

Practicing at the Front Lines of COVID-19: Complexities and a return to the basics

by David S. Prescott, LCSW, LICSW

“I’m obviously much less narcissistic than I thought,” I said to myself during a recent videoconference. “When did my neck start looking like that?” Of course, compared to many others – colleagues and clients alike coping with crises on a daily basis – I had it easy in that moment.

Two months into what is clearly a long journey, the emphasis is shifting from how we are going to live through the pandemic to how we are going to live with it for the foreseeable future. The effects have been devastating in many ways. What’s happening?

An early adaptation to changing times was, appropriately enough, in the area of legal and ethical telehealth practice. The American Psychological Association offered [information and resources](#), followed by numerous states, provinces, and other jurisdictions. This has become a vital consideration, given that rules regarding telehealth can vary by location. Beyond jurisdiction, questions arise about financial reimbursement rates and practices. COVID-19 has forced us to re-examine virtually every aspect of the structures underlying our practice.

Everyone’s situation is different. In one example, a program in Maine serving adolescents primarily from nearby New Hampshire faced a complicated situation when the students had to shelter in place. A clinician licensed in Maine but not in New Hampshire could no longer provide services to much of her assigned caseload. In the eyes of the New Hampshire licensing authorities, she would technically be practicing without a license. Although many restrictions have eased, it is still vital that all professionals be clear about the various agency policies and regionally varying laws that affect them.

Questions among professionals about practice quickly exploded: In an era of social distancing, what will become of the penile plethysmograph? What about the polygraph? These technologies were among the first to be placed on hold. How are other practitioners working within their new confines? As the



parameters of social distancing became clearer, treatment providers had to change their approach dramatically. Let's face it, many inpatient programs were already facing scarce resources.

People working in inpatient settings have conducted group therapy in notoriously scant environments (sometimes even unused prison cells). Groups got smaller, often with clinicians having to double their efforts by dividing groups and facilitating multiple small groups in place of fewer larger ones. In many cases, group treatment has stopped altogether. One inpatient program in the northeastern US has a clinician on a videoconference link facilitating group therapy while a front-line staff member supports the process from within the room. Readers can imagine the in-house dynamics of clinicians literally not being allowed to enter their own treatment programs due to social distancing rules.

These hurdles have not been limited to inpatient programs. Community practitioners have often found it impossible to meet social distancing guidelines in the confines of chronically small offices. Some have tried unsuccessfully to get out of lease arrangements, which only creates further problems for clients and professionals alike, as concerned neighbors and other logistical considerations pose challenges to siting a program in the community.

Then we have our own responses to videoconferencing. Many professionals have difficulty acclimating to videoconferencing. In some cases, it can be as simple as a client or colleague's cat jumping onto the keyboard, appearing to "moon" the camera. During one large staff meeting, an otherwise charismatic director spent most of her time asking participants to please mute their microphones. Too frazzled to read the instructions from her staff in the "chat" feature, she was unaware that she could have muted the participants (particularly those whose dogs were barking or who were paying no attention and talking to others). Distractions abound. Virtually anyone participating in a videoconference has had the experience of looking at others' offices and having their own observed in return. Many have quipped that videoconferencing is an excellent way to study others' bookshelves.

At a more nuanced level, adapting to Zoom has required considering what backgrounds are acceptable for others to see. Many among us have turned corners of our offices into virtual television studios, while client responses can be unpredictable. One client took note of the Celtic cross on a decorative Irish drum on the author's wall, a souvenir from a conference. It led to a discussion in which the client wandered into a detailed conversation about the cross and its meanings. While many of us have mastered the art of professional boundaries, we now face increasing challenges considering the minutiae of our workspaces.

Interestingly, the opposite can also be true. Platforms such as Zoom enable the user to set up a "virtual background," making it look as though they are on a tropical beach, off-planet, or in the sky with the Aurora Borealis. Given the backgrounds of our clients, it's worth thinking about how a fabricated background might alienate clients for whom trust is concern. After the novelty wears off, do clients wonder what we might be hiding or whether this choice signals a lack of genuineness on our parts? The full impact of our adaptation remains to be seen.

It does seem that clients and practitioners alike are adapting to videoconferencing surprisingly quickly. In many regions, the refrain was, "This is just for a few weeks until I can get back into the office." At this point, no one is entirely clear when that might be. Some psychotherapists have indicated that they intend to continue practicing exclusively by videoconferencing even after the pandemic is behind us.

Clients also seem to be adapting. Where some clinicians viewed shelter-in-place orders as short term and couldn't imagine providing intensive services via video, they –along with their clients – are rising to the occasion. One client reportedly told his clinician, “How about you write me a letter if there's something you want to say, and we'll talk when you can come back.” Within two weeks, they had both worked through the transition to video, and treatment was back on track.

Of course, each of the above examples involved situations where phone calls and videoconferencing were possible. Clients whose rules of supervision prevent cell phones or internet access have not had it so easy. Many jurisdictions are still sorting out the details of making treatment happen. One thing appears to be clear: It is in everyone's best interests when clients can stay in routine, predictable contact with their treatment providers. Even where clients do have access to technology, they often lack the necessary skills to participate in videoconferencing.

During the month of March, the author collaborated with a number of providers in the New Hampshire (NH) to establish a tip sheet for practitioners. Among our suggestions (which are by no means exhaustive):

1. Use services, such as Zoom, that can be considered HIPAA compliant. In NH, Zoom is the preferred vehicle for meetings that involve confidential client information.
2. Have a plan for what to do if the session is unexpectedly disconnected due to technical difficulties.
3. Therapists should discuss risks and benefits of engaging in on-line therapy versus face-to-face therapy during the initial session. Professionals engaging with clients electronically should be aware of the presence of others listening on the client end and adjust conversation accordingly.
4. Remember that you need to be licensed in the state where the client is located. If your client is in a different state, for example, you may need to check the regulations for their location.
5. Provide earphones with mics for the client, and use them yourself. This will decrease problems with audio and enhance communication.
6. Be thoughtful about your background, proximity to the camera and composition of the video shot. Many websites are available for tips on this. Search “setting up a good video shoot” or “how to take a great picture.” A little knowledge and effort in this area can make a big difference in the client experience for your on-line interaction. Think about what your client will see when they are looking at you on the screen.
7. If you are assisting a client for a video conference, help them be as visible as possible for the person they are meeting with. As much as possible, safeguard their privacy and provide a quiet distraction free space.
8. Before you start a session:
 1. Ensure that the client is in a private location where others will not unduly influence the nature of the discussion you are having.
 2. Ensure that the session is not recorded unless all parties agree in writing.
 3. Ensure that all parties on the call are dressed appropriately (as they would for an in-person appointment) and in an appropriate location (as they would be for an in-person appointment. For example, not in bed or in the bathroom).
 4. Consider whether the client may have access to weapons or other methods of self-harm.
 5. Ensure that the client is able to send you any homework or related materials for review prior to the session.

Even with these safeguards in place, however, many clinical questions remain. One clinician took note of the fact that prior to talking to their therapist, some clients' experiences of videoconferencing had been limited to encounters of a sexual nature. It was therefore all the more challenging to adapt to talking with a therapist. Other challenges ensue when some group members can see each other on a videoconference, while others can only participate by phone. Another point to notice is that conducting therapy via phone actually creates a kind of intimacy that isn't necessarily as apparent in in-person settings; this intimacy stems from a sharpened focus on slight changes in the rate, pitch, and volume of the client's voice along with shifts in breathing. Although most people would agree that in-person treatment is preferable, voice calls are also not without merit.

As much as these front-line situations have been challenging, it isn't much easier for supervisors and administrators in programs. All too often, staff members are stressed and anxious as they sit through daily COVID-19 briefings. One clinical director observed that among the changes to his daily activities at work is simply bearing witness to the suffering and worries of those he leads.

Ultimately, the most compelling stories are yet to be told. Those involve the people unable to reach out as they shelter in place with abusive individuals. Within weeks of being locked down, reports circulated of code language being used in the limited contacts with people outside the home. News media accounts described, for example, how women were calling pharmacies and using the words "Code 19" and "Masque 19" in order to signal their distress and indirectly summon the police. Likewise, there were accounts of people calling pizza shops and demanding repeatedly that a pizza be delivered to a particular address. Realizing that something was wrong, the pizza shop would in turn notify the police to go to that address.

The full effects of the pandemic on abuse rates may not be known for years. In a recent interview, Jenny Coleman, the Director of Stop It Now!, an organization dedicated to preventing child sexual abuse, noted how calls to their helpline and to child abuse hotlines had not increased, almost certainly because the usual people who would learn about suspected abuse (for example, teachers and childcare workers) are not currently in a position to observe and take action. Psychotherapy researcher Scott Miller, who interacts with a massive database of up-to-the-moment self-reported client wellbeing information, also stated in a recent interview that clients currently in treatment are not signaling an increase in overall distress at this time. However, the nature of these reports, and the fact that many people who are experiencing distress are not in treatment, suggest that global mental health will doubtless suffer in the coming months and years. It is still simply too early to know what the trends will be.

Ultimately, practitioners in our field are returning to one of the basic elements of what works in treatment: connection and communication. In browsing social media and listening to the accounts of numerous professionals, a recurring trend is one of concern for the wellbeing of others and attempts to bridge the gaps between professional and client. Our ability to connect with clients simply through conversation may well be the most important lesson that we (re-)learn through the pandemic era.

What's next for professionals in the field of assessing and treating those who have sexually abused? Much remains unknown. Some things are certain: Our services will be needed to address the challenges of returning to whatever new normal unfolds across the coming months and years. Above all, we will need to take exquisite care of ourselves along the way. As the saying goes, alone we can travel faster, but together we will travel further.

