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Hospital-based Psychological Interventions during the COVID-19 Pandemic: A Literature Review

Intervenções Psi em Hospital durante a Pandemia COVID-19: Uma Revisão de Literatura

Intervenciones Psi en Hospital durante la Pandemia COVID-19: Una Revisión de Literatura

Interventions Psychologiques à l'Hôpital pendant la Pandémie de COVID-19 : Une Revue de Littérature

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Abstract

This article maps scholarship in psychology and psychoanalysis on clinical interventions during the COVID-19 pandemic. It is a narrative literature review derived from a master's research project and grounded in the author's clinical experience with patients in a COVID-19 referral intensive care unit. Data were collected from April to September 2022 using the descriptors "psychology," "psychoanalysis," "hospital," "interventions," and "COVID-19 pandemic," with no language filter. Publications span 2020–2022. The corpus comprises 38 articles, two guideline manuals, one advisory booklet, three books, and a live-stream by a hospital psychologist and contemporary psychoanalyst. Results indicate that, in the international literature, early Chinese publications served as key references for conceptualizing psychological interventions in the pandemic context. In Brazil, hospital psychology accounts for most publications, while psychoanalytic work in hospital settings remains comparatively limited. Across both international and national outputs, a common thread is the strategic use of technological devices (tablets, smartphones) to enable and sustain clinical practice.

Keywords: psychoanalysis, hospital, COVID-19 pandemic.

Resumo

Este artigo objetiva mapear as produções do campo da psicologia e da psicanálise, sobre suas perspectivas de intervenções clínicas durante a pandemia COVID-19. Trata-se de uma revisão narrativa de literatura, derivada de uma pesquisa de mestrado, originária da experiência clínica da pesquisadora com pacientes em unidade de terapia intensiva (UTI) de referência COVID-19. A coleta de dados foi realizada entre os meses de abril e setembro de 2022, utilizando, sem filtro de idioma, os descritores "psicologia", "psicanálise", "hospital", "intervenções" e "pandemia COVID-19". As publicações são datadas de três anos, no período de 2020 a 2022. O acervo dessa revisão está composto por 38 artigos, dois manuais de diretrizes, uma cartilha de orientação, três livros e uma live de psicóloga hospitalar e psicanalista contemporânea. Os resultados mostram que, na literatura internacional, as produções chinesas aparecem como as primeiras referências de estudos para pensar as intervenções psicológicas no cenário pandêmico. No Brasil, o campo da psicologia hospitalar é o que reúne maior número de publicações, enquanto as produções psicanalíticas no hospital encontram-se em número ainda reduzido. Assim, o fio em comum que conecta todas as produções – internacionais e nacionais – é o uso dos aparelhos tecnológicos (tablet, smartphone) a favor das intervenções e sustentação das práticas clínicas.

Palavras-chave: *psicanálise, hospital, pandemia COVID-19.*

Resumen

Este artículo tiene el objetivo de mapear las producciones del campo de la psicología y del psicoanálisis, sobre sus perspectivas de intervenciones clínicas durante la pandemia COVID-19. Se trata de una revisión narrativa de literatura, derivada de una investigación de máster, originaria de la experiencia clínica de la investigadora con pacientes en unidad de cuidados intensivos (UCI) de referencia COVID-19. La recogida de datos fue realizada entre los meses de abril y septiembre de 2022, utilizando, sin filtro de idioma, los descriptores "psicología", "psicoanálisis", "hospital", "intervenciones" y "pandemia COVID-19". Las publicaciones son con fechas de tres años, en el período de 2020 a 2022. El acervo de esta revisión está compuesto por 38 artículos, dos manuales de directrices, una cartilla de orientación, tres libros y una live de psicóloga Hospitalar y psicoanalista contemporánea. Los resultados muestran que, en la literatura internacional, las producciones chinas surgen como las primeras referencias de estudios para pensar las intervenciones psicológicas en el escenario pandémico. En Brasil, el campo de la psicología hospitalaria es lo que reúne mayor número de publicaciones, mientras las producciones psicoanalíticas en el hospital se encuentran en número todavía reducido. Así, el hilo en común que conecta todas las producciones – internacionales y nacionales – es el uso de los aparatos tecnológicos (tabletas, smarthphone) a favor de las intervenciones y sostenimiento de las prácticas clínicas.

Palabras clave: *psicoanálisis, hospital, pandemia COVID-19.*

Résumé

Cet article vise à répertorier les productions dans le domaine de la psychologie et de la psychanalyse, concernant leurs perspectives d'interventions cliniques pendant la pandémie de COVID-19. Il s'agit d'une revue narrative de la littérature, dérivée d'une recherche de master, issue de l'expérience clinique de la chercheuse avec des patients dans une Unité de Soins Intensifs (USI) spécialisée en COVID-19. La collecte des données a été réalisée entre avril et septembre 2022, en utilisant, sans filtre de langue, les descripteurs « psychologie », « psychanalyse », « hôpital », « interventions » et « pandémie de COVID-19 ». Les publications sont datées de trois ans, allant de 2020 à 2022. La collection de cette revue est composée de 38 articles, deux manuels de directives, une brochure d'orientation, trois livres et un vidéo en direct d'une psychologue hospitalière et psychanalyste contemporaine. Les résultats montrent que, dans la littérature internationale, les productions chinoises figurent comme les premières références d'études pour réfléchir aux interventions psychologiques dans le contexte pandémique. Au Brésil, le domaine de la psychologie hospitalière est celui qui rassemble le plus grand nombre de publications, tandis que les productions psychanalytiques en milieu hospitalier restent encore peu nombreuses. Ainsi, le fil conducteur qui relie toutes les productions – internationales et nationales – est l'utilisation des dispositifs technologiques (tablettes, smartphones) pour favoriser les interventions et soutenir les pratiques cliniques.

Mots-clés : *psychanalyse, hôpital, pandémie de COVID-19.*

The novel coronavirus SARS-CoV-2, which causes the COVID-19, emerged in China in December 2019. In January 2020, 1 month later, the World Health Organization (WHO) declared a Public Health Emergency of International Concern (World Health Organization, 2022). Then, in March 2020, 2 months later, the WHO officially characterized COVID-19 as a pandemic (WHO, 2020). Given the virus's high transmissibility, health services had to redesign physical spaces, routines, and care pathways. Organizations such as WHO and Brazil's National Health Surveillance Agency (ANVISA) issued sanitary regulations that included infection-prevention and control measures for patient care; contact and isolation precautions; and the use of personal protective equipment (PPE), along with staff training in PPE donning, doffing, and disinfection (Technical Note No. 04, 2020).

The pandemic brought bodily isolation into the hospital setting. Families were removed from in-person caregiving, and patients experienced hospitalization away from their significant others. Whereas a general intensive care unit (ICU) typically treats patients with diverse diagnoses, a COVID-19 ICU concentrates a single clinical phenomenon and requires stricter care-flow directives. Beyond the new patient profile and sanitary protocols, this context reshaped the psychology practice setting in hospitals.

Accordingly, this article stems from a master's research project grounded in the author's clinical experience with patients in a COVID-19 referral ICU, guided by psychoanalytic theory. The topic lies at the intersection of psychology and psychoanalysis, with the hospital as its setting. From this standpoint, we examined the literature in these fields to map perspectives on clinical interventions during the COVID-19 pandemic.

Method

We conducted a narrative literature review to map, with theoretical grounding and contextual framing, publications and updates relevant to the study. Searches covered the following databases and platforms: BVS, PubMed, MEDLINE, LILACS, Index Psi Periódicos, Portal de Periódicos da CAPES, SciELO, and Google Scholar.

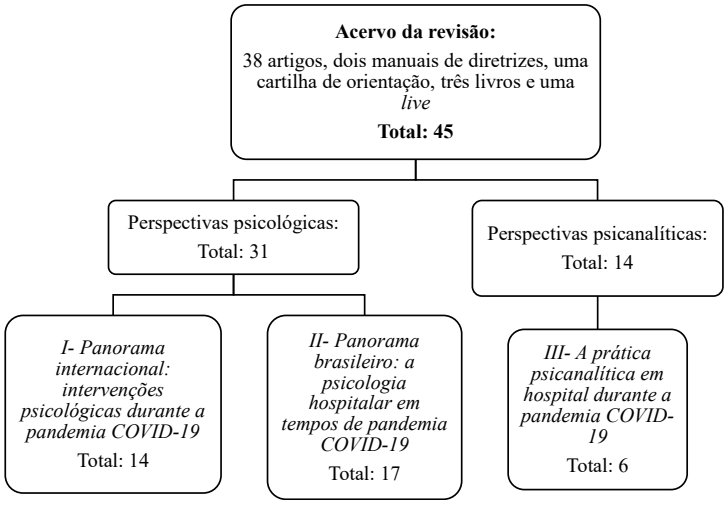
As the search strategy, we used the descriptors "psychology," "psychoanalysis," "hospital," "interventions," and "COVID-19 pandemic," combined with the Boolean operator AND, with no language filter. We also selected the "any field" option to broaden retrieval.

Inclusion criteria comprised studies addressing practices and specific features of psychology/psychoanalysis work in hospitals during the pandemic period (2020–2022). Exclusion criteria comprised studies outside that timeframe and theoretical materials that did not report concrete experiences of psychology/psychoanalysis practice in hospital settings. Because few psychoanalytic publications were found for the hospital context during the pandemic, we expanded the references to include books, live-streamed events, and guidance materials produced in that period. Due to the timeframe of the pandemic, all included materials were dated between 2020 and 2022.

The final corpus consisted of 38 articles, three books, two guideline manuals, one advisory booklet, and one live-stream. The review is organized into two major sections: 1) psychological perspectives and 2) psychoanalytic perspectives. The first section is divided into two topics: I — *International overview: psychological interventions during the COVID-19 pandemic*; and II — *Brazilian overview: hospital psychology in times of COVID-19*. The second section contains one topic: III — *Psychoanalytic practice in hospitals during the COVID-19 pandemic*.

Figure 1

Analyzed studies



Psychological Perspectives

International Overview: Psychological Interventions during the COVID-19 Pandemic

China's National Health Commission (2020) published, in February 2020, guiding principles for psychological interventions in crises and public-health emergencies related to the novel coronavirus, SARS-CoV-2. These guidelines drew on prior epidemic experience — such as the 2003 SARS outbreak (Duan & Zhu, 2020; Woong et al., 2021; Xiang et al., 2020) and the 2013 H7N9 avian influenza (Jiang et al., 2020) — when psychological intervention was recognized as an important tool for mental-health prevention and care in times of crisis and public-health emergency (Sun et al., 2021).

The first recommendation was to create mental-health reference teams to lead psychological interventions, aiming to unify the integration and implementation of these actions (Center for Disease Control, 2020). To operationalize the plan, the population was stratified into four levels: 1) patients infected with coronavirus who were hospitalized and clinically severe; 2) patients infected with coronavirus with a clinically mild presentation, either hospitalized or isolating at home; 3) people connected to the first-level group; and 4) the general population.

These guidelines became a reference for multiple studies (Duan & Zhu, 2020; Jiang et al., 2020; Jiménez-López et al., 2021; Xiang et al., 2020; Zhou, 2020). However, Xiang et al. (2020) and Duan and Zhu (2020) noted that, although mental-health professionals were not considered essential staff, Chinese health professionals in direct contact with patients in hospitals were not "trained" for mental-health care, which affected the quality of care provided. According to the authors, since the 2003 SARS epidemic the strategic response remained the same: assemble mental-health teams with external professionals. They suggest that mental-health professionals should be embedded in hospital teams, not only in epidemic situations.

Xiang et al. (2020) and Duan and Zhu (2020) also emphasized the importance — learned from previous epidemics — of ensuring secure communication among professionals, patients, and families. During the COVID-19 pandemic, this was facilitated through electronic applications on tablets and smartphones, which served as communication channels between patients and families and as a means for the medical team to share treatment information. The use of such applications became a hallmark of psychological-intervention strategies internationally, reported in China (Jiang et al., 2020; Liu et al., 2021; Sun et al., 2021; Wei et al., 2020), Singapore (Woong et al., 2021), Germany (Rentrop et al., 2020), Iran (Shaygan et al., 2021), Canada (Al-Refae et al., 2021), and Italy (D'Onofrio et al., 2022).

With respect to psychological interventions themselves, the literature shows that they were delivered remotely via electronic apps (Rentrop et al., 2020; Shaygan et al., 2021; Wei et al., 2020; Woong et al., 2021) or in person (Jiménez-López et al., 2021; Sun et al., 2021). Implementation was most often based on psychiatric and psychological assessments conducted by mental-health teams (Rentrop et al., 2020; Sun et al., 2021; Wei et al., 2020). The assessment findings guided the choice of intervention, such as brief therapy techniques for stress adaptation, psychological support, or medication prescribed by a psychiatrist (Xiang et al., 2020). In Shanghai, for example, Jiang et al. (2020) describe dividing the population into the four levels proposed by the National Health Commission: face-to-face psychological care was prioritized for the first level, while from the second level onward remote options were used, such as telephone-based psychological support. In this review, we focus on studies describing psychological interventions in hospital settings.

Still in the Chinese context, both infected patients and health-care teams underwent regular clinical triage (Jiang et al., 2020). Regarding patient-directed interventions, Sun et al. (2021) report work with 97 inpatients that consisted of psychotherapy or psychopharmacology aimed at reducing anxiety.

A different approach is seen in Rentrop et al. (2020), who developed an emergency plan providing psychiatric and psychological support to patients, families, and health-care teams via telephone or video calls. For patients and families, care consisted of psychotherapeutic support to foster stability through coping strategies and activation of cognitive resources; for staff, interventions included guidance on stress management (Rentrop et al., 2020).

Along similar lines are randomized studies by Wei et al. (2020) in China and Shaygan et al. (2021) in Iran. In Wei et al. (2020), electronic-device–based psychological interventions were offered to inpatients with psychological distress. The interventions were pre-recorded videos with instructions for daily tasks (Wei et al., 2020). In Shaygan et al. (2021), interventions targeted patients with mild to moderate clinical presentations who could use their own smartphones and manage psychoeducational activities. The program consisted of modules with cognitive-behavioral stress-management techniques, educational texts, relaxation methods, and related content, sent daily for 14 days (Shaygan et al., 2021).

In a general hospital in Singapore, Woong et al. (2021) used an electronic application as the intervention for ward patients. Patients received an iPad with the MyCare app, which included information sheets about COVID-19, interviews with survivors, curated reading materials, and artworks. Unlike Rentrop et al. (2020) and Wei et al. (2020), this study did not require psychiatric or psychological assessment to determine eligibility. Providing and using the MyCare app itself was considered a psychological intervention (Woong et al., 2021). Across Wei et al. (2020), Shaygan et al. (2021), and Woong et al. (2021), the interventions did not hinge on psychotherapy or clinician-led psychological support; rather, they were pre-prepared technical or informational materials.

These trends are summarized in the literature review by D'Onofrio et al. (2022). According to the authors, most interventions targeted patients and health care teams, were delivered remotely, and drew primarily on cognitive-behavioral therapy — whether in psychotherapeutic formats or psychoeducational programs, including app development and other technical tools.

From another angle, Jiménez-López et al. (2021) describe a hospital in Mexico where the psychiatry and psychology department reorganized into a mental-health reference team and delivered interventions for infected patients and health-care staff. Interventions were in-person and delivered according to clinical demand. The patient plan included individual psychotherapy with emotional support and containment, crisis-intervention measures, and psychoeducation about disease and treatment; referrals could also be requested via interconsultation (Jiménez-López et al., 2021). For staff, psychological care took the form of support groups for conversation and containment. Notably, patients who received psychological care had preserved speech. The authors did not report interventions for patients with severe clinical status, nor interventions with families, or interactions between these two groups (Jiménez-López et al., 2021).

In this brief international overview, psychiatrists and psychologists generally worked together. Interventions were understood as psychotherapy, psychological support, emotional support, or psychopharmacology, delivered to patients and/or staff, either remotely or in person (Jiménez-López et al., 2021; Rentrop et al., 2020; Sun et al., 2021). There were also

app-based psychological interventions providing psychoeducational materials with technical guidance for stress management and reduction — often grounded in mindfulness and positive psychotherapy — with psychologists and psychiatrists involved in preparing the materials and administering anxiety scales remotely (Shaygan et al., 2021; Wei et al., 2020).

As for patient eligibility, all cited studies required non-severe clinical status (i.e., patients not in the ICU) with preserved speech and, when applicable, the ability to operate electronic devices (Rentrop et al., 2020; Shaygan et al., 2021; Wei et al., 2020; Woong et al., 2021). This raises questions about contact between these patients and their families and about end-of-life processes — topics that would warrant a separate review.

Brazilian Overview: Hospital Psychology in Times of the COVID-19 Pandemic

The onset of the COVID-19 pandemic required hospital psychology services to reorganize, creating new care pathways and routines that accounted for contact-precaution regulations and the health crisis produced by the pandemic (Castelo-Branco & Arruda, 2020; Catunda et al., 2020; Costa et al., 2022; Grincenkov, 2020; Kuybida et al., 2021; Lessa, 2020; Lima et al., 2020; Miguel et al., 2021; Nascimento et al., 2021; Nunes et al., 2020; Oliveira et al., 2020; Silva & Lima, 2020; Zanini et al., 2021).

Early guidance documents for hospital psychological care discouraged psychologists from entering COVID-19 referral units, recommended suspending in-person visits, and advised that psychological interventions be delivered remotely — limited to "frontline" professionals, non-infected patients, and families bereaved by COVID-19. Infected patients were not to receive psychological care due to their respiratory status (Sá-Serafim et al., 2020).

Recommendations issued by the Brazilian Society of Hospital Psychology (SBPH, 2020) and the Guidance Manual for Hospital Psychologists (Schmidt et al., 2020) took a different view. They suggested assessing the feasibility of remote care; if in-person care was necessary in units with suspected or confirmed patients, psychologists should strictly follow donning and doffing protocols and use PPE, with institutions responsible for training and supplying equipment (SBPH, 2020). The handbook also left it to the psychologist to decide between in-person and remote formats. For family care, the guidance established telephone-based workflows to facilitate contact between patients and relatives through electronic devices, set specific schedules for virtual visits, and, for unconscious patients, allowed families to send audio messages to be played at the bedside (Schmidt et al., 2020).

Virtual visits are the defining feature of psychological interventions in Brazil. In this vein, Crispim et al. (2020) offer practical recommendations for virtual visits during the pandemic. According to the authors, the goal is to maintain bonds and psychological support between patients and families. They therefore recommend virtual visits for patients with preserved speech and suggest scheduling fixed visiting times and keeping a distance from the bedside (Crispim et al., 2020). For Zanini et al. (2021), virtual visits allow families to see the patient and the physical space, which can help dispel fantasies and uncertainties about hospitalization. Grincenkov (2020) notes that virtual visits can lessen the helplessness experienced by patients and families in the face of illness and isolation and at the end of life, facilitating farewells and supporting grieving processes.

Unlike the international context, where bespoke apps were created, Brazil used WhatsApp because it is broadly accessible to the general population. Most studies are qualitative, largely experience reports (Catunda et al., 2020; Costa et al., 2022; Kuybida et al., 2021; Lessa, 2020; Lima et al., 2020; Miguel et al., 2021; Nascimento et al., 2021; Nunes et al., 2020; Silva & Lima, 2020; Zanini et al., 2021), along with two literature reviews (Oliveira et al., 2020; Rodrigues et al., 2021) and one care protocol (Castelo-Branco & Arruda, 2020). Experiences occurred in public, private, and philanthropic institutions.

The two literature reviews (Oliveira et al., 2020; Rodrigues et al., 2021) indicate that hospital-psychology interventions during the pandemic targeted patients, families, and health professionals. Core approaches included psychological care by phone or in person. Lima et al. (2020) report their experience in a philanthropic hospital in Fortaleza, Ceará: interventions served hospital staff, patients, and families through psychological appointments plus the development of actions and educational materials. Infected ICU patients — sedated and intubated — did not generate demand; thus, care focused on ward patients, with a preference for remote delivery. For families and staff, support occurred by phone, providing listening and psychological containment (Lima et al., 2020). Virtual visits were not part of these interventions.

Lessa (2020) and Nascimento et al. (2021) describe interventions directed to families of patients in the COVID-19 ICU, conducted remotely by telephone. In Nascimento et al. (2021), the hospital's IT department set up a dedicated extension and an isolated room to ensure confidentiality. In Lessa's (2020) report from a public hospital in Rio de Janeiro, follow-up with families occurred by phone without a dedicated line; the author notes in-person meetings with families in the event of patient death.

At the Hospital de Urgências de Goiânia, Miguel et al. (2021) adopted strategies aligned with international practice: patient-focused interventions centered on psychoeducation guided by cognitive-behavioral techniques. Patients were assessed for their ability to manage contact with family and convey clinical information. In a private hospital in the city of Fortaleza, state of Ceará, Catunda et al. (2020) implemented virtual visits as a humanization resource to care for the

subjectivity of patients and families, coordinated with the multidisciplinary team rather than restricted to psychology. Also in Fortaleza, at a public hospital, Silva and Lima (2020) proposed virtual visits according to patient preference and demand. Psychological care targeted infected patients through in-person brief psychotherapy, accessed via interconsultation. The authors note scarce technological resources for video calls.

Costa et al. (2022), reporting from another public hospital in Ceará, provided psychological care to patients with preserved speech. Ward patients were seen in person; COVID-19 ICU patients were seen online. Virtual visits were encouraged, although the authors do not specify whether this applied to ward or ICU patients. Psychological follow-up for families occurred by video call, with psychologists working from home. Hospital staff received walk-in psychological support (Costa et al., 2022).

In a public hospital in Curitiba, Paraná, Nunes et al. (2020) implemented virtual visits to bring patients and families closer, enabling speech and emotional expression. Patients were seen in person, and families were supported by phone. Initially, video calls were limited to lucid patients with preserved speech. As phone support revealed the distress of families with unconscious, intubated relatives, the team began inviting families to send audio and video messages to be played for patients. A similar perspective appears in Kuybida et al. (2021), also in a Curitiba public hospital, where in-person visits were allowed for families of patients at end of life. A psychologist accompanied relatives throughout the visit, guiding PPE donning and doffing to enable farewell rituals and support grieving.

At the Hospital de Clínicas de Porto Alegre, Zanini et al. (2021) report in-person care for patients, remote care for families, virtual visits, and conditional flexibility for in-person visits, all decided with the multidisciplinary team. In-person psychological care was offered to patients with preserved speech and to those pre-intubation or weaning from mechanical ventilation. Lucid patients who could handle their own phones were allowed to use them and were encouraged to manage contact with relatives (Zanini et al., 2021). Patients awaiting intubation were also offered virtual visits. In response to the distress of families of intubated patients or those with limited speech, virtual visits were extended to these families as well. The practice was discussed with the multidisciplinary team, including the hospital's legal department, and considered bioethical issues. For virtual visits, the psychology team assessed not only desire but also the psychological and emotional conditions of families and of patients with any level of consciousness. During visits, relatives could voice messages and feelings and often asked the psychologist to touch the patient with affectionate gestures. In these moments, "the psychologist is perceived as an extension of the family, which cannot be present" (Zanini et al., 2021, p. 51). Farewell rituals occurred by video call or through special authorization for in-person visits.

Castelo-Branco and Arruda (2020) present distinctive work with severely ill patients on mechanical ventilation (MV). They developed a protocol for psychological care during MV weaning: psychologists offered care to these patients, created alternative communication methods, and mediated communication between patient and team. When patients requested family contact, the psychological and emotional conditions of both sides were assessed and virtual contact was proposed.

In this synthesis of Brazilian hospital-based psychological practice during COVID-19, each psychology service restructured its care flow in its own way, although certain practices recurred across experiences. In line with our research experience, Rodrigues et al. (2021), Catunda et al. (2020), and Silva & Lima (2020) consider the literature on hospital psychology during the pandemic to be sparse and underscore the need for formats beyond experience reports. Nunes et al. (2020) suggest one reason for the limited output: the psychological burden on frontline psychologists made it difficult to process their experiences and convert them into written work.

Psychoanalytic Perspectives

When surveying psychoanalytic work in hospital settings during the pandemic, we found few studies (Almendra et al., 2020; Andrade, 2020; Moretto et al., 2021; Rocha, 2020; Soares & Rodrigues, 2020). Most focus on clinical experience with virtual sessions (Capoulade & Pereira, 2020; Colao et al., 2020; Dacorso, 2020; Leite, 2021; López, 2020; Rocha, 2020; Verztman & Romão-Dias, 2020), as the pandemic put the traditional modus operandi of this clinic in question and prompted theoretical and technical reconsiderations (Dourado et al., 2021; Dratovsky et al., 2021; Quinet, 2020). It is worth noting, however, that virtual care did not originate during the pandemic (Verztman & Romão-Dias, 2020).

According to these authors, what turned virtual care into an online setting was the need to sustain psychoanalytic work amid a catastrophic context. This new clinical arrangement triggered a range of questions for analysts, many centered on the body. For Brunetto (2020), the analyst's presence is not merely bodily presence; it is also an act — a function that opens the patient's unconscious. Capoulade and Pereira (2020) refrain from definitive answers, but argue that to think through the tension between presence and virtuality in psychoanalytic practice, "one must keep in mind that, in psychoanalysis as in any other clinical modality, technique must serve ethics and can find its justification only therein" (Capoulade & Pereira, 2020, p. 10). Dratovsky et al. (2020) revisit Lacan's formulation that the analyst's position is that of the semblant of the object and the cause of desire, and they ask how an analyst can uphold this position while also being affected by the pandemic context.

Questions about online practice and the body therefore revolve around presence and virtuality, with analyst and patient mediated by the screen. In this vein, Melo (2020) and Pinto (2021) contend that even in a virtual space — where the material body is not present — the analyst's function of presence operates through the drive-objects of voice and gaze. Rocha (2020) also highlights the role of the image, noting that in virtual sessions analyst and patient both have their own image and the other's in view. Quinet (2020) maintains that online psychoanalysis may be regarded as "in-person," insofar as it entails the analyst's presence. This debate links back to the analyst's position, a notion revisited by most authors to consider the analyst's body in virtual practice (Capoulade & Pereira, 2020; Colao et al., 2020; Dacorso, 2020; Dourado et al., 2021; Dratovsky et al., 2020; Leite, 2021; López, 2020; Rocha, 2020; Verztman & Romão-Dias, 2020).

Accordingly, psychoanalytic literature during the pandemic has concentrated on the bodies of patient and analyst as mediated by the screen. This focus invites us to question psychoanalytic practice in hospitals during pandemic times, since in some hospital practices the analyst's physical body is explicitly at issue.

Psychoanalytic Practice in Hospitals during the COVID-19 Pandemic

Moretto et al. (2021), in *A psicologia hospitalar no enfrentamento da pandemia COVID-19 a partir da psicanálise*, recall that, at the outset, mental-health professionals—feeling helpless and powerless — turned to the Brazilian Society of Hospital Psychology (SBPH) for guidance on "what to do." The authors argue that answers lie in revisiting psychoanalytic theory, because in psychoanalysis "there is an ethics that orients our practices and that also guided us during the pandemic: attention to what is singular in each clinical case" (Moretto et al., 2021, p. 244).

Guidelines and handbooks were, of course, necessary as a compass to reorganize clinical work. Still, the authors emphasize that each clinician and hospital service must factor in their prior trajectory and institutional history to build, in their own way and within real constraints, new care pathways. Regarding virtual visits, they note that any team member could conduct them. When led by a psychoanalytically trained professional, however, the visit can become a space for listening and containment in which the clinician serves as a symbolic mediator:

> (...) making it possible for patients' words to be narrated to families—and for the impact of those words to be conveyed back to patients (the reverse may also occur). This symbolic intermediation helps patients and relatives construct narratives around illness and hospitalization, transforming them into a subjective experience (Moretto et al., 2021, p. 249).

With these contributions in view, we turn to reports of hospital-based interventions by psychoanalytic practitioners. These works weave together theory, practice, and research, often through clinical vignettes (Almendra et al., 2020; Andrade, 2020). They are grounded in Freudo-Lacanian psychoanalysis (Almendra et al., 2020; Rocha, 2020; Soares & Rodrigues, 2020). Andrade (2020) also draws on Sándor Ferenczi's formulations (2011).

Rocha's (2020) article differs from experience reports. It arises from the question, "what can a psychoanalyst do in a hospital during a pandemic?" The practical field was a university hospital in Niterói, Rio de Janeiro. The author outlines feasible interventions: continue offering in-person care to lucid patients and provide remote support to families. Virtual visits were conducted with lucid patients; for sedated and intubated patients, families were invited to send audio messages to be played at the bedside. For the author, "in the encounter with the analyst lies the opportunity to say what was not said and to re-signify the painful experience that deprives these people not only of their loved one but also of all the customary rituals surrounding dying" (Rocha, 2020, p. 12). Along this line, she proposes a specific intervention for relatives, the "memory box," a place where families could deposit something written about the deceased patient.

In a private hospital in Rio de Janeiro, Almendra et al. (2020) directed interventions to families through remote care, as most patients were sedated and intubated. Phone contacts "functioned not only as a device for containment, but also for identifying states of anguish" (Almendra et al., 2020, p. 5). A similar approach appears in Soares and Rodrigues (2020) at Casa da Caridade in the city of Muriaé, state of Minas Gerais, where interventions likewise consisted of remote care for families. They focus on the psychic demands of farewell rituals when relatives could not say goodbye in person. Families found alternative paths: sending a piece of the patient's clothing to accompany the body — garments that, in other times, would have been worn; requesting the medical record to have something to "see" about the death; writing letters for staff to read to the patient, among other rituals. The authors note that, depending on the pandemic phase, some in-person farewells were permitted.

We examine in greater detail Andrade's (2020) work at the Rio de Janeiro Military Firefighters' Hospital. Interventions targeted patients and families. No formal workflow was set for staff; support was offered to professionals who sought out psychology. For patients, in addition to clinical encounters, "care strategies" were designed based on literature on psychological interventions in major disasters. Lucid patients were encouraged to use their own phones to manage family contact. When patients lacked the clinical condition to do so autonomously, virtual encounters were facilitated by the psychoanalytic practitioner according to patient interest. For sedated and intubated patients, families were invited to send audios and messages to be conveyed to the bedside.

Andrade (2020) devotes part of the report to patients in extreme situations, described as "patients in full anguish," unable to sustain communication due to respiratory compromise. "In these cases, I offer myself as someone with the courage to listen and respond without dread, but I also resort to silent presence and touch, merely accompanying the agony so that it is not lived in utter solitude" (Andrade, 2020, p. 87). The author turns to Ferenczi's *elasticity of technique* (2011) and to Luís Claudio Figueiredo's notion of *implicated* or *preserved presence* (2007). *Elasticity* supports the flexibility required of the analyst's position when working with patients at the limits. *Implicated presence* sustains being available at the patient's side without necessarily acting through speech.

Finally, we draw on a live-stream held June 10, 2020, by the Regional Psychology Council of Mato Grosso, featuring psychoanalyst Maria Lívia Moretto. Moretto (2020) underscores the need for "responsible invention" in the face of the patient's and family's urgent subjectivity and the pervasive use of virtual tools. Even so, she cautions that — even with widespread virtual devices in hospital practice — the true resource is not the tablet or smartphone; the resource is the analyst's own physical presence.

Final Considerations

This article set out to map scholarship in psychology and psychoanalysis that addressed clinical interventions during the COVID-19 pandemic. The review presents an overview of publications on potential interventions in hospital contexts, helping to situate clinical practice within the pandemic scenario. Overall, most studies used a qualitative approach, typically experience reports. A common thread across both international and Brazilian literature is the use of technological devices to enable interventions and sustain clinical practice. In the international literature, early Chinese publications served as initial reference points for thinking about psychological interventions during the pandemic. In Brazil, hospital psychology accounts for the largest share of publications — alongside guideline manuals, recommendations, and handbooks — whereas psychoanalytic output in hospital settings remains comparatively limited.

In the psychoanalytic literature, publications focus on online practice and on discussing presence and virtuality — how the bodies of analyst and patient are mediated by the screen. This perspective offers theoretical guidance for psychoanalytic practitioners in hospitals but does not fully encompass situations in which the practitioner's body is physically present at the bedside. Even so, the psychoanalytic studies highlight sustained efforts to uphold clinical practice through listening and the singularity of each case, revisiting theoretical premises and adhering to psychoanalysis's ethical commitments.

It is therefore necessary to underscore the presence and integration of psychologists and psychoanalysts as members of multidisciplinary teams in Brazilian hospitals — by contrast with international experiences in which psychologists are not embedded in hospital teams but instead belong to mental-health units assembled by government action during crises and public-health emergencies.

Finally, it is essential that mental-health professionals continue to produce scientific knowledge and disseminate their clinical practices in light of their lived experience. We hope this theoretical study contributes to the ethical commitments of psychology and psychoanalysis amid the pandemic and its calls to reinvent clinical work.

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