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.

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*Marco Trabucchi, *Diego De Leo*
d.deleo@griffith.edu.au

Italian Psychogeriatric Association, Brescia, Italy (MT); and Australian Institute for Suicide Research and Prevention, Griffith University, Queensland 4122, Australia (DDL)

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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.

Give the patient your full empathic attention; do not take notes during sessions. The therapeutic alliance could have particular potency in a time of crisis.

Social support. Similarly, the patient's social interaction presents a dilemma. It is important to make the most of social engagement given the limitations of the moment, to maintain social bonds, and to seek interpersonal support even as one must maintain a safe physical distance. Social engagement—attachment—is a basic human need.[5] At a time when developing new relationships might be hard, taking a good interpersonal inventory[1] can identify existing relationships that the patient can use to minimise isolation. The phone, FaceTime, Skype, and the like can help to lessen social isolation and maintain social support. Failing that strategy, more isolated individuals might want to use social media to maintain a sense of connection with others.

Because most new therapies require in-person intake visits, a patient you terminate with is unlikely to be able to start new treatment elsewhere. Hence, even if you were planning to terminate a time-limited treatment with a patient, it might be appropriate—depending upon clinical status—to add continuation sessions to a treatment you would normally end, in order to ensure the patient's continuity of care.

Every cloud has a silver lining. Objectively, this situation is a terrible moment in world history, and not one to trivialise to patients. From a therapeutic stance, however, bad news can be good news. IPT therapists capitalise on environmental stressors and losses—the death of a significant other (complicated bereavement), a painful interpersonal situation (role dispute), or other major life event (role transition)—as helpful explanations for why patients are feeling the way they do, contextualising those feelings and symptoms in a current personal crisis that the patient can work on and resolve in time-limited treatment.[1] A pandemic can helpfully be reframed as a role transition in which the patient needs to mourn the (hopefully temporary) loss of old roles and to adaptively restructure activities and relationships in the present. Forty years ago, another frightening and initially untreatable virus with very different course, stigma, and social reverberations struck. Because the news was so bad, IPT proved particularly efficacious in treating HIV-related major depression,[6] and might have similar potency today.

This setting is a painful but powerful moment for psychotherapy. Patients need therapy more than ever, yet are physically distanced from it. Psychotherapy might be harder in some respects to do at a distance, but teletherapy does work, and the basic principles remain the same. The interpersonal, environmental context can provide a useful frame for treating the problems patients now face.

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John Markowitz
jcm42@cumc.columbia.edu

New York State Psychiatric Institute, Columbia University, New York, NY 10032, USA

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COVID-19, unemployment, and suicide

The COVID-19 pandemic has led to the introduction of strong restrictive measures that are having a substantial effect on the global economy, including an increase in the unemployment rate worldwide.[1] In a previous study,[2] we modelled the effect of unemployment on suicide on the basis of global public data from 63 countries, and we observed that suicide risk was elevated by 20–30% when associated with unemployment during 2000–11 (including the 2008 economic crisis). We have now used this model to predict the effects of the currently expected rise in the unemployment rate on suicide rates.

Close to 800 000 people die by suicide every year.[3] We used our core model's estimates (intercept, sex, age group, and unemployment)[2] to describe the non-linear connection between unemployment and suicide. We applied the overall estimates to World Bank Open Data (ie, worldwide number in the labour force in 2019, unemployment rate [modelled estimate from the International Labour Organization] for 2019, and male and female populations in 2018 in the four age groups). Because the model predicted only 671 301 suicides with this data, instead of 800 000, we added a correction term of 0·17 to address differences in space (194 *vs* 63 countries) and time (2020 *vs* 2000). The expected number of job losses due to COVID-19 were taken from the International Labour Organization's press release from March 18, 2020,[1] reporting a decline of 24·7 million jobs as a high scenario and 5·3 million jobs lost as a low scenario. In the high scenario, the worldwide unemployment rate would increase from 4·936% to 5·644%, which would be associated with an increase in suicides of about 9570 per year. In the low scenario, the unemployment would increase to 5·088%, associated with an increase of about 2135 suicides.

For the **World Bank Open Data** see https://data.worldbank.org