[0:00:01]

Riggenbach: Today is January 21, 2022, and my name is Amanda Riggenbach. I am the manager for Tumultuous 2020, an oral history project at the Abraham Lincoln Presidential Library and Museum. I'm currently in the Southern Illinois University School of Medicine, the Centrum Building, in Springfield, Illinois, with Mehul Trivedi. We're going to be talking about his experiences as a clinical neuropsychologist at the height of the Covid-19 pandemic.

[0:00:28] Thank you so much, Mehul, for having me.

Trivedi: It's a pleasure to speak to you.

Riggenbach: So we kind of start usually with the basic information to get the background knowledge on who are.

Trivedi: Sure.

Riggenbach: So when and where were you born?

Trivedi: Name, Mehul Trivedi. I was born and raised in Springfield, Illinois. I was born December 26, 1977, so I just turned 44 years old.

Riggenbach: Well, happy late birthday.

[0:00:56] And what were your parents' – or are your parents' – occupations?

Trivedi: They're both retired. My father, they came to India in the early to mid seventies. My father worked for – he was a civil engineer for the Illinois Environmental Protection Agency here in Springfield, and my mom was an accountant at the Department of Revenue. They both have been retired for several years.

Riggenbach: I'm sure that's nice to have been state employees.

Trivedi: Yeah, they got a nice pension.

[0:01:30]

Riggenbach: And where did you go to high school?

Trivedi: I went to high school at Springfield High School. So here in Springfield. I graduated in 1995.

Riggenbach: And so we know that you're a neuropsychologist, and I believe in our pre-interview, we discussed that you knew from a young age that you wanted to pursue psychology.

Trivedi: Yeah. Yeah, that's an accurate statement. I took a class in sophomore year of high school. I took an intro to psych class, and the teacher was fascinating, and so I just got very interested.

[0:02:03] And so when I transitioned to college, I majored in psychology. I knew that right away.

Riggenbach: What was it about psychology?

Trivedi: It focuses on what makes us human, like our thoughts, our emotions, our experiences, and how our biology relates to the lives that we live and the experiences that we as humans have.

[0:02:27] So I really think it's just a fascinating field.

Riggenbach: And where did you go for your undergraduate degree?

Trivedi: I went to Lincoln Land Community College first. I did two years there, then I went to Colorado State University for like a semester, and then I finished up here at University of Illinois in Springfield.

Riggenbach: Colorado just wasn't quite the fit?

Trivedi: Yeah, there was also just some personal issues at the time. Mostly I didn't have a car, and I couldn't go to the mountains.

[0:02:59] And so I got a little angry with my parents, and I was like, I'm not going to stay here anymore. We were about ten miles from the front range, the foothills of the mountains. And so I could look at the mountains, but I couldn't actually go to the mountains, and the reason why I moved to Colorado was to go into the mountains, and none of my roommates had cars, so it was kind of – yeah, it was kind of a bummer, but whatever. I liked it. I loved it. I still love Colorado. I love going back there.

[0:03:25]

Riggenbach: And I know in our pre-interview, we also discussed that there was a – at UIS, there was a specific senior year internship that kind of brought you to your goal a bit further?

Trivedi: Yeah, so when I was a junior, I think it was towards my first semester at UIS, because I did my first semester of my junior year at Colorado State, and then I came here. And so I was just looking, I wasn't getting interested in research. I was considering graduate school. Some of my faculty professors recommended that I get involved in some type of research to improve my curriculum vita.

[0:04:04] I saw this opportunity to work with Dr. Ronald Zeck, who was also a neuropsychologist at SIU. He retired in 2016. And yeah, once I worked on the project with him, I kind of knew that that's what I wanted to do was study brain behavior relationships, and neuropsychology and biopsychology, really.

[0:04:29] That's what you do in this field. It's the study of brain behavior relationships. So yeah, it was kind of fortuitous. Maybe it was a good thing I came back to Springfield. Who knows where I'd be if I didn't do this? I'd probably be doing something massively different.

Riggenbach: So was it this experience with Dr. Zeck that brought you into neuropsychology?

Trivedi: Yeah, and once I did that, I knew exactly what I wanted to do. I knew I wanted to do what I'm doing now.

Riggenbach: Wow.

[0:04:58] What made you choose NIU for your PhD?

Trivedi: To be honest, I didn't do very well on the GRE, so I took a year off after my senior year. I graduated in 2019. I took a year off, and I still worked with Dr. Zeck, because I wanted to publish some papers, because I thought that would improve my chances to get directly into a clinical psychology program.

[0:05:30] I started to get some anxiety because I didn't have a job. Psychology bachelor's degrees don't really offer a lot of opportunity for jobs. It's not the greatest degree to get your bachelor's degree in if you're not going to go on and pursue graduate training in some way. So I applied to several schools that were kind of in the lower tier, and NIU offered me full tuition remission and a stipend.

[0:06:00] And so I was basically able to – I got paid to go to graduate school, at least at that time. And so it was a good fit. No other place I interviewed at gave me that much money and covered all tuition, and the faculty that I was working with was studying things that I was interested in already.

[0:06:29] So it seemed like a good fit, even though it wasn't what would be considered a top tier institution for graduate training. But in retrospect, I learned a lot while I was there, so it was good.

Riggenbach: What year did you say you graduated?

Trivedi: My PhD? I got my PhD – so I started at NIU in 2000, and I got my PhD in 2004, which is a pretty sharp timeline.

[0:07:00] Most people that get research PhDs do not complete it in four years. So I went into the PhD program – I didn't get into a clinical psychology PhD

program. Those are really difficult to get into usually. There's hundreds of applicants for like five to six spots. More competitive than getting into medical school. And so I got the PhD program I went into as an experimental psychology with the emphasis on behavioral neuroscience.

[0:07:26] So I was still able to study brain behavior relationships, but I was mostly working with rodent models of fear. And so I was doing some drug infusions in brains, making lesions in brains, and then testing rats for different types of behaviors. I pretty much knew, though, when I was getting towards finishing graduate school, in line with, I don't want to work with rats anymore. You know, because you always have to kill them to look at their brains and make sure that you did everything the way you expected to.

[0:08:01] And so it just wasn't something I could see myself doing for the next 30 or 40 years. So I knew when I got done, I only applied for fellowships that would allow me to work with humans. And since I had already done that as an undergrad, I had some experience with neuropsychology in humans. And so I reached out to faculty, Dr. Sterling Johnson, who is at the University of Wisconsin in Madison.

[0:08:35] He's the man. He's the man in Alzheimer's disease research. And so he had a study that was looking at the adult children of people that were diagnosed with Alzheimer's disease, and that study's still ongoing, and they're following people with a lot of cognitive testing, with biomarker analysis, blood specimens, genetics, neuroimaging.

[0:09:05] I stayed there for two years, and it was a great place, and I was very productive while I was there. It was a nice way to transition. I feel very fortunate looking back on the fact that he took a chance on me even though I wasn't a clinician, or I didn't have the traditional type of – I wasn't a traditional candidate.

[0:09:29] He wasn't that well known at the time, so I think that's why he took a chance on me, is because not a lot of people knew who he was at that time. So yeah, that was a good two years.

Riggenbach: I think we also discussed that we spent some time on the West Coast?

Trivedi: Yeah, so I did the two year research fellowship with Sterling at Madison, and then I continued my postdoctoral training at Rush University Medical Center.

[0:10:04] So I went there, and I was at Rush until 2013. And at the time, around 2008, 2009, there was obviously the huge financial crisis, which really restricted the amount of funding or grants that the federal government was supporting.

[0:10:29] So my mentor, they lost their grant funding, and they were like, you know, we can't support you after X date. And so that's when I was – I'd already been

considering respecializing in clinical psychology, so then I reached out to the Illinois Institute of Technology, which is on the south side of Chicago, and they had a clinical respecialization program.

[0:10:56] So I interviewed, they accepted me into the program. Since I had already taken a lot of the basic psychology requisite courses like in statistics and social psychology and all that. I just had to take the clinical courses and then do practicum training. So getting clinical skills. So I did that, and then in 2013, I applied for an internship, which is part of the process. You need to get licensed as a clinical psychologist. And it's a match process.

[0:11:27] And so I matched at the University California San Diego, and I lived in San Diego, and I worked at the VA in La Jolla, and then also at the UCSD Gifford Clinic in the outpatient mental health center. And those are standard one year internships. And so I did that for one year. Yeah, San Diego's awesome. What can I say? And then after that, I did a clinical fellowship at the Medical College of Wisconsin.

[0:11:58] And I was there in Milwaukee for two years, so 2014 to 2016. August of 2016. Then I got licensed as a clinical psychologist, so I passed my exam. The Illinois state exam, to get licensed in the state of Illinois. And then I moved back to Chicago. I was working at a private practice in the suburbs while living in Chicago. I didn't really enjoy the commute from Chicago to the suburbs, and I wanted to return to an academic medical center.

[0:12:28] Dr. Zeck, who I worked with, retired in 2016, and I applied for this job in 2017. And I was hired, and I started here in July 2017, and I've been here at SIU since then. And I now run the study that I became – it's all come full circle. I am not the principal investigator of the aging study that when I was an undergrad got me interested in the field that I'm in.

[0:13:02] So you know, I never intended to move back to Springfield, but they made me an offer I couldn't refuse. And so I came back, and I've been here since then, and yeah, it's been good so far.

Riggenbach: Do you enjoy being closer to your parents?

Trivedi: Yeah, I do. My dad's 81. My mom's going to be 80 in September, so I know that there's not a lot of time left for them.

[0:13:27] Obviously I hope they live as long as they can or as long as possible, but yeah, it's good to be here and they transition into needing more assistance. I'm hopeful that I can provide them so that they live a wonderful life in their twilight years.

Riggenbach: Was it a difficult transition coming back to Springfield after living in more…

Trivedi: Major metropolitan areas? Yes, it was.

[0:13:55] I still don't think I'm fully – I don't think I'll ever transition fully. The great thing about Springfield, one, the things that were attractive to me were obviously the compensation package was top notch. Like, in terms of our salary survey for neuropsychologists, I was receiving on the higher end of the range of salaries for our field.

[0:14:26] So I was probably in the 95th percentile in terms of what you get directly out of fellowship, with the opportunity to get more if I was productive. And so that was one of the reasons. Obviously, being closer to my parents. But also, the fact that we are located very centrally, and that there's an Amtrak train that takes you directly from St. Louis to Springfield and to Chicago, so I knew that I would be able to – you know, when I wanted to leave Springfield, I'd be able to.

[0:15:00] So while I live in Springfield, I take every opportunity I can to travel and explore places that I've been many times, places that I've lived, like Chicago and Milwaukee but also to go to new other places. And the cost of living here is very affordable, compared to Chicago where I was paying $1,400 a month for rent for a very small apartment. Here, I was able to purchase a house.

[0:15:30] Then I paid off my mortgage. And so now I have more flexibility in terms of finances. So there's not a lot of negatives. But if I could do what I do now and do it somewhere else and be as comfortable, that would be maybe a better situation for me, but those situations don't arise.

[0:15:56] And I've learned through my life that you never find the perfect situation. Nothing's ever going to be perfect. So I've just learned to make the best of my opportunities that I have here. And all my colleagues here are great, and having been from Springfield, obviously, I've got a lot of friends here. And so I knew that I wouldn't be alone with no social network. So that's a good thing. But yeah, definitely the first year or so was a challenge.

[0:16:29] Because I'm just used to the hustle and bustle of big city life and that's not what this community is. It's more chill, slow paced. Which is good in a way as well.

Riggenbach: Can you tell me a bit more about what your position is here? So you have this clinical component research, any teaching?

Trivedi: Yeah, so I'm an assistant professor in the department of psychiatry.

[0:16:57] We're within the division of psychology. There are three of us now. One of the other neuropsychologists, this is his last day. He's moving to Nashville for a job at Vanderbilt, which is closer to his home. He's from Atlanta. And then we're actually recruiting and interviewing another candidate to fill his position

next week. So my primary responsibilities here are to see patients and do clinical work. And so I see anywhere from five to eight patients a week.

[0:17:31] So usually, it's three to four days a week, morning and then afternoon slots that I see patients. And then I do do research as well. Obviously I'm the PI of – it's called the SIU Longitudinal Cognitive Aging Study, which I describe was what Dr. Zeck started in the 1980s.

[0:17:53] And that's focused on just better understanding the natural course of cognitive changes that are associated with either the development of Alzheimer's disease or healthy cognitive aging. And so I hope to write a grant to the National Institute on Aging as soon as I can, really. And then I do a very small amount of teaching. I do the psychology assessment seminar for the residents.

[0:18:27] That's like a six week, one hour a week. I do grand rounds. A lot of my teaching is informal, so it's more one on one. I have three UIS undergraduates that work on the study and then four medical students. And so I do informal teaching with them, like one on one. But teaching is a very, very small percentage of my clinical responsibilities, and we don't have a psychology training program here, so there's no – this is primarily a clinical research position that I do with only a very small component of teaching.

[0:19:05] I'd say it's less than 5% of my effort is teaching. So probably the way I would talk about my breakdown is probably like 75% clinical work and then probably about 20% research, and then 5% administration and teaching.

Riggenbach: Is that how you like it to be? Would you prefer to have more of one thing or another?

[0:19:29]

Trivedi: I would prefer to have more time dedicated to research. I can do that, I just have to buy out my clinical time, which would involve getting a grant. And so if I get a grant, then I can buy out and say, okay, I'm going to buy out 30% effort from my total compensation package. So if you think about 20% effort is one day, 100% is five days, so 30% would be – I already have 20% I'm dedicating to research, so that would be another 30%, so it would be 2.5.

[0:20:00] And then the other 2.5 days, I would continue to do the clinical work and the teaching and some of those small things. So yeah, in an ideal world, I would just want to be a researcher. Like, I always just wanted to clinical research. I never imagined doing clinical work. But the trajectory I was on when I was at Rush, it was to be a career postdoctoral fellow, and postdoctoral fellows don't get paid all that well.

[0:20:27] And so I didn't want to just be a career postdoctoral fellow, so I wanted something more. I was already doing what I do now, I was just doing it in research studies. So I was like, well, you're already doing this stuff, why not give yourself a better baseline, a more consistent baseline? People are always going to come in needing clinical neuropsychological evaluations, so it's like, okay, you know you're always going to have that base salary.

[0:20:58] Which is a very lucrative salary. And so I still want to do research, but it's like, I'm not a slave to grants anymore. So if I can get a grant, it will just make things better. But it's just a lot more work, you know? Like, I work a lot. When I say 20% effort, and 5 days a week, what does that mean in terms of hours?

[0:21:27] You know, if you work 60 hours a week, well, that translates into 12 hours a day. And so that's one thing. It's not 40 hours a week. I work more than that. I work from home, I come into the office on weekends, I try to do as much as I can without losing a sense of life-work balance. I try not to work from home. I always try to – like, home is home, and office is office.

[0:22:00] Which has made it a challenge for Covid, because everybody's being encouraged to work from home. Like, I don't work from home. When I got Covid, I had the opportunity to work remotely, and I didn't have to take sick days if I was able to do it. But I found that when I was at home, I wasn't doing any work, you know? So then when I got back into the office on Wednesday I had all this stuff I had to do.

[0:22:31] And this is probably something I need to improve on, just given that I don't believe we're ever going to return to a five day, everybody onsite work week. I think people are going to enjoy this flexibility that they're having, so I think it will stay and be maintained. So I need to adapt better to these new circumstances. And it's a slow process. Since I work so much, having that separation of home and work, I feel like it helps me to keep a good work-life balance.

[0:23:06] Whereas if I was bringing my work home, I don't think I'd have as much of a balance. It's like, what's my outside of work life, and what's my work life, when everything's being mixed together. I just think it presents challenges, and some people do that more effectively than others, and maybe I'm just on an opposite side of the spectrum.

[0:23:29]

Riggenbach: I can see how difficult it is to bring some of this work home too. When you have – yeah, we'll get into that telehealth stuff too.

Trivedi: Yeah, one of the downsides of SIU is that it's not a research institution. You know, it's not well known for its clinical research.

[0:23:55] And so they don't have the – this institution does not have a well developed enough infrastructure to support clinical faculty who want to do research. Like, I have a research fund. That's my own salary that I put in there. It's like, I'm paying to support people to do research, and it's like, shouldn't SIU be helping me? Like, I could bring in millions of dollars, which is what they do at other institutions, like more well known research institutions like some of the places I've worked at, like University of California San Diego, University of Wisconsin Madison, Rush Medical College of Wisconsin.

[0:24:39] They had much better infrastructure to support their clinicians, so if they did have a faculty who was ambitious and wanted to get a grant, those people didn't have to necessarily work 80 hours a week, because they had the support. I don't have that here.

[0:24:58] So the only options I have are don't do it, or work your butt off and hope that you'll be successful at getting the grant. And by no means is there – you know, it's more likely that I won't get a grant. They only fund 10% of grants at the National Institute of Health. So the odds are not in my favor, but does that mean I shouldn't do it? I mean, I have a plan.

[0:25:26] Like, I want to submit this grant twice, and if I don't get it, that's fine. I'll be fine being a clinician. I'll study to get board certified. That will open up a lot more opportunities for me here. But it's like, I'm only – I also have to constantly be aware that I'm only one person, so that I don't…

Riggenbach: Spread yourself too thin?

Trivedi: Yeah, that's exactly what I was looking for, so I don't spread myself too thin.

[0:25:57] And I'm able to manage what I'm doing now fairly well. If I tried to add studying to get board certified right now, I don't think I could juggle all three of those things at the same time. Because like I said, I'm just one person. And so I just try to always constantly be aware of that and always try to just make sure that I'm being mindful of my own mental health.

[0:26:30] Which sometimes can be difficult, especially when you are ambitious.

Riggenbach: I hope that you're able to get those grants and are able to continue towards those goals.

Trivedi: I hope so too, thank you. As much positive vibes as I can get, I'll take them all.

Riggenbach: And kind of moving then into 2019 and the end of that, so you've been in this position about two years at that point?

Trivedi: Yeah. So like July 2019 would have been my two year anniversary here.

[0:27:04]

Riggenbach: And so what did life look like for you then? You were probably settled back in Springfield. Had you already bought your house?

Trivedi: Yeah, I bought my house in March of 2019. So I came back, I rented for a while, saved as much money as I could so I could put the highest down payment for my mortgage. Yeah, so right around that time, things were going pretty well.

[0:27:29] My referral base was good. Patients were coming in. I was meeting my clinical quota, my clinical expectations, and I was exceeding them, so I was getting bonuses from the SIU Healthcare for that. So yeah, things were going very well. That's also right around the time that I reopened the study, so I was kind of – you know, I had an undergraduate who reached out to Dr. Aaron Haskup, who is now the director of the Alzheimer's Center.

[0:28:00] But at the time, she was not. And she does basic science work, and Gabriella Waybright, who was a capital scholar, she graduated from UIS in May 2020, she sent an email to Dr. Haskup wanting to do clinical research, and Dr. Haskup's like, well, I don't do clinical research, you might want to check in with Dr. Trivedi.

[0:28:27] So I met with her, she was great. She wanted to get paid for research, and I was like, well, I don't have any grant money. I can't pay you. And so we were able to somehow get together enough funds through a variety of different pools of money from psychiatry and from other areas at SIU, and we were able to cobble together enough money to kind of pay her as an extra help student worker.

[0:28:57] And so she worked like 24, 28 hours. She was amazing. This study would not be where it is if it wasn't for her and some of the students that have followed her. So yeah, at that time, things were really rolling, and things were going very, very well in terms of everything. The clinical workload was good. The research workload was manageable at the time.

[0:29:28] So yeah, things were going very well then.

Riggenbach: And on a personal level, did you have big plans for 2020?

Trivedi: It's hard to say. I don't know. I like to travel. Right before I bought my house, I went to London with my brother, and we went to see Arsenal play Manchester United, and it was absolutely amazing.

[0:29:56] And I loved it. And then I was traveling all over, in Europe and then in different cities in different parts of the United States. And then that all kind of stopped. I can remember vividly – what's the last thing I did before Covid?

And so, like, you know, we started hearing about this in December, and everybody's making jokes about, oh, the coronavirus and blah blah blah.

[0:30:31] And then I went to a concert in Milwaukee. It was They Might Be Giants, who I've loved since I was in high school. Great band. They were doing a full cover of their album Flood. And so I went to the show. I used to live in Milwaukee, so I have lots of friends that still live there. So we had a great time. And then I came back to Springfield the next day and, like, everything shut down.

[0:30:59] Like, I had concerts coming up in April. Canceled. Not rescheduled. Like, everything just stopped. And then obviously everything changed. I mean, life as we know it changed within a matter of a couple of months. And so yeah, those were interesting times.

Riggenbach: And that's actually one of my questions, was, did you know much about the virus before it became prevalent with the shutdowns and stuff?

[0:31:34]

Trivedi: Yeah, I mean, I have a pretty strong biology background. I took a lot of basic science courses when I was – like microbiology and things when I was an undergraduate, when I was in graduate school, so I have a pretty well developed understanding of human systems and human biology. So I knew that coronaviruses were what caused the common cold and they still cause the common cold. And so I knew that this was a variant of a coronavirus.

[0:31:59] And from all the science and what the scientists said at the time, yeah, there were a lot of signs that this was different and that this was something very significant that humanity had not experienced in life in generations. And so I understood from a biological perspective. I understood the significance of it.

[0:32:26] From a psychological perspective, I had some difficulty transitioning my behavior. Like, I didn't wear masks all the time. You know, initially in March, until people started – until the faculty were like – and SIU made mandatory policies that face masks are required here, etc., etc. And since then, I've been pretty mindful of the public health recommendations.

[0:33:00] Until I got Covid, I thought I'd been doing it all just fine. I was like, man, you've managed to outrun this virus for almost two years now. And the only reason why I found out that I tested positive was because I was supposed to have a colonoscopy last Friday at the Springfield Clinic, and it was just a routine – not because I have colon cancer or anything – and so they were like, you've obviously got to get Covid tested before that.

[0:33:26] I had some sniffles. I have sniffles all the time. You know, I have allergies, so I was like, this is nothing. I mean, I didn't lose my sense of taste or smell. I

didn’t have shortness of breath. I didn’t have any of the other symptoms. And so they were just like, okay, they were like, no news is good news. So if you don't hear from us, that means you didn’t test positive. So then on Thursday, I go home from here, my Thursday morning, last Thursday morning patient no showed, and then I had a patient scheduled for the afternoon.

[0:34:00] I went home for lunch, and I saw that Springfield Clinic was calling, and I was like, uh oh. I was like, the only reason why they’re calling probably is because I tested positive. And so then they called, and they were like, this is so and so, and I was like, did I test positive? And she’s like, you did test positive, and she’s like, are you experiencing any symptoms? And I was like, I’ve got some sniffles, you know? I was like, I don’t have a sore throat, I don’t have anything else.

[0:34:27] She’s like, you know, sometimes that’s the only symptoms people experience. And she’s like, are you fully vaccinated? And I was like, yeah, I got two – I’m triple vaccinated, you know? So definitely breakthrough infection. Yeah, so that was – you know?

Riggenbach: Yeah, what a time, though. I mean, did you think when you started hearing signs of the pandemic, or I guess even before it was a pandemic, did you think that it would last this long?

[0:34:59]

Trivedi: No. I don’t think anybody did. I mean, you know, because just like I said, from knowing biology, you know that viruses mutate. That’s why you get a flu shot every year, because the viruses mutate, and last year’s flu shot is not going to be enough for next year’s flu, because viruses adapt. And so I knew that, but yeah, I did not think at the time that it would go on this long.

[0:35:25] Although you know just scientifically that worst case scenarios can result in something like this, especially when you put in human – especially when there’s a significant – especially when human nature and human behavior interacts with health and biology and these types of viruses and things like that. That these types of poor outcomes, or where things don't kind of continue on can happen.

[0:36:04] I mean, and, you know, again, being a student of biology, I knew that there had been awful pandemics throughout humanity, starting in BC years. There have been pandemics that have killed off half of the humans on earth at the time.

[0:36:26] You know, if there were 100 million humans, there was a virus that killed 50 million of them, you know? And you know that that can happen, and we’ve had certain outbreaks, Ebola, the other – there was a version of coronavirus

a couple of years ago that occurred in Africa. And so you know. But those were so virulent that they weren't able to spread like this one was.

[0:36:54] So, they killed people in two weeks, and once the person's dead, they can't spread it really. So if you have something that causes such severe illness in all of the people who get it, the viruses don't have a chance to spread. The problem with this virus is that it's bad for certain people, whereas other people don't experience any symptoms, and we don't know enough right now about – we know some – about what predisposes a person to poor outcomes, to severe Covid versus those that experience mild Covid.

[0:37:34] We know that there are certain risk factors: diabetes, high blood pressure, being obese, respiratory illness, immunocompromised people for whatever reason, but there's been no virus that's acted like this virus. And so yeah, who knows, man? I do have some hope that this Omicron variant might actually be a good thing.

[0:38:04] Now, hear me out. When I say that, this is the best case scenario. You have a highly contagious variant that's not very virulent. It does not cause severe disease, but if people are exposed to it, they're going to develop antibodies too, so they're less susceptible to getting it again.

[0:38:25] Or if they do get it again, it's not going to be as severe. And then if you combine that with the percentage of people that have been vaccinated, you might reach that herd immunity that all the public health experts are saying, like Dr. Fauci, is, you know, once we can get to that level where 90%, 95% of people have either gotten Covid and have a level of antibodies that are high enough to protect or you've been vaccinated.

[0:38:57] If we can get both together, maybe we'll get to that point. And Omicron might get us there. I mean, the worst case scenario – and Dr. Fauci said this recently – he's hopeful that we will get to an endemic phase after Omicron. The caveat is, what if there's another variant that is highly contagious and causes severe illness in a lot of people, so that even if you're vaccinated, you still could get it like I did.

[0:39:30] But it's going to still cause you to get really sick. That's the worst case scenario. And fingers crossed. We just hope for the best, right?

Riggenbach: In years before the pandemic, were you the type of person who would get their flu shot?

Trivedi: Yes, every year. I'm a scientist. I know how to read science.

[0:39:57] I know when science is questionable. I review science. I review research papers. I know when the science isn't good and when the science is good. And I know that the science is good for this. So like in that the research has

been done and it's been done in a large amount of people. So yeah. And I've always been that type of person. Like, I've always gotten all my flu shots, I've always – you know, even before Covid, when people would still come to work when they had the common cold, just because they were like, oh, I don't want to take any sick days or this that and the other, you know, we don't do that nowadays.

[0:40:35] Because there's always this concern about Covid. I was still that guy that would take the sick day, because I was like, I don't want other people to get what I've got. This isn't very fun to have, you know? I'm congested, I have a sore throat, I'm fatigued all the time. Like, I don't want anybody to feel that way, so I would always be the guy that would stay at home.

[0:40:56] And then worry that people at work were thinking that I was not really sick and that I was just milking the time because I wanted to not be in the office. So I've always been kind of that person, so I've always been very health conscious in those parts of my life.

Riggenbach: That makes a lot of sense given your background.

Trivedi: Yeah.

Riggenbach: And so kind of to get us back to this chronological order, we talked about your experiences – even joking about it, you said in December.

[0:41:29] And so it was January 30 when the World Health Organization declared Covid a public health emergency, and then of course it was March 20 when the stay at home order came from the governor's office.

Trivedi: Two weeks after the They Might Be Giants show.

Riggenbach: Wow.

Trivedi: It was on March 8 or 9 of 2020, is when I saw that show. So, like I said, literally, about a week before the world changed, because they put in the stay at home orders.

[0:41:59]

Riggenbach: What did you think when you kind of became aware of the pandemic? Were you like, oh shoot, I hope I don't have it, having traveled? What were your thoughts at the stay at home order?

Trivedi: I'll be 100% honest. This sucks. That was my thought. You know, literally. I was like, man, this sucks. I was like, I was going to go see one of my favorite bands who were doing a reunion tour, and I was going to see them at the Aragon Ballroom in Chicago, and they canceled the show, and they didn't reschedule.

[0:42:29] And I was so bummed. And so, yeah, I was basically like, well, this sucks. All bars and restaurants, closed. Anything that I find entertaining – sports, music, travel – like, all the things that I do when I'm not working, that I enjoy, that I'm passionate about, I was not able to do those thins anymore. Like, at least for that very brief time when they had those stay at home…

[0:43:00] You know, the full lockdown. So I think that was just challenging for everybody, really.

Riggenbach: Now maybe this isn't the right thing to say to a neuropsychologist, because I don't think these are terms backed in science, but do you find yourself to be more extraverted or introverted?

Trivedi: I tend to be introverted. Like, that's just my demeanor.

[0:43:26] But I also feel like in the appropriate contexts, I can be extraverted as necessary. But by default, I tend to look inward when I think about life, and I think about my place in this world and in this universe. I tend to look inside, not necessarily outside. So yeah.

Riggenbach: And the reason I ask is because I know a lot of people who tend to be more extraverted had a hard time with the pandemic partly also just because of that isolation.

[0:44:03] Which I don't think you have to have been an extravert to have been negatively impacted by that.

Trivedi: Yeah, I agree with that.

Riggenbach: And so work completely shut down for you guys?

Trivedi: So we moved everything to telehealth. There was a period for maybe about two to three weeks where SIU was just figuring out what its policy was going to be.

[0:44:28] And during that time, I saw a couple of patients face to face, you know, using hand sanitizer, cleaning everything off. But then SIU came up with the policy that only medical necessity appointments will be seen face to face, and if you can transition everything to virtual telehealth, Webex, Zoom type of things, that that was what they wanted us to do.

[0:44:56] What's unfortunate about what I do is that a lot of the test measures that we give aren't well suited for virtual environment. Covid has made my field work diligently to improve that situation because of this, so we can do telehealth neuropsychology. And there are ways to do it, but it was hit or miss.

[0:45:26] I work with people that have memory disorders, I work with people who have difficulty using technology and living independently. And they weren't always

sophisticated enough to be able to set up a Webex meeting. Like, the way it would be is somebody from SIU – you'd get the appointment scheduled, SIU had a team that would practice setting up the Webex with the patient over the phone. And then most of the older adults are like, yeah, we're okay, we'll just wait. We'll come in when you guys are doing face to face again.

[0:45:58] And then the people that would actually do the telehealth appointment, I mean, it was a test in and of itself to be able – for them to set up the Webex. It was almost like, if you can do this, I don't even need to test you, because that's like an executive – you know, you have to plan, organize, using technology, getting a camera set up, turning it off mute. It requires a lot of organizational skills, which is an executive function. So what I found is – and this is just anecdotal – I didn't do any research to support this.

[0:46:30] If you are able to set up the Webex technology, more likely than not, you performed within normal limits on my testing. Only I'd say maybe 5% to 10% – so one out of every 10 or 20 patients that I saw via telehealth had any type of impairment.

[0:46:56] And usually when they did, they had a family member that set up that appointment for them. But I went from generating double my clinical quota to performing 20% of what I was expected. So it hit me hard financially. Thankfully, I had done a couple of legal evaluations in March to like May of 2020, and those are very lucrative for me.

[0:47:34] So I was able to kind of like – even though my clinical income took a significant decline, I was able to manage. So the net loss to my income wasn't as bad, but if I hadn't done those legal cases, there would have been some pretty significant consequences.

[0:48:02] SIU, there's two salary structures. There's my academic based salary, which is static, and then there's my healthcare salary, which is based on clinical productivity. Well, if you're hot seeing patients, you're not billing insurance companies, and SIU's not taking any income in, but they're still paying you. So every three months, they have what's called reconciliation, and it's like, okay, if you did more than we expected, you get a bonus.

[0:48:30] If you do less than we expected, we're taking money from you. Because we've already paid you money that you never earned. So then over the course of the next three months, they take like a small percentage of your money until you're fully paid back, and then you go back to your normal compensation. Now, there's only about four months, and I could show you a figure because I keep track of this every month since I've been here in 2017.

[0:48:55] There was like a four month period where I went from like way above to totally cratering, and then I was back up again, like when SIU started to allow

face to face visits again, which was in I want to say like around July of 2020. And since then, things have generally been good, although I can say I'm noticing – I don't know how much far ahead you want me to go, so if you want to kind of keep it on a certain time?

[0:49:29] So now I'm noticing that people are getting sicker. I've had a lot of cancelations and no shows. I've had people rescheduling because they're quarantining at home because they got Omicron or they were exposed to somebody with Omicron. So I'm starting to see similarities. I don't think it's going to be nearly as bad, because in general, winter months, there's a lot of cancelations and no-shows just because I work with old people. They don't want to get out. They're like, it's six degrees, there's five feet of snow on the ground. I don't want to come into the clinic.

[0:49:56] And there's nothing you can do about that. But summer months and things like that, everybody shows up, and so it all evens out eventually. And even during – if you look at the entire year of 2020 from January to December, I was still – like, clinically, I was still above what my expectations were. So even though I took that four month hit, after we went back to face to face, the floodgates were open, and I went back up to being very productive.

[0:50:32] And so in the totality of it, it really wasn't that bad. But if you look at that four month period of like February to June, early July, yeah, it was tough going. Not just for me, for the entire institution. SIU lost $50 million in productivity. Psychiatry was great because we already had a strong telehealth component because a lot of people live in rural areas.

[0:51:03] So you're able to do – the psychiatrists and the psychotherapists were able to do telehealth. Unfortunately for me, like I said, my specialty is not as conducive to telehealth visits, so it hurt me more so, but our department – psychiatry, of all the clinical divisions at SIU, psychiatry was the one that had the least difference between pre-pandemic and pandemic.

[0:51:33] Like, neurology, family medicine, OB/GYN, they all just took substantial hits. And so SIU, the dean, Dr. Cruz, when we reopened clinics, they wanted everybody to add a half day extra that they would see patients, so that we could reduce the money that we lost.

[0:51:59] And, you know, in Memorial Health System, which is one of our hospital partners, they took an even bigger hit because they were not doing elective procedures, which are the lucrative procedures. And so they stopped. They started providing less money for SIU. So our I'm not sure that took quite the big hit. We get email updates from Dr. Jerry Cruz, who's the CEO of SIU healthcare and the dean of the medical school.

[0:52:34] And we've come back very well. So we're almost back in the black. So we've dug ourselves out of that hole as a system to the point where all faculty were able to go to sort of pre-pandemic schedules. So we could close out that extra clinical time that we were doing.

[0:53:00] I never had to do it because my clinical time's always been very high. I spend more of my time on clinical work than some of the other faculty do, so I was already above what I should be at. So when they asked me to take on more, I'm like, I can't take on more. I see patients every day. So it's like there's not any more time to see more patients, and in fact, I'm seeing more than I should be. So I didn't really change my schedule. I wasn't impacted by that.

[0:53:29] That was more for the psychiatrists and psychotherapists that had to kind of ramp up their clinical load.

Riggenbach: I spoke to a nurse who talked about how in the beginning of the pandemic, because of the loss of elective procedures, some hospitals were even furloughing nurses.

Trivedi: Mm-hm.

Riggenbach: Which I think is quite painful for some people to think about considering the nursing shortage now.

[0:53:56] It's interesting to think about the difference between March 2020 and now what will be March 2022 eventually.

Trivedi: Yeah, absolutely.

Riggenbach: And so what makes your field of psychiatry not conducive to telehealth?

Trivedi: It's that we do pencil/paper tests of people's memory and thinking skills. So, you know, sometimes they'll play with blocks, they'll be asked to do connect the dots tests. They'll be asked to do tests on a computer.

[0:54:26] You know, there were some tests – if the tests were verbal, we can do them via telehealth. If the tests are nonverbal, then it's much more challenging, like when you have to present stimuli that people have to kind of look at, or they have to draw things. You can't really do that. We tried a lot of different novel ways of doing things. There's also an issue of test security. You know, what if this person's recording everything? Part of my field is that these people are naïve to the tests that they're being administered.

[0:54:55] They haven't taken the test before. So we're able to get a good snapshot of how they're doing. But people are always trying to game the system, you know? And I do legal work, forensic work, so this is a huge issue, is test security. Like, sometimes lawyers want to come in and be present or try to fight you to be present in the office, and you'd be like, no, that's a distraction

for the patient. Or they want to coach their patients. They'll be like, if you're asked to do a test like this, make sure you do really well on it.

[0:55:30] If they read you a word list, make sure you do really bad on that test, you know? Because a lot of these are disability or wanting long term disability. So we're as a field – neuropsychology as a field is very careful about the security of our tests. Because without that test security, we lose our credibility.

[0:55:57] If everybody knows what they're going to get and practices the test, then our tests are not as useful if the person knows. We have ways to measure effort and overreporting symptoms. The patients don't always know. Patients don't think that we're as sophisticated as we actually are. Because what we do is fairly straightforward. But the process behind the scenes is very sophisticated.

[0:56:31] And I usually am pretty good at determining whether a person is trying to fake that or thinking they're trying to fake me out when they're not. And so that was one of the challenges. You know, it's like, well, this is – and these are copyrighted tests. Like, they have test publishers, like Psychological Associates, like Pearson and things. You know, if you're showing somebody a stimuli that's copyrighted on a Webex meeting, and that person clicks take picture and posts it on the internet for everybody to see, you've lost all your test security.

[0:57:09] And so for us, we were very careful about trying to use test measures that were open access that, like, if you searched the Trail Making test on the internet, you're going to find it, you know? If you search the complex figure test on Google, you're going to find it, because these are not copyrighted.

[0:57:31] I mean, they're not necessarily copyrighted. They're easily accessible. So we tried to focus on those tests when we were doing telehealth, because we're like, you know what, this test doesn't have a lot of test security anyways. But we can still do a competent evaluation with the patients that we're seeing via telehealth. And as I said, since Covid, a lot of people in my field have started to develop tests geared specifically towards telehealth and virtual environments.

[0:58:06] And so that's all – I mean, the publications have been coming out. So like now, I feel as a field, since I do believe that we'll be doing this for quite some time, and these types of telehealth appointments, I feel better suited if I needed to do that now than maybe I was in May of 2020.

[0:58:30]

Riggenbach: Did you ever have the issue of people breaking into the meetings?

Trivedi: You know, you'd hear dogs bark in the background and you're like, oh, no, this is such a distraction or like a kid run across screaming. Yes, that happened all the time. We would always try to tell them, it's like, you need to be in front of a computer, in a quiet room that is free from distractions. And in most instances, that was perfectly fine.

[0:58:56] But yeah, there were definitely a few times where you'd have some things that you're like, oh, I wish that didn't happen. But that happens in here at face to face clinics. We'll sometimes get patients – not my patients, but other people will have patients who are having acute psychiatric issues, and they might scream in the hallway, things like that, which are distractions. So that will happen. But yeah, it happened a few times. But I wouldn't say it was anything that was real common.

[0:59:25] Because we emphasized that to get the best data, to help your healthcare team make clinical decisions, or the person who referred you to me, we need you to be in a quiet room free from distractions, preferably nobody's going to enter the room while the testing is being done. And for the most part, people were able to kind of go along with that. But yeah, obviously every once and a while.

[0:59:54]

Riggenbach: So that sounds like thankfully you never had hackers break in and yell obscenities?

Trivedi: Yeah, so Webex is very secure, and that's why SIU uses that over Zoom, is because it has much more – our IT department has much more control over that, and it has safeguards in place that make it very, very difficult for hackers to interfere with those virtual appointments.

[1:00:30] So SIU, you don't do a telehealth appointment, it's always done via Webex. It's never done via Zoom. We have faculty meetings and things that are minimal. We're like, you know what, if a hacker wants to come in here and hear us talk about our internal budget, knock yourself out. So for those faculty meetings and certain didactic meetings that we have, we do those via Zoom. But if you're doing any patient visit, it's done via Webex.

[1:00:58]

Riggenbach: The state of Illinois does Webex as well, for the same reasons.

Trivedi: Yeah.

Riggenbach: During this time period, was there a strain on your own emotional health because of the financial hit, the work from home?

Trivedi: Yeah, that's a great question. It's hard to say. If you're asking me, did I ever feel like I was super depressed, and that things were terrible? No.

[1:01:33] But I'm not that type of person. Like, that's not my baseline. But looking back, did it affect me? Yeah, sure. I mean, I was drinking a little more alcohol. Maybe that's because I was bored. Maybe that's because I didn't have anything else to do. Because all the things that I like to do were taken away from me, you know?

[1:01:55] But overall, I feel like I had a pretty good emotional – I was pretty grounded emotionally. Some of the issues that my patients experienced, I definitely did not experience anything nearly as significant as that. And maybe that's because we kind of did this thing where I had a group of about – there were three of us. We were friends.

[1:02:28] We only hung out with each other. We rotated between – like, one weekend, we would go to Chris's house, the next weekend, we would go to Joe's house. The third weekend we would spend at my house. And we just kind of closed off our social network. And we're like, okay, none of us are hanging out with anybody else but the people in this room. And so that I think – I didn't feel as socially isolated as maybe other people did.

[1:02:58] Because I feel like we approached it in a pretty good way. Like, besides that group of people and my parents, I wasn't seeing a ton of people, you know, just because we purposely did that. And we did that with awareness that we were doing that. Like, we talked about it. We're like, you know, we should just do this so we don't have to worry about getting Covid or any of these crazy things that are happening.

[1:03:30] If we're just kind of hanging out with each other, and we're not really hanging out with other people, and we know that we're all pretty healthy, there's probably a less significant chance that we're going to contract Covid before they were able to get the vaccines out. So I felt like from a social network perspective, I probably didn't take as much of a hit as maybe some people.

[1:03:55] And also, like you said, and as I mentioned to you, I'm not a social butterfly. I have a handful of very close friends that I value, and I don't necessarily expand that, even now, even before. Like, so I think people like me can maybe say that I didn't have to adjust a lot because it didn't really change my behavior beyond obviously not being able to go to concerts and sporting events.

[1:04:27] But when I'm not doing that, and I'm staying in Springfield, yeah, I'm not going out and socializing with hundreds of people every day of the week. So I felt like maybe for me, being an introvert was actually a positive during the pandemic. And I definitely can see how people who are more extraverted

would have a much more significant negative impact of the isolation and the stay at home orders.

[1:04:57]

Riggenbach: You mentioned when we started this portion of the discussion that, like, you saw some of your patients that there was an increase of negative behaviors. What kind of things did you see?

Trivedi: Depression. I was dealing with more crying episodes in my office, when I was seeing patients. Like when we returned to seeing patients face to face, like in July.

[1:05:24] I noticed that. A lot more depression, a lot more anxiety. People complaining. People that are healthy, free from any medical condition that would cause concerns about cognitive decline coming in reporting cognitive problems secondary to depression and anxiety. So yeah, I saw definitely those were the biggest things. And that's not anecdotal evidence, that's like supported by research. Like, the pandemic has caused an increase in mental health problems across the spectrum.

[1:06:00] And it's not any one state, any one country, it's worldwide.

Riggenbach: What do you think it is about the pandemic and these situations people have been in that have caused this increase?

Trivedi: I think the perfect example, the social isolation, not being able to engage in activities that people found pleasurable before. And not because you don't want to, because you're being told that you can't.

[1:06:29] And then in general, humans are selfish, they don't like to be told what to do. I'm not saying all humans are like that, but I'm like, it is a component of the human condition to think about oneself and not put yourself in the context of the entire system, the macroscopic view. It's more of a microscopic internal view. And so definitely people having their freedoms taken away, and every freedom.

[1:06:55] There are people who are religious not being able to go to a house of worship, people who like sports not being able to go to sporting events. People being told that they'll be fine if they don't wear face masks. That's what I think is responsible for it, is that it's been a huge change in life, and people don't necessarily adapt well from a mental health standpoint to significant, abrupt changes in their life that were unexpected.

[1:07:26] Like, that's a recipe for nervous breakdowns, and that's what you see a lot of, is that people are having nervous breakdowns. It causes people to become more irritable. These are symptoms of depression, being more irritable, being

more indecisive, being more self-critical, not experiencing pleasure. These are all symptoms of depression and anxiety. And so it's I think a lot of what people are experiencing, is that, is because of mental health problems.

[1:08:02] Like, I think there's definitely a component to people – you know, these people you hear about on flights getting in fights with flight attendants. I think that irritability might be one of the symptoms that that person's experiencing because they are having depression and anxiety issues and they're like, you know what, they have the short fuse, and they're doing things that they probably regret the next day.

[1:08:29] And yeah, that's in a nutshell, I think what we're experiencing.

Riggenbach: Going back to that part of the pandemic in the beginning, did your research just automatically halt because of it?

Trivedi: Yes, it stopped. We were not allowed to do – we had 54 patients scheduled for March to July 2020, and we had to cancel and postpone all of those appointments.

[1:09:01] Until SIU gave the green light to do face to face visits again. You know, some institutions – like, I know at Washington University in St. Louis, their Alzheimer's disease research center, they just recently went back to – they're not – they started doing face to face visits with research participants.

[1:09:27] They subsequently recently, a few weeks ago, changed that back to all virtual appointments for their research studies. And they're just evaluating what's – everybody's constantly reevaluating your processes and procedures for mitigating risk for Covid. But yeah, it was terrible. I had three student interns from UIS that were working.

[1:09:58] So the one that started in July of 2019 that I talked about earlier, and then there were two more, and they – SIU stopped allowing outside learners from being onsite. And so since they were UIS students and not SIU employees, they all had to – they all could not complete their internships. So they had to go back to UIS and come up with creative ways to sort of fulfill their requirements for the internship courses that they were taking.

[1:10:30] So yeah, then in July, when SIU was reallowed – I had talked to one of the students. Two of them were seniors and graduated in May of 2020 and already had plans to move out of the area. And then one, Madison, she graduated in May of 2021. But before Covid, before I was like, you guys can't come onsite anymore, and you can't continue your internship, I had talked to her.

[1:11:00] I was like, you know, the minute that they allow us to see face to face people, I'm going to be in touch with you and see if we can get you back on. And we

were able to get her back on. And so we had to go through some hoops. Like, I had to hire her on and pay her money so that she could do her internship. Because then she was technically an SIU employee. So it was a way for us to get around the system.

[1:11:27] And because she was an SIU employee, they allowed her to do her internship. I also had a graduate student who was going to come on – a clinical psychology graduate student, Courtney, who was going to come on and do a practicum with me in neuropsychology, and we did the same thing with her, because our psychometrician went to – Angie went to half time, because she had to do schooling for her kids from home.

[1:11:56] So she's like, I have to be at home 50% of the time. My husband's going to be at home. The other 50% of the time so we can do home schooling with our young kids. And then so I kind of gamed the system a little bit and I talked to our administrator, and I was like, look – I was like, if we hire Courtney, she can do the testing, and we won't really skip a beat, you know? And he was like, how much do I have to pay her? And I was like, pay her pennies on the dollar. She wasn't going to get paid anything when she was doing her practicum. She was going to be free.

[1:12:27] And then she was also able to meet her requirements for her graduate program. So she was able to do that, and then she finished that in September of 2021.

Riggenbach: I bet the students were pretty grateful to you for being such an advocate for their learning.

Trivedi: Yeah, I mean, it's a win win, you know?

[1:12:56] I get free work from them, and even though I'm paying a little bit, it's a very small amount of money that they're making. So I'm paying them, but it's like, you're not getting paid $50 an hour, you're getting paid minimum wage, basically. It's a little bit better than minimum wage. And so yeah. And I don't have to pay them for benefits, because they're extra help student employees. But they like it, because they want to do research, and they want to get their names on publications and papers, because they want to go to graduate school and things like that.

[1:13:30] So it's a win win. That's the way I see it. I think we're both using each other. So that's the way. In a mutually beneficial way.

Riggenbach: Absolutely. And did you know anybody who got Covid in that early part of the pandemic?

Trivedi: No. Not in the early part. I don't even know when I – the first person I know.

[1:13:58] Anecdotally, after the fact, like when things were opening up a little bit and I was seeing more than little group that I had isolated myself with when I was seeing other people that I hadn't seen for a while, I heard stories. People were like, yeah, I got it already, I got it last October or whatever. So I did hear, but at the time, when the stay at home orders, like between March and June, I didn't know of anybody that actually had it during those months.

[1:14:27] I did learn subsequently, later, people that I know well that did get it, yes.

Riggenbach: And then how were your parents doing? Was it a little bit stressful for you at their age?

Trivedi: Oh, for them? No, my parents are both very healthy. My dad's very, very healthy, and my mom, she has some health problems, but she's very, very healthy for someone of her age. And so they are kind of homebodies.

[1:14:54] So they don't really get out anyways. So for them, it wasn't really a big deal, you know? And for me, like I said, I just kind of – I felt comfortable going over there because I was practicing social distancing, and I was doing a lot of social isolation or at least isolating with a very small group of people. So I felt like I was being safe. Was it perfect? In retrospect, should I have done what I was doing? Probably not. You know, would I do – with Omicron, would I have been comfortable doing what we were doing then now? Maybe not.

[1:15:26] Because the spread is so high. But yeah, they I think did fine, because they tend to just be – they're older, and they're just homebodies.

Riggenbach: That's very good to hear. One of my follow up questions to that was going to be if you included them in your bubble, but you answered that already.

Trivedi: Yeah.

Riggenbach: And then moving into the summer, which we have been going into a bit. You said that you guys opened in July of 2020.

[1:15:56] And so you were able to kind of make up that financial loss?

Trivedi: Yeah, yeah. I was able to make it up and then some. Yeah, also, at the time, I had gotten a couple of other legal evaluations to do, which also kind of helped mitigate the loss during that three or four month period. So it ended up working out well. And like I said, at the end of the day, if you look at the entire year, I was above what I was expected to be, and that's all you really want to be.

[1:16:30]

Riggenbach: End of 2020, including that beginning portion?

Trivedi: Including that four month period, yeah.

Riggenbach: Wow, that's very good to hear.

Trivedi: Yeah. I mean, I was seeing eight patients a week, which to meet my quota, I only need to see five patients a week. So I was seeing eight, because at the time, I was the only neuropsychologist here. And I had a wait list of four months.

[1:16:56] So I opened up two slots not when Alfonso, who's leaving today, but Dr. [Nattle], he left SIU in July of 2019. And then we hired Angie as a psychometrician. And so I was like, well, I can go from seeing five to seeing eight, because now I have some help. And so I did that, and it was like, there was the need, because I was booking out four months.

[1:17:30] And sometimes, people want these things to be done sooner, because they're like, there's a legal hearing about this, and we need this before then. Or doctors are making decisions about whether to proceed with the surgery or whether to determine if this person needs to be started on a new medication. And so I expanded myself and opened up more slots to fulfill the need from the referral sources that I have. Because you always want to keep your referral sources happy so they keep coming back, you know?

[1:18:05] And it's going to present challenges now that Alfonso's leaving. I'm already booked out until April, you know? Because when he came on, he took half of the referral load. And so I went down from seeing eight to seeing six, and then he was seeing six, and so we were booking out still then two months and now he's leaving. And so I'm back to booking out four months in advance.

[1:18:28] Thankfully, we have this guy we're interviewing next Friday and hopefully he's great and he wants to come here, you know? Fingers crossed.

Riggenbach: Does that provide any stress for you?

Trivedi: It did at the time. It doesn't now, because I'm not changing my schedule. I'm not going to kill myself, you know? If the chair comes and says, we have a really long waitlist for your services.

[1:18:57] And I'm going to be like, that's great, you should hire some more people. Like, one neuropsychology is not enough. Two is not enough. You need three. And she wants to. Dr. Wolf, she's got like a $2.5 million grant or something, and so she's going to be able to improve mental health – the training of mental health provides, so social workers, psychologists. And so there's talk of starting a training program.

[1:19:25] And so with that, she's going to need to expand the number of faculty. And so she knows. And I don't think she would ever come to me, but if she did, that's what I would say. At that time, I felt more obligated, but I'm doing a lot right now. I'm trying to write a grant. I need that time. I can't go back to seeing eight patients a week and writing the grant. And like I said, it all comes back to, like, I'm one person, and I don't want to work like two people.

[1:19:58] It's not my responsibility to work harder because you're not hiring people to do work. Like, it's not my responsibility to do extra work when you're understaffed. I'm not going to put that on my shoulders. That's not what I'm here for. It's your job. You're the chair of the department. It's your job to recruit and retain faculty. That's not my responsibility.

[1:20:30] And so that approach, I feel like, absolves me, and it makes me less stressed. And I'm not going to stress out about that. I'm not. That's a conscious decision I made. It's probably a shift, actually, from before.

Riggenbach: Do you think the pandemic had something to do with that shift in thinking?

Trivedi: No, I think it's just I know I want to write this grant, and I know that if I start seeing more patients, that's going to cut into my time, that I can dedicate to it.

[1:21:06] I'm not willing to do that. It's a cost-benefit analysis. Like, obviously, if I saw more patients, I'd make more money, you know? I'd make a lot more money. Does that increase in salary and the time commitment that goes to meet it, is that enough to pull me away from doing these other things?

[1:21:27] And it's not. I do want to get board certified at some point. But I need to see this project through, because I've already committed so much time to it. I've thought about stopping. Again, why am I working so hard for this? It's like nobody else seems to care. If you did, you'd help. But I've put so much time into it, so I made the conscious decision, like, you know what, you started this, see it through to its end, whether it's a positive outcome – you get the grant – or a negative outcome – you don't get the grant.

[1:22:05] And I'm okay with either possibility. If I don't get the grant, I'm going to literally stop doing research, and I'll just do clinical work, and I'll be perfectly happy with that. I'll see a lot of patients. I'll get board certified. I'll start doing more legal work, and I'll make a ton of money, and I'll travel the world. And that sounds great, doesn't it?

[1:22:26] If I'm lucky and fortunate enough to be successful at getting the grant, that's a great opportunity for me too, and I'd be equally as happy. So that's something that maybe is relatively new. It's a shift in my mindset. And most of that shift was – I was overworking myself, and I was like, this is not healthy, you know?

[1:22:56] This is not a way to live. And so I just had to become okay with potentially not succeeding or allowing some things that would be beneficial to me. Like, they don't promote people who aren't board certified at SIU. When I had my tenure meeting, my promotion meeting with Dr. Wolf, she's like, what's your plan? Are you going to get board certified?

[1:23:28] I was like, yeah, I want to get board certified. I was like, but I also want to write this grant. And she's like, well, SIU won't promote you to associate professor unless you're board certified in your specialty. This isn't just for psychology, this is for every department, irrespective. And so I kind of looked at her inquisitively. I was like, are you saying that if I brought in $5 million to the institution, that they would not promote me to associate professor like they do at every other institution that has strong researchers?

[1:23:59] And she's like, well, we would probably have to talk to somebody about that. I'm like, yeah, because if you didn't, I would leave. And that was effectively the conversation. So I told her, I was like, look, I want to write this grant once. It might not get funded the first time. I want to submit it one more time after I get some other eyes on it, some reviewers, and if it doesn't get funded the second time, that's it. I'm going to stop the project, and I'm going to focus on clinical work, and then I'll get board certified.

[1:24:27] So I was like, that's kind of my timeline of things. And she was like, okay. She didn't put any pressure on me. And I knowingly know that until I either get board certified or get a grant, I'm going to still be an assistant professor. But I don't have a problem with that. Becoming associate professor doesn't define me. I know if I do well, I'll get promoted, irrespective of whether that's getting board certified and doing clinical work or getting a grant and being successful and sort of an academic research track.

[1:25:05] Yeah, so these are the things I deal with.

Riggenbach: Wow. But good for you for kind of putting your foot down. Summer of 2020, you mentioned things started reopening and we moved into phase two, Illinois, which had restaurants and stuff. Were you able to move outside of that bubble, did you say?

[1:25:33]

Trivedi: Yeah. Those were the summer months, so it was a little bit easier to social distance outside. You know, like on Adams Street, they closed down all of Adams Street between Fourth and Fifth Street so that Buzz Bomb could have socially distanced events, and they would have bands that would come out and play on the street. And so you were able to space out and still kind of socialize with your friends.

[1:25:57] That was a lot better. It allowed for a sense of return to normalcy, even though it was not full return to normalcy, it was a sense.

Riggenbach: And then unfortunately, in autumn, and then that winter, the cases started going up again. So did you guys move back to telehealth?

Trivedi: No, we did not.

Riggenbach: What did you guys do then?

Trivedi: They encouraged you. They were like, if you can do it via telehealth, if it's clinically feasible, then do it.

[1:26:27] If it's not clinically feasible, then bring people into the office, take all the precautions that you can, masking, washing hands, social distancing, plexiglass dividers, hand sanitizer, and sanitize your work area after you see a patient. Then do it. And so that's the approach that we took, is that. Have I done a couple of telehealths here and there? Yeah, but that was more because the patient didn't want to come into the clinic, or we were like, you know, don't drive three hours from Carbondale if we can do Webex.

[1:27:00] And so in those instances. But yeah, starting around July, we – the one thing I will say that we've shifted back to is we were doing – we had moved to allowing small face to face meetings that had like six people. Everybody was socially distanced in a large room. Then they went to 50%, and you could have gatherings with up to 50 people.

[1:27:27] And then it went up to 100 people, and then that got walked back as we got into the fall and into the winter. And then it was like, okay, let's go back to just having meetings via Webex. And then they even took the policy – before Omicron was found, it was like, if both people in a small room are vaccinated, and they both agree to remove their masks, then that's fine with us.

[1:27:59] Because it's their personal responsibility. They were giving us that. And then they went back on that too once the Omicron. And now it's like, okay. And now we're even wearing N95 masks or double masking. So I double mask now when I'm seeing patients. I've got to get fit tested for the N95 masks. I was out with Covid last Friday when they did fit testing.

[1:28:30]

Riggenbach: Oh, to get you the right size?

Trivedi: Yeah, to make sure. Because you have to have it set up so that there's no exposure spots along your entire – like the mask. So it has to be very close fitting. And different people's faces, they need certain – there's subtle differences in N95 masks that fit different faces better.

[1:28:58] So last Friday, they did fit testing. If you don't use fit testing with N95, then you're required to wear these, which are medical grade masks. These – those like that green one right there, which is a cloth mask, we're not allowed to wear those anymore, unless it's on top of one of these medical grade masks. Yeah, so that was another shift that happened.

[1:29:27] You know, who knows what's next month? Every week, Dr. Cruz sends out a kind of Covid update. And I mean, the case counts have been plummeting since about two weeks ago. We're at about 50% of the four week high. And that's happening all over the states in multiple different states. So things are looking a little bit better over the past week or so.

Riggenbach: I think it came as quite a shock to a lot of people not to be able to wear the cloth masks alone anymore.

[1:29:58]

Trivedi: Yeah. If that not being enough, yeah, I think a lot of people took that – it was difficult. Because those are easier to come by, because you can make them. If you're a seamstress or something like that, or have those types of hemming skills, or being able to use a sewing machine and things like that. And fortunately, my mom is a seamstress, and she loves doing that stuff, so she made me like 20 of those masks.

[1:30:28] It was great. You can wash them, you can reuse them. They're better for the environment. These you've got to throw away or, like, ah, I wear one of these every day, and I throw it away, which is causing more garbage in these world. But it is what it is. And I think once – like I said, hopefully, we'll reach a point now soon where they'll start to go back – things will start to go back in a positive direction. Not Covid, but in allowing us a little bit more freedom, you know?

[1:30:56] And obviously, we all want to eventually not have to wear masks anymore.

Riggenbach: Yeah, when is the question.

Trivedi: I don't know.

Riggenbach: And then going back a little bit, in winter 2020, that's when vaccines started coming out.

Trivedi: Yeah.

Riggenbach: December 15 was when they first became available to healthcare workers and long term resident stuff, etc. What were your thoughts at that point?

Trivedi: Thank God. That's my two words, thank God.

[1:31:28] This might be the beginning of a new phase. Hopefully the phase that results in the end of the pandemic. Obviously we know now that that wasn't the case. But if you're asking me what I was thinking at the time, I was like, sign me up, when can I get my first shot? And I can tell you when I got my first shot. I don't know if I still have my Covid card here. Yeah, here it is. I got my first shot on January 6, 2021.

[1:31:57] The second shot on February 9, 2021. And I got my booster on 11/5/2021. So I was at the front of the line when they allowed healthcare workers to get it. And plus, you can see the way I do testing, it's like, you can't really maintain six feet of social distance. So I was like, you know, since it's much more difficult for me and the type of work I do to maintain appropriate social distance, I was like, this vaccine is going to help me feel a little bit safer when I'm interacting with patients.

[1:32:27] And hopefully, make the patients feel safer because I've been vaccinated.

Riggenbach: Absolutely. Did you think that we would have this amount of vaccine hesitancy?

Trivedi: Yes, because I know – I study human nature. And because I study human nature, I know flaws that humans have.

[1:32:56] Not all humans, but I know when people – I know the range of human behavior, and because I know the range of human behavior, I know that there are going to be a certain percentage – certain groups of people who are going to be skeptical about certain things. People have to get nine vaccines to join the military. What's one more? What's one more? Like, you get the flu vaccine, you get the measles, mumps, and rubella, you get the polio vaccine.

[1:33:31] You get the vaccine against yellow fever, you get a nine series of vaccine before you can join the army. But now you're raising a stink about one? It's no different, man. It's no different. They're, well, it was developed so fast. That's because we have better technology than we had when the last new vaccine came out. So yes, I totally knew that, and I know that people who are more conservative tend to be a little bit more skeptical about government and their personal freedoms being infringed upon.

[1:34:13] And you know, public health guidelines go against that type of belief system. And there's nothing you're going to do to change that. There's nothing anybody can do to change that. And now they can say, oh, you got three vaccines, and you still got it?

[1:34:40] Why should I get one? Why? I'll still get it, it doesn't matter. And then you try to – well, it means you'll experience less severe illness. They don't care. That's not the point. The point is, it doesn't matter, so why should I do it?

[1:34:58] And you can't change that approach. I'm not saying that everybody who hasn't gotten a vaccine is because of that reason, but there is a significant percentage of people who are not vaccinated who have that type of belief system. Some people are – like, for, you know, example, some minority communities like black Americans and Hispanic Americans, there's systemic distrust of healthcare providers.

[1:35:27] Tuskegee, all of these things. Whenever there's a new drug, you always want to try it first on black people. Because we're third class citizens. So there's that thought process. So there's a lot of routes to vaccine hesitancy. The ones that are most difficult to penetrate are the ones who are, like, these are my liberties, this is my body.

[1:36:00] You can talk about how hypocritical that is if you look at their entire perspective on what's liberty and who deserves liberty, but for them, liberty means don't tell me what to do. And that's the end of it. And you can't change that mentality. They've shown – research has shown this – they're always doing research on why, and they've identified a subset of about 20% who will never get vaccinated.

[1:36:34] And there are very specific reasons why. It's high distrust of government, a high distrust and skepticism of healthcare providers. And yeah, so that's I think a lot of it. So I did expect this.

[1:36:58] If we have another pandemic in ten years or whatever, or 100 years, it's still going to happen, because that's humans. We're wonderful in all good ways, and in a lot of bad ways as well. The range of human experience is so variable and different among all of us, and we're so different in our own ways. And so this is just something you've got to expect. What's different about this is that there's seven billion people on the planet, which is six billion more than there were when we had the last pandemic in 1910.

[1:37:38] So you have that many more people to be skeptical. And if you say 25% of people are skeptical, you want to know what? 25% of seven billion, that's a lot of people. And so you know, that's, yeah, that's just kind of the way things are. It's okay. And I'm okay with that. I never tell.

[1:38:02] I have good friends, their logic is so poor. She's like, I won't get the vaccine because somebody wants me to do it, even though she also knows that if she got Covid, she's going to have a worse experience. And I'm like, you're allowing other people to tell you what to do anyways, because you just don't want to be told what to do, and in a way, that's somebody telling you what to do.

[1:38:34] The man is still running your life. It's just in the opposite way of the man running my life. And the man, I don't mean a specific man, I'm talking about a colloquial term, the man. Authority.

Riggenbach: I'll put that on the word list in quotes, so future people can understand it.

Trivedi: There you go, yeah. People will understand that.

[1:39:00] People will understand when somebody says, oh, I don't want the man telling me what to do. They know what that means.

Riggenbach: Oh yeah. So what about holidays? What does a normal year of holiday celebrations look like, and what did Covid look like?

Trivedi: Yeah, that's a great question. So I had not been able to see my brother until we went and saw him on Thanksgiving. We always go up to Eau Claire. That's where my brother and his wife and family live.

[1:39:27] And so we always – that's our kind of family tradition, is every Thanksgiving, we go up to my brothers, and we spend the weekend there with him and celebrate Thanksgiving. And we didn't do that in 2020. And this year we did go up there, and it was a lot of fun, and I hadn't seen him for a couple of years since then. Obviously we talk on the phone all the time. But just seeing him, and then him being able to see my parents, who are getting older, obviously. So that was really the challenge.

[1:39:59] For the Hindu community in Springfield, Diwali is obviously the really big holiday. So they did a lot of virtual events in 2020, and then they did very small selective events for 2021's Diwali, which is in November. But there was a little bit more enjoyment or spending time with others in the community in 2021 than there was in 2020.

[1:40:29]

Riggenbach: Are you part of that community?

Trivedi: I have like a half of a foot in the door. I was born and raised in America. I am Indian. I was born and raised in America. Everything I like is American. I'm not saying that I dislike – I love Indian food, I love Indian music. But it's different, you know?

[1:40:57] I always think, as a psychologist, you know, it's called attachment theory, and it's like, how are you integrated? Like, people who are well integrated, like they say, oh, it's a nice mix of east and west. Like, you know, you value your traditions and the culture that your ancestors were part of, but that you're also a good mix of American values and your Eastern values.

[1:41:28] I just have values. Like, they're not Eastern or Western. My value system is based on one principle, and it's the golden rule. Do unto others as you would have them do unto you. If you live your life with that in mind, I can't see a better way to live life than to live it that way.

[1:41:55] I don't want to hurt anybody. I'm here to help. And if I do that, I'm good, man. Like, I don't need anything else. I'm not religious. I am spiritual. I don't have contempt for organized religion. We're all different. We all see spirituality, and we all connect with the unknown in different ways. And this is my way, and that's – I feel that's fairly healthy.

[1:42:28] I grew up – I went to this really conservative – my parents wanted me to start kindergarten when I was four, so public schools in Springfield at the time would not let you do that. Now no schools will let their children start school at age four. Calvary Academy, which is a very conservative Christian school in Springfield would allow me to enroll at age four.

[1:42:56] My parents are Brahmin Hindus. That's the highest caste. The next place that you can go is to attain nirvana, which is ending the cycle of rebirth. Because there's no higher caste. The next place for you is to attain nirvana and go to heaven. In school, I'm like, Jesus Christ is your savior. If you don't believe in Jesus Christ, you're going to hell.

[1:43:27] At home, you can't believe in Jesus Christ. You gotta believe in Shiva and Vishnu and Krishna and all these things. And so it was – you know, looking back on that, it was a turmoil for me. I mean, I would never wish that on any child, to have to go through that conflict at such a young age, between two devout religious systems. I'm certain it shaped me as a person, but I also think it's allowed me to develop a healthier view of religion and spirituality.

[1:44:04] And understanding that at the end of the day, all religions preach the same thing. Be a good person. Do good things. Don't do bad things. Try to help people when you can. Understand that there's more to life than just life. I think all religions have that in common.

[1:44:24] And so I just view myself as agnostic but not an atheist. I know that's totally tangential.

Riggenbach: That's what we like here.

Trivedi: Yeah, but it's – I think it's allowed me to be more resilient in a lot of these times. Like, for example, in Covid, when people who are devout Christians, devout Jews, devout Hindus, being told that they can't go to their temples as a place of worship, I can't imagine having to go through that when that's such a big part of their lives.

[1:45:05] For me, as a spiritual, not religious person, I wouldn't miss that that much, you know? Does that mean that we're different in some way? No. It's just they have different – they need different things than I do. So those stay at home orders and not being able to gather for religious purposes wouldn't have had as much as a negative impact on me as it clearly did for certain groups and certain people, people of certain faiths.

[1:45:42] So yeah, I think for me, it didn't have as much of a negative impact, but I can see that viewpoint and how that could really change things for somebody and make them maybe more depressed or more anxious or more irritable and things like that.

[1:46:00]

Riggenbach: Yeah, absolutely. And then kind of moving into the spring and the summer of 2021, I think for a lot of people, it was a time of a lot of hope. I mean, vaccines became available to all Illinoisans in April. I think maybe it was April 5, 2021.

Trivedi: Yeah, that sounds about right.

Riggenbach: Where was your head at at this point?

Trivedi: I was also in that camp of being hopeful. I'm like, people are getting vaccinated. The vaccines were very effective for the strains that were prevalent at that time.

[1:46:35] Delta, when the alpha was still going on, still somewhat going on. So yeah, I was hopeful. But also, with the understanding that viruses mutate, and that if we don't get the most people vaccinated, that it's highly likely that it's going to mutate into something that could evade the vaccines.

[1:47:02] But yeah, hope. Hope, optimism, those were things I was feeling, just like I think the world was feeling at the time.

Riggenbach: So it sounds like things were relatively stable for you since summer of 2020 in terms of work here.

Trivedi: Yeah, work wise, things were stable. Things were good. I can't think of a period like I'm experiencing now where I was having a lot of cancelations and no shows, specifically when people were canceling because they were quarantining or because they had been exposed to Covid or because they had Covid.

[1:47:38] Whereas when our front desk staff say, oh, your 1:00 p.m. patient canceled because they're at home quarantining, because they got Covid, don't worry, they rescheduled, it's like, okay, well, that's fine. But that was not happening from summer 2020 to like basically until recently.

[1:48:01]

Riggenbach: Wow.

Trivedi: Yeah, until Omicron became a big… So I'd say maybe over the last month. If there was any time that I felt like it was anywhere close to March and April of 2020, it's been this last month, where the Omicron variant has really taken over, and it's so effective at infecting people.

[1:48:32] I have noticed it in my clinical practice, because I've noticed that I have a lot less – I've been seeing a lot less patients. Which does affect my bottom line. Like I said, as we talked, if I don't meet my quota, SIU takes money away from me. I don't want people to take money away from me. I want them to give me more money because I'm more productive. Nobody wants to take a pay cut.

[1:48:57] I don't think that's going to happen, because like I said, I think if I look over the totality of the year, everything will be fine. But yeah, if you're talking about the last four weeks, I'm like, man, I really wish my patients would show up. And then I got Covid. I'm like, oh no, now I'm going to have to cancel almost a whole week of seeing patients. So this week, I was only able to see two patients because Angie – what we were going to do on Tuesday, our plan was, I was going to call in, do the interview with the patient who comes in the clinic, and then Angie would do the testing.

[1:49:30] And then she would let me know when the testing was done, and I would call in and go over the test results with the patient. So doing my part over the phone. And then she tested positive. So Tuesday, we had to reschedule those patients. Wednesday, I got cleared to return to work this Tuesday afternoon, and they said I could come in. So my Wednesday patients who the plan was, we were going to do that same situation, I just came in and saw them myself.

[1:50:02] And then Thursday is the day where I normally see – like, I do everything on my own. Like, I do the testing on my own. Because the other neuropsychologist and I split Angie. She works with him two days a week, she works with me two days a week. So Thursday's the day where I work on my own. So we rescheduled those two patients, because it's like, I don't know when I'll be able to return to the office.

[1:50:29] So they did all of that the Friday, after I found out I tested positive last Thursday, they did all – like the staff here took care of all of that. And then I emailed our scheduling staff, I was like, hey, if you can find two people to put for yesterday, I'll see them. And they were like, so like Wednesday afternoon, they were like, we just wanted to let you know we filled your 1:00 p.m. slot for tomorrow.

[1:50:55] And then Thursday morning, they sent me another message saying your afternoon patient's not coming in because he's quarantining because he tested positive for Covid. I'm like, oh, wonderful. So now this person's rescheduled because he got Covid. So I'm like, okay. But next week should be fine. Like, I'm full. But again, I have no idea. Like, are people going to no show or cancel because of all this that's going on? It's an open question, you know?

Riggenbach: And people would rather cancel and reschedule than do it virtually?

[1:51:26]

Trivedi: I don't believe we've been really offering too much that option of virtually. It's not my preference, because of all of the reasons I provided earlier, when we went through that discussion. Test security issues. It's not standardized the way it should be. The possibility of distractions is higher and things like that. That's not my preference. So I'm fine with it. I'm fine with, like, if you want to reschedule to later, that's fine. I'm perfectly okay with that and not doing the virtual visits.

[1:51:59] Yeah, it's not my preference. I just feel like it's not the way this is done. You know, these tests, when they were developed, they weren't developed to be done virtually. They were developed to be done face to face, examiner, examinee. Like I said, our field is evolving very quickly by developing tests that are created specifically for the virtual environment, not taking traditional face to face measures and modifying them for the virtual environment.

[1:52:37] Because this is – you always want to approximate the way the test designer envisioned the tests being administered. When you're using standardized procedures. When you start to unstandardized procedures, then your ability to generalize and make inferences about behavior and changes in behavior, it also changes. You've changed the game.

[1:53:06] Does the same scoring system apply to this new game? We don't know the answer to that question. So there's always caveats. You know, it's like, when I would have somebody that showed impairments, I'd be, well, is this just because we did this virtually? I saw a patient two weeks ago who I tested in 2021 via telehealth.

[1:53:26] I saw her in person, and we did the same test, and she scored impaired on that same test when we did it virtually. She tested completely normal on that same test when we did it in person. That suggests that that change in the standardized procedures probably had an effect on her. The reason why I saw her face to face was because I recommended it, because she had those weaknesses, and I was like, I don't know what this means, so I'm going to recommend follow up in a year face to face.

[1:54:03] And she did a lot better. And I don't know the reason why she did a lot better, but certainly one factor would be that the game has now been shifted back to the way the game was supposed to be played, and you haven't changed the rules of the game. You changed the rules of the game, all bets are off. So that's why I have a reticence to kind of offer that.

[1:54:28]

Riggenbach: No, it makes a lot of sense.

Trivedi: Plus also, when I discuss the challenges that we had, I'm not seeing different patient populations. I'm still seeing people with memory disorders, geriatric patients with Alzheimer's disease and Parkinson's disease and stroke and things like that. So the struggles that they had in March and April of 2020 with the technology, it's not like those struggles just disappear. They're going to still struggle with it now.

[1:55:00] My believe is that the same thing will happen. They'll be like, you know what, whenever you guys start doing face to face again, call us and we'll reschedule. That's what they'll say, because that's what they were saying then. So is there a small percentage of the patients that would do, like the younger cases I see for ADHD and things like that? Absolutely. I think they could potentially do it. But there's certain things that we do for those evaluations that we can't do that must be done face to face.

[1:55:28] And so that's why we always encourage the people to come into the clinic. But there might be ways. I thought that was a pretty novel and outside of the box thinking of me, like, doing the interview over the phone and then doing the testing face to face. If that would have worked out, that would have been a great compromise. At least since I had Covid, I wasn't exposing anybody else to Covid.

[1:55:57] And we don't have to close clinic given that I'm booking out until April now. So these patients that I had to reschedule on Tuesday and yesterday, when are they coming in? Is it four months from now? I mean, it's like who knows. And so I always try to avoid closing clinic because of me. Like if it's because somebody no shows or cancels, there's nothing I can do about that. But if I can always be here, then at least I know that it's not me that's causing the changes to my schedule.

[1:56:30] So that's always a bit frustrating, when you're like, you feel a little bit helpless. You're like, there's nothing. I didn't want Covid, I didn't want to get it, I tried everything to get away from it, and I still got it, and now it's compromising my patient care.

Riggenbach: No, all those points make a lot of sense. And then going back a little, which I feel like I say a lot this interview.

Trivedi: That's fine.

[1:56:59] You have the benefit of being able to move things around when you edit. You're like, okay, we talked about 2021, and then we talked about 2020. Well, I can take the 2020 part and move it in front of the 2021 part so that the timeline goes effective. Not that you're going to do that.

Riggenbach: But if needed.

Trivedi: By recording it, you have that option.

Riggenbach: There's that power, yeah.

Trivedi: Yeah.

Riggenbach: But in your personal life, did that summer of 2021 include any travel, or were you not quite ready for that?

[1:57:31]

Trivedi: Not necessarily in the summer of 2021, but like towards the fall and when things started to kind of open up, like when we went to phase two, phase three. I was doing very limited things, like going to St. Louis, going to Chicago, driving, not taking Amtrak. You know, staying in hotels and things like that. So yeah, I was doing more of it, but not necessarily return.

[1:57:55] It definitely wasn't like anything pre-pandemic level. But yeah, I was. In certain very select situations, I was traveling. But I restricted it mostly to Chicago and St. Louis.

Riggenbach: And then in that fall and winter of 2021, that autumn, it was in September that the FDA approved the Pfizer vaccine, which was pretty exciting. And then there's the development of the Merck pill for Covid. There was just a lot going on.

[1:58:29] What were you thinking of that? Did that give you any sense of hope, were you kind of like, oh, life is just going to be the same?

Trivedi: It did give me a sense of hope. I'm hopeful. I'm an optimist by nature. And so hearing the research machine of the world working towards more effective therapeutics and more effective vaccines, how could it not be a positive? How could you look at that in a pessimistic way?

[1:59:00] Like I said, that's not my nature. I would never do that. I'm like, yeah, this is great. People now, even the unvaccinated who get Covid, there are medications that result in almost zero mortality. Like, nobody who's taken – I don't know which one it is, but one of the medications that they found, not

one person that was given that medication when they had their Covid syndrome has died.

[1:59:32] So it's been very effective at significantly reducing mortality to almost zero in people who have severe Covid symptoms and are hospitalized for long periods of time. So how can anybody not be optimistic about that. You'd have to be the most skeptical person to not be optimistic about that. I mean, like, what's wrong with you? This is great. Even if you're skeptical, you've got to admit, that's a good thing.

[1:59:55] But yeah, as we discussed, there's a percentage of the population that just can't find the hope in anything. Or the optimism.

Riggenbach: In our pre-interview – was that in November?

Trivedi: It was in November.

Riggenbach: That's crazy to think about time gone. But you were planning a trip out of the country. And how was that travel?

Trivedi: Yeah, so I went to Belize. It was fine. I had to get Covid tested before I left.

[2:00:28] 24 hours before – within two days before I left. So I went to one of the free clinics, and I tested negative. They sent me an email. So then when I got into Belize, they were just like, can you show us your proof of Covid vaccination? I pulled out the email, and I was like, here you go. She's like, stamped my passport, done. And then in Belize, even though Belize – I think they're tier four, which means don't go to that country – surprisingly, everybody was wearing masks everywhere.

[2:01:01] Like, in the cops. I walked by a police station, and the guy was like, you can be fined $750 for not wearing a face mask, or $750 Belize dollars. I was like, really? And I was like, okay, I guess. But yeah, people walking down the streets wearing masks. Like the police officers telling you, hey, put on a mask and things like that.

[2:01:28] That was what it was. And then when I had to fly back on the second, I had to get a Covid test within 24 hours of my departure. And it was great, actually at the airport in Placencia, like right next door to the airport, was a Covid testing place. And so I just went there, and then I tested negative.

[2:01:59] And then when I came to the U.S., when I went through customs, they were just like, where's your proof of vaccination, and I just pulled out the paper they gave me. And I was like, here. And so that was fine. It was great. It was a great experience. I loved it. But one thing I can say is, I was supposed to go to New Orleans for a conference on January 31, so the week after this week.

[2:02:27] And that was a hybrid in person virtual conference they were doing. They moved it 100% to virtual. And I was going to go see my friend Greg. He's a physician in New Orleans, and we did our fellowships together, or at the same institution at the same time. And we were great friends. And I haven't seen him for a while, and we were going to party it up and have a good time.

[2:02:55] I'm not able to do it. And I already paid for registration. And if it wasn't going to be in person, I probably wouldn't have registered for the conference. And I thought they would reimburse me, so I emailed the conference host, and they were like, the registration was for either online or in person. And then Madison was going to go too, and she actually had a poster she was going to present. For her, she just graduated college, and she's never been able to go to a conference that was traditional, like in person.

[2:03:34] All of her conferences have been virtual. So she hasn't really experienced a conference. And the great part about conferences is networking and socializing and interacting with your colleagues and other people who do the same things you do, like other neuropsychologists. And she wants to be a neuropsychologist. So I was really – I was kind of bummed for her. You know, I was like, oh, this kind of sucks, you're not going to – you know, you may – you made the poster, and now it's only going to be virtually.

[2:04:00] And you're not going to be able to stand and take a picture of yourself. You know what I mean? That's unfortunate. Yeah, so that was just kind of a bummer, that she won't get an experience. She's worked so hard on it, you know? It's a bummer that she's not going to get an experience, sort of one of the rewards of all that work, which is presenting your work to your peers in these types of settings.

[2:04:25] And so that's – in terms of travel, that's – so far, my trip to Madrid I believe is still – I'm still hopeful for.

Riggenbach: When is that?

Trivedi: That's supposed to be in March, yeah. So fingers crossed that by then, things will be better. I haven't bought tickets yet for the match or flights, but I did take the days off work and closed down my clinic for those days. So that's fingers crossed, like you said.

[2:04:55]

Riggenbach: And kind of getting to these concluding questions, we talked about what January of 2022 has been looking like for you, these cancelations. Did you say that there is some sense of concern about the financial position, or are you pretty safe in knowing that people will come back eventually?

Trivedi: Oh yeah. That for sure. People will definitely come back. And there's ebbs and flows. Like, you know, I've been doing this for six years now independently.

[2:05:29] And there are just ebbs and flows. And I tried to figure out – like, is it seasonal? And there's really no rhyme or reason. Some months, you just get a lot of no-shows and cancelations. And then you'll have like three months in a row where nobody will cancel, and you're like, I want somebody to cancel. Like, God, I want cancelation. Everybody's showing up.

[2:05:55] I've just learned to understand that there are ebbs and flows. You always try to – you know, when something is different or something changes, we're humans, we always try to explain, say why did that happen, why is this happening, why? Sometimes there's not an answer to your question, so you have to be comfortable with it. And that's the approach I've taken. Like I said, I think there is a component to it, but that's because I'm knowing why people are canceling.

[2:06:24] They're telling me they're canceling because they're quarantining or because they tested positive for Covid. So there is that knowledge. But I have no concerns about this returning back. I mean, like I said, for God's sakes, I'm booking out until April, full schedule. So if all my patients show up, I'll be just fine. And even if a couple don't show up, like I said, I feel like I've got enough experience where now I know this is the way things happen.

[2:06:56] And I'm not the only one. It's clinic wide. We've had increased cancelations over the last month. But some of the other – like the psychiatrists, where they're just doing med management appointments and things like that, those are more conducive to telephone visits and telehealth visits, which we're still able to bill for with the appropriate modifiers, like the insurance companies will still reimburse us for those.

Riggenbach: That's good.

Trivedi: Yeah, definitely.

[2:07:29]

Riggenbach: What were some of the – I'm trying to look at my concluding questions and get a sense, because in some way or another, we've kind of gone over a lot of these, and I am mindful of that 4:30 meeting.

Trivedi: Yeah.

Riggenbach: What were the kind of different effects that the pandemic has had on you?

[2:07:57]

Trivedi: I feel like we have kind of covered that.

Riggenbach: Yeah.

Trivedi: I mean, it's had an effect, right? It's affected everybody, professionally, personally, socially. I mean, it's affected every aspect of my life and not really in a positive way at all, you know? Yeah, that sums it up. It's completely changed my life.

[2:08:26] And it's completely changed everyone's life. And I think that many of these changes are going to be permanent, and some of them will be good, like the flexibility in working from home, having the part time in office, part time at home, that's probably a good thing for some people. Children. Young children who were learning to understand emotions not being able to see facial expressions in people.

[2:09:01] Like, you know, that's going to have a negative impact on their emotional and social growth. So there's other aspects of it which are going to be difficult for a certain percentage of the populations that are maturing and transitioning from early childhood to adolescence and from adolescence to adulthood, and from adulthood to the job, from college to the work environment, and to graduate school and things like that.

[2:09:33] And I think in those instances, it's a really negative effect that it's having on certain aspects. But I do think the cons will far outweigh the pros, like when we look back on all of this, like how it's changed our lives as a society and a culture.

Riggenbach: You discussed a little bit about the uptick in depression, anxiety, and then the crying episodes.

[2:10:06] In our pre-interview, you mentioned a lot of people coming in to be diagnosed with ADHD and people's concerns that they have ADHD. What are your thoughts on that?

Trivedi: So concentration problems are very common. If you look in the DSM V, and you look up depression, one of the symptoms, short term memory problems, concentration difficulties.

[2:10:34] Now, people are fed a lot of information in the news. A lot of – I wouldn't want to call it fake news, but misinformation about – not just about Covid and all this stuff, just about health. And this predates the pandemic. Like Prevagen and Lumosity and those things. Those have not been approved in clinical trials.

[2:10:57] Like, those are all anecdotal, right? But one of those things is, people are thinking, there's no such thing as adult-onset ADHD, it's a

neurodevelopmental condition that's present when you're a kid, and it causes a negative impact on aspects of life, academics being one of them. You can't be diagnosed with ADHD if those cognitive problems that you're having aren't having a negative impact on your ability to function in school.

[2:11:29] Like, you're doing really poorly in school because you can't pay attention, you're not getting homework assignments done on time, you daydream, you interrupt people, you're hyperactive, you're running around, you're not sittings still. Those have a negative impact on kids. And when you see ADHD in kids, you're like, I know what ADHD is. In adults, like when somebody's like, oh, when did your symptoms start, just a couple of years ago. It's like, you don't have ADHD. You're 35 years old, and you just had your symptoms start two years ago.

[2:11:55] You by definition cannot have ADHD because those symptoms have to be present when you were between the ages of 5 and 12. Some people will come in and be like, well, I think I've had these my whole life, and I just started noticing them recently. And then you find out that they had some trauma in their childhood, and they have a long history of depression and anxiety that dates back to childhood. And because, like I said, cognitive problems are common symptoms in depression and anxiety, it's like, what's causing it?

[2:12:28] Is it ADHD, is it the fact that you are depressed or anxious? So ADHD, it's a challenging diagnosis, because there's no cognitive profile like people with – high functioning people can have ADHD and they can do just fine on all of the tests that we administer. You have other people with ADHD who will do poorly on some of the tests. That's why neuropsychological testing is not required to diagnose ADHD, because there's no consistent pattern.

[2:13:01] So a lot of it's based on clinical interview and questionnaires, and the reason why I see so many ADHD cases is because the residents and the psych faculty, they do their clinical history, and they're like, man, Jane, you tell a pretty good story here, it really does sound like you have ADHD. And they'll want a second opinion. And we can do it. We have certain measures which look at, like, symptom overreporting or faking bad.

[2:13:31] These are like patterns of responses to questions that even people with severe psychiatric illnesses would not endorse. And when you see those profiles, you're like, this person is overreporting symptoms. They're faking bad. They're over pathologizing themselves, because what do people that have concerns about ADHD want most? They want Adderall. They want Ritalin.

[2:14:00] They want amphetamines. That is a secondary gain. And when there is obvious secondary gain, you have to evaluate whether this person is trying to

pull a fast one on you. And so that's why I see so many ADHD cases. But yes, I have noticed that. It seems like I'm seeing a lot more.

[2:14:29] But I attribute that more to depression and anxiety and the fact that there's overlapping symptoms than I do to the fact that more people are getting ADHD. Because ADHD is a really – it's controversial, and it's misdiagnosed a lot, and that's because primary care physicians who shouldn't be diagnosing ADHD in the first place just think that because a person complains of attention and concentration problems that they have ADHD.

[2:14:57] There's more to it than that, you know? A lot of people can have attention and concentration problems, and that doesn't mean that they have ADHD. And you don't want to give somebody a medication – and this is just a general statement, not for ADHD only – no physician ever wants to give a patient a medication that they don't need to take or that's not indicated. And so that's why. And there is a huge street value for amphetamines.

[2:15:26] And so the black market. So psychiatrists are like, I want to cover my butt in all ways, because I don't want to be liable for anything. And so they'll sometimes do that over testing, and so I think that's a lot of… You knew this wasn't ADHD. And I'll talk to them in the hallway, and they'll be like, you know what, I don't think he had ADHD either, but I wanted him to see you to get a second opinion. And if you don't think he has ADHD, and I don't think he has ADHD, then he doesn't have ADHD.

[2:15:58] And so it's more like, I just want to confirm that my suspicions are right or wrong, and that's why they refer them. And I'm happy to provide that service. Our ADHD evaluations are mostly questionnaires that people fill out.

Riggenbach: Do you think that people might be concerned that they have ADHD – an uptick in that during the pandemic – because you have people suddenly inside so much more, on a computer so much more?

[2:16:28]

Trivedi: Yeah, absolutely. That's definitely a component to it. People start to notice these things more when they're left to their own devices and they're alone. And they're like, man, why am I – especially for students right now. Like, that's the big thing. When people went to full virtual classes, that's when people were like, man, I'm not finishing my homework assignments on time, I'm not paying attention.

[2:16:54] It's like, of course you're not. This is something brand new. You're used to the traditional schooling model where you go to class and a professor teaches you and you get homework assignments. And now all that's being done virtually. And it's like I said, you've changed the game. But the criteria don't change. Like, the diagnostic criteria don't change even though the game

changed. But that's what people I think are noticing more, is that they're more aware of, you know, oh, this wasn't a problem before, why is it a problem now?

[2:17:31] And it's like, well, maybe this model – like me, I can't work from home. Maybe this isn't for you. Maybe you need that traditional structure to succeed and be effective in your life. But again, usually, there's always a component of depression and anxiety. Like, when you have these people coming in concerned about, do I have ADHD, they're like, I was talking to my primary care physician, and I mentioned that I've been having some attention and concentration problems over the last few months, and that's why they wanted me to come see you.

[2:18:06] They wanted me to get an ADHD evaluation. And so I provide that. And then I make a recommendation based on their history, their clinical history, their childhood history, and things like that.

Riggenbach: And kind of one last question to end things. I think we've kind of talked about this this whole interview. The overall impact of the pandemic on people's mental health.

[2:18:34] We talked about this in our pre-interview as well, that the healing of this will take a long time.

Trivedi: Oh yeah.

Riggenbach: I guess why do you think that is, and what do you think people need to be able to hear?

Trivedi: That's a good question. I think it's going to take a long time to heal, because things are never going to go back to what they were before.

[2:19:03] And people are inherently resistant to large scale, quick changes in their lives. I mean, we're creatures of habit. That gets way worse when you get older. You get your routine, you drink your coffee at seven in the morning. You read the newspaper. You go to work at eight. You have lunch at noon.

[2:19:27] You go home at five. You take your kids to soccer practice. You watch TV, you eat dinner. Like, this is all changed. It's like, oh, one day of the week, you're in the office. One day you're at home. Some days you're half in and half out. And things are changing, and things have changed, and they're never going to return to normal. It's just going to take people more time to adapt.

[2:19:55] Healing's not probably the appropriate term for what we're talking about. I think adaptation, adapting, is probably the more appropriate term. And that's going to take a long time for people to adapt fully and be comfortable in

whatever this new normal is going to be like. When this converts to an endemic phase like the cold and like the flu, people are going to figure out, okay, this is the new normal.

[2:20:28] Like, it's been endemic for two years now, and we're doing okay with it as a society and as human culture, and once that happens, people will be allowed to adjust and become comfortable with this new normal. And when that happens, hopefully, things will kind of go back to being what they were before, but in a new way.

[2:21:00] And you know, I don't see that as a bad thing, though. I mean, we adapt. We adapt slowly. This is something that we've had to adapt to very quickly, and that's the difficult part. Because like I said, we're creatures of habit. We're ready to evolve, like iPhone 1, iPhone 2, iPhone 3. And then you're at iPhone 13, and you go and you think back on the iPhone 1, and you're like, man, this iPhone 13 is way better than that iPhone 1.

[2:21:31] Yet because it happened so gradually, you didn't notice how amazingly different and better the iPhone 13 is than the iPhone 1, because you were given it in small servings. So it's not like you went directly from iPhone 1 to iPhone 13. That would have been jarring. You know, the fact that it's like, oh, we're going to improve the pixels on the phone, oh, we're going to improve the pixels on the phone.

[2:21:57] Oh, now we're going to introduce video. Oh, now we're doing 4G. You know, it's all so gradual that we're able to sort of – the creatures of habit part of us were able to sort of adapt more with that when it happens gradually over a long period of time. This is not that. We went from literally, like, They Might Be Giants concerts in big settings with lots of people, to a week later, everything's closing, and you can't do what you did anymore.

[2:22:37] Like, in a day. And then it's like everything's evolving. We take one step forward, we take two steps back, we take two steps forward, one step back. And it's just a matter of getting to that point where we can get back to slowly adapting over time.

[2:22:56] And I believe that will happen. Don't ask me when. But I believe that it will eventually happen, probably within the next four or five years, I would say. But yeah, that's what I mean by, it's going to take a long time, because I don't think it's going to happen overnight, certainly.

Riggenbach: That makes a lot of sense. Well, that concludes my questions. Do you have anything you would like to add, anything you would like to end with?

Trivedi: No, I think I said this during the pre-interview.

[2:23:27] You know, we as providers don't get to talk a lot about – and talk about these things. Actually, people in general don't get to talk this in depth about their perceptions of things that are happening and how they affect us. I've learned some things about myself by going through this process with you that I didn't know, and that I may not have known had I not gone through the process for you.

[2:23:55] So for me, this was rewarding. I was able to learn some things about myself in this circumstance that I never expected to be in. So I think that's a good way to wrap it up.

Riggenbach: Well, perfect. Thank you so much for that perspective and your words. I think they're very important to get your perspective. So thank you.

Trivedi: Yeah. Only thing I'd ask is if whenever you have produced your product, I'd love to know.

Riggenbach: Oh, absolutely.

[2:24:26]

Trivedi: You know, and see what all this work that you've done and all these interviews that you've done with so many different – such diverse people – what it leads to. So definitely send me an email whenever you've uploaded these things to the websites or edited, or you're closer to a final product than maybe you are today. Just yeah, shoot me an email and be like, you know, go to the website, check it out, here's the edited version of your interview or whatever. I'd love to just kind of see what this all leads to.

[2:24:57]

Riggenbach: I will definitely do so.

Trivedi: Definitely, all right.

Riggenbach: Thank you.

Trivedi: Yeah, absolutely.