Commentary

COVID-19 pandemic and clinical psychology placements: a provisional psychologist's perspective

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In late December 2019, a novel coronavirus (COVID-19) was identified in Wuhan, China, which rapidly spread globally over first 2 months of 2020, resulting in a pandemic being declared by the World Health Organization (WHO) on March 11th, 2020. On March 15th, the Australian Government announced immediate measures and restrictions to daily activity that impacted not only social interactions but also all aspects of health care delivery. Health services rapidly developed protocols on 2 fronts: the screening and treatment of COVID-19 and the continued provision of essential non-COVID-19 clinical services, including cancer care. Clinicians in outpatient populations quickly moved from face-to-face consultations to telehealth—conceptualized as any telecommunication that facilitates delivery of care to patients when and where they choose to receive it. Although the term can encompass mobile applications and online programs, we refer to telehealth in this commentary as the telephone or videoconference delivery of health care consultations.[1] Telehealth has been trialed in randomized controlled trials in Australia and internationally with comparable efficacy to face-to-face therapy in improving emotional distress across a number of disorders.[2–4]

These challenges, while unsettling for established staff members, differ from those experienced by those undertaking their clinical placements at the time of COVID-19. Although medical students[5,6] and paramedic students[7] have described the unique challenges faced by their disciplines, the perspectives of psychology trainees in a front line health setting have not yet been reported.

Trainee perspective

Postgraduate clinical psychology training programs in Australia consist of coursework, a research thesis, and 3 clinical placements, each of 20 weeks' duration. This particular placement was offered to second or third placement students, with a maximum of 10 clients including 3 assessments seen over 2.5 days. The placement is structured with increasing autonomy, working under supervision and observation from the senior clinical psychologist before transitioning to fully independent sessions. Trainees are expected to conduct assessments and deliver therapeutic interventions to individuals affected by cancer, drawing from a combination of cognitive behavior therapy and acceptance and commitment therapy. Commencing this as a second placement, my clinical experience was limited to 1 previous placement in a sleep psychology setting which was delivered entirely face-to-face.

My second placement commenced in January, which was met with concerns about starting a new placement; orientating to the organizational setting; and developing therapeutic relationships with clients in the context of cancer outpatient care. Five weeks later, the declaration of a global pandemic occurred and the clinic was briefly closed to establish new COVID-19 protocols. The hospital was quick to change hospital procedures including reduced patient flow, social distancing, use of hand sanitizer, and temperature check upon arrival. New protocols also resulted in the abrupt cessation of my face-to-face contact with clients, and commencement of telehealth, initially via telephone consultations, then video-conferencing some weeks later.

Soon into my first telephone consultation, I realized the stark contrast in the therapeutic relationship and dynamic across 3 therapeutic factors:

First, as a trainee we were educated on various forms of *nonverbal cues* to monitor when working therapeutically, including eye contact, body positioning, and facial expressions. When nonverbal cues are nonviewable, silences in conversation, once used as a therapeutic tool, were now perceived as awkward or perhaps as technology failing ("are you still there?"). Lack of feedback from patients was perceived as a possible lack of understanding. Many cancer patients experience significant fatigue, which is observable in face-to-face consultations; however, fatigue is easily perceived as disinterest via telephone. These observations led to quick upskilling in listening to both the content and tone of conversations; frequent check-ins and summaries were utilized to ensure I understood their experiences.

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Second, was the concern about *maintaining a therapeutic relationship* with a client who I have never met in person and cannot see, with the ethical, professional, and organizational requirements of using telehealth. Conducting identity and safety checks at the commencement of every session indeed impacted therapeutic dynamics. Additionally, comments from patients that I sounded "young," could have served to alter the therapeutic relationship. I became distracted worrying about how patients were perceiving me, my internal self-criticism increased, and my newfound confidence was shaken. These comments increased my concern about how credible patients thought I was and whether they would take on board my therapeutic strategies.

Third, the ethical dilemma of how to provide a service to patients who expected or *preferred face-to-face* services. On some occasions, patients had not received the notification not to attend in person, and arrived for appointments as scheduled. Refusing to consult in this context would have been unethical; thus, these select consultations were conducted face-to-face while adhering to social distancing requirements. In other instances, patients were already attending chemotherapy or appointments with their consultant on the same day as the psychology appointment, so asking them to go home for a phone call was inappropriate. Some patients outright refused all forms of telehealth, which left us with an ethical and equity dilemma: how do we decide who gets face-to-face consultations, and who has telehealth?

After 6 weeks of delivering telephone-therapy, videoconferencing technology was then implemented across the hospital/placement. This presented new challenges including the limited options for, and availability of, formal training by either the university, placement provider or from online sources. Although many professional societies offered webinars about videoconference-consultations, most of these were paid, or were only available for students with membership. My supervisor and I collaborated to collate all available resources, to assist in delivering the best possible telehealth service, covering both telephone and videoconferencing for our patient group. Although this was challenging and added to my workload, this increased my awareness of online resources (eg, Finding My Way) and apps (eg, Goal in Mind), summarized in Table 1.

Issues with technology arose when using videoconferencing. In some instances, contact numbers were incorrect, out of service, or would not accept government (blocked) numbers. Internet connection, device charge, and audio quality, were challenges experienced in most sessions. For those accessing the video via smartphones, many patients accidentally positioned the video towards the roof or top of their head. Many patients also needed to be reminded to sit still to maintain good internet connection. This was often a source of distraction and I found that I often lost my train of thought while patients maneuvered their devices. These technology issues left us with less time to review changes, discuss homework, and implement a new therapeutic technique.

Although videoconferencing promised capabilities such as using interactive whiteboards, uploading and downloading forms through the platform, in my experience, these features have not been utilized frequently—pragmatically, it is difficult for those patients who are contacting us via mobile phone rather than laptop. However, the benefits of being able to "see" patients has been the big benefit of transitioning to videoconferencing. In some instances, we transitioned to telehealth after having previously worked together in person, but in other cases, we "met" for the first time during a telephone consultation. Seeing patients for the first time (and them seeing me) was yet another unnerving experience.

Table 1

Useful online Australian-based websites and apps.

Helpful Australian online resources	Weblink
E-Mental Health in Practice (eMHprac)	https://www.emhprac.org.au/
Finding My Way	https://findingmyway.org.au/
Head to Health	https://headtohealth.gov.au/
MindSpot	https://mindspot.org.au/
myCompass	https://www.mycompass.org.au/
This Way Up	https://thiswayup.org.au/
Australian-based Smartphone APPS (downloadable via app store)	• Beyond now • Daybreak • Goal in mind • ReachOut breathe • Smiling mind

Once again, my inner critic increased my worry about how patients would perceive me once "sighting" me via videoconferencing. Equally, I had mental representations of my patients, and interestingly I had not factored in the visual cancer reminders, such as wigs or head scarves, which were a source of distraction for the initial stages of the videoconference consultation. I was also aware of the increased vulnerability of patients now that we could see into their homes. At the beginning of each session I asked if patients were comfortable before commencing and if others were present in the room (ie, to make sure they did not want to reschedule or move to a more private location).

Summary reflections and recommendations

This experience highlighted many benefits of using telehealth, including increased access for patients who otherwise may have cancelled appointments due to treatment side effects or fatigue, and for patients with significant anxiety about leaving their homes due to being part of a vulnerable group during COVID-19. Conversely, some patients were reluctant to try telehealth and this presented a challenge in itself. However, once connected, most patients quickly adapted and this was used as a therapeutic tool (eg, demonstrating persistence and perseverance). Completing a placement in a clinical setting did not increase my concerns about my own safety, this was largely due to relatively low COVID-19 case numbers in South Australia. However, once restrictions began to ease and visits to family and friends were allowed, I did avoid visiting people at a higher risk of contracting the virus (ie, elderly or immune compromised). Although the transition to telehealth increased overall workload, including the need to send summary emails and homework to patients after each session, it has also increased my ability to adapt my therapeutic skills quickly, increased my knowledge and awareness of online resources, and opened a new door for many people who may not be able to easily access face-to-face services. A summary of the key challenges and recommendations for future psychology trainees and supervisors is provided in Table 2.

Supervisor perspective

Supervising trainee psychologists has always been rewarding; facilitating the development of the next generation of psychologists, while simultaneously increasing the capacity of our hospital's psychology service through student-led clinics, has been of mutual benefit. Indeed, as the sole psychologist providing cancer services in my hospital, without a trainee our service would have closed for a month due to caring for unwell family

Table 2

Key recommendations/lessons learned when transitioning to telehealth during the COVID-19 pandemic.

Challenge	Recommendation
Concerns about pandemic	Supervisor: • Provide support and relevant upskilling • Provide safe space for students to express their concerns Student: • Seek support and supervision • Communicate needs and concerns to supervisor
Low knowledge of telehealth services	• Participate in professional development webinars/training (eg, Australian Psychological Society) • University upskilling/training
Low knowledge of ethical obligations for telehealth	• Review ethical obligations for conducting telehealth sessions for psychological services • Seek supervision
ID verification	• Have this done by admin staff prior to session • Make ethical obligations clearer for telehealth services (ie, once you have met the patient does ID verification need to be confirmed each time?)
Low literacy with telehealth platforms	Student: • Familiarize with video-conferencing platform and associated modalities • Practice this with "mock" patient Patient: • Provide patients with a detailed telehealth manual • Allocate homework task to patients in upskilling in telehealth (so all modalities can be effectively utilized)
Increased workload (eg, emailing)	• Have patients take notes and download resources in-session (where possible) • Allow for more time at the end of sessions to write emails

members and undergoing routine screening for COVID-19. However, through providing remote supervision, the placement and thus the service was able to continue.

Some aspects of placement-supervision were improved from telehealth—session observation felt less obtrusive as the patient did not see/hear me (though was always informed of my presence), and feedback could be delivered and incorporated "live" via written notes, without interrupting the flow of a session. Patients were less self-conscious and confused about who to address compared to face-to-face, where patients would often get distracted and turn to include me in their discussions; having me out-of-sight/out-of-hearing resolved this issue. Overall, although many challenges arose, having the opportunity to supervise a trainee during COVID-19 as they developed skills and confidence in delivering therapy flexibly across these varied modalities has been positive.

Future directions

At the time of writing, South Australia is reaching another COVID-19 milestone of gradually reintroducing face-to-face sessions. For some patients this return to traditional modes of care will be welcome, whereas others may express an ongoing preference for telehealth. From a health service delivery perspective, having the capacity to offer choice is beneficial, and may help to address some of the traditional access barriers faced by patients with cancer. However, for telehealth to reach its full potential, it is important to understand the barriers and to identify the factors associated with successful integration into psycho-oncology practice, including how to address the training needs of psychology students. A national mixed-methods study is planned to explore these important implementation questions.

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