



How Will the Crises of 2020 Shape the Clinical Practice of Psychology in 2021?

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This issue of the *Journal of Health Service Psychology (JHSP)*, the first of 2021, serves as a marker to remind us how the events of 2020 have affected us not only as individuals but as healthcare providers. The Black Lives Matter movement that was catalyzed by the killing of George Floyd has direct implications for clinical practice and poses an immediate challenge for us to confront how systemic racism affects the provision of mental health services. COVID-19 has magnified healthcare inequities in access to care and has made transparent long-standing, racially based inequalities that heighten the burden of disease on those of nondominant ethnicities, as Farquharson and Thornton (2020) noted in a recent commentary. Examination of such inequities should also lead us to question the extent to which current standards of education and practice perpetuate inequities in the provision of healthcare services, including psychological services. From basic assumptions about behavior by individuals of nondominant ethnicity to economically mediated deficits in access to care, it is time for a frank assessment of implicit ethnic and economic assumptions that permeate healthcare service provision. The economic upheaval of the past year starkly illustrates how economic disadvantage, which is increasing and often ethnically mediated in the United States, perpetuates enduring societal stratification, thereby guaranteeing inequalities in access to health care. Just as COVID-19 has led to widespread adoption of telehealth, it should also cause us to actualize solutions to persistent inequities that have long been discussed but less-frequently acted upon.

All such discussions must perforce take place in the context of a continuing pandemic. Our first article (VandenBos, 2021) offers some guidance for psychologists who are seeking input regarding returning to practice as vaccinations against COVID-19 begin. It is our assumption that all psychologists who intend to return to in-person practice will do so using appropriate social distancing and sanitization procedures—and will become vaccinated themselves. Since the Department of Health and Human Services has determined that psychologists, like other health care providers, should be prioritized for vaccinations, all practicing psychologists should make every effort to seek early vaccination.

Because no vaccine is 100% efficacious, and because it remains unknown if vaccinated persons can serve as virus transmitters, it is essential, even after vaccination, to maintain proper cleaning and hygiene regimens. Psychologists who employ office staffs should familiarize themselves with the latest U.S. Equal Employment Opportunity Commission, (EEOC, 2020) guidance.

Current EEOC guidance states that employers may require employees to be vaccinated before returning to the workplace, that they may inquire about employee's health status, and that inquiring about vaccine or COVID-19 status is not a violation of employee privacy. At this time, however, employers may not require a negative COVID-19 test before allowing employees to return to work (largely because negative test results are transient and infection may occur at any point after a negative test). Although we are lacking case law to guide us, it is reasonable to believe that there may be some liability for psychologists who do not provide a safe environment for patients and staff. While we await such developments, we urge all psychologists to lead by example and get vaccinated and continue to engage in all hygiene practices thought effective in reducing viral transmission.

Lingras (2021) speaks directly to issues surrounding racism and provides readers with excellent resources to share with parents who struggle with the challenge of deconditioning children who are socialized to view the world through a race-centric lens—as well as the necessity of acknowledging the protective function of such lenses, such as when a Black parent is forced to teach their child(ren) about how to safely interact with law enforcement. Lingras notes an obligation of psychologists to familiarize themselves with such resources. Here we should add an obligation to reflect on the privilege associated with being a member of a doctoral-level health care profession and to reflect on the biases that continue to be imparted during our training.

Standardized psychological testing has long been biased against members of nondominant cultures, and ethnicities. Even if such assessments (many of which are the direct product of eugenics-based philosophies) are no longer used for

nefarious purposes like involuntary institutionalization or sterilization—practices for which psychology holds some culpability—they are still used for classification purposes that may reflect bias. Many versions of the standard mental status examination or standard psychological intake used today require that the clinician identify the patient's race. I suspect that most often the identification of race, generally in the first lines of a report, is unimportant in understanding the presenting issue but rather a persistent artifact of training that reflects long-standing assumptions by generally White clinicians and more fundamentally deeply ingrained racism pervasive in mental health training (Strakowski et al., 2020). It is long past time to acknowledge that this categorization imparts no vital information but simply perpetuates implicit biases about patients' backgrounds and behavior. To be sure, members of nondominant ethnicities are more likely to suffer the effects of systemic racism, but if this is indeed contributory to the clinical presentation it will be elicited by careful history taking, not a superficial categorization of skin tone.

Telehealth, as we have seen during the pandemic, is likely to become a permanent fixture in the mental health armamentarium. As has been noted, in the first weeks of the pandemic, telehealth visits increased exponentially, although such visits have since stabilized. The COVID-19 relief bill (Consolidated Appropriations Act, 2021) recently passed by the US Congress extends telehealth flexibility through all of 2021. Funding for telehealth has been significantly expanded and reimbursement strategies clarified.

There are still some significant limitations. As written, to be eligible for Medicare reimbursement, rules require that the provider see the patient at least once in the six months before telehealth services began. There are still no provisions for Medicare reimbursement for telephone, or audio-only telehealth services. The National Register, as a member of the Mental Health Liaison Group, advocated to the Department of Health and Human Services for the abolition of an in-person initial assessment, particularly during the pandemic, and will continue to do so, along with advocating for the extension of reimbursement for audio-only services.

I anticipate that as telepsychology becomes firmly established as a component of psychological practice, we will see such barriers eventually disappear. What will continue to be required, and what the government cannot provide, is the innovation required to allow us to expand psychological services available via telepsychology. We must continue the work to norm the remote administration of standardized psychological tests and enable the ability to administer neuropsychological devices using distance technology.

From a governmental perspective, what will also be required is continued vigilance to ensure that third-party payors also reimburse at parity levels for telepsychology, and governmental intervention to overcome the persistent digital divide that makes accessibility difficult for disadvantaged

citizens. Parity provisions and funding for broadband access have been included in the COVID-19 relief bill, but we as a profession must be continually vigilant that both government and private payors meet these obligations.

It is quite obvious that telepsychological interventions can assist in solving many of the clinical problems focused on in this issue of *JHSP*. A family check-up, as Metcalfe et al. (2021) illustrate in their vignette, may take place in the context of abuse and a history of negative interactions with caregivers and law enforcement. Such factors might suggest that telepsychological assessments would be more palatable to families wary of health care providers, but here economic disadvantage likely compounds difficulties in accessing care. Families in distress are probably among the least able to afford equipment or subscription fees to access the internet. Provisions in the recently passed US COVID-19 relief bill explicitly address expansion of internet access to economically disadvantaged and rural citizens by partially subsidizing the cost of access, but this is insufficient. As telepsychology becomes an established modality, psychologists must advocate that all patients have equal access.

Numerous psychological interventions have proven to be adaptable to the electronic environment and there is no reason that well-being therapy, as outlined by Maccarrone and Nierenberg (2021), cannot also be successfully accomplished via telepsychology, inasmuch as it involves basic therapeutic maneuvers common in other online therapies. Well-being therapy was developed in response to the common observation that antidepressant medications may palliate psychic distress but do not provide a framework for long-term psychological health. A focus on positive psychological functioning, rather than distressing symptomatology, is required to achieve this. But well-being therapy, while of demonstrable efficacy in person, raises some cautions in that it relies on iterative patient diaries that provide the basis for cognitive restructuring. While hand-written diaries may certainly be misplaced or read by others, risks to privacy are magnified with electronic diaries. At the very least, patients should be educated about best practices in the electronic transmission of highly personal data, and it goes without saying that an electronic diary should never be incorporated into an electronic patient record.

Factors other than economic disadvantage, rural status, and privacy concerns are equally important in mediating access to electronic healthcare. Sexual minorities have traditionally been neglected by the healthcare system but are among those who may benefit most from telehealth. Because of past systemic discrimination, such groups may be the least likely to access electronic health care. It is as important for LGBTQ+ citizens to be fully accepted as members of society at large as well as full participants in electronic communities. Numerous barriers to this participation exist, as Ream and Peters (2021) enumerate in their review of treatment issues with LGBTQ+ youth. Obviously, homelessness, a particular concern for

sexual minority youth, is a barrier to community participation in person or online. Policy and legislation drive healthcare access. Because sexual minorities have often been ignored in the federal policy-making process, long-standing obstacles to care remain largely in place.

Telehealth may also be of benefit to patients with rare conditions. The condition of misophonia, for which putative diagnostic criteria and assessment techniques are clearly spelled out in an excellent clinical review provided by Wiese et al. (2021), may be amenable to telepsychological assessment devices and possibly interventions. Misophonia is an evolving diagnosis around which consensus is yet developing. It is not included in standard diagnostic nomenclature in part due to dissent about its uniqueness as an independent disorder. If indeed it is a separate disorder and not a variant of established conditions like obsessive compulsive disorder, it is uncommon and quite possibly rare. We have previously seen the potency of electronic communities in providing both research opportunities and support for patients suffering from rare disorders. Electronic dissemination of information regarding rare conditions assists providers who are unlikely to encounter such conditions in education or clinical practice and may result in more rapid and accurate diagnosis as well as access to specialized treatment. Whether or not it represents a *bona fide* diagnosis, a number of online support groups for misophonia have already coalesced. Such groups may provide socialization for afflicted persons and may serve the additional benefit of providing researchers with access to patients with suspected conditions, but they are by definition unregulated and are all too frequently fonts of misinformation and ill-advised advocacy.

In sum, the current issue serves as a *precis* of the future of the clinical practice of psychology. It is incumbent upon us to continually update our knowledge about new diagnoses, problems, and procedures. At the same time, we must develop a more accurate understanding about how long-standing institutional and systemic biases affect the access to and experience of disadvantaged groups in the treatment process. Finally, we must contextualize all of this in the expanded electronic environment where an increasing number of patient encounters will take place.

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