



On the clinical psychologist's role in the time of COVID-19, with particular reference to experience gained in pediatric oncology

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Abstract

Objective: The COVID-19 pandemic seems to be developing into a planetary-scale mental health experiment, undermining the foundations of our being human, obliging us to keep physically apart from one another, and inducing us to see other people as a potential threat.

Methods: In the world of pediatric oncology, we have found ourselves up against new challenges. In this article, we discuss the difficulties found in conducting psychological support sessions while complying with physical distancing rules, as well as wearing protective face masks, and even gloves; or while using modern remote communication telecommunications.

Results: The classic reasons behind requests for psychological support have been compounded by other, novel problems, such as: fewer relational resources for families at home, less chance to socialize, hospital stays with only one parent, the suspension of all teaching and group activities on the ward, economic difficulties caused by the pandemic, the rising levels of family conflictuality and generalized anxiety.

Conclusions: It is essential to find new solutions that can be promptly implemented, reconfiguring the way we humanize our hospital wards.

KEYWORDS

COVID-19, pediatric oncology, psychological support, remote communication, social distancing

The COVID-19 pandemic and the subsequent lockdown seems to be developing into a planetary-scale mental health experiment, undermining the very foundations of our being human, launching an attack on our thoughts, obliging us to keep physically apart from one another, and inducing us to see other people as a potential threat.

In the sphere of clinical psychology, in the absence of evidence-based guidance to point our efforts in any particular direction, professionals and services have taken largely spontaneous steps to respond to the situation. The few shared rules and recommendations have mainly concerned how to protect ourselves, limit our direct contact with patients as much as possible, expand our use of tools to stay in touch with the aid of communication technologies and the Internet

(remote working). Meanwhile, pediatric oncology departments have had to reorganize their logistics and activities, adopting restrictive measures to minimize the risks of in-hospital infections for patients and staff members. Among the various steps taken to limit access to the wards for educators, teachers, and even volunteers (partly to comply with central government legislation), even the physical presence of clinical psychologists on the wards has been much reduced in many cases.¹

These changes have been implemented, often with some difficulty—and even a degree of confusion at times (partly due to the diverse recommendations issued by different professional associations). In some cases, there have been signs of a dialectical

misalignment between two ethics, the work ethic (where working remotely can only partially compensate for the professional's physical absence), and the health ethic (and government rules) focusing on protecting individuals and the community by limiting people's movements (which is currently seen as our sole defense against the spread of the epidemic).

In the world of pediatric oncology, where great attention has always been paid to the need to provide psychological support for patients and their families, we have found ourselves up against new challenges. Even in our wards—where we are already used to wearing protective masks when working with immunosuppressed patients—we have come up against many difficulties.

When it has been possible to stay in person in the wards, clinical psychologists have had to conduct psychological support sessions while complying with physical distancing rules, as well as wearing protective face masks, and even gloves. It soon became obvious that these distancing measures interfere with our efforts to capture non-verbal cues, our ability to interpret emotions, and our chances of nurturing empathy. A mask over the face can facilitate misunderstandings, and can increase children's fear toward the healthcare personnel. When any physical contact is a potential source of contagion, we can no longer greet someone with a handshake. It has become impossible to use physical contact as a tangible sign of emotional participation in another's pain. Alongside our empathy, there is now a corrosive fear of other people. This experience goes to show yet again that a session with a psychologist is not just a string of bits of information.

The alternative approach we used has been that of providing psychological support remotely using modern telecommunications. Various experiences have taught us that this could be “better than nothing”, but it is hardly ideal. We have observed that the use of communication technology tools was useful for conversations with patients already in our care: in these cases, the fact that there was already an established doctor-patient relationship allowed to limit the discomfort and lead to a productive discussion. For new patients, conducting the first interview remotely seemed extremely difficult. In addition to the various problems caused by discussing intimate and delicate topics through the screen of PC or smartphone, there is also another aspect to consider: holding a conversation online entails two people establishing a connection from inside their own domestic worlds. For psychologist and patient alike, this makes it difficult to recreate the sense of being in a suspended time and place during the session. There is a risk of the neutrality of the setting being contaminated, and the analytical attention being distracted by thoughts relating to home life.

We need to bear this in mind, given that in recent days we have heard proposals for online psychological consulting services for patients or public health workers as a possible way to meet current needs, since it is clear that nothing will be as it was before for some time. Moreover, it is important to underline how such proposals have been described with enthusiasm by the media.

While it is essential to find new solutions that can be promptly implemented, we should not underestimate the complexity and

Key Points

- The COVID-19 pandemic seems to be developing into a planetary-scale mental health experiment, undermining the foundations of our being human, obliging us to keep physically apart from one another, and inducing us to see other people as a potential threat.
- In the absence of evidence-based guidance, recommendations for clinical psychologists have mainly concerned how to protect ourselves, limit direct contact with patients (using face masks and gloves), expand our use of communication technologies.
- Conducting psychological support sessions while complying with physical distancing rules or using modern remote telecommunications, interferes with our efforts to establish a genuine and effective relationship and nurturing empathy.
- The COVID-19 emergency has given rise to a huge need for psychological support; in pediatric oncology, we have found ourselves up against novel problems.
- It is essential to find new solutions that can be promptly implemented, reconfiguring the way we humanize our hospital wards.

particularities of the interaction between clinician and patient, or risk impoverishing the value of clinical psychological support efforts.

The present emergency has given rise to a huge need for psychological support. Family units are often under huge stress. Society is showing a widespread and deeply rooted need for a sense of humanity. The fear of death is permeating our daily lives. Those who become mortally ill with COVID-19 die alone and the bereaved cannot even hold a funeral to say their goodbyes. The scientific literature is already reporting on the psychological fallout on the general population of the pandemic and the collective measures taken to contain it. The effects include rising levels of demoralization, anxiety, despair, depression, and sleep disorders, and there is a risk of a worsening mental health in patients with psychiatric disorders.²⁻⁷

In pediatric oncology, we have learned a long time ago how it is important to take care of our patients (and their families) and address their requests for support, for example, the difficulty adjusting to the diagnosis, the compliance with treatments, the relational problems in the family, the coping with a terminal disease, the emotional distress, and the adaptation issues in survivors. The care is particularly demanding for adolescents, who need to feel that their independence and sense of freedom, their body image and their sexuality, their relationships and wellbeing, and their projects for the future, are not being held up by their disease, or not entirely at least.⁸

In the COVID-19 era, all the classic reasons behind requests for psychological support have been compounded by other, novel problems. We may report a long and varied list:

- fewer relational resources for families at home: the absence of grandparents, as well as little contact with friends, represent real struggles that make families more fragile; limitations to leisure and exercise are stressful challenges for young patients;
- less chance to socialize through schooling activities: these have been transferred to online platforms, which are poorly adapted (especially for patients with difficulties, such as ours); a mother told us how she could not manage the additional burden of following the school activity of her children, and at the same time her job through smart working, and how this led to a profound sense of guilt;
- hospital stays with only one parent: we could mention the recent example of a distraught father who brought his wife and daughter in for a hospital stay, saying goodbye as if it were the last time he expected to see them alive;
- the interruption of psychosocial support group activities, such as those generally implemented for adolescents^{9,10} or for parents, who also lose, due to the rules of social distancing, that support given by the informal network of spontaneous relationships between parents and between patients during their stay in the ward;
- the suspension of all teaching and group activities on the ward, which serve an important emotional containment purpose for patients and parents;
- economic difficulties caused by the pandemic, which become a further cause of important concern for families;
- the rising levels of family conflictuality and generalized anxiety (perception of disease, hypochondria) in many parents—and operators, too—reacting to the invisible threat of the virus, and a worsening problem of suicidal ideation in some parents struggling to adjust.

In addition to all these issues, there is an extra emotional burden on healthcare workers, exposed not only to greater professional stress but also to more difficult personal situations (their children at home from school, worries about their own health, and concern for their elderly parents). All in all, the complexity of the situation partly escapes our attempts to treat it objectively, posing a huge patient care challenge.

All we can say for now is that we will probably need to reconfigure the way we humanize our hospital wards, in the short to medium term at least. We will need to be flexible, consider unconventional methods, assessing their strengths and weaknesses, indications, and contraindications, but also paying attention to the value of the unique relationship between clinician and patient. Scientific considerations, cultural background, and capacity for sharing will be needed for us to see how best to offer psychological support

for patients and their families as an antidote to their fears at least, if not to the virus.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

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