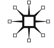
The American Journal of Psychoanalysis, **2020, 80,** (119–132) 
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A PSYCHOANALYTIC VIEW OF REACTIONS TO THE CORONAVIRUS PANDEMIC IN CHINA*

Jerome S. Blackman, M.D.[1]

The coronavirus pandemic, which apparently began in Wuhan in December 2019, and has persisted to the present day, has had several psychological effects in China. The real danger has produced prolonged stress. Large-group phenomena have been stimulated. Overwhelming affects generated by the real danger have led to regression in the stimulus barrier (or "filter"). The COVID-19 has also triggered unconscious defensive reactions, including obsessional cleaning, counterphobic behavior, humor, and denial. The nationally imposed home quarantine of millions of families has caused in-home conflicts and neurotic repetitions of unresolved childhood issues. Prior psychiatric illnesses have been exacerbated. Health workers, including psychiatrists, psychologists, and psychoanalysts, have experienced emotional depletion. Finally, in families where there has been infection or death, delayed mourning and post-traumatic phenomena have been observed. In each of these situations, different interventions based on psychoanalytic principles have been useful.

KEY WORDS: coronavirus; psychoanalytic responses to pandemic; stress; PTSD

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Jerome S. Blackman, M.D., FIPA, consultant/lecturer and supervisor, Wuhan-German Psychological Hospital and at Shanghai Mental Health Center; Professor of Clinical Psychiatry at Eastern Virginia Medical School in Norfolk, VA; Training and Supervising Analyst with the Contemporary Freudian Society in Washington, DC; and Distinguished Professor of Mental Health at Shanxi Medical University in Taiyuan.
Address correspondence to: Jerome S. Blackman, M.D., FIPA, Suite 204, Lynnhaven Station Bldg.,101 North Lynnhaven Road, Virginia Beach, VA 23452 USA. Email: jblackmanmd@aol.com; Phone: 757.463.3000; Fax: 757.431.2023
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INTRODUCTION AND DIAGNOSTIC PROBLEMS

The reality of a potentially life-threatening illness (*realangst*) (Freud, 1926), makes everyone frightened (for exact statistics, see Qiu et al., 2020). So, one of the questions for psychoanalysts is what happens to individuals when they experience this real fear. One way of viewing this problem is as a question of differential diagnosis. First, is a person reacting appropriately to the reality by wearing a mask, being careful about going outside, washing hands, and restricting exposure to people who are sick (intact autonomous ego functions—Blackman, 2010)?

On the other side of the diagnostic spectrum, are people deficient in affect tolerance, so that the fear is overwhelming their relationship to reality? In that case, we may have a traumatic psychosis. In the middle, people who have borderline personality disorder, where the capacity to regulate affects and impulses is already damaged (although their relationship to reality is intact), may become more paranoid and perhaps have a breakdown in other functions such as the sleep/wake cycle and psychomotor control.

Finally, there are a group of people where the reality stirs up personal problems from their current life or their past life. Those other conflicts generate symbolic reactions and defenses—the repetition compulsion to master past trauma (Blum, 2012), as well as avoidance and symptoms such as phobias and compulsions.

STRESS AND TRAUMA

Coronavirus has no doubt been a trauma to people who have experienced the illness and to people who have had a close relative die from the illness. For other people, it is not exactly a trauma, but a persistent worry which is very stressful.

Like most things in the mental health field, Sigmund Freud first defined trauma (together with Breuer in Breuer & Freud, 1893). Freud was impressed with various types of situations, particularly in childhood, where the amount of emotion that was generated caused the person to feel disorganized and helpless. He focused primarily on events during the first genital phase of development (1905). In the 1950s, Ernst Kris wrote a series of papers expanding on the idea that trauma could be incorporated into various types of neurotic structures and that the analyst needed to pay attention to the reality of the patient's history, aside from the patient's fantasy life (Kris, 1950a, b, c, 1956). Becker (1974) describes sexual abuse trauma during latency as an etiological factor in the development of adult borderline personality disorder.

The Sandlers wrote about the effect on children raised in chaotic households (Sandler & Rosenblatt, 1962; Sandler, 1977; Joffe & Sandler, 1979). They did not address epidemics, but they described emotional disorganization in the household interfering with people's development of a sense of well-being and security (See Sandler, 1989). The essays in Levine's (1990) edited book describe the trauma caused by the sexual abuse of children, especially damage to ego functions such as intelligence (Blackman, 1991). More depth about the effects of childhood trauma is found in *Sexual Aggression against Children* (Blackman & Dring, 2016). A comprehensive discussion of seduction trauma was edited by Good (2006).

Abuse and trauma can cause interference with affect regulation and intactness of the self-image (Lansky, 2000). Other trauma associated with adolescent or early adult relationships can become rekindled (Blackman, 2018; Blum, 2010) by interpersonal stresses in the current situation, leading to renewal of mistrust and self-diffusion anxiety.

Next, epidemics and stress require mentioning the work of Hans Selye (1956, 2011). Although some of his positions can color the importance of his discoveries, his formulations can be useful in thinking about the effects of external phenomena. Selye described the stress reaction as having three different stages. The first stage he called alarm. In this stage, danger is perceived, the body produces stress hormones such as epinephrine and cortisol. Selye called the second phase resistance. Of course, analytically speaking, this refers to defensive operations (Blackman, 2003), as well as affect tolerance (Kernberg, 1975). The third phase Selye called exhaustion, similar to what Kris (1956) called strain trauma. In exhaustion, the amount of anxiety or emotional depletion reaches an intensity where people can no longer manage it with ego functions and defense mechanisms. They are overwhelmed, dysfunctional, and may experience general corporeal algesia.

Selye was interested in the production of hypothalamic-pituitary and adrenal hormones in relation to external factors that cause alarm and affect overload. So before we get to fancier explanations, we should recognize that strain trauma involves moving from resistance to exhaustion in Selye's format.

Further, Slavson (1947, 1964) wrote about psychoanalytic views of groups. In groups where there is some cohesion, people can interstimulate each other through verbal interactions about any issue. They may use "mutual induction," where members of the group cause exacerbation of emotional intensity in others in the group. Mutual induction, interstimulation, and mutual identification can occur in groups where some people's emotional excesses stimulate other people's emotional reactions, resulting in what is commonly called emotional contagion.

Of course, as people become anxious in groups or as individuals, they may use the defenses of denial or minimization and therefore not take appropriate protective measures. Colleagues in Wuhan noted that some health workers were refusing to wear an N95 mask when they left the house; they seemed to be using both denial and a counterphobic mechanism (Blackman, 2003, 2010).

Finally, we must include the work of Vamik Volkan. Using Volkan's idea of transgenerational transmission of trauma (Volkan, 2011, 2014) and the intertwining of internal and external events (Volkan, 2015), we can see cases where the current danger also stimulates group fears that are based on common knowledge of past, nationally shared traumas (such as mass starvation). Volkan terms these *chosen traumas.*

SPECIFICITY OF REACTIONS

Some people who have not been infected are still dealing with the danger of reality. They need support, i.e., others' verbalization of emotional understanding, Bion (1963) called this containing. In Wuhan, some women formed WeChat groups where they find out which neighborhood captains have food, so they can share. They support each other practically as well as emotionally.

A common symptom that has arisen is compulsive cleaning, used as a defense to relieve the fear that the virus is infecting various articles in the house (the latest information is that the virus can be spread by droplet, fomite, vector and aerosol transmission). The Centers for Disease Control and Prevention—(CDC, 2020)—recommends thorough handwashing. New York City has begun sanitizing all their subways every 72 hours, the apparent time the virus lives, on average, on non-animal surfaces (Johnson, 2020), at least this is our understanding of this aspect of the Covid-19 virus at the time of writing this article. Thus, cleaning is a reality necessity, to guard against *realangst*—but it can become a psychological symptom. Judgment would dictate that if people who have not had any exposure are cleaning the house continuously and not sleeping, they may be developing a compulsive symptom to relieve other anxieties which were triggered by the reality.

Colleagues in Wuhan also report that some patients are screaming at their children, sometimes out of sheer frustration. In other cases, however, screaming and criticizing others can represent, unconsciously, a fantasy of forcing someone to listen and protect the screamer (Brenner, 2006, emphasized that any mental function can be used defensively). Screaming can also carry the fantasy that it will relieve children of their fears (actually,

it has the opposite effect). Patients who are using the defenses of anger, screaming, or compulsive cleaning, usually require interpretive understanding of the defensive purposes of these negative actions, so that the extreme, symptomatic behavior can be ameliorated.

One woman, Lili, in psychotherapy in Wuhan, reported obsessional cleaning and disinfecting after her 4-year-old son became sick, running a fever of 105˚ F. Lili and her husband argued about whether they should take the child to an emergency room at the local hospital. Lili was terrified to do this because she feared catching the virus in the hospital, and because of the apparent reality fear, she had reverted to cleaning. At her husband's urging, she took her son to the E.R., where the child was diagnosed with coronavirus and a streptococcal superinfection causing otitis media. He was given antibiotics, sent home, and gradually recovered.

Lili's therapist told me that, in therapy, Lili had confessed previously to ambivalence about her marriage. After the therapist's expression of empathic understanding of the guilt and reality problems of managing marital problems during the pandemic, Lili was able to discuss how having a son made decisions about divorce difficult. Lili reported a dream where she was single, swimming alone near the Great Barrier Reef in Australia. With this data, I could advise the therapist to organize an interpretation that the compulsive cleaning had become severe to protect her son at the same time it relieved Lili of her guilt about not wanting to be married or to have a son. After the therapist interpreted this conflict to Lili, Lili revealed she was already glancingly aware of it, and added that she had harbored unwanted envy toward her son, who was favored by the husband and the grandparents, often to the exclusion of considerations about Lili. Lili reported her compulsive cleaning eased after these discussions.

Blechner (1993, 1997), in his articles about the 1980s/1990s AIDS epidemic in the United States, found that patients who had contracted AIDS often used projective blaming. These AIDS patients blamed relatives, doctors, and various bureaucratic institutions as a way of relieving shame, guilt, and fear of dying.

Another overlap of reality with more symbolic kinds of conflicts occurs in the phenomenon of "cabin fever." Cabin fever refers to discomfort staying in the house for long periods of time. If it's just cabin fever, usually that can be handled through discussion, verbalization, and sometimes humor. A number of internet memes defensively make jokes about the virus. North Americans who are scared of the Coronavirus have been posting pictures of the Mexican beer, Corona Extra, with a note across the bottom, "Now you know what EXTRA means." In Nanjing, China, a friend posted a poem: 不能笑, 带口罩【bu neng xiao, dai kou zhao】! ("I can't smile; I wear a mask").

But cabin fever can unconsciously trigger all sorts of experiences people have had previously, particularly of being punished. One Wuhan patient, suffering with depression and insomnia related to the coronavirus, told me: "I can't stand being in the house all the time. I feel like I'm in jail. What can I do?" I pointed out that the thought that she was in jail no doubt indicated that she was feeling guilty about something, since jail is a punishment. She responded, with a laugh, "I want to kill my children! They are driving me crazy!" She laughed again, "Oh, that's a terrible thought!" Actually, she loves her children, but their frustrations at being indoors were difficult to handle. That difficulty stirred up previous ambivalence she had seemed to resolve, before bearing children, about motherhood. Once she could express her infanticidal fantasy and guilt, and tie these to her previous conflicts, the intensity of her discomfort was mitigated considerably.

REGARDING HEALTH WORKERS

Psychotherapists who are taking care of sick or quarantined people may use counterphobic mechanisms; they take too much risk. Of course, like unconscious guilt producing incarceration fantasies, counterphobic mechanisms require confrontation and interpretation of the underlying conflict.

Wuhan professionals also complain of depletion ("exhaustion") as described previously. They need sleep to "re-charge" their immune systems and rejuvenate, through supportive interactions, what Blum termed the "stimulus filter" (2004, p. 540).

For example, Dr. Zhang Xiaochun, a physician working in Wuhan, after working nonstop for several days, "... had forgotten about her 9-year-old daughter, who was alone and scared... Dr. Zhang's eyes welled up, but she had no energy to cry.... Around the world, doctors are being stretched to the limit. Short on supplies and sleep...". (One doctor's life on virus's front lines, March 4, 2020, page 1).

REGARDING GRIEF AND PTSD

In relatives of people who have died, a number of different types of reactions are possible. Normal grief requires emotional discharge, support, and verbalization about the person who has died. People grieving must talk about the good and the bad about what they remember (Freud, 1917). If people are not doing those things, they are likely to develop what Volkan (1983) calls "reactive depression" because of suppressing grief. Nevertheless, they are irritable, unhappy, and may withdraw from family members.

In those cases, it is necessary to interpret their avoidance of grief as a defense against emotional pain. Blum (1987) added that identifications will form with the lost person; but for recovery, a bereaved person needs to form identification with survivors.

The other phenomenon seen in people who are not grieving is called "established pathological mourning" (Volkan, 1983). In these situations, a person may be carrying some object that belonged to the deceased. It may be a special pin, something in their hair, or something carried under their arm. It can be any object that represents the dead person. In those cases, the therapist will gently say, "I see you're carrying something." The patient may respond: "Yes. This belonged to my child who died" or "my father who died." An empathic dynamic interpretation might be: "I see you're keeping that to keep that person alive, because it's so painful to face the fact that they are gone."

People engaged in this "re-grief therapy" (Volkan, 1983), will often grieve with you. They may cry. This can go on for several days or several weeks. It's important to have the families discuss it together, if possible. Antidepressant medicine is relatively contraindicated because the patient needs to feel the pain and be able to discuss it. Allen Frances, in his book (2014) criticizing the *DSM-5* (*Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition*, American Psychiatric Association, 2013), points out that normal grief should not be considered a psychiatric disorder. I agree with him.

Finally, there are many definitions of PTSD, so for brevity, I'll tell you how I see it. First, something quite terrible has to happen (*DSM-5*, 2013, Criterion A, p. 271). For example, a patient's mother gets sick with Coronavirus: the patient is frightened. Second, the fear has overwhelmed the daughter's ability to think clearly—to use her integrative function, abstraction ability, and possibly, her relationship to reality—briefly. Understanding, support, and discussion of reality may be offered to help her in thinking about the realities of the illness (where the therapist becomes a "good mother" transference object).

When her mother gets treated and recovers, your patient may still show emotional symptoms. The most common symptoms of PTSD are shame over being overwhelmed (Lansky, 2000) and special types of dreams (Renik, 1981). These dreams are very similar to the illness and what happened, although they always have some symbolic meaning. Renik (1981) theorized that "traumatic dreams," similar to "examination dreams" (Freud, 1900), have the function of reassuring the dreamer, upon awakening, that the trauma has passed.

During this period, the patient can be reassured that traumatic dreams last anywhere from a couple of weeks to one or two months, and the dreams

have a reassuring function. However, after a couple of months, the patient may start having new types of dreams which still incorporate something about the virus and the illness but have many other symbolic elements. Those are called "post-traumatic dreams." These dreams reflect unpleasant or even traumatic experiences from previously in the patient's life. Exploration and understanding of the conflicts that were caused by the older traumatic experiences will then be requisite for recovery.

A third characteristic of post-traumatic stress disorder is rumination. People keep thinking about what could have happened ("If only" fantasies, Akhtar, 1996). Even though the mother recovered, the patient may think, "Oh, my mother could have died! What would we do if she died? What would happen to my father?".

Another commonly noted symptom of PTSD is the occurrence of "flashbacks." These are memories of the incident. They can have several origins. Sometimes patients have become psychotic, where their ego functions are overwhelmed. They then may concretely reconstruct reality and blame the virus for their disorganized condition. Premorbid obsessive–compulsive patients were already harboring conflicts between their guilt and hostile-destructive thoughts. Their defenses handling the resulting affects—perfectionism, hyper-cleanliness, and rumination may all attach to the reality danger of the virus. Complex interventions will be needed to help them.

For the first few weeks after recovery from COVID-19, many people will have memories of what happened fairly frequently. Reassuring them that those memories will dissipate after a few weeks is reasonable. But if people continue to have very disturbing memories for months, usually there is more symbolic meaning involving other conflicts. They are resolving those by developing obsessional defenses. These patients present clinicians with the challenge of carefully diagnosing the level of personality functioning underlying their obsessions (Kernberg, 1975).

PTSD can include a variety of other symptoms. Sometimes people will avoid the room where the mother was sick or they may withdraw. There are at least 101 other defensive operations which may need confrontation and clarification (Blackman, 2003).

REGARDING QUARANTINE

A psychologist colleague in Wuhan said some of the people who are quarantined "are acting like babies." They will not get things for themselves and "they whine for soup." These patients are using a defense called "oral regression" (Freud, 1946) to avoid unpleasant emotions. Here, the patients

are relieving their fear by whining, which can be discussed along with the reality of the fear. Patients often then reveal other fears they had been too ashamed to talk about.

Another problem which has arisen during China's massive home quarantine is that during the day, children have to stay at home. In many cities, especially Wuhan, there are no internet classes. Commonly, parents become overly critical of their children for not studying, causing arguments and worse. 李晓驷 (Li Xiaosi, 2019) described a syndrome characterized by modern Chinese parents' preoccupation with their child becoming number one in the class:

> The imperial examination [that] lasted over 1300 years was set up in the Sui dynasty, which would be used to select officials in Chinese history. [F]ounded in the Sui dynasty, established in the Tang dynasty, completed in Song dynasty, thriving in the Ming and Qing dynasties, [it was finally] abolished in the late Qing dynasty. . . . Although such a system was abolished in the end of the Qing dynasty, the Number One Scholar effect, as well as the hoary adages of Chinese traditional culture, such as "to be a scholar is to be [at] the top of society," "there are golden palace[s] and fair lad[ies] in books," and so on, have far-reaching influences on the development of Chinese history and the Chinese mentality (p. 6).

Parents must be advised that children will rebel against overemphasizing studying under the current circumstances. For latency children, playing games with them that involve obsessional defense mechanisms, such as chess, cards, board games, and educational games regarding math and history will keep them learning and more settled. Parents who force their children to study without any play are using an obsessional defense to relieve their own fear of death.

Chinese parents routinely worry about their adolescents passing final exams in high school that determine college placement. These parents will shame their adolescents because of the rather onerous reality danger of failing.Shaming children to study during the quarantine, however, mostly relieves the parents' own anxiety; the side effect is causing more depression and rebellion in the adolescent.

In other cases, if parents do not acknowledge the dangerousness of the illness, the children may identify with their parents' minimization but also sense the parents' anxiety. If the parents force the children to study as if everything is normal, unconsciously the parents inject their own anxiety ("projective identification") into the children. The children will then pick up the anxiety and become more irritable and unmanageable.

A CASE OF EXACERBATION OF PRE-EXISTING ILLNESS

Ming, a 15-year-old girl, had been hospitalized for anorexia. She had received dynamically oriented psychotherapy daily in the hospital,then had been discharged home, eating, after several weeks. The father, however, now returned to controlling her food intake. The entire family was home, together, due to the quarantine. Ming had been arguing severely with her father about the amount of food she could eat and the type of food. The father eventually felt exhausted. Ming's mother had tried to mediate between the father and the girl, with no success.

The father at times projectively blamed the mother for the girl's problems. Arguing was persisting for hours each day. On one occasion, Ming and her father actually had a physical fight. The father consulted a therapist, who attempted two family therapy sessions online (because the virus prevents all from leaving their homes). The father missed the first session. In the second meeting, family arguments interrupted the session.

DISCUSSION

In this case, there was a pre-existing illness (anorexia nervosa) that was exacerbated by the virus and the need for home quarantine. There was a question about death present before the virus started: the girl was in danger of dying from not eating. Her anorexia seemed to be, at least in part, symbolic behavior representing an unconscious, guilt-ridden, angry response to her father's control. So, in the next session with the family, I recommended that the therapist point out to the father that arguing with his daughter about which foods she eats is his problem. Moreover, he is provoking his daughter to be angry and depressed. So, he needs to be told that his behavior is going to kill his daughter—and it will be *his* fault.

In other words, I opined, the father needed to feel more guilty, in order to try to stop his acting out. The therapist responded, "He asked if they were supposed to just let her eat whatever she wants." I explained that the answer is "yes," because the girl still has symbiotic problems—so anyone telling her what to eat will intensify the symbiosis. She will then use hostile-destructive aggression to establish autonomy—but because of conflict with shame, she will turn her hostile-destructive aggression on the self (depression), provoke punishment from her father, and stop eating again, which would symbolize her rage and suicidal defense against it.

SUMMARY

The COVID-19 virus poses an ongoing, world-wide threat, and many psychoanalysts and psychoanalytic organizations are already involved in sharing information, listening empathically, and endeavoring to learn how to help in this situation. I hope that this contribution, derived from my experience teaching and supervising dynamic therapists in China, may shed some light on how, in China at least, the risk of the virus and the reactions to the severe quarantine can be understood psychoanalytically. With these understandings, it is my hope to add to the efforts of all who are attempting to make therapeutic interventions "on the ground," dealing with people in crisis. Many of the 150 people who attended the Shanghai Mental Health Center lecture, on which this paper is based, work on a variety of "hotlines" handling psychological difficulties (Zhao, 2020).

To sum up, the pandemic seems to have produced various types of stresses. Some people's reactions are realistic, handled with reality testing, group cooperation, and humor. Some people have developed cabin fever which has been handled supportively, unless group dynamics supervened. On the other hand, some people have developed individual psychopathology: obsessional cleaning, oral and some psychotic (ego-) regressions have been observed. There has also been stimulation of premorbid and even previously resolved neurotic (anxiety and depressive) disturbances, as well as exacerbations of pre-existing problems such as marital ambivalence and anorexia. It is my impression that psychoanalytic concepts of individuals, groups, and large-group structures have been of help in understanding the problems and advising therapists in China about different approaches based on those understandings.

NOTES

1. Dr. Blackman is currently a consultant/supervisor at Wuhan-ZhongDe (China-Germany) Psychological Hospital, a lecturer at Shanghai Mental Health Center, and Distinguished Professor of Mental Health at Shanxi Medical University in Taiyuan, China.. He is also Professor of Clinical Psychiatry at Eastern Virginia Medical School in Norfolk, VA; Training and Supervising Analyst with the Contemporary Freudian Society in Washington, DC.
2. This is the first chapter of *Studies on Hysteria*, the joint work of Josef Breuer and Sigmund Freud. When it was later included in Freud's collected volumes of his shorter works in 1906, the following footnote was appended to this later print: "Also printed as an introduction to *Studies on Hysteria,* 1895, in which Josef Breuer and I further developed the view expressed here and illustrated them by case histories" (Breuer and Freud, 1893–1895, p. 3).

3. To be precise, Selye's notions of stress are not controversial, but his acceptance of financial support from the Canadian tobacco industry in the 1960s, and his subsequent reluctance to acknowledge that tobacco can create a biological stress for the body, are often debated.
4. I am indebted to 武 春艳 (Wu Chunyan) for sharing the review of shame in China (Fan and Huilongjiang, 2009), which is commensurate with Selye's concept that (shame-based) stress may be "eu-stressful" [true, good stress] and promote diligence and good behavior. On the other hand, too much (shame-based) stress on children may become "distressful" (Selye, 2011, p. 1) and therefore counterproductive. Thanks also go to Cheng Hao, in Nanjing, for his description of multiple tragedies that occurred when Hong Xiuquan failed the Emperor's exams in ancient China.
5. Dr. Blackman consulted to the Eating Disorders Center, at SMHC, for Director Chen Jue, during most of 2019.

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