COVID-19 and the psychiatrist/ psychoanalyst: My experience

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How I adjusted my practice during the pandemic to keep my patients at the forefront

COVID-19 affected all aspects of psychiatric care. As a psychiatrist who is also a psychoanalyst, I faced some unique challenges to caring for my patients during the pandemic. In this article, I describe how COVID-19 impacted my practice, and how I adjusted to ensure that my patients received the best possible care.

The loss of 'normal'

Our recognition of the loss was not immediate since no one knew what to expect. From March 11, 2020 through the end of the warm weather, when we could be outdoors, personal life was still gratifying. There was even a new spirit of togetherness in my neighborhood, with people seamlessly cooperating by crossing the street to avoid getting too close to one another, practicing proper social distancing in the grocery line, and smiling at everyone.

November 2020 through Spring 2021 was an unprecedented period of no socialization and spending time exclusively with my husband. By the end, I was finally aware of the exhaustion I felt trying to work with patients via phone and video sessions. Beyond that, we were (and still are) conducting administrative meetings and national organization meetings by video.

Spring 2021 until the arrival of cold weather felt more relaxed, as socializing outside again became possible. But from Winter 2021 to now has been a weary repeat of

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isolation, and a realization that my work life might never go back to "normal." I would have to make peace with various sorts of losses of gratification in my work.

Life before COVID-19

I am a psychiatrist and psychoanalyst in a group private practice near the University of Cincinnati Medical Center. As a former full-time faculty member there, I maintain some teaching and supervision of residents. I typically see patients from 8:30 AM until 6:30 PM, and for years have had an average of 5 patients in psychoanalysis on the couch for 3 to 4 sessions per week. I see some psychotherapy patients weekly or twice a week and have some hours for new diagnostic evaluations and medication management. In addition, as a faculty member of the Cincinnati Psychoanalytic Institute, I take part in several committees, teach in the psychotherapy program and psychoanalytic training program, and supervise students and candidates. Most weeks, I see between 35 and 40 patients, with 4 to 6 weeks of vacation time per year.

Major changes with the onset of the pandemic

Once the threat from COVID-19 became clear in March 2020, I thought through my options. My office comprises 5 professional offices, a waiting room, and an administrative area. Our administrative assistant and 1 or 2 practitioners were in the office with me most days. We maintained appropriate distance from each another and wore masks in common areas. The practice group was exemplary in immediately setting up safe practices. I learned a few colleagues were seeing patients outside using lawn chairs in the back of our lot where there was some privacy, but many stopped coming to the building altogether.

I felt real sadness having to tell patients I could no longer see them in my office. However, I was relieved to find how quickly many patients made an immediate transition to telephone or video sessions. Since I was alone in my office and not distracted by barking dogs, ringing doorbells, or loud lawnmowers, I continued to come to the office, and never switched to working from home.

Since I was not vis-à-vis with patients on the couch, those sessions shifted to the telephone. I offered psychotherapy patients the option of video sessions via the Health Insurance Portability and Accountability Act–compliant Doximity app (doxy.me) or telephone, and found that approximately 75% preferred video. When I used the telephone, I used a professional-grade headset, which made it less onerous than being tied to a receiver, and I occasionally used the speaker option. I also installed a desk platform that allows me to raise and lower my computer from sitting to standing height.

I worried a great deal about patients I felt would do poorly with video or telephone sessions: older adults who found comfort in human contact that was sometimes curative, less well-integrated individuals who needed real contact in order to feel there was a treatment process, those with serious mental illnesses who needed reassurance at their reality-testing, and new patients who I couldn't fully assess without in-person meetings.

In the beginning of the pandemic, as we were still learning about the virus, nothing seemed safe. We were washing our hands constantly, afraid to touch doorknobs, mail, or groceries. Thankfully, we learned that COVID-19 transmission occurs primarily through inhalation of droplets and particles containing the virus.[1] Masks, good ventilation, and adequate distance from others considerably cut infection rates. By January 2021, the availability of a vaccine made an enormous difference in vulnerability to severe illness.

When I stopped seeing patients in my office, I set up the conference room that had doors on either end so I could sit on one end of a table and have the patient at the other end, keeping about 8 feet between us. I also kept a fan blowing air away from me and parallel to the patient. After each session, I opened both doors to allow for full ventilation of the room. This provided a solution for the patients I knew I needed to meet with in person.

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Seeing patients during COVID-19

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Seeing patients in their homes or cars during video sessions allowed me to gain a new set of impressions about them

Case examples: How it worked

The following case examples illustrate how I provided care during this time. To protect patient anonymity, these vignettes are composites.

Psychotherapy patients

Established patients in psychotherapy have seemed to work well with video or telephone sessions. The video option added a new element I never appreciated: seeing patients in their homes or cars allowed me to gain a new set of impressions about them. The use of technology is clearly another element I would not have identified before. Less technically adept older patients are likely to join a video session with only the top of their head visible, or with insufficient lighting. In some cases, I coached patients to rearrange their computer so I could see their faces, but only if it seemed that doing so would not cause them greater distress.

Ms. A, age 74, is a widow who retired from a high-level professional position 5 years ago. She was brought to the hospital due to ongoing anxiety, especially about her health. Ms. A maintained a wide range of relationships with friends, colleagues she mentored, and neighbors who provided a satisfying social network, and she continued to contribute to her field via scholarly writing projects. Before the pandemic, she found occasional sessions helpful in putting her health fears into perspective. When the pandemic led her to isolate at home, Ms. A became anxious and depressed to an unprecedented extent. Video sessions were unsatisfying, and she was terrified of taking tranquilizers or other medications. Once COVID-19 vaccinations became available and both she and I received both doses, we switched to meeting in the conference room every 2 to 3 weeks, with considerably better results.

Mr. B, age 41, is a single male who I diagnosed with schizophrenia at age 19 when he developed paranoid delusions and auditory hallucinations. Mr. B was not interested in taking antipsychotic medications, and his situation did not improve even when he did try taking them. He volunteered at a local emergency department doing odd jobs—moving gurneys, cleaning rooms, hauling boxes of supplies—for many years, and had always been employed in jobs such as grocery stocking or janitorial work that did not involve extensive interactions with people. He repeatedly enrolled in programs that would provide a skill such as phlebotomy or medical billing, only to find that he was never hired for such work. We talked once a month for 30 minutes about his frustrations trying to find women to date and marry, and how he was repeatedly taken advantage of (one "date" from an escort service took him to an ATM and got him to withdraw most of the money in his account).

Coincident with COVID-19, Mr. B's father died from widespread metastatic cancer. His father had been Mr. B's guide, friend, payee for Social Security Disability Insurance funds, and source of advice. To provide humane and somewhat effective treatment, I saw Mr. B in the conference room. His capacity to express grief and distress at the loss of his father has been impressive, as has his initiative in finding a grief group to attend, which he has done consistently.

Several patients who had been seeing me for weekly psychotherapy chose not to continue, many without specifically informing me of their decision. I understood the situation was in flux, and it would not be clear to anyone what to expect for the future. To avoid pressuring anyone, I chose not to contact patients to inquire about their plans.

Ms. C, age 50, is a professional with 3 children whose marriage had been highly dissatisfying for years, and she was now ready to investigate it. She was very successful in her career, having taken on a leadership role in her firm and earning a high income, while her husband was erratic, unreliable, and self-absorbed. Though he was well-educated and competent in his field, he could not maintain employment in a corporate environment and worked as a consultant with relatively little success. Along with the hours she spent working, Ms. C took responsibility for the family finances, was the chief wage earner, managed the needs of their children, made sure meals were prepared, and took on many other responsibilities.

We agreed to a weekly session that fit Ms. C's schedule, and she seemed able to

Box

Suggestions for optimizing self-care

Self-care has always been a requirement of doing psychotherapeutic work, and I encourage practitioners to be sure they are attending to themselves. We can't be effective as listeners, empathizers, diagnosticians, and problem-solvers if we ourselves aren't healthy. We evaluate our patients in terms of mood, outlook, sleep, appetite, energy, motivation, and energy; we also investigate their capacity for relationships that are sustaining. Self-care is the same, taking care of both our physical and relationship beings. Getting enough sleep, exercising daily, cooking healthy meals, and making time to relax are all ways of caring for our physical identities that should have been in place before COVID-19. Making personal time for ourselves in the face of constant demands for time from patients, colleagues, partners, children, parents, siblings, and friends never happens without the resolve to do it.

As a psychiatrist who is used to sitting for up to 10 hours per day, I strongly recommend making a daily habit of walking, running, biking, or using an elliptical trainer, treadmill, or stationary bike for 30 minutes or more.

Sleep is necessary for adequate concentration and attention to patient after patient. If you have trouble sleeping, talk with your doctor about remedies. If you use a sleep aid, I strongly recommend alternating medications so you don't develop tolerance to any of them.

Plan your food and cooking ahead of time so you aren't tempted to order out. If you cook simple meals yourself (ideally with your partner helping or in range so you can chat), you will consume fewer calories, less sodium, and more nutrients.

Even if you have a spouse and young children at home, work out a plan with your partner that allows each of you time for exercise or to recoup after a long day with patients. Babysitters allow you to take the time to be with each other that is necessary to sustaining a connection. Think about time for sexual intimacy if that has dropped off the calendar.

Relationships with others, such as parents, siblings and their families, and friends are invaluable. The time spent with others might seem inconsequential, but is critical to our internal sense of security, even in the face of external disorder.

relax and talk about herself. I found Ms. C quite likeable and enjoyed meeting with her, though I worried about whether we would need a greater intensity to get at the reasons such a successful and intelligent woman would fear setting limits with her husband or even considering ending the relationship. The reasons were clear as we put together the story of her early life, but conviction only develops with full emotional awareness (transference provides this in psychoanalysis).

The pandemic started approximately 18 months into our work, and Ms. C disappeared. She called my administrative assistant to cancel further appointments but did not ask to speak with me directly. While I knew this might represent resistance, I also felt unwilling to pressure Ms. C if she chose not to continue. I remain hopeful that I will hear from her once again; if not, I will send a note by mail to say that I enjoyed working with her, am happy to see her again, and hope she found some benefit from our work.

Mr. D contacted me for psychotherapy following the death of his father, who I had seen as a patient many years earlier. I was aware of the likely impact of his father's outsized personality and emotional dysregulation on Mr. D and agreed to meet with him. He had taken over the family business and had made it an even greater success, but had trouble feeling confident about setting limits with employees who he knew took advantage of his avoidance.

Mr. D and I met weekly for several months and then moved to every other week, a form of resistance I expected as we got closer to his feeling pain. At the same time, I recognize that many patients use this tactic to "dose" themselves with the intensity they can tolerate, and Mr. D was quite observant and able to pick up themes where we'd left off.

When the pandemic shut down office visits, Mr. D immediately agreed to video sessions, which he has continued at roughly the same frequency. While I miss sitting with him, we continue to make progress towards his goal of learning to see himself as able to compete with his father.

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Audio-only communication might encourage patients to talk about topics they might not have otherwise brought up

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Via video, I have done many diagnostic evaluations and gotten treatments underway without discernible problems

Psychoanalysis patients

I found that patients in psychoanalysis had no trouble with the transition to telephone sessions, and the intensity of the work was not diluted. In some ways, audio-only communication is more intimate and might encourage patients to talk about topics they may not have otherwise brought up. I have not seen any evidence of less progress among these patients.

Dr. E, age 45, is a divorced physician who began psychoanalysis 3 times per week on the couch in 2018 for problems with frustration and confusion about his career, his identity as a father, and intense loneliness. He had worked up to 80 hours per week to earn as much money as he could, but also to avoid time at home with his then-wife and young children. The lack of time to recover led him to hate his work, left no time for social connections, and led to binges of heavy drinking. Our work had begun to allow him to develop a narrative about his early life that had never been considered, and to identify patterns of repetition of old defensive strategies that had never served him well.

At the onset of the pandemic, I told Dr. E that we would have to switch to telephone sessions, and he agreed immediately. In fact, he came to prefer telephone work since it spared him the 2 hours per day he had spent coming to my office. While I found it less satisfying than working in person, we have continued the same schedule and with the same intensity and trajectory established before the pandemic.

Working with new patients

Seeing new patients for diagnostic evaluation is always best done in person, because the information I gain from the patient's appearance, clothing, demeanor, gait, postures, gesturing, and facial expressions (among other elements) gives me important impressions I miss with video or telephone. In many cases, patients gain a sense of who I am from sitting in my office, and using the conference room eliminates that benefit. I attempted to create a warm environment in the conference room by obtaining lamps that produce warmer indirect light and hanging artwork that reflects my tastes. There are clocks in places that allow me and my patient to keep track of time. In meeting new patients by video, I get some impressions about their surroundings that add to the information I get through our interview. I have done many diagnostic evaluations during the pandemic and gotten treatments (whether medication, psychotherapy, or both) underway without discernible problems in the outcomes. Patients who started with me in person have mostly wanted to continue with in-person meetings, but as many have told me, interspersed video sessions save them travel time.

What about vaccination?

Once COVID-19 vaccinations were widely available, I assumed patients would be as eager to get them as I had been. When I began asking patients about whether they had gotten their vaccines, I was surprised to hear that a few were not going to get vaccinated, clearly based on political views and misinformation about the danger of vaccines. (The topic of political beliefs and their impact on psychological treatment is beyond the scope of this commentary.) I tried to counter obvious misinformation, repeated my recommendation that the patient get vaccinated, and then turned to other topics. I later decided to tell all patients that vaccination was required to enter the office. Only 1 patient who had been coming to the office dropped out, and she eventually returned to meeting by video.

COVID-19's toll on the therapist

While the first several months of the pandemic were so full of uncertainty about the future, once vaccinations were available, it seemed cause for hope of a return to normalcy. As time went on, however, it became clear that normal was still a long way off. With vaccine refusal and new variants upending my naïve view that we were near the end, I began to feel aware of the impact this had on me, and began to focus on self-care **(*Box, page 31*)**. I had always seen myself as unusually lucky to have a full practice, a supportive partnership with my husband, grown children who didn't need me to homeschool

them, a strong social network of friends who could share the burden and cheer each other up at outdoor gatherings, and a wonderful group of siblings and in-laws (all in different cities) who stayed in touch via video calls and quarantined in advance of getting together in someone's home.

Staying busy and engaged with my practice, spouse, family, and friends kept sadness away most of the time. But I surprised myself a few months ago when I sat down to reflect and check in with myself. I felt enormous loss, resentment, and exhaustion at the privations of the pandemic: every trip to the grocery story felt dangerous. I hadn't seen the inside of a concert hall, movie theater, restaurant, or museum in nearly 2 years. Travel for meetings and visits to family and friends and various adventures had been abruptly stopped. I lost both parents (not to COVID-19) during 2020; both were older adults living in senior communities that could not allow visitors. The usual grieving process would include attending services at my synagogue where I could say Kaddish for them, and video services were simply not tolerable.

Most of us have become experts at video meetings and likely have come to despise them. While our Institute has always held classes with some out-of-town students joining by video, with a very sophisticated system that provides excellent sound and visual fidelity, teaching entirely by video is another matter. I now teach students I have never met in person and might not recognize if I passed them in public. The art of creating discussion around a table is much more difficult on a computer screen. The first class I taught to residents during the pandemic was completely disorienting as I faced a wall of black screens with names and silence. Each student had turned off their camera and muted their microphone, so I was lecturing to a computer. That never happened again after I insisted on seeing everyone's face and hearing their voices.

Thankfully, my usual experience of a long day seeing patients followed by chatting while cooking dinner with my husband and walking the dogs before settling down to read didn't change. But the pleasure of sitting with patients was replaced by the daily grind of figuring out who will need a video link, who will be on the telephone, and who will come to the office, and it doesn't feel the same. Again, in the big picture, I realize how fortunate I have been, but it's been a big change in the world of the psychotherapist.

References

1. Centers for Disease Control and Prevention. COVID-19 frequently asked questions. Accessed March 8, 2022. https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Spread

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