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Psychotherapy with Patients More Deeply Troubled During the COVID Pandemic

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ABSTRACT

During the present pandemic, patients with psychiatric illness may become more emotionally troubled for several reasons, such as increased financial stress and social isolation. When their difficulties increase, this poses increased challenges for the mental health care providers treating them. These providers may then respond in several ways to try to meet these patients' increased needs.

This piece will present five ways the author, a psychiatrist, has sought to do this. Though only anecdotal and thus not evidence-based with larger numbers, they may prove helpful to other providers seeking to meet these current challenges.

Keywords: Pandemic, Psychotherapy, Bibliography, Self-disclosure

INTRODUCTION

During the present pandemic, patients with psychiatric illness may become more emotionally troubled for several reasons. These reasons may include, for example, increased financial stress and social isolation. As one psychiatrist recently said this, "It only takes 1 traumatic event to trigger posttraumatic stress disorder (PTSD)," but "the confluence of political instability, a deadly pandemic, economic collapse and racial tension were like the 4 horsemen of mass PTSD" [1]. They may feel that "something destructive and vast is making all of this happen and that no one is stopping it or protecting them from it" [2].

If and when their difficulties increase, this poses increased challenges for their mental health providers. These providers may then need to find new ways to optimally help these patients. The author, a psychiatrist, presents here five interventions that he has found appear to be exceptionally effective. These are, of course, only anecdotal and, thus, not empirically evidence-based. The gains or maintenance of well-being patients have reported, too, may be due, even entirely to other factors. It may even be that these interventions have harmed, not helped. The first intervention, increasing contact, may, for instance, have reinforced any proclivity patients had for un-adaptive dependency. Their response to each intervention would, however, suggest that this was not the case. Times of increased frequency of contact were, for example, short-lived. Once patients' increased turmoil was resolved, by mutual agreement, this added frequency of contact was decreased and the usual, longer time between contacts resumed.

The potential gains from these interventions may, notwithstanding these limitations, be useful to providers provident psychosocial support to patients, especially during the time we and they remain exceptionally stressed by the COVID virus. I present them as potential additions to provider's usual practices in that they might want to consider adding them now in some way or another to their usual clinical practices.

There is in general, of course, widespread agreement that if therapists have a strong therapeutic relationship with their patients, this may best protect their patients from emotionally declining [3]. This principle underlies, then, all these interventions. Their core theoretical basis would be then in attachment theory [3,4]. That is, if patients can sufficiently trust their therapists, this may most sustain them through rougher times. As one therapist has said this, "When the client started to feel safe in the relationship and could trust the therapist, their sense of connectedness tended to

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increase, their perspectives changed and suicidality decreased" [5]. Therapists may, then, generally seek to act in those ways that will increase these connections [5].

This effort may, of course, too, pose emotional challenges to providers themselves. One therapist reports now, for instance, that after therapy sessions now, he feels more tired. He suspects that this is due to the additional wear and tear this pandemic exerts on him [2]. Therapists may feel in addition or instead, though, even buoyed up after these sessions. These efforts may give providers more continuity with what they have done in the past. They may also give them greater meaning in their lives by being more able to help. As one therapist noted, "any of us need to be connected with someone" [5].

I. FIRST INTERVENTION: MAKING MORE FREQUENT CONTACT

There is, perhaps, no awareness more critical to patients than their knowing that their therapist is there for them as their back-up. This supposition is based on attachment theory which itself is buttressed by empirical studies supporting it. Research has been conducted, for example, in which toddlers have been purposefully stressed and then observed as their mothers go in and out of the room they are in.

Providers, like mothers' succeeding in letting their children know that even when out of the room, they are there, may sustain adult patients, too, so that emotionally they feel better [4,5].

An initial new step may be, then, for therapists and other providers to take initiative to contact these patients more often. They should continue this only, of course, if these patients indicate that this is what they want. Patients may say that they want to talk more often, as, for example, for shorter times but more time every week.

I ask myself when deciding who I shall ask this which patients seem more vulnerable, and I call these patients first. One therapist has called patients at first several days each week. This exceptional "initial holding" this therapist reports, "get[s] some light into the darkness" [5]. Increasing this frequency has been shown in several studies to tend to result in quicker, more positive outcomes [5].

When I have called, patients seemed pleased to unexpectedly hear from me. Some have said they had wanted to call but did not.

Often, it is enough to just ask these patients to say what is most often on their minds. Patients may then, when we only listen, go on to share memories also fraught with distress. They may then report longer term relief, having been able to share this.

I asked this of one patient. He said that he had just had a spat with his grown son. I asked him then how, more generally, he felt toward his son. He said he felt proud and that his son helped care for people homeless. He felt then, he said, much better. As another provider has said, patients' course is likely to be better when an insight they discover "comes from the client's own wider belief system than from that of the therapist" [6].

An effective approach often used in brief therapy and built on this above principle is to ask patients sharing such stress what has worked for them in the past [7]. He said that as he just had, thinking of his pride in his son enabled him to put these angry exchanges behind him. I asked him then what if anything made his doing this most difficult for him.

He said his believing that his son could and should do better. I informed him that sometimes people have beliefs wholly wrong but beyond their capacity to dispute and control [8]. He had not imagined this, but hearing it and then considering this, he reported feeling even greater relief.

II. SECOND INTERVENTION: USING METAPHORS

Some patients' pain may be caused mostly or even wholly by others. Their pain may also, of course, be a two-way street. When one person regularly abuses the other, however, the abuser may blame the other and the other may then accept this blame and become clinically depressed.

The person abused may be, in addition, exceptionally emotionally "sensitive". They, then, may be still more vulnerable for this reason to mistaking this abusing person's problems as their own. One therapist has put this this way: "Toxic relationships can have a negative effect on one's ability to develop adaptive connections with others due to perceived lack of safety and trust in relationships. Such relationships may also have a negative impact on an individual's self-connection as they can inform themselves that they are incapable of developing meaningful connections and thus are not worthy of life [5].

Few among us are so sufficiently confident that we never need or benefit from external confirmation. Attachment-based therapy which provides this confirmation is particularly beneficial to persons who "exist" in toxic relationships. This provides them another relationship in which they can know that they can, in a healthier way, still connect [5,9].

Another such patient I saw was devoted to a partner addicted to alcohol. When this partner became drunk, she would verbally greatly abuse him. He chose still to stay in this relationship, as he had, because he hoped that in the future, she might get better. He knew he could end it. His need at this time as he expressed this was to find some better way to weather her abuse as he "held on". One major source of his pain was that he kept trying to "get through"

to her and could not. She promised then to change her behavior, but she "never did". He felt that this failure was his fault.

Here, I reminded him that he had choices and that though we often can't change others' behaviors, we may at least to a degree, change our own. Prior to saying this, I stated my intent before I said this.

I did this - and do this when it seems needed - to lessen the risk that my saying this to him would result in his feeling infantilized. My intent was to help him reduce his feeling that he had repeatedly failed.

We first discussed grounding techniques. These included breathing, imagining - or actually - sucking on a lemon and the use of all the other senses. I sought then to give him a metaphor that he could refer to visually, immediately, whenever he felt he was failing [6]. I asked him whether he thought that he might be banging his head against a wall. Another therapist who had done this reported an immediately beneficial result. This therapist said this to a patient who then immediately recognized that "talking to a wall is a foolish thing to do" [6].

I would not be doing this usually for several reasons. First, this is "leading" the patient. As we have seen, it may be preferable to facilitate patients themselves discovering their answers. Second, my doing this creates the risk of patients seeing me as disparaging those they care for. If the relationship is sufficiently strong, this risk may be less. My indicating in advance what I will say and why, as I have described above, is an additional precaution.

This greater visual directness of a metaphor may be warranted, nonetheless, as a more rapid way to free patients from continuing to respond in ways that for them have proved futile [10-14].

This may have had this effect. This patient then set new limits and their relationship then went a different direction. This may, too, have helped result in this patient's then resolving his depression.

III. THIRD INTERVENTION: RECOMMENDING READINGS

Psychotherapeutic DVD's and books may be beneficial [15,16]. Providers recommending these, particularly at this time, may be helpful by providing patients additional means by which they can work on their own between sessions when they are at home. Two caveats: Providers doing this should make clear that their patients should fully permit give themselves to not do this if this feels burdensome since they may already have too much stress at this time. Second, they should indicate that they will not be asking patients whether they have followed through on these readings, though if they would want to later discuss them, they, of course, can.

Therapists doing all they can to recommend to patients a resource most fitting their needs also further conveys to patients their provider's commitment to their doing maximally well. My recommendations, spurred by patients' increased needs over this pandemic, have gone many different ways, accordingly. These have ranged from my recommending self-help books, like one of my favorites by Kristin Neff, to pieces on the internet describing grounding techniques as I have alluded to [17].

The example which most illustrates this effort to match the resource to the patient's interest is, however, the following. This patient loved philosophy. She came in when I first saw her, I remember, with a book by Descartes. She had become during this pandemic newly discouraged. She had been seeking after having put her career goals first to then find a partner as she had previously planned. During the pandemic, this was, of course, more difficult. We discussed then Nietzsche's theory of Eternal Recurrence, which encourages one to choose to do today what they would want to do forever if this was their only choice [18]. She then read this writing by Nietzche and said that this helped inspire her to make different choices more productive and fulfilling for her in the "here and now". These examples may not be all right for others but they are paradigmatic of the wide range of resources that providers can suggest to patients. Providers' primary limitation here is likely the extent to which they are aware of such references.

Providers may, too, in a like manner, want to share stories. These may "get through to patients and move them in a way that slower discovery relying, for instance, more on bit-by-bit discovery through associations may not. Stories may also enable patients to connect with people in the story more emotionally and immediately, as with a metaphor and in addition then to feel not so alone.

An example, here involves a Native American patient who was feeling bad for something he in his past had done. We reviewed doing what to make up for this he could do. Then I shared with him a Native American so-called "windigo" story that he didn't know [19]. A windigo is a monster who eats people. In this version, a weasel, pure white and shiny, saves his people by crawling up this windigo's bottom, chewing up to the windigo's heart and killing him. This weasel then keeps going on and comes out the dead windigo's mouth. This weasel is soiled, but another picks him up then by the tail and dips him in a cleanser.

This weasel is clean again. He is able to proceed newly. He still, though will have a small spot on his tail.

This patient then grinned. He got the point feelingly and it might be that this is what in part helped to divert him more quickly and in a more positive direction.

IV. FOURTH INTERVENTION: CALLING IN FAMILY

A fourth patient was formerly an executive who had been laid off. He had been used to telling others what to do and having this followed. He also then did this with his children both before and after they became adults. This, of course, caused them to become more distant from him. Now, with the additional isolation brought forth by this pandemic, he became depressed.

I had little to offer him. He missed his children and he had brought this on himself and then knew this. I asked him then if I could call each of his adult children. He said yes [6,20,21]. Each then shared the not surprising same story. The story I already knew. He had treated them as he had his employes.

I initially told each why I was calling: "The one thing that I can promise they care for," I said, "is that I will try to *hear* you. This is all that in calling I have in mind. But this would be most helpful to me." I relied here on the most disproportionate gains made from just listening. I was mirroring another therapist who likewise said, when pursuing this same end, "I will actually with a heart and a half, look to sit with you and really try and have an opportunity to walk with you through this time" [5].

Each seemed glad to talk. I don't know, why what then occurred, occurred. It may be as another therapist has said that he was able to "promote calming while also remaining responsive to the needs for changes to occur, "thus providing" a key antidote to the prevailing forces at work [21]. My phone calls in any case seemingly triggered their willingness to re-contact him.

Members in families "are often in pre-contemplation as to their own role in the problem in terms of stage of change" [21]. Providers may then by contacting family members with permission possibly release "pre-contemplation" that is already there. This may too evoke hope. I should add that when calling these family members, I above all else sought to remain and more than this communicate that I was and would be wholly non -judgmental. I made clear to them that as I was not judging him for giving them orders, I was not judging them for shutting him out in response [21]. The message here must be that there is no panacea but that the situation can change and that even one individual can significantly reduce the level of dysfunction and conflict [21].

V. FIFTH INTERVENTION: SELF-DISCLOSING

A last patient would not leave her house. She, too, had lost her job as a result of the pandemic and then became depressed. She too felt afraid. She feared people protesting the election results would go after her or harm her house and the police, overcome, might then not come.

A first need here I believed was to help her overcome her shame. "Would you judge others for losing their job as you have done?" I initially asked here as my and others' common entry into this fray.

I informed her before saying this that I would be asking her a question that could sound like a criticism but she should know and would see that this was not my intent. She responded to this just as I hoped. She uttered more or less an "Aha!" [22] "No," she said. She added that she had not thought of this.

I then asked her to tell me more about how she had been laid off. Here, I was merely pursuing what I said before, her talking and me listening. She described for me her pain at feeling helpless. I then shared with her how and when I had felt helpless too, adding that this was I believed among the most painful feelings we can experience. I then went further with this and spoke to of my anger.

She in response, hesitating slightly before speaking, said that this anger, too was what she had felt. It in fact, she then acknowledged, was what was keeping her inside. She feared what she might do if she went outside. She was sure she would not but this fear itself that she could was just too much. Her staying inside lessened this. This freed us, it surely seems, to go a different course which, newly focused on her anger, was beneficial [23].

CONCLUSION

I have shared here five interventions that I have come to use and rightly or wrongly see as likely beneficial for patients, especially during our current pandemic. I have heard that up to a third of people may be, due to this, more anxious and/or depressed. Thus, more impactful techniques, promoting more rapid responses, may be now needed. Those I offer here are all already well known, but providers not thinking of them presently may not be as likely to consider and then use them.

The overall goal of this piece is then to highlight these particular interventions in the hope that providers of every sort may freshly consider these and other approaches favored by them to see if now they now want to use them. These five interventions are fundamentally intended to be paradigmatic, to encourage providers to take steps they otherwise might not choose to take.

All have in common that they are intended to help offset the additional stress caused to patients by this pandemic. These interventions are calling more and taking initiative to talk more, using metaphors, suggesting readings, involving family members and self-disclosing. They each may be regarded as helpful primarily because they are additionally supportive. A provider has voiced their underlying rationale to be that supportive therapy "may be the most important tool we have in helping patients with loss and uncertainty during these challenging months" [24]. He adds

that "simply staying in contact with patients plays a major role in preventing care discontinuity" [24]. Other supportive interventions may have similar, beneficial effects [25].

This piece, through this discussion and case examples, hopefully then will encourage providers to use interventions they otherwise might not use. Those listed here would be unlikely to be harmful, with the possible exception of self-disclosure. As I have indicated above, however, in the case of calling more, even if there are potential cons, pursuing these additional interventions may be warranted. Our pandemic is for us unprecedented. Exceptional interventions may be necessary or at least optimal to counter this threat.

DISCLAIMER

The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.

CONFLICT OF INTERESTS

None.

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