# The early response to Covid 19 –

# A psychoanalytic and trauma perspective

I want to begin by emphasizing a central paradox that faces us in the current situation of the worldwide pandemic. When under threat, we are all primed to find safety in our attachments, to turn to trusted others for comfort, support and strengthening in the face of terror. Yet, with this virus what will keep us (and others we love) safe is to keep our distance – our social distance. Thus, we are potentially deprived of our natural response to threat and instead to survive must do the opposite, which may leave us without the capacity to manage our emotional responses to what is happening through social regulation.

The threat of ill-health or even death to oneself, and danger to or loss of loved ones is at the heart of the anxieties that are raised by Covid 19. These are life and death anxieties which Melanie Klein described as powerful forces that assail us from the beginnings of life. Facing this level of threat inevitably stirs up and connects with earlier experiences that provoked similar anxieties – of annihilation, disintegration, fragmentation and persecution. We have all experienced such moments in life and have found ways of surviving them. However, when threat strikes again, we are back in the maelstrom, the place where our worst nightmares have been realised and our good relationships – internally and externally – have failed to protect us.

From this perspective it is possible to see the kinds of universal defences that may be employed to bear such unbearable states. Splitting as a defence enables us to manage a frightening and chaotic experience of the world and what we feel inside by categorizing into very good and very bad. That we can identify the enemy, we know who to either direct the fight at or run away from. One may see this is President Trump's description of Covid 19 as the "Chinese virus", a racist way to identify who is bad, who is the persecutor here. The other side of the splitting is the wholehearted identification of the NHS as "good", full of heroes who will save us, with no ambiguity or ambivalence possible.

Another defence that can hold sway in these times is called projective identification whereby what is intolerable to feel in oneself is, through unconscious phantasy, "given" to the other in such a way that this has an effect on the other. In times of trauma, terrible feelings of helplessness and uncertainty can thus be located in the "victim" so that the rescuer feels instead powerful and competent and this can deny the other of access to their own capacities.

What is perhaps unique to this current situation is the universality of the experience – we are all struggling to various degrees with the reality of this threat, the anxieties it generates and the defences we may employ. Therapist and patient, doctor or nurse, care worker or supermarket shelf stacker alike may have moments of helplessness, hopelessness and terror in the face of this invisible persecutor and will need to find ways to live with this. As a society we need to understand what impact the threat has on us and the ways in which these powerful defences can be used to manage these anxieties but often at the cost of a more nuanced and compassionate way of seeing each other and the world around us.

There has been an explosion of understanding of the impact of threat and trauma on the mind and body in the last two decades from many different disciplines. We know more than we have ever done about the physiological, genetic, inflammatory, neurobiological, and psychological impact of trauma. Trauma is held in the body or as Bessel van der Kolk so aptly says “the body keeps the score”. The immediate response to threat is automatic, physiological and immediate.

When a potentially threatening event occurs, the experience is registered in the brain, particularly the limbic system where the amygdala resides. The amygdala registers the possibility of danger and sets in motion the stress response system to the event to facilitate the fight / flight response through the Sympathetic Nervous System and the release of adrenaline. Activation of the hypothalamus leads to triggering of the HPA (Hypothalamic Pituitary Adrenal) axis, central to the stress response, which ultimately leads to the release of cortisol.

The fight / flight response facilitates immediate action. It causes a shutting down of body functions that are not necessary requirements (such as the immune and digestive systems) and gives extra help to those functions most needed. If the danger passes, all of this will usually settle over 20-30 minutes.

However, if the situation is such that fighting or fleeing will not suffice or are deemed to be impossible, the third response is to freeze. This is mediated by the Parasympathetic Nervous System through the Dorsal Vagus Nerve. This is the most primitive reaction in evolutionary terms to danger and involves complete shutdown of our systems, immobilization and dissociation.

Stephen Porges, a psychiatrist and neuroscientist, describes a third element of this system called the Ventral Vagus. This is the most evolutionarily advanced component of the system and links the brainstem, heart, stomach, other internal organs and facial muscles. It is involved in complex processes of attachment, bonding, empathy and social communication. It is opposite in its effects to the sympathetic fight / flight system and shuts down when we are threatened.

So, a state of threat, such as in our current experience, potentially re-activated each time we hear the news on television or hear another ambulance siren nearby, fight / flight and for some the freeze response. Our usual ways of turning off our threat response are likely to include the activation of Porges’ Ventral Vagus – our attachment system through social interaction with others. It may also include other ways of helping the body and mind manage the hyper-aroused state of fight / flight such as relaxation exercises, breathing exercises, aerobic exercise of any form, distraction techniques, connecting to nature including through gardening, walking or even interacting with pets.

Managing the freeze response, which is often accompanied by dissociation (at its simplest an experience of the world or oneself feeling unreal or dreamlike and at its most extreme causing amnesia for the threat event), requires adoption of methods that can help ground oneself in the present. The freeze response is more likely to occur if the situation is extreme or there is a history of significant trauma in the past. I will return to this in a consideration of who is more at risk of developing post-traumatic symptoms in a moment.

What is clear is that whilst the virus causes the threat response and its sequelae as described, the social isolation and lockdown has led to many of our usual ways of

dealing with threat either not being available or needing to be adapted to the situation. For example, someone with a stressful job might have previously used informal contact with colleagues as a way to downgrade the threat response generated by an awful encounter with their boss through activating their attachment system. They may then have gone to the gym or even the local park on the way home or had an evening out with friends. For someone else, perhaps with a significant history of childhood trauma, freeze and dissociation may have been managed in the past by avoiding situations that made them too anxious or threatened, having a regular routine of exercise, social contact and creative distractions and attending therapy.

What this also raises is the degree of loss that we have all suffered through the social isolation and shutdown that has been necessary in response to the pandemic. Coupled with these many losses which may feel more or less temporary, some of us may have also had to struggle with the reality of bereavement. Bowlby's attachment theory emphasizes that we are primed to seek re-union and that loss activates the need to re-find the attachment figure. Grief and mourning for what has been lost is inevitably more difficult when we have lost our sense of safety and stability.

Lisa Feldman Barrett, a psychologist and neuroscientist, has convincingly described how much of our experience of the world is based on the brain predicting what the experience will be and then correcting the predictions based on the sensory input it receives. If we are living in a world that is new and unfamiliar – the most common word that was used at the beginning of the crisis was "unprecedented" – then our brain's capacity to make these predictions accurately may be impaired. She describes how:

…uncertainty is more unpleasant and arousing than assured harm, because if the future is a mystery, you can't prepare for it. For example, when people are seriously ill but have an excellent chance of recovery, they are less satisfied with life than people who know their disease is permanent.

The response to date

Despite what I have been describing above, there has been an impressive gathering of minds and wills to respond to the current crisis. Much of the effort has initially focused on the impact of this experience on frontline staff. This may well connect with the need to have idealised the NHS as I described earlier, along with a realistic recognition of what is being asked of them by society. And whilst the efforts so far made have been appropriate, necessary and helpful on the whole, it is also necessary for us all to keep in mind that some of this effort may be linked in with our own defensive needs. It is also important to recognize that many different groups, including those perhaps less visible than frontline staff, are likely to be profoundly affected by what is taking place.

The focus so far has been based on previous trauma responses to major societal trauma. Much of this trauma research comes from single events which have a limited time span such as natural disasters, terrorist attacks and so on. The Covid 19 pandemic response has relied on much of this whilst recognizing that the cumulative and on-going nature of the trauma that frontline staff are exposed to has potentially significant differences.

Much has been learnt in the last two decades about the appropriate early responses to traumatic incidents. One basic principle is that until the individual feels they are safe and secure; time zero post-trauma has not commenced. Thus, whilst the traumatic

event is on-going in some form, the appropriate clinical response is Psychological First Aid. Essentially this involves interventions which focus on the need to:

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors to articulate immediate needs and concerns and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- Support positive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors to cope effectively with the psychological impact of disasters.
- Facilitate continuity in disaster response efforts by clarifying how long the Psychological First Aid provider will be available, and (when appropriate) linking the survivor to another member of a disaster response team or to indigenous recovery systems, mental health services, public-sector services, and organizations.

One can immediately see that the focus is on basic needs – practical assistance, physical comfort and social support. This has been seen in some of the best practice evident in the current crisis – the delivery of hot food, or sofa beds on site to staff. Psychoeducation and simple relaxation techniques have also been potentially helpful. The widespread usage of Staff Wellbeing leads in NHS Trusts to lead the programs of support for frontline staff clearly also fits in this model. There has also been an emphasis on strengthening teams and using local, embedded resources to provide support to the frontline. This is again supported by evidence that suggests pre-existing support structures are most helpful in these early phases.

What has been potentially unhelpful and yet is repeatedly seen after any major traumatic event that captures the public's attention is the widespread rushing in to assist of untrained and often overzealous counsellors, therapists and others. It is an understandable response, fuelled by perhaps many different reasons. Trauma by its very nature impairs symbolic capacities and stirs up very powerful emotions. Our ability to think is inevitably impaired, and the push to action is very powerful. One common form of action is through identification, generally within the various positions of the traumatic scenario. Feeling perhaps helpless and overwhelmed at times ourselves by what we are having to face, many may have felt propelled into action, especially in the role of rescuer (a common position for people working in the helping professions). The wish to get involved may also be fuelled by a manic excitement, a vicarious pleasure seen in the slowing down to view the accident on the side of the road. There is also, inevitably the wish for reparation, often fuelled further by guilt – survivor guilt and in this instance the guilt linked to the socio-political context. All of this can help to explain why there has been such a propulsion into action. However, this wish to help in the early stages often needs to be carefully considered so that precipitous action does not actually make matters more difficult.

Whilst the wish to be involved and to contribute clearly may have altruistic, reparative aims inherent in it, there is also a growing sense of competition that is emerging – competition for who is the expert, who will lead the research, the clinical pathways mapping or write the best paper on Covid 19. This jostling for position may be fuelled

by survival anxieties both in relation to the threat of the virus (life and death anxieties that propel us to action) but perhaps also anxiety for what will occur when the threat has passed. We have lived with the reality of austerity in the NHS for many years, and services have become accustomed to the competition inherent in the marketplace economy. With the threat of serious economic downturn and recession looming, this causes further anxiety in relation to the long-term viability of services. Holding in mind a compassionate, thoughtful position that allows for cooperation becomes so much more difficult when this part of the brain is turned down when under threat – survival in the immediate threat does not make use of this more sophisticated mode of thought and behaviour.

Chen et al published in the Lancet 2020 a description of attempts to implement mental health care for medical staff during the Covid-19 outbreak. More formal offers of reflective spaces or one to one counselling were generally not felt to be helpful. During the acute crisis, staff concerns were essentially practical. They worried about not having enough protective equipment, they needed a space to rest and get refreshment whilst working and they requested help in dealing with patients who were anxious and uncooperative. The responses were therefore of a much more concrete nature – clear guidelines on use of protective equipment, a protected rest space where psychological therapists may be available to chat in a more informal way if needed, guidance and training on dealing with anxious patients and relaxation and stress reduction exercises offered to all staff.

This last study demonstrates a key feature in these situations and links with a watchful waiting response described in NICE guidance or indeed with British Red Cross guidance on managing these kinds of disaster situations in the immediate aftermath. It is vital to attend to what is needed and not offer something that is too sophisticated for the requirements. We will be in the middle of the trauma for some time to come and thus interventions need to focus on containment, psychoeducation, practical skills training including relaxation and self-care and management of anxiety.

What can be particularly helpful in these early stages is:

1. Clear guidance as a container of anxiety – at all levels of communication and this may be part of helping higher management to help their staff to attend to the primary task of the work.
2. Encouraging taking personal responsibility within a community context – holding the broader systems of individual, family, community, society in mind in any intervention.

A study by Wu et al in 2009 on hospital employees in China during the SARS epidemic showed that 10% of staff had high levels of post-traumatic stress (PTS) symptoms. These were increased if they were quarantined, were in high risk locations or had friends or relatives who developed SARS. They also found that altruistic acceptance of work-related risks negatively related to PTS symptoms – i.e. it increased resilience.

A study by Lancee et al in Canada (2008) after SARS found that resilience was increased in health workers with increasing years of experience and reduced if there was a psychiatric history. They found that overall rates for depression, anxiety and PTS were lower than the general population. This is particularly important to note as it suggests we are dealing with a potentially resilient population in terms of health workers.

What happens when the social distancing is lifted and we pass the peak of the pandemic hospital deaths may not be a “return to normality” as some may envisage but it may be

the beginnings of moving into the recovery phase, when frontline workers will, hopefully begin at time zero. At this point we move into the early phase of trauma response. NICE guidelines are clear that in the initial phases after a major trauma the following needs to be held in mind:

1. Many people will experience trauma symptoms in the early phases, but this does not require expert intervention. It is best managed with "Watchful Waiting" – a combination of psychoeducation and encouragement to use usual supportive network.
2. Debriefing is not appropriate as a general rule and indeed some studies suggest it may be harmful.
3. One needs to attend to the "hierarchy of needs" – a safe place, food, clothes etc are the priority.

Watchful Waiting is the term coined by NICE guidelines to describe the most appropriate response in the first month or so. At its heart is the recognition that the majority of people who are involved in a traumatic event will not go on to develop Post Traumatic Stress Disorder (PTSD). With straightforward psychoeducation, traumatised individuals can understand that the usual response in the early days after the event is to have a variety of symptoms that are likely to settle over time. These symptoms may include nightmares, vivid images or thoughts of the event, trouble sleeping, irritability, low mood, feeling numb or cut off from others, tearfulness, temper outbursts, avoidance of any reminders and so on. For most people this is normal and with support and care will gradually resolve. The best care involves support from one's usual social and familial network, good basic self-care around eating well, not using alcohol or drugs, keeping to a reasonable routine and getting back to life's usual pattern as soon as possible.

There is a higher risk of PTSD developing if someone is socially isolated and doesn't have a good support structure around them (or that is their perception), if they have a previous history of trauma or mental health issues or there is a history of trauma or psychiatric illness in the family. A history of childhood trauma is a strong predictive risk factor. Some demographic factors also increase risk – female gender, low socio-economic group, minority status and low educational attainment. The severity of the trauma and the degree of loss also increases the risk, as does dissociation at the time of the event.

There is also growing evidence for moral injury to impact on risk. This is essentially a situation, first described in the armed forces, whereby an act of perceived moral transgression causes an injury to one's moral conscience, producing profound guilt and shame. Any of these factors especially if there are a few present, may suggest a closer eye should be kept on that individual to ensure their symptoms settle over time. They may require intervention earlier or from a more specialised service if there are concerns.

It is likely over time that the focus on frontline staff will move to include those who have survived Covid 19 infection, especially individuals who have been on intensive care, where we already know the risk of PTSD is higher. Individuals who have suffered traumatic bereavements will also need support and care. There is also growing evidence for a number of high-risk groups in the community for whom the impact of the pandemic and the social distancing and shutdown is likely to require significant mental health input. Holmes et al 2020 paper in the Lancet highlights, amongst others that individuals who may be particularly vulnerable would include:

1. People with existing mental health issues who may be affected by relapse, disruption to services, isolation and so on

2. Children, young people and families who may be exposed to substance misuse, domestic violence, gambling and child maltreatment
3. Older adults with multiple co-morbidities who may be more affected by social isolation, bereavement and end of life care
4. Those individuals who suffer from social and health inequalities
5. Socially excluded groups including prisoners, the homeless and refugees
6. People with learning disabilities and neurodevelopmental disorders

What is clear is that there will a great deal of work to be done across all aspects of society to mourn what we have lost, make reparation in whatever way we can and support and care for those more vulnerable groups.

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