



Returning to In-Person Treatment During COVID-19 - If, When, and How

Reopening Taskforce Daniel W. Prezant, Ph.D. (Chair), Holly Crisp-Han, M.D., Todd Essig, Ph.D., Jonathan Kersun, M.D., Linda Michaels, Psy.D., Cynthia Playfair, M.D., Timothy Rayner, M.D., Mark Smaller, Ph.D., and Wylie Tene.

Changing from working in-person to working via video or phone was difficult for patients and analysts. Having to do it overnight, with little or no preparation, made it even harder. However, it was a crisis, so we rose to the challenge and adapted. Most of us thought it wouldn't last long. Now that the terrifying sprint has become a depressing marathon, the question has become: When can we get back to normal?

Although many therapists and patients prefer in-person work, it is important to recognize that part of the wish (for both patient and analyst) to go back to in-person work, may be a wish to deny the risks of COVID-19 and the profound changes, loss, anxiety, and depression it brings to our everyday lives. Recognizing this as an understandable wish to deny the pandemic and our pain, may help us realistically assess if, when, and how to do it in ways that promote physical and psychological safety.

Seeing patients in-person or via telehealth is an important decision with powerful ramifications on the physical and psychological health of our patients, their families, their coworkers, and ourselves. Insurance reimbursement should not be part of this equation. State and federal rules and regulations should permanently require insurance reimbursement for telehealth and require the same reimbursement for telehealth as for in-person work.

If you're thinking of seeing patients in-person, you need to consider a complex set of circumstances. These include the viral prevalence in your specific area, the type of office you have, the type of patients you see, the ability of your practice to comply with this new way of working, the guidelines of your subspecialty, the local, state, and federal regulations, the psychological effects of doing this new type of in-person work, and your own comfort with working in this way. These factors are fluid and variable. They will likely change rapidly and vary depending on your locale, office setting, etc.

Conditions Necessary for Resuming In-Person Work:

I. Local Prevalence of COVID-19:

The first thing to consider is what percentage of people are testing positive in your local area. You can go online and get current rates for your county [here](#). Keep in mind that you will need to check if a patient and/or family lives in a neighboring county, has traveled lately, or if your practice is in a tourist area in which people are regularly being exposed to folks from all over. If the positivity rate for your local area is less than 5% it might be safe to see patients in-person. Ideally, you would want the local incidence to be 1-3% before you start in-person work. These numbers change quickly and if they go above 5% you should stop doing in-person work. Before you start in-person work, you should discuss with your patients that depending on the numbers you may have to go back to only doing video and phone treatments.

II. Office Setting:

The type of office you work in will influence your ability to accomplish the actions discussed in the next section. A freestanding private office with its own entrance and bathroom(s) will be safer for your patients and you than an office in your home, or an office in a residential or office building which requires sharing entrances, elevators, and bathrooms.

III. Physical actions you should take to try to keep everyone safe, reduce the risk of spreading COVID-19, and reduce your liability risks:

1. Contact your patients the night before, morning of, or upon arrival to each session and perform a symptom checklist for any COVID-19 like symptoms (fever, loss of smell and/or taste, breathing difficulties, fatigue) in them or in the people they live with. Take patients' temperature upon arrival to your office. Inform any patients who have COVID-19 like symptoms that they can't come to the office or will have to leave the office and meet with you via video or phone. Consider not charging for missed in-person sessions so that you don't create an incentive for sick patients to see you in-person. Please note that symptom screening will only help detect COVID-19 for those patients, family, and/or us who are already symptomatic. Symptom checklists will not help detect anyone who is asymptomatic, presymptomatic, or tends to deny or minimize their symptoms.
2. Eliminate your waiting room. It's very hard to practice physical distancing in a waiting room. Patients and family members should not be sitting together in a waiting room with other patients and their families. Patients should be told to not enter the office until the time of their appointment or ideally until you text them to do so. Patients should wait in their car until you admit them. Those who don't travel by car (e.g., many city patients) would have to wait outside, regardless of the weather. Patients should be told to come alone to their appointments. Child patients or patients who need a parent, babysitter, or aide in the waiting room should not be seen in-person, as it means having someone in your waiting room for 45 minutes.
3. Patients and their families should be discouraged from using the bathroom in your office. You and/or your patients should disinfect bathroom seats, handles, doorknobs, faucets, etc. before and after use.

4. Doorknobs, intercom buttons and buzzers, waiting room and consultation room furniture should be disinfected before and after each patient arrives and leaves. This would necessitate not seeing patients back to back.
5. Patients, anyone who comes into the office with them, and analysts should wear a proper fitting mask for the entire session. Patients who arrive without a mask should be provided with a free mask by you and/or told that they can't be seen in-person until they can wear a mask. Patients who remove their mask during a session should be told to leave the session as they are creating an unsafe condition for everyone.
6. Patients and therapists should maintain a minimum of 6 feet of physical distance between themselves at all times. Ten to 12 feet distance would be preferable. This includes when laying on a couch, sitting in a chair, playing with child patients, entering, or exiting the office.
7. Physical greetings, such as handshakes, should not occur.
8. Patients and analysts should wash their hands frequently. At the very least this should be done before and after each session. Whenever you or a patient blows their nose, coughs into their hand, or wipes their eyes or tears that person should wash their hands.
9. Therapists who have office windows should leave them open during their sessions and workday. This influx of outdoor air decreases the chances of spreading COVID-19. However, it creates obvious problems with confidentiality, street noise, and cold or hot weather.
10. HEPA air filtration machines may reduce the risks of spreading COVID-19 by sanitizing the indoor air at a reasonable financial cost. A modern building might attempt to reduce these risks by upgrading the entire HVAC system for all the tenants. Ultraviolet light systems are usually seen as an unnecessary step beyond what is required and a cost prohibitive measure. Creating an office with negative air pressure is probably not possible and is believed to be an even more unnecessary step and even more costly than UV light. If you use any of the above, it is important to consult with experts to see that you are using the right equipment for your office and waiting room. Installing a small HEPA air machine, that doesn't perform the required number of air changes per hour, will not reduce the COVID-19 risk. This equipment requires regular testing and service to replace filters and ensure that it's doing the job. Keep in mind that some of these machines create noise that may interfere with you and your patient hearing each other.
11. Since COVID-19 can spread in all directions - from patient to patient, from patient to us, from us to our family, from our family to us, and from us to our patients - it will be important and/or required by public health laws to participate in contact tracing. This should be discussed with your patients prior to beginning in-person treatment. You can explain that you would only give officials a list of names and contact information of who was in your office on a certain day or week. Although you would not say why anyone on the list was in your office, it does place a limit on confidentiality.

12. Have patients and the parents of minor patients sign an informed consent for in-person treatment. It should explain the COVID-19 risks of in-person work to them and their family, the above changes in how you will be working, and the changes to confidentiality with contact tracing.

13. Follow all guidelines from your subdiscipline.

14. Follow all city, county, state, and federal laws and regulations.

IV. Psychological Safety:

Performing the above steps for in-person work will help reduce the physical risks of spreading COVID-19, but they come at a psychological cost. Seeing patients in-person in this new way is not the same as going back to the way we used to do things. Pretending that we're going back to our normal work lives runs the risk of denying fundamental changes to how we work and the effects of this on our patients and ourselves.

If you're considering in-person work, you need to make a realistic cost benefit analysis of whether this new type of in-person work is worth the risks and outweighs the benefits of telehealth work.

1. Creating and maintaining a safe space where the patient feels as free as possible to express their innermost thoughts, feelings, wishes, fears, and fantasies is fundamental to our work. Wearing masks, disinfecting surfaces, temperature checks, symptom checklists, asking direct COVID-19 questions, issuing directives about what one can and can't do in your office, refusing to meet in-person with your patient on a day when they're sick, requiring your patient to leave a session in progress because they're sick or can't use a mask, releasing your patient's names and contact information changes the confidentiality, therapeutic alliance, and psychological safety of our work. The implicit communication that it's safe here and that we're in this together changes to it's not safe here and we're not in this together. In fact, we are a danger to each other.

2. This new way of doing in-person work impacts the expression and exploration of the transference and countertransference. It puts us in the role of a parent, doctor, or teacher instructing and judging the patient. This tends to limit the transference and its exploration. Patient's fears and/or wishes of hurting and/or being hurt by us, our family, and/or our other patients can best be explored when they are fantasies instead of realities. In the COVID-19 world, telehealth may prevent these fantasies from becoming realities and thus help us work on the transference. In-person work may create so much reality fear that it becomes too difficult to explore the fantasy.

3. Consider whether in-person work models denial and risk-taking behavior for our patients. How do we best explore the patient's denial of their risky behavior in other situations, when we may be enacting it by seeing them in-person? How do we explore their ideas about what we're

doing, if we're also promoting a defensive not knowing? Is this a way, in the transference and countertransference, of saying do as I say and not as I do?

4. Think about whether it's more or less therapeutic to meet in-person wearing masks and disinfecting surfaces or to meet on the phone or video without a mask and disinfectant. What is more real? What imposes a greater help or hindrance to the work?

5. Avoid the temptation to give the patient the choice of how they want to meet. This may appear to be empowering, but it may also be a way of denying our ultimate responsibility for the safety of the patient, their family, our other patients, and ourselves. Giving the patient this type of choice may be a way of protecting us from our guilt, but it shifts the guilt onto the patient. We should not be asking patients to make decisions for the safety of our other patients or for our safety and that of our family.

6. Going back to in-person work when there is the significant chance of having to return to telehealth work because someone gets sick and/or the positivity rate in your community rises above 5% decreases the stability inherent in the structure of regular appointments. This has an impact on the psychological safety of our work. Is it worth it?

7. Consider that the patients who may need in-person work the most because they easily feel abandoned and/or tend to need to see us as a check against their destabilizing fantasies about our hostility toward them are also the patients who may be most negatively impacted by our wearing masks or refusing to see them if they're sick or if they refuse to wear a mask.

-more-

8. If doing in-person work replaces your free-floating attention to the patient with anxiety, anger, or guilt about spreading and/or catching COVID-19 you should not do it. To be an effective therapist you need to be comfortable with how you work, whether in telehealth or in-person. If the disease prevalence in your community, the age or medical conditions in your patients, you, or your family, your discomfort with these new procedures, and/or the difficulties of modifying your office setting make you uncomfortable, you should not feel pressured to do this new type of in-person work. If this newly defined situation of in-person work makes you too anxious to think, then you can't help your patients in-person and telehealth is the best practice.