Acknowledging and sharing my own process of adaptation to the "new normal" (overused term but very useful) was therapeutic and calming.

[Sessions during the following week] opened with a recounting of the health status of all members in the household or immediate family in other locations. I was spared that any of my patients or their families showed signs of COVID-19. The therapeutic mode was still "reality-oriented therapy." This week there was an increased focus on interpersonal relationships My psychodynamic approach could then be defined as interpersonal therapy with some cognitive techniques to correct some distorted cognitive processes fueling the interpersonal conflict.

Why interpersonal therapy? Because this was the week where the "new normal" entailed all family members who usually only interacted in limited capacity during the day and went to their places of work or learning were now "working remotely" from home. Content was again concrete, focused on subjects like scheduling, meals, responsibility for chores, noise level, physical location for each working member, etc. Technically again I was supporting mature defense mechanisms and enhancing universal altruistic feelings like patience for oneself and others, tolerance for one's limitations and the limitations of others . . . Patients needed to universalize the experience with questions like, "Is that happening to others, is it happening in your home?" I responded honestly and used this concern to expand and, if possible, deepen the exploration of their reality, their unrealistic expectations of themselves or others, and continue to work on the attributes of patience, acceptance of limitations and empathy for oneself and others

[Subsequently, themes already established were continued, such as] checking on the health status of patients' worlds and mine and comments on the success or failure of keeping safe, disinfected, successful basic shopping . . . working with "family dynamics" which is a mix of understanding and working with group dynamics and family systems of communication . . . clarification of current interactions to correct cognitive distortions and continue to work on developing such attributes as patience, empathy for self and others, tolerance for one's and other's limitations . . . [New themes emerged, such as] the role of past formative others in reference to the presence in the patient's behavior of certain primitive defense mechanisms and their limited usefulness in the present. Also, we connected the patient's limited ability to be tolerant or understanding of their own or others' limitations to their experience with these same formative relationships . . .

[Later] for the patients that still have parents alive in all kind of circumstances, the increased death toll and the concern for the safety of an elder population, fostering a shift in the emotional reaction of patients'

> psychological relationship to original formative others. At the beginning [of this process, patients] voiced only positive concern for their safety. Slowly while still caring for their safety, patients were available to recognize old patterns learned in the context of formative relationships. This "surrealistic reality" is giving them an opportunity to experience these relationships in the here and now. They were more accessible to developing empathic acceptance of the patterns that they now have to modify, perhaps welcoming the possibility of a more reality-based relationship.

Such smooth sailing is not always the case. In the following clinical vignette offered by Jennifer Downey, the therapist is confronted with a clash of values between herself and her patient:

> C* is a 49-year-old industrialist who runs a large manufacturing business. He sees me regularly for psychodynamic psychotherapy. He suffers from several chronic medical conditions. His temperament is hypomanic. His elevated mood, agile mind, and gregariousness are assets in his work; and he has never desired treatment for a mood disorder since he has never been depressed. He has been divorced and originally consulted me for troubles in his romantic relationships. Eventually, he married again and has 2 small children. He also has several young adult children from his first marriage.
>
> Since the COVID-19 virus became epidemic in the US, C has had a lot of work to do because of the economic slow-down. His personal wealth is not at stake, but he has had to contract his business.
>
> Once the entire population of New York City was told to stay home, C decided to move his family including all his children away temporarily. He extensively researched localities with excellent hospitals within driving distance, chose one, purchased a large car, rented a spacious house, and left town. He is working from home and continues his sessions remotely.
>
> At our next weekly session C called me from his new temporary home. He had found entertainment for everyone in his family, and people were having fun. C mentioned his strategy for making sure everyone was safe to be together in his home. He coached each adult child on how to lie to medical professionals so as to obtain COVID-19 tests, which were extremely hard to get in the Northeast then and available only to people who were going to be hospitalized. Once these came out negative, the young people could join the larger family.
>
> At this point I'd like to turn to how the psychiatrist feels about a situation like this. As psychodynamic physicians, we are used to helping people with a variety of personal problems. Rarely does it happen that the personal problem is shared by everyone, including the therapist and *all* of his or her patients. In a place like NYC where the epidemic has hit hard, everyone is anxious and faced with questions about how to take care of themselves and their families.

* Names and details have been changed to protect patient privacy

> The fact that we are all in this together raises challenges in the counter-transference area. It is hard to achieve appropriate therapeutic distance when you, the therapist, are afraid to touch your mailbox and have to stay away from all the loved ones who don't live with you. This fear and the personal sacrifices involved in social distancing have similarities to the feelings C is experiencing (fear for himself and family), which he is fending off with big actions and displacements. C is a person of wealth and power who is used to bending the rules to make his own family's life more comfortable. In such an instance the therapist is compelled to face personal values. Does it bother you to learn that someone's children are being taught how to "game" the medical system to allow everyone in the family to mingle and have a good time? Yes, but this issue is not necessarily most important for C. It is important for the therapist because he/she is focused on sacrifices imposed by the virus; and C's manifest goal is to avoid sacrifice.
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> There are times when one can draw a patient's attention to his or her sense of entitlement. This was not one of those times. But if you choose not to confront behavior like this, how do you feel as the therapist?
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> In writing about different kinds of counter-transference" Poland (2006) contrasted CT in the "narrow" sense with the experience of being with the patient that is what I would call "existential." I think it applies to this case. Poland speaks of the analyst's "human engagement with the patient that engenders attachment, loss, self-doubt in the face of resistance, and the requirement to face fearful aspects of the human condition Poland, 2006)."
>
> The session with C where he talked about getting the COVID-19 tests for his family was a window into his world, which is not the same as the therapist's, and where different rules of behavior apply. No patient shares our values precisely and people don't have to share our values to improve and "get better." To address what came up in this session, the therapist needed to wait until the protagonists are not in the middle of a life-threatening emergency. Of course, even when that time comes, other issues may be more important for C.

The clinical content described above in this early phase of the COVID-19 epidemic involves already existing treatment relationships. As the epidemic progresses, new patients with different concerns are likely to emerge. Blumenfield and Ursano (2008) reports that based on his experience with mass psychological trauma such as AIDS and 9/11, there is likely to be an influx of first responders seeking psychological care.

PATIENTS' REPORTED PERSONAL EXPERIENCES

The impact of the pandemic on patients has been overwhelming. Of interest is that for many patients, the recommendations of mass confinement and isolation have brought relief.

Forrest writes:

> Paranoid patients may feel better. One said to me, "This feels normal for me." This is the Blitz effect—because everyone is affected, she is included . . . An agoraphobic patient who rarely goes outside now says he feels happy. Instead of his usual feeling that he needed to overcome his fears and join the world, now he feels relieved because the world had joined him.

Kanter offers a similar observation:

> I wonder whether this early positive response may be related more to the depressed and anxious individuals now "enjoying" that the rest of the world is experiencing what they have suffered with for so long. No longer marginalized and misunderstood, these patients can experience a self-cohesion through the twinning of the shared suffering. However, as the general populace "recovers," will this exacerbate the envy for health our patients struggle after and bring with it the return to the depressive position? I ask these questions not to dash the hopes of true sustained growth, but to help us and our patients anticipate these long-term consequences of this current world disaster.

Best reports that when asked about the epidemic, one of her patients who had significant success in spite of serious trauma shrugged and said, "Another crisis." This patient who had had decades to develop skill in dealing with adversity felt some sense of mastery and familiarity in the midst of the epidemic.

In her work with pregnant and postpartum women with substance abuse, Chambers similarly reports substance-abusing pregnant and postpartum women to be:

> remarkably resilient to the stress and anxiety that we are all facing. The women who are pregnant have some anxiety, especially if they are further along and planning to deliver soon, in what the effects will be on their hospital care and the risks to them and their babies. However, even with the pregnant women, the anxiety in general has been quite low. Many of the women have stated that they are home with their young children all the time anyway, so this has not changed anything for them. Many are on food stamps, so getting food has not been an issue. They have remained clean from substances in part because they don't leave their houses; they seem to be more afraid of COVID-19 than of opioid overdoses. I have wondered why this vulnerable group of women have been so resilient to this and I don't know the answer. I suspect it is multifactorial, however, it may be that the lockdown provides a unique predictability for them. This particular group of patients suffer tremendous stigma and the world can be very unpredictable for them (losing Medicaid arbitrarily, transportation difficulties, managing their social network, etc.). Ironically, the lockdown

> may allow for these issues to dissipate as our social welfare has been more lenient, transportation is no longer an issue, and they have excuses to minimize their social interactions that do not serve them well. It is not to say that every single patient has improved, but to be clear, the great majority have really done very well.

The salutary impact of the COVID-19 may likewise extend to children. Bridget Downes reports the following:

> This patient is an 18-year-old male who has been my patient since he was nine years old because of his overwhelming anxiety, social awkwardness, impulsivity and obsessive-compulsive tendencies. Through the years he worked very hard to address these issues. As he matured and worked his way through middle school and high school, he made use of therapy, his medications were fine-tuned and school accommodations were updated yearly. He struggled with his anxiety daily but was tenacious with respect to reaching his goals and thus was able to navigate his way. He was recently admitted to several colleges and has accepted the offer of admission from his first college choice.
>
> Three weeks into social quarantine, he greeted me through videoconferencing saying, "I have absolutely no anxiety at all! You know I have always enjoyed being by myself and doing my own thing. I am in the college of my choice. School pressure is off, and I don't have to be anywhere or interact with anyone I don't want to. I won't always want to live this way, but right now, it feels great!"
>
> He was the happiest and most relaxed I had ever seen him. We will speak again in the next several months or as needed.

Patients with meaningful histories of depression and bipolar disorder participating in a support group likewise adapted to the pandemic, as John Tamerin writes:

> One might assume that a population of depressed people would deteriorate under these current conditions of major stress and uncertainty both in terms of health and economic instability . . . to my surprise, members of our group seem to be doing surprisingly well. In confronting severe trauma, the best predictor of PTSD is not the severity of the trauma but the underlying fragility of the individuals. So, should we expect that the members of a support group for people who are currently or have been diagnosed with depression or bipolar illness would do well? Indeed, how can we begin to understand this (assuming that it continues) since this observation seems to run counter to everything we might expect based on those factors predictive of resilience vs. deterioration in times of stress.
>
> I think a huge factor that has been helpful to the members of our support group, which numbers 20–30 at any time, is the sense of community, human connection and shared vulnerability. Amazingly, this works well without

group members even being in the same room which I find fascinating. Our groups are now held on Zoom and over 20 people regularly participate.

I feel it is essential to study and analyze the personal stories of our individual members as they go through this unforeseen journey in their lives and to focus particularly on the role of the group in facilitating wellness, optimism, hope and stability.

Myron Glucksman adds his voice to the general finding of an absence of severe psychopathology:

> By and large, everyone has an increased sense of fear, isolation, and uncertainty. Naturally, this expresses itself in mild to moderate symptoms of anxiety, depression, insomnia, and anxiety dreams. In a few cases, patients with more severe psychopathology have experienced an increase in symptoms. For example, one of my patients with Borderline Personality Disorder who lives by herself is experiencing a significant increase in feelings of abandonment and aloneness. Another patient, who suffers from a chronic psychotic disorder, is contending with an increase in obsessive, quasi-delusional ideation. Nevertheless, somewhat to my surprise, I have been impressed with the resilience of my patients. The majority of them appear to be coping quite well without a significant increase in symptomatology. This observation is supported by telephone calls I have initiated with a number of patients that I see infrequently. By and large, they are grateful to hear from me, and to reconnect. They, too, seem to be adapting well to the social isolation imposed by the pandemic, without an increase in symptomatology.

In addition, Glucksman offers an historical perspective that may help us understand the resilience some participants are also seeing.

> My limited clinical observations appear to reflect studies that were carried out during the London Blitz in World War II. By and large, there was no significant increase in psychiatric disorders during that time period (1940–1942). Investigators found that symptoms of anxiety, confusion, and depression were transient. However, persistent psychopathology did occur in those individuals with predisposed personality difficulties (Fraser, et. al., 1943; Harrison, 1941; Jones, et. al., 2004; Lewis, 1943). Of interest is that a mental health clinic set up by the psychoanalyst, Edward Glover, for the treatment of people traumatized by the air raids, was forced to close because of a dearth of patients. One of the reasons given for the lack of increased psychopathology was that people found meaningful and constructive roles for themselves during the war. I hope that the same holds true for the current pandemic.

Eugenio Rothe reports that his experience and that of his patients were prompted by the confinement imposed by the pandemic. These are remembrances of past abandonments. He describes:

> a 71-year-old Hispanic woman, who reminisced about how her aloof, narcissistic mother oftentimes forgot or delayed picking her up at school functions, at birthday parties, and other places where she was left. She was always the last one to leave and experienced a lot of shame and embarrassment because she felt that she was imposing on her hosts, and felt a lot of anxiety when the mother didn't really arrive or took a long time to arrive to pick her up. So, that was her memory. The second patient is a 67-year-old male who remembered his divorce about 25 years ago and how he felt when he had to move out of his home, leaving behind his soon-to-be ex-wife and their two children and the desolation that he felt when he had to move into a studio apartment alone. And that was the memory that was elicited by isolation from the coronavirus.

PSYCHIATRISTS' REPORTED PERSONAL EXPERIENCES

Psychiatrists have been no less impacted by the pandemic than their patients. One clinician reported feeling fortunate that her cancer treatments were completed just as the patients with COVID-19 began to monopolize hospital staff time and beds. Her sense of good fortune was cut short as she learned that two good friends were ill with the virus, that her spouse had been laid off, and that her aged father was ill—and the family was in lockdown.

Bringing added emphasis to a theme that had been mentioned earlier in the conference, Joseph Silvio captures a thread of guiltiness of several participants: "the sense of feeling somewhat guilty, that we are not able to participate in taking care of people during this crisis. And I found myself feeling a sense of kind of being out of place in some way." Similarly, Ronald Turco, at age 80, sought to work professionally in a triage unit:

> I am a licensed medical first responder in this state and an advanced life support EMT. I tried to volunteer for triage and was told to go home. They considered my age, asthma, new heart valve and other conditions. Now, the only time I go out is for a hike in the woods. Overall, I am comfortable since most of my time is spent studying and reading anyway. And I like to cook. My last full year of four in the military was spent living under the tundra/ice in the arctic. This isolation, in a way, is nothing new for me. I feel sorry for folks in this country who do not have food for their families and help out here when I can through the church serving food, giving money away etc.

Peng Pang, an associate training director and child psychiatrist, contracted COVID-19 while visiting in Beijing. Still recovering, she writes:

> In China, I joined my colleagues providing online psychological support to the frontline care providers in Wuhan. I witnessed the anxiety, fear, and suffering of both care providers and the patients. Delayed responses from the local Wuhan government contributed. I've learned about the severity of the disease and then the tragedies of the people.
>
> Initially, I visited my parents in Beijing, which is 700 miles from Wuhan. Actually, I felt quite safe in Beijing. It was during the Chinese New Year. I came back before the United States banned flights from China. So, I spent a week there before there were any reported positive cases in Beijing. When I left, I felt, "Wow, it's all behind me, I'm so safe here." I continued to provide online support to first-line responders in China. But then, from the end of February, and then in March, gradually, it basically spread all over, including European countries and then the United States. I couldn't believe this was happening in New York. Neither could my colleagues in China. Not in New York! When I told them how little protection we had, they could barely believe it.
>
> Now, when I work with our residents serving on the frontline in the hospital, I see how they have little protection. That was my experience, too. After all, that's why I was among the first batch to get infected.

Rothe reports that the isolation occasioned by COVID-19 elicited a myriad of dreams, emotions, and memories, prompting him to reach out to old friends and family members. He was struck especially by the awareness of the passage of time and the loss of loved ones. Glucksman reports a similar experience:

> I can identify with some of the remarks that Eugenio Rothe made about his personal feelings of loss and abandonment. I have found, like many others, that I have been communicating more with friends, relatives, and colleagues with whom I have not been in touch on a regular basis. In doing so, I have found it very rewarding to feel re-connected with them. On the other hand, it has made me exquisitely aware of the passage of time, along with feelings of separation and loss. Of course, that resonates with issues of illness, death, and mortality that this pandemic brings to the forefront of our awareness. In that regard, it has re-focused me on the importance of emotionally meaningful communication with others. Hopefully, one of the benefits of this pandemic will be stronger bonds of friendship and love within families and between friends.

Ingram reports that his years-long peer discussion group moved to Zoom. Similarly, Silvio finds support in relationships and describes the way a group of colleagues maintain their long-term connections:

> As an older psychodynamic/psychoanalytic psychiatrist in full-time solo private practice, I have depended on a weekly lunch meeting with three colleagues for invaluable support and the attachment of deep friendships.

> We have been meeting now for over 15 years, always on the same day and at the same restaurant (until it closed, and we found another). When the COVID-19 pandemic struck quickly and with force, the mandated shelter in place made meeting in person impossible, so we began convening on the same day and at the same time by Zoom. Although it is a very different experience from meeting in person, our Zoom lunches quickly captured the important elements of mutual support, concern, and connectedness. It continues to be something I treasure and look forward to each week.

Chambers describes the fear, isolation, and mourning of customary routines:

> My own experience in this has been colored by my sister-in-law's passing away unexpectedly on March 12, the week before the lockdown occurred. My family was already in mourning and I noticed that I was preoccupied and not feeling like my usual self. It was not until one of my residents pointed out that she too felt preoccupied and distracted due to COVID-19 that I realized it was not just because of our family loss that I felt so out of sorts. Shortly after this, I read an insightful article in the *New York Times* (Kwon, 2020) discussing the notion that the entire world is in a state of mourning—mourning the loss of our usual routines, the loss of being together, the loss of work, the loss of a sense of normalcy. It completely resonated with me and I think explains why we may feel somewhat anhedonic, amotivated, and possibly depressed and/or anxious. I see this in my children (ages 16 and 14) who have not once complained about our situation and have found ways to enjoy being home but have expressed that their motivation to learn and do schoolwork seems to be far below what it usually is. It is a feeling that I think we may all share to some degree.
>
> To add to this . . . I developed a dry cough and a fever; I isolated myself from my family and stayed in a separate room for 3 days until my COVID-19 test came back negative. My mood changed significantly and I became quite depressed—both by the thought that I may have a life-threatening illness, but more so from the intense isolation from my loved ones. We were lucky that I did not have COVID-19, but for a moment I shared the intense fear and isolation of those who are facing imminent morbidity and mortality. It has been a time for our family to hit the "reset" button and look at what is really important in our lives. Perhaps the way we lived before COVID-19 was not good in many ways—too busy with activities that did not matter and too little time with the people and activities which matter the most. I would not have wished for the pandemic under any circumstances, but I see a silver lining in the changes that may come. While I am adjusting to the social distance, I am pleasantly surprised when I see my friends or family in Zoom meetings and realize how good it is to see them. I then am faced once again with the mourning process. I suppose this may be the conflict we all share—finding the silver lining (with and without guilt) while being in mourning. It is a strange and surreal conflict.

By contrast, another elderly psychiatrist discovered that his hours of clinical practice were unaffected by reliance on telepsychiatry. He began to wonder if he needed to pay rent on his expensive office. Referrals, he learned, accepted readily that he would evaluate and treat them through one of the video platforms. Whereas he had supposed reliance on telepsychiatry would hasten his retirement, he learned that was not to be the case.

Emphasizing the importance of resilience and adaptability, another psychiatrist reports the impact on his practice and his daily routines:

> The common elements in my own experience are flexibility and adaptability. When this came about and I had to transfer my whole practice to Skype and Zoom and other tele-therapies, I set up in my attic at home. I have a wife and three kids downstairs. I needed to be flexible and adaptable. And I think also showing flexibility and adaptability with our patients is important in terms of best helping them and helping them set realistic goals. Our own perspective about the situation, our own comfort and confidence sets a good example for people.
>
> Taking care of ourselves deserves to be highlighted. Conveying something like this to patients is of value. I have usual routines for stress management and what-not: my usual morning yoga meditation that might take up 10 or 15 minutes, and I'd give myself a half an hour for my 10,000 steps a day that have turned into 15,000. And I try to take more breaks in the course of the day to help manage stress. I found that useful and helpful. In addition to our own psychological mindedness, it's good to keep in mind that every crisis can be an opportunity of sorts as well. An example is the opportunity for more collegiality. For me, I like to write, so I'm trying to take some time and I see others taking the opportunity to write as well.

DISCUSSION

The invisible threat of COVID-19 brought rapid change to all of us, all at once. Suddenly we were uncertain where danger might lie. All of us, patients, colleagues, friends, family, and literally everyone across the world, were in danger of infection with the coronavirus. Seemingly without rhyme or reason, symptoms could be mild or severe. Faced with such uncertainty, everyone made rapid changes in the way they did almost everything that involved others. What began with handwashing and so-called "social distancing" progressed rapidly to "lockdowns" in which we were instructed not to leave our homes except for essential activities, and soon we were instructed to wear masks that covered the lower half of our faces. Communication with others outside of

our individual household very rapidly shifted to telephone and social media platforms, many of which were unfamiliar to the majority of us.

These sudden changes in how we appear, communicate, and relate to others have powerful significance, both in terms of how we navigate this new reality and in terms of the meanings that reverberate through the minds of each of us. The members of AAPDPP who were able to participate in this meeting hosted over the Zoom platform found the opportunity very useful. Several significant themes emerged in this meeting and in personal writings prepared in conjunction with the meeting.

A Paradoxical Separateness

One of the most dramatic and obvious features of the early stage of the pandemic is that we were all suddenly physically separated. Initially six feet apart, we could no longer hug one another, shake hands, or sit side by side. Later, we were advised to stay home, and could not encounter one another as full-bodied humans, but only as voices or two-dimensional images on video. There was a sense of loss and longing, illustrated by the fact that most of the speakers on this Zoom conference began their comments by saying how good it felt to see everyone.

This radical separation was mitigated by the powerful togetherness of a shared experience. Patient and doctor alike faced a serious threat, and often began sessions with an inquiry about the well-being of one another and families, as described by Olarte. Kanter noted that some depressed and anxious patients felt better and speculated that the "twinning of shared suffering" may account for this. Forrest similarly reported that some paranoid and agoraphobic patients felt better because now the world had joined them. Tamerin found members of a depression/bipolar support group to be doing surprisingly well, which he attributed to a "sense of community, human connection, and shared vulnerability." In contrast, patients who avoided the experience of shared vulnerability and made exceptions for themselves elicited complex countertransference responses, as described by Downey.

The peculiar quality of being together in a shared separateness is matched by a second paradox. Staying apart, ordinarily a sign of weakened libidinal ties, is in this case a sign of love and concern. By staying apart, we show care and concern for our own bodies and for those we care about. We acknowledge the vulnerability of our shared humanity and demonstrate resourcefulness in maintaining ties while apart. Silvio and Ingram reported that long-standing groups of peer colleagues had moved to Zoom. Chambers described, "I am pleasantly surprised when

I see my friends or family in Zoom meetings and realize how good it is to see them." Our shared moments of connection are all the more sweet for being hard won.

Seeking an Optimal Distance

An invisible contagion has radically changed the calculus of finding optimal distance. While the multiple meanings of contagion can be expected to emerge later, for the moment the most powerful meaning is the idea that we are all simultaneously both vulnerable and a danger to others. We must maintain a degree of physical distance that would have been scarcely imaginable a few short months ago. Even our language is evidence of the difficulty. We use the expression "social distancing" to describe the collection of behaviors we are using to reduce contagion. Some have objected to this expression, stating that we are practicing "physical distancing" and need not be socially distant. Perhaps those who coined the term "social distancing" instinctively understood something about the inevitable connection between physical and psychological closeness.

In some situations, patients actively distanced themselves from those providing treatment. Sullivan describes a drop in the census on inpatient, crisis, consultation, and outpatient centers. The drop in census he reports corresponds with a general hesitation for patients to seek care, including the care warranted by heart attacks (Krumholz, 2020; McFarling, 2020; Wendling, 2020). Similarly, Pfefferbaum and North (2020) emphasize the impact on mental health of COVID-19. Duan and Zhu (2020) offer suggestions for addressing adverse mental health issues in China.

In Sullivan's department, psychiatrists who might otherwise have been idled were re-assigned to help internal medicine physicians maintain communication with families who were barred from visiting their desperately ill loved ones.

Chambers had previously supervised residents by joining them in their therapy sessions with patients. With telepsychiatry, this was no longer realistic. While she was no longer able to help residents integrate psychodynamic concepts on the spot, they may benefit from greater independence and autonomous connection with patients.

Downes, Forrest, and Kanter all noted that some anxious patients found the new distance from others to be a welcome relief. In hearing their description of that pleasure to their therapists, one wonders whether the distance has created a new freedom to be close to their therapists. Glucksman, on the other hand, noted that some patients with severe psychopathology were struggling with the new distance. Once

we depart the relatively elite socioeconomic strata of our psychiatrists' patient group, matters are far worse, as reported in editorials of *World Psychiatry* (Ghebreysus, 2020; Unutzer, Kimmel, & Snowden, 2020). Our psychiatrist groups, we need to acknowledge, like the patients we treat, are in no way representative.

Changes in the frame went beyond the use of teletherapy. Lopez made multiple modifications to his office to make physical presence safer. Glucksman called patients he saw infrequently, and they deeply appreciated the call. Silvio and Turco, echoing what many feel, expressed the wish to be taking (physical) care of people during this crisis.

Blumenfield notes that many who have tried remote therapy believe that remote sessions are inferior to in-person sessions. Prior to the epidemic, remote sessions were the exception rather than the rule. Of course, there was a need to transition to teletherapy just to keep the treatment and our practices alive. However, the remarkable speed with which we transitioned to teletherapy and the relative low frequency of complaints might be seen as testimony to our commitment to closing the distance between ourselves and our patients.

Finding New Idioms

The small routines of being together that each therapy couple develops are now interrupted. The physical dance as each person settles into position, the latency between greeting and sentence, the shared visual space, all are changed. Best, a patient as well as a therapist, felt that her first telephone session was occupied with finding new routines. Kestenbaum noted that children adapted more readily than their parents. Fyer, relying heavily on non-verbal communication to understand her patients, found it much diminished with remote therapy. Kanter and Ingram wondered about the meaning of virtual backgrounds such as the Golden Gate Bridge in video-based therapy. Chambers, in her classroom work with residents, found them initially reserved in the Zoom platform, adjusting about a month later. Perhaps the effort of building new interpersonal routines accounts for some of the fatigue at work reported by a number of participants.

Reality and Symbolism

In ordinary circumstances, reality and symbolism shift between background and foreground in sessions. In these new and frightening circumstances, participants are reporting increased attention to concrete

reality. Most sessions begin with a "checking in," some assurance that both therapist and patient are well. Fyer said that many treatments have shifted drastically towards practical considerations. Lopez shared his perspective on danger with patients and thus promoted adaptation to our new reality. Friedberg observed patients responding to the single-minded goal of not getting sick and discussing such things as "where to walk the dog, when to buy groceries." Forrest recommends that the therapist should find a way to be useful—to be the helper.

While real concrete concerns took center stage, especially in the first few weeks, symbolism and repetition of past trauma continued to be important. Olarte described a progression of strategies across the early weeks, beginning with education and advice-giving, then interpersonal therapy, and later recognizing the role of past formative relationships in shaping the patient's response to the current crisis. Rothe reported that for a number of his patients the confinement imposed by the pandemic brought remembrances of past abandonments.

Loss, Mourning, and Isolation

While there are moments of sweetness and acts of resilience, it would be a mistake to minimize the loss and pain caused by the pandemic. In addition to the realistic fear that has motivated the changes in clinical work and personal lives, many psychiatrists, their families, patients, and communities are experiencing losses. The full weight of the epidemic does not fall equally on all. Some losses are specific and individual. One clinician reported that two friends had fallen ill and a spouse had become unemployed. Chambers described a sense of depression and deep isolation when she experienced COVID-19–like symptoms. While in China, Pang witnessed fear and tragedy as she supported frontline workers, only to return to New York and contract the illness herself.

Other losses are shared more widely. Many found that the epidemic heightened awareness of aging and mortality. Turco was not accepted as a medical volunteer due to his age and other risk factors. Rothe was struck by an awareness of the passage of time and the loss of loved ones. Glucksman similarly found himself reflecting on illness, death, and mortality.

Some losses are more diffuse and difficult to articulate. Chambers and one of her residents both felt preoccupied and distracted. Sullivan described a drop in the patient census, leaving psychiatric staff largely unoccupied. A number of people commented on inexplicable exhaustion associated with telepsychiatry. Fyer noted the loss of the energy that fills the room. Rubin, quoting Petriglieri, says "Our minds

are tricked into the idea of being together when our bodies feel we're not. Dissonance is exhausting." Ingram similarly reported fatigue, and Katz-Bearnot described taxing aspects of teletherapy.

CONCLUSION

The ideas expressed in the Academy's Zoom meeting of April 13, 2020, were wide ranging, and included both painful and enjoyable experiences. They represent a snapshot of one point in time, early in this pandemic, and emphasize the elite demographic of the psychiatrists and their patients. The current period of rapid change and dislocation is drawing to a close. Already, social distancing and face masks are becoming routine. How long will this go on? What further phases will we pass through? How will the themes of isolation, community, grief, and loss evolve? We wonder what the future holds. Will a medical solution be found as was the case with smallpox and polio, or will we simply grow tired of mitigation practices, such as social distancing, and accept the inevitability of ongoing illness (Kolata, 2020).

Our human connectedness and our shared curiosity about the human mind have shaped our experience of the early weeks of the pandemic. Whatever happens next, our reliance on these same qualities will be essential to sustain our wellbeing and that of our patients.

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