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Nursing homes or besieged castles: COVID-19 in northern Italy

The tragic events in Italy, with more than 10 000 deaths due to novel coronavirus 2019 (COVID-19), are causing pain and demoralisation to a still incredulous and shocked general population. It is particularly distressing that outbreaks of infection have developed rapidly in many nursing homes, where staff have been completely neglected by health authorities and can offer only little protection to many frail and needy older people.

In the province of Bergamo, more than 600 nursing home residents, from a total capacity of 6400 beds, died between March 7 and 27, 2020. A similar hecatomb is occurring in many other parts of the administrative regions of Lombardy, Veneto, and Emilia-Romagna, where nursing homes commonly have 10–15 deaths due to COVID-19 out of 70 guests. In some cases, 3–4 guests died in a single day.

In the past decade, especially in the north of Italy, residences for older people had reached a good standard of quality, similar to the European average.[1] However, the system was seemingly operating at the limit of economic survival, with no provision for an emergency. At the first crisis, the system thus met with serious difficulties. Today is time only to reduce the suffering of the present; at the end of the drama, planning the functioning of nursing homes in a different way must be essential.

In our view, during the COVID-19 epidemic, nursing homes of northern Italy are like isolated citadels, with very little contact with the external environment. Loneliness, therefore, is the general condition in these nursing homes, where nobody enters and nobody exits. The prevailing feeling is that of living in a trap, in a generally modern residence, where everything happens in the most complete closure, to defend those who are inside from the risk of contagion and those who are outside from the possibility of witnessing the progressive, unavoidable, and unmodifiable shutdown of many lives.

The situation is characterised by various dynamics. Residents struggle with the absence of relatives and their visits. An attempt has been made to replace direct contacts with the use of tablet computers. However, this provision has limited effectiveness on residents with dementia, who need a caress, a massage, and a nearby voice. In many cases, this attempt has caused serious discomfort, which manifests itself as delirium superimposed on dementia, in particular a hypokinetic type, with the consequent refusal of food and the difficulty of getting out of bed.[2] We are not yet able to measure the frequency of these reactions, but empirical observation indicates a prevalence of over 50% of the residents.[3] Older residents who are cognitively intact also breathe the atmosphere of anxiety and anguish, even if staff try not to convey their worries and fears.

Relatives struggle with the breakdown of direct relationships with their loved ones. In some, serious feelings of guilt develop. One relative told us, "if I had not put my dad in the nursing home, he would still be with me and in these dramatic moments I could make him understand all my affection". In others, aggression towards nursing home managers arises. All are dominated by fear and anguish because the messages filtered by the staff regarding the condition of their loved ones do not eliminate anxieties for the future. This feeling is aggravated by television and newspaper reports that residents cannot be transferred to emergency hospital facilities because these are too overcrowded. Family members feel like they are left outside the walls of a castle, without knowing anything about what is going on inside.

Doctors working in nursing homes feel responsible (even if the blame lies with government administrations) for not having isolated residents in a timely manner, meaning that many residents transmitted the virus to their relatives. Doctors feel powerless and completely disoriented. They have seen their colleagues become infected and die despite protections and cautions. Doctors feel exhausted and unable to make good clinical predictions: some patients seem to be seriously ill and recover, whereas others appear to be fine then die. Swab tests are only done in hospitals, when patients are symptomatic.

The staff fear for their own families, particularly for the older people and children with whom they live at home. Moreover, every time a resident dies, a bond that has been built in months of closeness gets broken; this loss causes a pain that most of the time cannot be shared with anyone because the numbers of staff on duty have decreased because of contamination with the virus. Psychological support services for staff have been abolished during the epidemic. In some cases, staff have been provided accommodation

that is separate from those of their families, which creates an additional castle effect, provoking, in turn, complex dynamics between care team members, who frequently lack effective leadership.

The managers of nursing homes feel guilty about the absence of preparation; there is a shortage of oxygen, ventilators, masks, and eyeglasses. The risk of managers soon crossing from anxiety and anguish to loss of energy and renunciation, without producing any positive reactions, must be monitored.

Despite the critical situation, operators and guests do not exhibit manifest signs of aggression, and episodes of verbal or physical violence are seldom recorded. Unexpectedly, an atmosphere of particular sweetness has often been observed, as if people transformed their anxiety into extraordinary acts of closeness and kindness. Guests should continue to see light at the end of the tunnel, and for health professionals, death should not turn off the light in their eyes; instead, they should continue to provide hope to residents.

The feeling of living in a besieged castle is reinforced by the fact that the residents who die do not receive a public funeral, with no involvement of relatives and local communities; therefore, no evidence exists of a relationship between inside and outside. This lack of connectivity is unprecedented. Dead people disappear without any contact with those who previously knew them and loved them. Because there is no more room in the local cemeteries and no cremation can be done nearby, military trucks have transported the coffins of dead people to other regions. Television pictures of these scenes have made a huge impression on all Italian citizens. From the besieged castles desperate appeals for help frequently emerge. Overwhelmed by the magnitude of the catastrophe or unable to find adequate answers, nobody answers.

We declare no competing interests.

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Virtual treatment and social distancing

The coronavirus disease 2019 (COVID-19) pandemic is raising levels of anxiety worldwide: both appropriate anxiety in reaction to real dangers and maladaptive panic. Beyond handwashing, a key public health directive is social distancing, which entails avoiding public gatherings and generally keeping physical distance from others. The economy is shutting down, leaving people at home without the structure of their daily work routine. The closing of theatres, museums, restaurants, and bars has disrupted and diminished social life. Rapid shifts in information (and misinformation) about a previously unknown pathogen amplify ongoing uncertainty and anxiety. Social distancing seems to mean increasing social isolation while worrying about a potentially lethal illness. Isolation can easily translate to loss of social support, particularly for individuals who live alone; and loss of social support often compounds symptom severity.

The current crisis is transforming both our society and our practice. This situation has large implications for psychotherapy, and perhaps particularly for interpersonal psychotherapy (IPT).[1] Overnight, psychotherapy has changed from in-person treatment to teletherapy, which maintains the therapist–patient alliance despite the emotional and hygienic distancing of a computer or smartphone screen. Teletherapy is functional,[2–4] but is not exactly like being in the same room with another person. In IPT, we generally aspire to have patients look up from their screens to make eye contact, but now we distance. Now talking heads might be the safest substitute for personal encounters.

Whereas other treatments like psychodynamic psychotherapy and cognitive behavioral therapy have intrapsychic targets, IPT focuses on the interpersonal arena. IPT therapists usually encourage patients to interact with others. Social contact is already a challenge for depressed and anxious patients, and it has just become far more complicated. It is not a good time to join a social group or meet new individuals. So how should therapists handle the current crisis? Recent virtual supervisions and treatments have offered the following suggestions.

Address reality. The first step is to acknowledge the extraordinary situation. To strengthen the therapeutic alliance, therapists can be clear that we would rather meet in person, but that in this public health emergency that is not a good idea. The therapist might want to privately recognise his or her countertransference, which might well include relief at avoiding infection by maintaining a distance. The message to the patient, however, needs to convey that the therapist will stay in touch and continue working to help the patient get better, the crisis notwithstanding. Indeed, isolated patients need a lifeline now more than ever. Try to maintain a regular schedule, and have the patient find a space where he or she will not be overheard or interrupted. It is important to try to use Health Insurance Portability and Accountability Act-approved media to make eye contact through the screen.