Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Adapting cognitive behaviour therapy for tele-psychotherapy services for COVID-19

Dear Editor,

Around the globe, we are facing great challenges fighting the novel corona virus disease (COVID-19) pandemic. In addition to the direct medical threat it poses, psychosocial well-being of people is also threatened by several factors related to the spread of this global contagion. (Holmes et al., 2020) The highly contagious nature of this infection precludes the use of traditional face-to-face psychotherapeutic interventions to a significant extent. Hence, tele-psychotherapy, which utilises internet technology, has gained importance in delivering psychological help to the distressed people in this hour of need. Also, the response from tele psychotherapy approaches has been determined as nearly equal to face-to-face sessions. (Milosevic et al., 2021) Within the psychotherapy community, different models are being followed to deliver psychotherapy. amongst the various models, cognitive behavioural model has the largest evidence base regarding its effectiveness. (Hofmann et al., 2012) Introduced by Beck and his colleagues, the cognitive behavioural model emphasizes the role of dysfunctional thinking in determining one's emotional state. According to this model, a person can alleviate his/her emotional suffering if he/she learns the ways to identify and respond to his/her dysfunctional thought processes and by avoiding maladaptive behaviours. (Beck et al., 1979) Adapting the cognitive behavioural model for psychotherapy in this stressful period would prove beneficial for large segments of the population. But recently published literature on CBT in the context of COVID-19 does not provide any specific modules or protocols that could be followed while implementing CBT in this pandemic situation. (Weiner et al., 2020; Murphy et al., 2020; Li et al., 2020; Alavi et al., 2020; Cheng et al., 2021; Surmai and Duff 2021) This paper attempts to offer a COVID-19 context-based CBT formulation that is applicable to the psychological issues of different population groups in different situations.

During an infectious disease outbreak, generalised fear and fear-induced behaviours are common. As more information regarding the situation continues to emerge, the intensity and pervasiveness of the fear response vary on a day-to-day basis and the fear itself serves the purpose of helping the individual to adapt to the situation. A certain degree of anxiety is normal; individuals need to strike a balance between safety-seeking behaviours and fearful mental states. If someone experiences an increased level of distress that is disproportionate to a given situation, the underlying cognitive processes must be identified and worked upon to find emotional relief.

Some cognitive states that could cause emotional distress include increased self-threat, cognitive reflections on being stigmatised, pathological angst, maladaptive perceptions about lockdowns and cognitive representations of financial crisis. One of the easiest ways to manage dysfunctional cognitions in crises is to help the individual develop an adaptive cognition or offer an alternative perspective to manage his/her cognitive disturbance. (Stanley et al., 2009) Cognitive behaviour therapists could choose one of the methods described below to help their clients to overcome their difficulties.

1 For persons experiencing increased self-threat as a result of negative self-threat processing, the therapist could work in collaboration with the client to develop adaptive cognitions. Having an alternative cognitive perspective would reduce the impact of self-threat and help the individual to cope better.

An example:

Dysfunctional cognition: "It's horrible that I face a threat like this, I can't bear this situation."

Adaptive cognition: "Fearing for what I have to fear will only do good for me and that protects me from dangers." "The threat is not exclusively for me; it's a threat for the entire human race."

Additionally, several individuals' cognitive processes and safety seeking behaviours during the COVID-19 crisis closely match the cognitions and behaviours previously identified in obsessive compulsive disorder patients. Hence the therapist may consider extrapolating the therapeutic approaches that are used to deal with those obsessive cognitions, viz., thought action fusion (imagined transfer of germs from one object to another), inflated responsibility (sense of being an agent who could carry the germ to the loved ones) and inferential confusions (using facts out of context).

1 If an individual feels that he/she is stigmatised or ostracised because he/she has contracted COVID-19, the therapist could use a problem-solving approach and emphasize the need to manage plausible cognitive distortions like selective abstraction, arbitrary inferences (here, the perceived discrimination) and labelling, which would play out excessively when someone perceives being ostracised.(Knight et al., 2006)
2 If someone develops a pathological angst which is rooted in the uncertainty of the present moment, a cognitive experiment (Rachman, 2003) of recounting from the past the victory of human race over several crises could weaken the individual's hold over his/her negative beliefs.
3 It is evident that the lockdown imposed in several countries to mitigate the spread of COVID-19 has significant psychological consequences. The mental health issues stem from experiencing a sense of loss of freedom and other hardships faced during lockdowns. From the cognitive perspective, instead of thinking about the lockdown as a coercive measure, if people start to think that they are doing this for the common good, their distress level would probably reduce and their compliance to the lockdown would improve.

Looking at the economic costs of lockdowns, anticipation of financial

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strain and uncertainty over economic security are the two major psychological fallouts of an economic recession. These stressful events predominantly affect the people belonging to low income group because financial security is the bare minimum to meet the basic human needs (i.e., food and water). (Abeyta et al., 2017) The impact of existential consequences of financial insecurity can be reduced by proper behavioural planning. By implementing behavioural hibernation (i.e., acting/behaving in a way that would conserve finances for the very essential needs, foregoing other needs) for protracted periods, one can attempt to tide over a crisis. In contrast, for those who belong to the high-income group and are predominantly worried about future financial debt, it will be helpful if they address the metacognitive aspects of worry and the cognitive errors regarding the intolerance of uncertainty.

In addition to the usual work pressure that health care workers face during this crisis, they also face an additional challenge because they fall into the high-risk category related to the occupational hazard posed by the corona virus. Even though apprehensions such as fear of infection and fear of spreading the infection to their family members could be conceived as normal in anyone who is exposed to the imminent risk of infection, it is likely that these distortions may become overwhelming in health care workers, causing increased emotional distress. In those situations, cognitive distortions like catastrophising and overestimating the risk of contracting and dying from COVID-19 may play out excessively, leading to a heightened fear of getting infected. Additionally, distortions like inflated responsibility could fuel the fear of spreading the infection to family members. If a health care worker is trained to address these distortions through cognitive means, he/she could breathe a sigh of relief. (Clark, 1986; Salkovskis et al., 2000; Hofmanand Reinecke, 2010)

Since the behaviour of children is mostly based on their observation of the parental behaviour, calm and composition in parents in times of crisis will minimise any negative impact of COVID-19 crisis on children's behaviour. (Burstein and Ginsburg, 2010) Also, this is the right time for parents to prepare their children to face future pandemics in an efficient way by training them to identify themselves cognitively as global citizens. They could use the real-time examples of common human involvement in every aspect of a pandemic that helps build a social cognition of connectedness, inclusiveness and belongingness. The cultivation of pro-social attitudes fosters evolvement of pro-social behaviours, which will help them to handle future disasters in a better way.

Since the case–fatality ratio increases with increase in age and medical comorbidities, the older adult population and those people with underlying health conditions can be considered as the special population when dealing with the COVID-19 crisis. (Centers for disease control and prevention, 2020) As this group faces a heightened threat and since the risk is real, each time it is better to not underplay their safety cognitions as erroneous or distorted during therapy sessions.

Let us look at some possible distorted thoughts that the elderly may harbour during this crisis situation. "I am doomed to die." With a cognition of this sort, the therapist could identify the specific distortion that is present in it, namely, catastrophising, and could coach the client to handle it.

Compared to this, there may be another cognition, "Everyone is dangerous." If we look at this cognition through the therapeutic lens, it qualifies for overgeneralisation, but during this pandemic it sub serves the purpose of practising "universal precaution," thereby protecting the elderly from getting infected. It is, therefore, better to address the health anxiety of the elderly through a pragmatic cognitive and behavioural means. (being cautious in taking up particular cognitions and eschewing others during therapeutic work)

Admittedly, a nearly constant input of news reports about health hazards related to COVID-19 would cause anxiety and distress to anyone. The frequent engagement with news media and checking for COVID-19 updates could prove to be even more harmful in the elderly and those with underlying health conditions who have a higher risk of contracting a severe form of COVID-19. This specific population should exercise safety by engaging in comprehensive avoidance behaviours, that is, actively avoiding the source of the virus and passively avoiding COVID-19 updates checking behaviours. Abandoning the updates checking routines will break the chain of distress in the cognitive behavioural cycle and help them to cope with stress. Additionally, behavioural techniques like applied relaxation, deep breathing techniques and yoga can be recommended to overcome an emotional crisis. (Sengupta, 2012; Hayes-Skelton et al., 2013; Perciavalle et al., 2017) Also, for elderly people with age-related cognitive deficits, a predominantly behaviour-orientated strategy will ease the process of learning therapy. (Grant and Casey, 1995; Mohlman, 2013)

People when mandatorily quarantined/isolated tend to experience emotional distress owing to the restrictions imposed on their liberty. In such situations, developing an altruistic attitude is better than compulsive endurance. (Brooks et al., 2020) Therapists, during their therapeutic sessions, could collaboratively formulate an adaptive belief that is altruistic in nature, which would help the quarantined people to cope better with the isolation.

An example:

Maladaptive beliefs associated with increased distress while in isolation: "I should be able to exercise my liberty at all times."

A more functional altruistic belief to cope with isolation is: "I shouldn't be allowed to use my liberty at the cost of other's lives."

Since altruism has its limits, it is better to provide adequate information on how their altruistic attitude would come back to save their loved ones when the society at large is benefitted from the sacrifices made by quarantined people.

If a COVID-19 suspected/confirmed patient experiences exaggerated self-stigma, the therapist may utilise cognitive restructuring techniques (such as pie charts) to handle distortions like personalisation and other negative self-stigma thoughts. (Larson and Corrigan 2010)

An example:

Dysfunctional cognition: "It's my fault that I have made others suffer from COVID-19."

Adaptive cognition: "The truth is that several other factors are involved in the spread of virus and I am not to take the full responsibility for the spread of the disease."

The gravity of the present situation demands an urgent need to revamp and repurpose the existing psychotherapy methods to suit the requirements of the ongoing crisis. Since the information related to the COVID-19 pandemic continues to emerge, the above suggestions can be considered as a preliminary input for guiding therapists who intend to deliver cognitive behavioural tele-psychotherapy for COVID-19-related psychological issues. In times of crises, therapists following the cognitive behavioural model have to be dynamic in adapting empirically validated regimens to form eclectic paradigms to deliver effective therapies.

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I, Jaiganesh Selvapandiyan, as author certify that I have participated sufficiently in the work to take public responsibility for the content, including participation in the concept, design, analysis, writing, or revision of the manuscript. Furthermore, I certify that this material or similar material has not been and will not be submitted to or published in any other publication before its appearance in the Psychiatry research.

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References

Holmes, E., O'Connor, R., Perry, V., 2020. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. Lancet Psych. 7, 547–560.

Milosevic, I., Cameron, D.H., Milanovic, M., McCabe, R.E., Rowa, K., 2021. Face-to-face versus video teleconference group cognitive behavioural therapy for anxiety and related disorders: a preliminary comparison. Can. J. Psych. https://doi.org/10.1177/07067437211027319. Online ahead of print.

Hofmann, S.G., Asnaani, A., Vonk, I.J., Sawyer, A.T., Fang, A., 2012. The efficacy of cognitive behavioral therapy: a review of meta-analyses. Cognit. Ther. Res. 36, 427–440.

Beck, A.T., Rush, A.J., Shaw, B.F., Emery, G., 1979. Cognitive Therapy of Depression. Guilford Press, New York.

Weiner, L., Berna, F., Nourry, N., Severac, F., Vidailhet, P., Mengin, A.C., 2020. Efficacy of an online cognitive behavioral therapy program developed for healthcare workers during the COVID-19 pandemic: the reduction of stress (REST) study protocol for a randomized controlled trial. Trials 21, 870.

Murphy, R., Calugi, S., Cooper, Z., Dalle Grave, R., 2020. Challenges and opportunities for enhanced cognitive behaviour therapy (CBT-E) in light of COVID-19. Cognit. Behav. Therap. 13, E14.

Li, J., Li, X., Jiang, J., Xu, X., Wu, J., Xu, Y., Lin, X., Hall, J., Xu, H., Xu, J., Xu, X., 2020. The effect of cognitive behavioral therapy on depression, anxiety, and stress in patients with COVID-19: a randomized controlled trial. Front. Psychiatry 11, 580827.

Alavi, N., Yang, M., Stephenson, C., Nikjoo, N., Malakouti, N., Layzell, G., Jagayat, J., Shirazi, A., Groll, D., Omrani, M., O'Riordan, A., Khalid-Khan, S., Freire, R., Brietzke, E., Gomes, F.A., Milev, R., Soares, C.N., 2020. Using the online psychotherapy tool to address mental health problems in the context of the covid-19 pandemic: protocol for an electronically delivered cognitive behavioral therapy program. JMIR res. Protoc. 9, e24913.

Cheng, P., Casement, M.D., Kalmbach, D.A., Castelan, A.C., Drake, C.L, 2021. Digital cognitive behavioral therapy for insomnia promotes later health resilience during the coronavirus disease 19 (COVID-19) pandemic. Sleep 44, zsaa258.

Surmai, M., Duff, E., 2021. Cognitive behavioural therapy: a strategy to address pandemic-induced anxiety. J. Nurse Pract. https://doi.org/10.1016/j.nurpra.2021.10.013. Online ahead of print.

Stanley, B., Brown, G., Brent, D.A., Wells, K., Poling, K., Curry, J., Kennard, B.D., Wagner, A., Cwik, M.F., Klomek, A.B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., Hughes, J., 2009. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. J. Am. Acad. Child Adolesc. Psychiatry 48, 1005–1013.

Knight, M.T.D., Wykes, T., Hayward, P., 2006. Group treatment of perceived stigma and self-esteem in schizophrenia: a waiting list trial of efficacy. Behav. Cogn. Psychother. 34, 305–318.

Rachman, S., 2003. The Treatment of Obsessions. Oxford University Press, New York.

Abeyta, A.A., Routledge, C., Kersten, M., Cox, C.R., 2017. The existential cost of economic insecurity: threatened financial security undercuts meaning. J. Soc. Psychol. 157, 692–702.

Clark, D.M., 1986. A cognitive approach to panic. Behav. Res. Ther. 24, 461–470.

Salkovskis, P.M., Wroe, A.L., Gledhill, A., Morrison, N., Forrester, E., Richards, C., Reynolds, M., Thorpe, S., 2000. Responsibility attitudes and interpretations are characteristic of obsessive compulsive disorder. Behav. Res. Ther. 38, 347–372.

Hofmann, S., Reinecke, M. (Eds.), 2010. Cognitive-Behavioral Therapy with Adults: A Guide to Empirically Informed Assessment and Intervention. Cambridge University Press, Cambridge, UK.

Burstein, M., Ginsburg, G.S., 2010. The effect of parental modeling of anxious behaviors and cognitions in school-aged children: an experimental pilot study. Behav. Res. Ther. 48, 506–515.

Centers for disease control and prevention, 2020. Severe outcomes among patients with coronavirus disease 2019 (COVID-19) — United States, february 12–march 16, 2020. weekly /march 26, 2020 69(12);343–346 https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm.

Sengupta, P., 2012. Health impacts of yoga and pranayama: a state-of-the-art review. Int. J. Prev. Med. 3, 444–458.

Hayes-Skelton, S.A., Roemer, L., Orsillo, S.M., Borkovec, T.D., 2013. A contemporary view of applied relaxation for generalized anxiety disorder. Cogn. Behav. Ther. 42, 292–302.

Perciavalle, V., Blandini, M., Fecarotta, P., Buscemi, A., Di Corrado, D., Bertolo, L., Fichera, F., Coco, M., 2017. The role of deep breathing on stress. Neurol. Sci. 38, 451–458.

Grant, R.W., Casey, D.A., 1995. Adapting cognitive behavioral therapy for the frail elderly. Int. Psychogeriatr. 7, 561–571.

Mohlman, J., 2013. Executive skills in older adults with GAD: relations with clinical variables and CBT outcome. J. Anxiety Disord. 27, 131–139.

Brooks, S.K., Webster, R.K., Smith, L.E., Woodland, L., Wessely, S., Greenberg, N., Rubin, G.J., 2020. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. The Lancet 395, 912–920.

Larson, J.E., Corrigan, P.W., 2010. Psychotherapy for self-stigma among rural clients. J. Clin. Psychol. 66, 524–536.

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