

It is illegal to post this copyrighted PDF on any website. Psychiatry's Niche Role in the COVID-19 Pandemic

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The challenges that confront mental health professionals during a pandemic reach beyond the realm of disaster psychiatry to encompass skills in crisis counseling, public health, organizational behavior, psychopharmacology, and providing mental health support services to nonpsychiatric health care workers. Psychiatrists, like all physicians, may respond to the “all hands on deck” battle call from many health care institutions—deploying wherever and however the communal effort demands. Our primary expertise, however, entails distinguishing and managing normal from pathological responses to stress. It is that unique professional role I wish to address here, examining how we can best implement its accompanying skill set in the coronavirus disease 2019 (COVID-19) crisis.

Let us first consider the needs of existing patients, including efforts to maintain continuity of care and anticipate how the psychosocial ramifications of the COVID-19 pandemic may exacerbate underlying psychiatric disorders. A pandemic creates its own objective reality as a backdrop for all forms of psychopathology. Do economic downturns, job layoffs, prolonged school and business closings, and threatened supply chain disruptions lend validation to depressive nihilism? Do handwashing mandates become a paradoxical injunction for patients with contamination-fearful obsessive-compulsive disorder? Some patients, preoccupied with more idiosyncratic concerns, may fail to grasp the reality of a true threat when it actually exists. And, for everyone, when does binge-watching the news during a time of crisis cross the line from anxiolytic to anxiogenic?

Patients oriented mainly toward pharmacotherapy may contact their psychiatrists because of increased emotional distress, reflexively requesting dosage increases of antidepressants, anxiolytics, or other medications, when in actuality it may be more appropriate to offer reassurance and counseling—or at least, advise a telemedicine assessment before assuming that medication dosage adjustments are warranted. How does the concept of telepsychiatry work for paranoid patients, or those who may be particularly uncomfortable with possibly less privacy or apprehensive about technological barriers? Other examples of potential

obstacles to performing usual work via telepsychiatry include (but are certainly not limited to) the following:

- assessing and safely managing alcohol, benzodiazepine, or other outpatient detoxifications;
- dealing with practical implications for acutely suicidal or self-injurious patients, particularly if assessment in an emergency department is not feasible;
- managing acute agitation or potential violence in patients from whom a more contained treatment setting might be preferable (but not necessarily mandatory);
- compensating, somehow, for the absence of team-based ambulatory programs (such as intensive outpatient programs or day treatment programs) that may be unavailable;
- addressing requests for new controlled substances or sight-unseen dosage adjustments for existing other medications in lieu of a proper assessment;
- maintaining uninterrupted administration of long-acting antipsychotic or other intramuscular injections (eg, naltrexone);
- greatly modifying physical examinations when relevant (eg, assessing involuntary movements); can dizzy patients measure their own orthostatic blood pressure changes?
- for consultation-liaison psychiatrists, determining when and how teleconsultations will be feasible.

For patients involved with 12-step recovery programs, online meetings can partly help to sustain the social connectedness thought to be critical to the recovery process, but the specter of social isolation may itself pose an increased risk for relapse. For that matter, crises can flush out ambivalence, and anyone loosely committed to their own treatment might readily capitalize on the pandemic to justify and rationalize taking a hiatus.

Answering the Call

As many states, and institutions, are asking mental health professionals to volunteer their services via hotlines for anyone in the community feeling pandemic-related distress, psychiatrists who render counseling services essentially perform several tasks apart from pure counseling (as defined mainly by active and empathic listening). Those other tasks include the following:

- assessing safety risks and risk factors (eg, for a distraught, recently unemployed older adult overwhelmed by consequent economic and social problems who lives alone);

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- differentiating psychopathology from nonpathological distress—this means ascertaining a history of past psychiatric or substance use problems (and treatments) that may now be recurring and warrant more formal intervention, including a role for pharmacology and subsequent monitoring and follow-up. In fact, during a crisis, the *absence of anxiety would be aberrant*. Anxiety, unlike panic, helps us maintain vigilance. Psychiatrists discriminate anxiety states that are normal (ie, motivating, and not incapacitating) from those that are pathological (ie, paralyzing, nonproductive, and displaced). Similarly, complaints of “depression” after major life upheavals can turn pathological if they entail apathy, despair, or anhedonia rather than chagrin or frustration (with the latter likely being a better substrate for psychotherapy than pharmacology);
- judging the extent to which exposure to traumatic events is likely to predispose to future posttraumatic stress disorder;
- deciding when short-term pharmacotherapies may be appropriate for symptom-based relief for distressing but technically “nonpathological” symptoms such as insomnia or apprehension that do not constitute a psychiatric syndrome;
- advising about possible pertinent adverse effects from psychotropic drugs that may increase risk for COVID-19 complications—eg, the rare possible myelosuppressant effects of carbamazepine, divalproex, and all antipsychotics. It is unknown whether benzodiazepines could jeopardize respiratory drive in anxious COVID-19 patients with fulminant pulmonary symptoms, but potential anxiolytic benefits may outweigh such theoretical risks.

Broader public health concerns may leave some psychiatrists feeling tasked outside their usual scope of practice. That could mean answering questions about morbidity risk factors from COVID-19, sharing health department guidelines about quarantining, and even entertaining questions about proposed novel therapeutics such as hydroxychloroquine. Now is an ideal time for psychiatrists to refresh their general medical acumen and stay current with COVID-19 medical developments.

Pandemic Adjustment Disorders

Reformulated under “acute stress disorders” in *DSM-5*, conditions formerly called “adjustment disorders” are, by definition, self-limited, but nevertheless warrant attention in order to both alleviate suffering and minimize progression to more enduring conditions. Pharmacotherapy should, ideally, facilitate psychotherapeutic goals and foster an overall sense of resilience—that is, the capacity to withstand adversity without becoming overwhelmed by a stressor and without developing psychopathology. Arguably, efforts to enhance

resilience are at the core of all psychiatric treatments, particularly in times of crisis.

The pharmacotherapy literature for adjustment disorders is meager and far less well established than the psychotherapy evidence base. While antidepressants such as selective serotonin reuptake inhibitors can be entirely appropriate in people with syndromal depression or formal anxiety disorders, evidence to support their use for adjustment disorders is scant (apart from 1 placebo-controlled trial of citalopram for complicated grief¹ and 1 small open trial with bupropion for bereavement without major depression²). Controlled (but mostly small) trials in adjustment disorders exist with benzodiazepines for short-term anxiolysis (notably, alprazolam, lorazepam, or diazepam) and sleep aids (especially trazodone).³

Apart from performing clinical assessments as described above, the fundamental treatment foci of crisis work involve helping people (a) manage immediate physical or emotional distress by providing verbal support, education, skills, and targeted pharmacotherapies when appropriate and (b) identify and implement strategies to better cope and solve tangible problems. “Distress” from crises commonly entails anxiety, agitation, insomnia, preoccupation, grief, feared loss of health, and isolation/loneliness. Behavioral strategies to reduce visceral distress and autonomic hyperarousal include relaxation techniques, meditation and mindfulness, exercise, yoga, spiritual activities, and (virtual) group-based supports.

Cognitive approaches to distress-management include reorienting of catastrophic or distorted and extreme beliefs (eg, “a job layoff spells permanent doom”) that otherwise disrupt productive problem-solving. Tangible problem-solving efforts involve shoring up adaptive coping skills, maintaining daily structure; finding creative uses of the Internet to minimize social isolation amid social distancing; strategizing about child care, home-schooling, and managing finances; and addressing maladaptive coping skills (eg, poor impulse control, substance use or behavioral addictions, self-harm, and loss of self-care). From a 12-step perspective, it can be useful to help people differentiate between things over which we are powerless (eg, COVID-19 itself) and things over which we are powerless but can manage (eg, we can practice social distancing, we can follow handwashing and disinfectant recommendations). From an interpersonal perspective, social distancing does not mean loss of social support (which should be cultivated and can be maintained virtually). And from a dynamic perspective, recognize that people who feel stressed and frightened can regress and appear demanding and entitled; clinicians unattuned to their own reactions may unintentionally come across as defensive, unempathic, or dismissive.

Liaison to Front-Line Health Care Workers

An underrecognized yet key role for psychiatry involves tending to the mental health needs and stress management of hospitalists and front-line medical colleagues who work directly with COVID-19 patients or toil administratively with an overtaxed health care system. Mental health

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outreach efforts involve providing support and validation for not only concerns about colleagues' personal safety and potential exposure to family members but also frustrations and uncertainties toward the health care systems in which they work. This includes acknowledging and tackling concerns about limited resources, patient volume, scarcity of personal protective equipment, and other professional as well as personal uncertainties.

Self-Care as a Prerequisite for Patient Care

Many of us find it hard to impart a mindful approach toward being in the moment and taking one day at a time without succumbing to our own fears and fantasies about possible dire future life uncertainties. People with existing psychiatric conditions share the same fears as everyone else: getting sick, disrupted continuity of their health care, social isolation, uncertain job security, loss of autonomy, economic instability, and maintaining family cohesion. A basic tenet in medicine is that clinician self-care is critical to mitigate the risk for "burnout, moral distress, and compassion fatigue."⁴ For mental health professionals, pandemics that shut down conferences and meetings challenge us to find innovative ways to maintain meaningful ties to colleagues, stay scientifically current, counter professional

loneliness, and maintain a sense of professional community. Professional organizations such as the American Society of Clinical Psychopharmacology have responded to this need by converting continuing medical education meetings to online formats, with the hope that other groups will follow such models. Psychiatrists teach patients that self-care is a cornerstone and prerequisite for taking care of others. The gauntlet that has been thrown down by fate now challenges each of us to take care of ourselves and others in unprecedented ways, leading by example to defeat a shared invisible foe.

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