Learning from the Pandemic

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Preface
I am writing this as a white woman, in my early 70s, who has been living in the UK throughout the pandemic. My views have been shaped by this experience, and may be quite specific to it. The UK arrived at the pandemic after a decade of political turbulence that led to the country leaving the European Union. We have a centrally coordinated National Health Service which is free at the point of need. Other countries will have faced the pandemic with different kinds of health systems and/or available resources but I hope what I have written will resonate with therapists from other countries and that we can start a dialogue about how best to support those who have been most affected.

Introduction

At Starehole Bay in South Devon there is a submerged shipwreck. It is a place I have visited throughout my life, but I have only seen it with my own eyes once because, to be visible, it requires an alignment of unusual circumstances – a very low tide, a stunningly clear sky and the sun at a particular angle. In ordinary times you don't notice it and it only takes ripples on the surface, or debris from a storm to obscure the upturned hull from view. The pandemic threw up a similar once in a generation alignment, one that elided in the UK with the divisiveness and xenophobia of Brexit and worldwide with the slow-burning panic of climate change. It laid bare the broken timbers of our own society, exposing its inequality, its injustices, and its cruelties for all to see. Usually, these aspects of how we live are made invisible by distortions, lies, smoke or mirrors. When they surface in episodes of violence or tragedy they are quickly pushed back under the surface – procedures whereby the more powerful get to render the less powerful invisible and construe their difficult circumstances as personal failings.

The daily death toll and rising case numbers soon highlighted those

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groups who were physically and economically the most vulnerable, those who were the most exposed, those who were the least rewarded and those 'key workers' who were to become the most relied upon. Small ripples of generosity surfaced in the early days, but these soon dissipated and now, while it is by no means all over, it seems as if this period, while painful to live through, has offered up important lessons. As Beckett (2021) remarked: 'A pandemic is a political event. It exposes who is vulnerable and who can afford to escape, who is prioritised for treatment and who is neglected. The politics of a pandemic are both large-scale and intensely personal.' In other words, the pandemic was a relational event, upending the networks within which we all live but also making inequalities explicit in the reciprocal roles that were enacted between individuals, communities and helping agencies.

CAT began its life as a radically social model of psychotherapy and one in which poverty and disadvantage were not allowed to be a barrier to receiving a service. It was paced and spaced so that it could be provided in public health settings within a limited time frame, and in a spirit of collaboration, without falling back on the more mystical all-knowing interpretations of orthodox psychoanalysis. Over time, and under pressure to produce measurable outcomes, this commitment to equality has been diluted, and CAT in the 2020s is at risk of being seen as just another therapy that is 'delivered' or 'done to' people seeking help for their distress or their sense of dispossession.

Many people within the CAT community have been trying to reset this imbalance by including within our formulations of what hurts, those structural disadvantages that seep into a person's soul. We have been seeking practice that rehabilitates social injustice as a proper explanation of mental ill-health and as a legitimate focus for shared understanding with our patients. The pandemic has made this adjustment even more necessary.

When a person grows up with insufficient or insecure income, it undermines the stability and connectedness of their relational lives. Poverty has even been shown to affect the developing brain of an infant at a neurological level leaving its indelible stamp on their progress through life (Rocheleau 2019). But international data at population level, compiled by Wilkinson and Picket (2011) demonstrated that it is not only the level of absolute poverty in a country that creates social 'problems' but the scale of *inequality*. Their analysis suggests that this is because it undermines social bonds and cuts across solidarity. Inequality is therefore closely correlated with addictions, suicides, early pregnancy,

depression, violence, divorce, stalled longevity, infant mortality, and other societal difficulties. The data proves, once and for all, that structural issues percolate down to cause individual stress and distress. A CAT understanding of this data might be to postulate that inequality fundamentally destabilises reciprocal roles making them more 'asymmetric' than truly reciprocal (Emilion and Brown 2017; and Brown 2019).

The pandemic provided further evidence, if it was needed, of the extent to which more unequal societies fare worse. Writing from the experience of the UK, years of austerity in relation to public services since the financial crash of 2008 had led to extremes of inequality within and between regions. Poverty then came to be implicated as a cause of increased mortality and morbidity in line with these existing inequalties. Pre-existing conditions were evident in the demographics of the early mortality statistics, as the virus took lives that had already in part been compromised. The final turn of the screw is that the pandemic has left an disparate legacy in human and economic terms that is creating even further tears in the social fabric and placing a still heavier weight of disruption and dislocation on the shoulders of the already disadvantaged. Our government put mandatory restrictions in place that were too little and too late, and they weakened their effect by accompanying official public health information with mixed messages as influential people close to power flouted rules and appeared unmasked in public. This hesitancy and ambiguity played a significant part in our country's higher numbers of infections and deaths to date than those in comparative countries.

Black and minority ethnic communities were disproportionately affected by a juxtaposition of biological vulnerability and long-term discrimination in the labour market, by the increased likelihood that people from these communities would be working in public-facing, economically insecure employment, and by the fact that they were often living in more crowded housing and in more densely populated and poorly served neighbourhoods. The international outcry that erupted in the face of the appalling racist murder of George Floyd, resonated with the voices of many who already felt that they had been unjustly left behind including those who had been hit disproportionately hard by the virus and further impoverished by its economic impact. People were also suffering from many bereavements washing over them in waves, many of which are laced with anger and 'if-onlys'. This sense of an overdue reckoning also emerged in relation to incidents of violence against women. When Sara Everard, Sabina Nessa, Nicole Smallman and Bibaa Henry were killed going about their ordinary lives, it was as if there had been what we call in CAT a 'bottling up' procedure that the pandemic

forced into the open. People protested despite the risk of infection, and they protested against the backdrop of burning forests and flooded streets.

In the UK, it is unlikely that anyone would have escaped the pandemic's ramifications. For some this will have meant painful separations and bereavements. Some found themselves better off with incomes held steady and reduced outgoings, while others have been plunged into poverty, debt, and homelessness. Some found the retreat into relative isolation calming, while others experienced it as alienating. For anyone living with a violent partner or family member the risks and pressures increased. What is clear is that many will not return to 'normal' at home, in their workplaces, their politics, or their sense of themselves. In CAT terms, reciprocal roles have become so changed and so charged that the procedures that previously worked no longer cut through. In this editorial I want to think about what we can learn as relational therapists about naming inequalities and acknowledging the impact of so many overturned reference points.

Absolute and Relative Poverty

My recent writing has focussed on making visible the underlying 'distal' causes of mental distress in terms of inequality, racism and poverty, arguing that as therapists we often render these pressures on individuals invisible, loading their personal and familial narratives with, what are often, societal problems. I have argued that reciprocal roles can rarely be seen outside the prevailing social hierarchies and that traps, snags and dilemmas are often hard wired into the conditions of a person's external life not only encoded in their internal dialogue. A person's diminishing options may lead them to seek ever more desperate ways of getting what they need from indifferent others, including from public agencies.

Absolute poverty

As we have seen, poverty may be absolute as in not having enough to meet one's basic needs, or it may be relative as in not having as much as others around you. In the UK the Joseph Rowntree Foundation (2020), which campaigns around these issues, reports that an adult with an income below £70 a week or couples with 2 children who have less than £140 are effectively destitute. The UK government, recognising that the basic level of welfare benefits (Universal Credit) was insufficient, raised

it by £20 per week at the start of the pandemic but then in the autumn of this year the supplement was withdrawn. Some changes were made to the adjustments for people in work, but despite advocacy from all sides of the political divide those who do not or cannot work were knowingly left without enough to manage. Many of the people who do not work are carers for disabled family members or disabled themselves; they have no way of generating sufficient income to get by. It is worth noting that children presenting to mental health services at this point in the pandemic are more than twice as likely to live in a household that has debts or that has fallen behind with key payments. The Royal College of Psychiatrists (2017) had published information before the pandemic showing that one in two adults with debts has a mental health problem and that one in four people with a mental health problem are also in debt. It is not appropriate for therapists to focus on personalised narratives when these circular links between poverty and mental ill-health have been staring us in the face throughout the pandemic.

Thus therapists in public health settings will often be seeing people who are necessarily preoccupied with their day-to-day survival while other people with mental health problems will be unable to attend therapy at all because they do not have enough for transport or childcare. Forgetting this undermines our service initiatives just as forgetting the pervasive messages poor people are being given about how little they are valued, has the potential to undermine the integrity of our clinical input.

Relative poverty
Wilkinson and Pickett's (2011 *op cit*) work *The Spirit Level* used international data to make explicit the damaging impact of inequalities on a whole range of mental health and wellbeing indices at population level. Their work focussed on inequality more than on absolute poverty, on status rather than on need. Their analysis cemented in place a layer of explanation about why people suffer, not only because they are unable to meet their basic needs but because this relative poverty imbues so many reciprocal roles encountered in everyday life with a sense of injustice and envy. These skewed roles lean towards one pole that is exploitative or withholding and another that is desperate and needy. The pandemic made visible these default settings, the low pay of key workers, the insecurity of their housing, the split between those who could retreat to work from their homes and those whose jobs disappeared overnight, and the lack of respect shown to benefit claimants.

The geography of inequality

Others have explored the geography of poverty (Ballas, Dorling and Hennig 2017), examining the regional inequalities that had prompted the supposed 'levelling up' agenda on which the current UK government was elected. In July 2021 the Health Foundation reported: 'The chances of dying from Covid-19 were nearly four times higher for adults of working age in England's poorest areas than for those in the wealthiest places.' They attributed this to years of austerity, cuts in public services and stagnant wages. Ballas *et al* (*op cit*) stated that 'cuts to public services had "frayed the nation's health" and contributed to the UK's disproportionately high Covid death toll compared with similar countries.' The lockdowns shone a harsh light on these disparities with their differential regulations for the different regions and countries of the UK. For example a recent report on the post pandemic needs of Manchester compiled by Sir Michael Marmot (2020) stated: 'the coronavirus death rate in Greater Manchester was 25% higher than the England average during the year to March, leading to "jaw-dropping" falls in life expectancy and widening social and health inequalities across the region.' These forms of inequality predated the pandemic, but they made it worse, and they were in turn made worse by it.

Bottled up injustices

So, it became clear in the first lockdown, that we were not 'all in this together' and as time went on this perception grew more stark. People in white collar jobs were able to withdraw into their own homes to continue working while 'key' workers continued in public-facing jobs, health care, transport, food delivery, retailing, teaching and social care, where they were disproportionately exposed to the virus. The government's first official report *Coronavirus: Lessons learned to date*, while lacking the heft of an official independent inquiry, laid out useful information and concluded that the initial handling of the pandemic had been a public health failure.

It had also become evident that communities of colour were facing the vagaries of the virus from structurally disadvantaged positions and that this was resulting in disproportionate exposure to the virus and excess deaths. At first it was thought that structural inequalities accounted for all of the increased exposure and risk to BAME patients, but subsequent research suggests that subtle genetic differences exist especially for those with South Asian heritage that may render some people more vulnerable to respiratory stress. So, it is likely that the causes

of this 'disparity' were both structural and biological, in that 'existing social, economic and health inequalities were exacerbated by the pandemic and combined with possible biological factors contributed to unequal outcomes including unacceptably high death rates amongst people from Black, Asian and Minority Ethnic communities (*op cit* para 16). The report also specifically acknowledged the failure to address the needs of people with learning disabilities and autism, that had included applying blanket 'do not resuscitate' notices in contravention of their human rights.

For a brief moment, it had seemed that the contribution of key workers was being really acknowledged and this was publicly expressed through weekly applause and rainbows but when the crisis abated, they were soon put back 'in their place'. In CAT we might frame this as idealisation and projected heroism that gave way to dismissal and abuse of the kind we might represent in a split egg diagram. Clinicians who had been left without adequate personal protective equipment (PPE) were then blamed for high rates of sickness and difficulty in meeting demand, for example GPs have recently been excoriated for not providing enough face-to-face consultations. Government sources began to challenge expectations that NHS workers would receive significant wage increases as soon as the crisis was seen to be somewhat under control. Individuals and organisations have since tried to reassert the values that had emerged during the early part of the pandemic with the hope that at least some of the public solidarity that had been witnessed on those Thursday evenings might remain when the rainbows had finally been peeled off the windows, but to little avail.

Instead, it is clear that while the rich were getting richer, the poor were getting poorer. More than a third of British workers lost their jobs in 2020 according to the Office of National Statistics. Compared with other European countries, the UK fared worse and (although we share a similar median wage) the poor are poorer. Income inequality is stretched at both ends of the range but hugely to the detriment of poorer people. Citing a report from the Policy Institute (2021), Bell compared the UK to both Germany and France where:

> 'The rich here have incomes 17% higher than their equivalents in France. . . [but] our poorest households have to survive on incomes a staggering 20% lower than those across the Channel (£14,700 v £18,500). That means higher poverty, lower living standards and no margin when things go wrong, such as a pandemic hitting.'

These levels of inequality corrode trust and solidarity. The early rhetoric about being 'all in this together' was never going to be sustainable: in CAT terms it represented the fantasy of perfect care that could rapidly descend back into neglect and deprivation. Early in the first lockdown (April 9th, 2020) the journalist Emily Maitliss, fronting BBC *Newsnight*, challenged the 'trite and misleading' language that was being used to suggest that people could survive if they were 'fighters' or that the illness would be a 'great leveller' affecting rich and poor alike. She noted that it was the key workers who were being disproportionately affected and that they tended to be in the lowest paid groups. She heralded the people who had died in that first wave, not as 'soldiers' but as ordinary people just doing their jobs with 'bravery and kindness'. Healthcare workers continue to bear the scars of anguised decisions and tragic deaths.

And the pandemic did not breed social cohesion, instead it has exacerbated the discord. It has also amplified generational conflict with the more vulnerable older population seeking higher levels of restriction because of their health status and the younger people resisting this because of their economic jeopardy. The organisation Hope not Hate has recently circulated a research study showing that, of 336 local councils, COVID is believed to have fostered such 'community tension' that risks inspiring far right activity in 52. (Clarke 2021).

The UK situation paralleled class and racial dynamics emerging in the US. Case and Deaton (2020) describe, how in the decades leading up to the pandemic, large companies had outsourced more menial jobs to separate companies that offered less secure and valued employment creating 'different worlds' (*op cit* p166):

> 'There is the world of the more educated, and a world of the less educated; no one in the latter has hope of joining the former. . . the outsourced workers are no longer part of the main company, they do not identify with it, and are no longer invited to the holiday party.'

. . . or, as it was manifest during the lockdowns, the ubiquitous Zoom quizzes. Against this backdrop of status anxiety, they described how white workers specifically came to 'see black progress as an unfair usurpation of their opportunities rather than as a weakening of the privileged racial position they held.' These *privileged to devalued* reciprocal roles on both sides of the Atlantic undermined local and national policy making. Without solidarity it is difficult to enforce mask mandates, bring about compliance with social distancing, get widespread adherence to

lockdowns, encourage people to be vaccinated, vote through adequate benefit levels, let alone get richer countries to donate aid and vaccines to poorer regions of the world.

There are also some important questions, if not yet answers, about the way that conspiracy theories have tapped into these fractures, undermining public health messaging and eroding trust in expert knowledge and the scientific process. Vaccinations have proven efficacy. Despite the fact that there is a drop-off in immunity over time, the US Center for Disease Control and Prevention (CDC) issued figures recently showing that cases for unvaccinated citizens are running at six times the level of people who are fully vaccinated and that deaths are 12 times as high, despite which considerable numbers of people refuse to be vaccinated and do not trust the scientists who have made this level of protection possible.

Mental health impacts

These early evaluations of the economic impact of the pandemic have been accompanied by studies that are beginning to delineate the additional mental health needs that are being presented to public service agencies. An international team writing in *The Lancet* (Davis 2021) estimate that there have been 76 million extra cases of anxiety and 53 million of depression worldwide, most affecting women and young people. In the UK, referrals for a first suspected episode of psychosis rose by 29% between April 2019 and April 2021 according to NHS figures (Pidd 2021). A Cardiff University study (2021) showed that 10-11 year olds, ate fewer vegetables, took less exercise and experienced worsening emotional difficulties in 2021 when compared with 2019 (Adams 2021). These studies suggest a hugely increased volume and severity of mental health presentations.

Clients of different ages will present specific cohort effects reflective of their developmental stage. We may be seeing young people who have missed out on critical periods when lasting friendships would have been formed (Dunbar 2021) or partners met, or we could be working with new parents who have not been able to set up the networks that would have provided them with future babysitters and cat feeders. The pandemic will be like the rings on trees and the dents will follow people through life. CAT's sensitivity to our clients' incremental developmental may help us to see what has been missed when significant milestones have been cancelled or hard-won independence reversed as a result of lockdowns

and economic instability.

In the coming years our practice and our research will need to quantify and understand these impacts. The studies in this journal describe good practice in relation to the mental health needs of young people and people with learning disabilities Before Covid (BC) but we will need to rigorously explore the increased demand for services and the right mix of interventions that can support them as they go forward, building resilience for themselves, their peer groups and for their communities. The papers here describe interventions that worked in relatively conventional mental health settings, but can we use them as a baseline for the development of innovative and far-ranging interventions in schools, antenatal clinics and inpatient facilities but also online and on air?

As we have seen, people with learning disabilities were also disproportionately disadvantaged by the pandemic and many of the protective structures around them proved insufficient to protect their basic human rights. Disabled people are often at pains to refute the fact that they are uniquely vulnerable but, as a group, they already had poorer health outcomes and compromised longevity and the pandemic has exacerbated this situation. As a group they illustrate a social model of vulnerability, one in which a particular group has a primary vulnerability because of health differences or disproportionate exposure, but then finds itself being discriminated against when trying to access services or being treated less favourably by helping agencies, which creates a secondary vulnerability. This is then made worse if that group finds it harder to garner resources for recovery in the aftermath of illness for example if they disproportionately lose their jobs, are made homeless or find themselves with insufficient income or in debt, all of which constitute an additional tertiary layer of vulnerability. So, people with disabilities have been *made* more vulnerable in ways that other citizens were not.

Anyone living with friends or family members whose behaviour was threatening, volatile or abusive also found it difficult to keep safe during the lockdowns. UK Women's Aid (2021) put out a statement saying: 'While Covid 19 did not cause domestic abuse, only abusers are responsible for their actions, it has led to the escalation of existing abuse and closed down routes to safety for women to escape.' One fifth of those seeking to leave unsafe situations could not do so due to lack of housing and refuge places. The pandemic clearly did not cause abuse but made it worse, we can only hope that this elicits more understanding of the plight of victims and a call for resources to be ear-marked for this sector, as countries recover. We not only need to 'build back better', as one

political slogan says, but build back safer.

At the other end of the age range, older people will have retired without gold watches, or been widowed without the comfort of friends or the rituals of a funeral. Grieving for loved ones who had to die alone added an extra layer of anguish. Each culture has its own rituals that surround bereaved people and keep them afloat through their darkest hours and the pandemic robbed us of these structures. People in care homes were deprived of visitors over long periods in ways that must have been bewildering for many and desperate for their relatives.

The UK's Office for National Statistics has produced figures suggesting that access to all mental health services has decreased during the pandemic with barriers emerging at referral and treatment stages. Referrals for talking therapies dropped from 150,000 per annum in 2019 across the country to 60,000 by April 2021. NHS figures show that most people referred were able to see a therapist, albeit online, within 18 weeks and that patients participating in group therapies were officially allowed to leave home during lockdown to attend their sessions. But despite this, adults starting therapy dropped by a third during the first lockdown. In my own practice most clients welcomed the chance to work online, and it has given some of them more choices as they no longer need to be tied to their local area and/or to make expensive child-care arrangements. But some have found that they do not have adequate privacy at home or cannot relax especially if they are living in a stressful environment or relationship. These delays mean that the person sitting across the room from you is likely to have waited to be seen and to have had to manage crises in their mental health with no one to turn to.

Silver Linings?

Resetting levels of 'busy-ness'
It seems perverse to look for silver linings in this dark period, but as with other kinds of adversity it has highlighted issues that can inform our theory and practice as relational therapists. The pandemic and its lockdowns have provided some people with respite from relentless engagement and sensory input. The role of temperament in shaping personality has never been discounted in CAT, although pre-pandemic we might sometimes have paid too little attention to those with introversion or a proneness to social anxiety. Not all clients found lockdown difficult, because for some it provided an acceptable reason for slowing down from previously frenetic working patterns or social

contact. As CAT therapists we tend to work from the premise that all our patients are driven to be social while, for a minority, constant exposure and activity creates stress and anxiety. Some of our patients may be more motivated to avoid being overwhelmed and to bat away difficult thoughts or interactions than to be always busy and engaged. The lockdown, for them, provided a safe space to reassess their levels of social interaction. Procedures designed to limit exposure and to avoid conflict may need to be made more explicit in our reformulations. Despite the ubiquity of social media, at times the pandemic returned our communities to a dependence on the local and the neighbourly and to a gentler way of relating.

Respecting people who live with chronic illness

Another unexpected development has been that the emergence of 'Long Covid' has made visible the way that post viral illnesses operate thereby exploding the myth that conditions marked by chronic fatigue, pain and brain fog are 'made up' or unworthy of attention. As Douhat observed:

> '. . . unlike other such conditions, which tend to creep up on society, long-haul Covid arrived suddenly, creating a large pool of sufferers in a short period of time and afflicting frontline medical workers and younger patients in large numbers. This created a sense of immediacy and urgency absent from other chronic-illness debates and a constituency for research and treatment among a population – doctors, especially – that's often sceptical of difficult patients and mystery illnesses.' (Douhat 2021)

This lent timely support to patients living with chronic illness who have been campaigning against the current orthodoxy of treating these disorders of the immune system with CBT and graded exercise.

People living with post viral illnesses have been very clear for some time now that exercise regimes do not work because exertion today means exhaustion tomorrow. They have asked that treatment decisions pay far more attention to the lived experience of those speaking out about their conditions both individually and collectively. There is no doubt that these conditions do not fit neatly with current practice in health services or the benefits system where the vagaries of the symptoms and their seeming lack of an identified aetiology have in the past led to people living with these chronic conditions being falsely labelled as lazy, unreliable and unworthy.

When the British Psychological Society (BPS 2021) rather hastily put

out a paper urging psychological screening to *prevent* what has come to be known as Long Covid, there was an instant challenge from those who had been campaigning around these issues (see Kenward 2021) and it was taken down. The new statement put out by the BPS challenges the assumption that 'if nothing shows up in (standard and limited) tests, 'there's nothing (physically) wrong'. It is indeed 'all in your head' (BPS *op cit).* Long Covid's *modus operandi* cast serious doubt on this state of affairs. The sheer numbers – with 2 million Britons and 1 in 7 children identified as having Long Covid symptoms in October 2021, and its multiple constellations of symptoms including parasomnia, joint pain and chronic fatigue, have presented an overdue lesson in how a novel virus can cause long term illness with the obvious corollary that other viruses might also operate in this way. As the author of this section of the bulletin stated 'when the attitude held is that there is a psychological predictor, a psychological interpretation, of people with chronic illness, the patient experience is silenced and undermined. Given all this there is hope.' (BPS 2021). The evidence from so many people affected by long lasting Covid symptoms backs up their accounts. Therapists as well as other health care professionals, insurers and welfare assessors (Kenward 2020) who have in the past treated people suffering chronic fatigue with disbelief or disdain will need to reset their commitment to listening to, and learning from, their clients.

Concluding Remarks

The distress caused by the pandemic will show up in many guises. People living in poverty across all communities have suffered doubly in that they were more affected by the illness itself but then also more disrupted by the economic dislocation that has followed from it. Communities will be struggling with the increasing racial, class and intergenerational tensions that have unfolded from this. Colleagues, whether researchers seeking answers or therapists facing questions, will need to work together to shape a research agenda that is fit for the future. The papers in this edition provide excellent examples of innovative practice in what we might come to see as the pre-Covid world but the pandemic will leave a trail of distress which needs to be dscribed and understood. Therapists will need to work collaboratively to identify each person's specific experiences and heartaches. Together we will need to assess the very particular relational disruption that has taken place for different cohorts and communities.

The UK government has recently started to refer to health *inequalities* as health *disparities* as if the differences exposed by the pandemic were neutral and voluntary which is not, of course, the case. Many organisations paper over inequality in similar ways as if this were kind rather than dishonest. The UK body representing CAT therapists, for example, has a committee that is working on an agenda to increase the participation of therapists from minority communities but decided to name this a Diversity and Equality Committee when the real issue is not that diversity comes bundled up with equality but that it is linked to, and made toxic by, *in*equality. As therapists we often falter when it comes to naming unequal and unjust circumstances even though these are often brought to therapy and activated in the therapeutic relationship.

When inequality and injustice are hidden from view they are kept out of the stories we tell each other and ourselves about who we are as individuals and as a nation. This leaves us hunting for scapegoats or clinging to unreliable solutions: it leaves us vulnerable to deceptive narratives and open to being duped. It leaves us open to drinking disinfectant instead of getting vaccinated. When key parts of the narrative are edited out, we cannot account for our own distress, and then as therapists our work involves helping our clients to discriminate between what is, and what is not, in their control and deciding anew where responsibility lies. Like the shipwreck that appeared once in the late autumn sun, the pandemic focused a harsh light on widening inequalities and the relational fractures they engender. As a society we all saw this and now we all know it is there. We must hold onto that knowledge as we process these years of loss and separation because, both as therapists and citizens, we cannot afford to turn away. □

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