Independent Practitioner

Summer 2020 • Volume 40 Number 3
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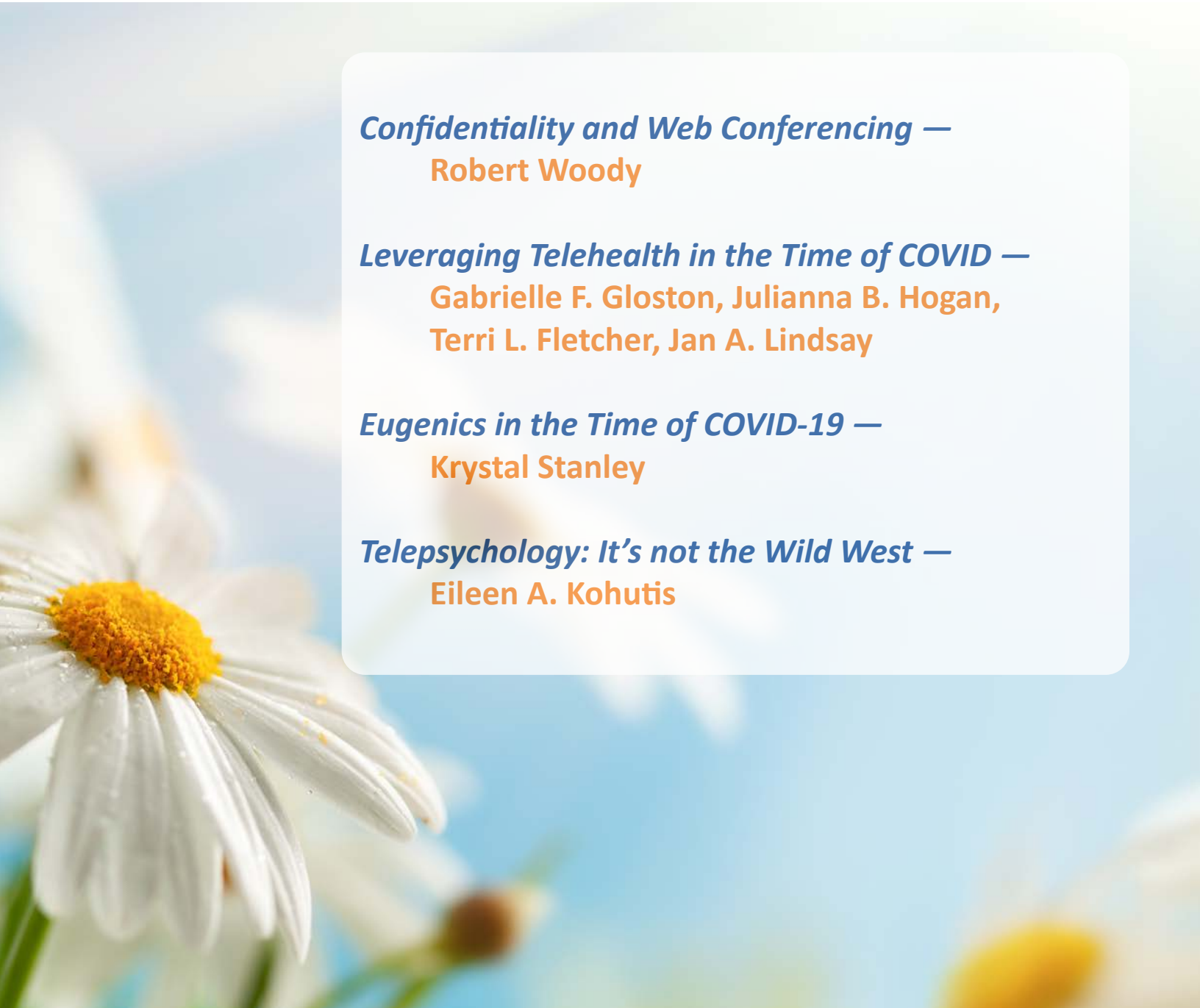

Independent Practitioner

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Submission deadlines: February 10 for Spring issue
May 10 for Summer issue
August 30 for Fall issue
November 15 for Winter issue

Submissions:

All submissions (including references) must be formatted in APA style (with the exception that abstracts should be omitted) and emailed as an attached Word file to the Editor and Associate Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write two sentences about yourself for placement at the end of the article and provide contact information you would like published (e.g., address, phone, E-mail, web page). Photos are appreciated and should be sent directly to the Central Office. Most submissions should be limited to approximately 2,500 words (6 double-spaced pages), although longer submissions will be considered at the Editors' discretion.

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Table of Contents

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President's Column

Dear 42 Colleagues and Friends

Judith Patterson

I am preparing this article in the midst of the COVID-19 pandemic. My thoughts go out to all of you, your families and patients. It is my sincere hope that you are well and that we will soon be through this challenge.

There are so many examples of the kindness and generosity of our members. Forty-two colleagues have been there for each other offering information, guidance and personal support. It is inspiring to see that while so many things have been cancelled or put on hold, the relationships between practitioners have flourished.

The APA Convention will not be held in person this year. Amy Van Arsdale, our 2020 Convention Chair, has arranged so many excellent presentations and we want you to have the opportunity to see them. While APA is looking at what this year's convention might look like, we at Division 42 are hoping to bring some of the Division's programming to you virtually. We have formed a group that is working to achieve that goal. Stay tuned for updates on division programming.

As you will recall, I promised to update you on the work of the Re-Envisioning 42 Task Force and the outcomes of the February Board meeting. After eight months of concentrated effort, the task force culminated its work with recommendations to the board regarding mission, structure, membership focus, marketing approaches, new products/services and a new division title. It responded to questions like, "Who do we want to be and who do we want to serve?"; "What products and services should we develop to provide members with helpful business of practice information, tools and resources?"; "How will we structure ourselves to get the work of the division done?" and "What do we want to accomplish for Practice?".

I am so delighted to tell you that the Board received the recommendations of the task force with great enthusiasm and gave unanimous approval for a new mission and name change. I will attempt to summarize some of the key recommendations and will end with the new mission and name changes proposed.

First of all, we focused on developing products that will help to launch our expanded focus, bring new energy to the division, and increase membership and member engagement. In order to accomplish that, we have developed a task-force that will focus on providing helpful business of practice information, tools and resources, that are not currently available, and that span all specialties and settings. We expect that these efforts, which have already begun, will culminate in a business of practice toolkit for our members.

Secondly, we established a task group to look at the structure and function of the board, the executive committee, standing committees, task forces and workgroups. Our goal is to maximize talents and resources to better fulfill our mission. As part of this work, the viability of establishing entities like sections and structured interest groups (SIGS) will be explored.

Next, we have established a task force that is looking at devising a pipeline and process for identifying leadership needs of the division.

This will include a structure for the program, initial steps and future goals. In addition, the Division's Policy and Procedure Manual is under revision and will be reviewed and approved by the board over the next three board meetings. There will be other actions that will follow, such as revision of the by-laws. Dr. Elaine (Laney) Ducharme, our president-elect, is committed to move the bylaws forward into 2021.

As mentioned above, the Re-envisioning Task Force gave a good deal of attention to our mission. Members brainstormed on the key purpose for the division, looked at who we want to benefit and what we want to support and encourage. After careful review of the 2002 mission, the Task Force presented the following to the board. It was enthusiastically and unanimously passed and sent to members for their approval, along with the proposed new name. The voting process was completed on May 20th and I am delighted to report that our new name and mission was approved by our members. There is pending APA approval, at this time.

Our Mission is to connect and support *psychologists*

- who are engaged in our evolving profession;
- across specialties and settings;
- at all stages of their careers;
- to build ethical business, practice and leadership skills.

And what is the name our members approved?

We are the:

Society for Practicing Psychologists

Our Board has approved a new logo, as well. We hope to introduce this on the cover of the next edition of Practice Innovations.

Thank you to the Re-envisioning 42 Task Force:

Nancy Molitor, Chair
Jana Martin, Process Consultant
Jeannie Beeaff, Division Administrator
Amy Van Arsdale
Linda Campbell
Paula DeFranco
Elaine (Laney) Ducharme
Gerry Koocher
Robin McLeod
Peter Oppenheimer
Judith Patterson
Lori Thomas
Pauline Wallin
Jeff Youngren

My best,

Judy

Judith Patterson, 2020 President

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Focus on Legal Matters

Confidentiality and Web Conferencing

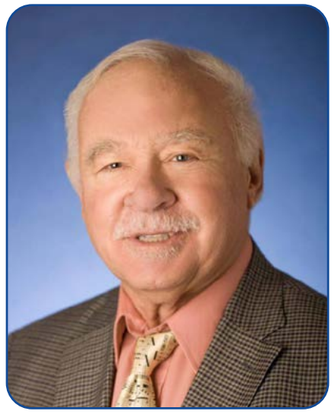
Robert Henley Woody and Karen K. Hein

In this onslaught of preventive measures for safeguards from the COVID-19, psychologists are challenged to maintain appropriate communications with service users (e.g., clients and patients). When there cannot be face-to-face meetings (e.g., due to avoiding potential exposure to the virus), a major issue is, of course, maintaining confidentiality for communications.

The basic premise is that special arrangements will likely be necessary to preserve a positive context for the professional services. Notwithstanding any unavoidable changes due to the use of web conferencing, there must be an unyielding commitment to preserving professionalism.

To retain some degree of "personalized" quality in electronic verbal intercourse, an option is video techniques. There are numerous tools for online meetings, video conferencing, calls, chat, and sharing content, such as: Zoom, Canvas, Skype, Adobe Connect, Cisco WebEx, GoToMeeting, and Google Hangouts (and there are others). In deference to space limitations herein, it is respectfully suggested that the reader gain additional information by googling each of the foregoing tools.

Given the complexity of digital programs for conferencing, it may be necessary for the psychologist to obtain specialized training from a "computer geek." In those situations, it is essential that the psychologist redact the identifying information from service users and obtain a written agreement that the instructor for usage of video techniques agrees to terms and conditions for preserving confidentiality. Also, as a reminder, there should be careful review of the security, access, and privacy settings that can be configured with each computer tool, as will ensure technical precautions can be taken along with the ethical and confidentiality considerations addressed.



If there will be professional communications by an electronic tool, the service user and the psychologist should sign, along with treatment plans, written informed consent for the service and acknowledgement of confidentiality (APA, 2002), as stated in the code of ethics in Standard: 3.10, and accommodation of Standard 4: Privacy and Confidentiality. The underlying problem is presented in Standard 4.04: Minimizing Intrusions on Privacy. Said simply, the psychologist should preface any electronic tool usage with clear and continual restrictions on who will have access to the communication. Incidentally, it is not unusual for there to be people in a conference room that are not depicted in the scope of the video—there should be assurances that only the service user(s) and psychologist will witness the intervention.

Both the psychologist and the service user need and should be committed to strict confidentiality for communications. Since communications may involve premises other than a formal office setting (e.g., a home room), prudence supports clearing personal items (e.g., family photographs) from the backdrop, making arrangements for precluding interruptions (e.g., a family member entering the scene to ask a question), and eliminating sounds (e.g., a ringing telephone, a TV turned on in another room, a child practicing a music instrument elsewhere in the house, etc.).

Although the COVID19 virus imposes requisite extraordinary efforts to communicate about professional information, quality control cannot be neglected. At least, there should be a written agreement that acknowledges mutual awareness and approval of specifics (especially restrictions) for all persons who will have access to the information intended to be confidential.

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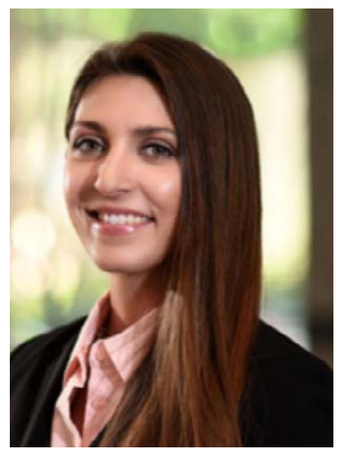
Focus on Clinical Practice

Leveraging Telehealth in the Time of COVID

Gabrielle F. Gloston, Julianna B. Hogan, Terri L. Fletcher, Jan A. Lindsay

In its professional practice guidelines, the American Psychological Association (APA) refers to psychological services delivered through telecommunication technologies as *telepsychology* (APA, 2013). Used interchangeably, the term *telemental health* can also be found in the literature to refer to the provision of mental health services remotely (Yellowlees, Shore & Roberts, 2010). Through various types of telecommunication devices and technologies, mental health professionals can provide consultations, psychotherapy, assessments, and/or supplementary treatment materials for patients to consume either in real time (synchronously) or asynchronously. Delivering services remotely can increase access to care by addressing logistical barriers that give rise to or exacerbate healthcare disparities in traditionally underserved populations. Common barriers to receiving in-person care include stigma, travel time, and arranging childcare (Lindsay et al., 2017). Aside from affording convenience and comfortability, telemental health can also be deployed in times of great need. For instance, the global COVID-19 pandemic has severely restricted in-person care and caused widespread shortages of personal protective equipment (PPE). Federal guidelines have facilitated increased use of telemental health to allow patients to continue receiving services without compromising quality of care. Telemental health also serves as "virtual PPE" for providers in healthcare settings, conserving PPE for emergency or high risk clinical services. Skillful use of this delivery mode can be a particularly helpful tool for independent practitioners to incorporate into clinical practice; however, it is important for practitioners to be aware of ethical standards, guiding policies, legal obligations, and patient-specific clinical considerations. This

Gabrielle Gloston



Julianna Hogan

article will briefly discuss the recent advances in telemental health, approaches to implementation, and some clinical considerations for practitioners.

Advances in Telemental Health

Early practice of telemental health typically consisted of diagnosis and treatment services delivered clinic-to-clinic, which was found to be as clinically effective as in-person services across a number of conditions (Hilty et al., 2013). Although clinic-to-clinic delivery did increase mental healthcare access, it failed to address others barriers to receiving in-person care, such as travel distance or lack of adequate transportation. In addition to the barriers addressed previously, delivering services directly to the patient's home (video-to-home, VTH) further widens access to mental health care. Until recently, it was unclear whether VTH had similar benefits as clinic-to-clinic delivery.

However, in a recent review, we evaluated VTH-specific telemental health in terms of clinical and cost effectiveness, patient and provider satisfaction, and treatment adherence. To determine clinical efficacy, Fletcher et al. (2018) examined eight randomized clinical trials (RCTs) and two pilot studies of various populations and mental health conditions. Among the studies, independent research teams reported large effect sizes for clinical outcomes, comparable rates of symptom improvement, and/or longer treatment effects for patients who received care via VTH. Notably, four of the eight RCTs reported noninferiority analyses that suggested mental health treatment delivered via VTH is equivalent to in-person care (Fletcher et al., 2018).

Because patients receiving mental health services via VTH do not face some traditional barriers to in-person care, VTH can potentially increase treatment adherence or reduce attrition rates. According to the studies surveyed by Fletcher et al., patients receiving treatment delivered remotely had similar drop-out rates to patients receiving in-person treatment. On the other hand, there is some evidence that VTH might increase adherence to treatment. Patient choice may positively correlate with treatment adherence for VTH users, as patients from two different studies who chose to receive mental health services via VTH were significantly less likely to drop out of treatment and/or "no show" (Fletcher et al., 2018). Practitioners experiencing problems related to patient attendance, adherence, and premature drop-out, might consider discussing VTH when appropriate and feasible to alleviate these treatment issues with patients. More recently, our team examined VTH delivery of evidence-based psychotherapies for Veterans with posttraumatic stress disorder in a specialized mental health clinic. Veterans received a majority of the EBP sessions via VTH and completed an average of six sessions. It was noted that providers used a hybrid approach (combination of in-person and VTH delivery) to treatment delivery with approximately 70% of Veterans, exhibiting the true flexibility of VTH (Boykin et al., 2019).

Terri Fletcher

Jan Lindsay

Although few, some empirical studies provide information about the cost effectiveness of VTH. In a handful of studies conducted within the Veterans Health Administration (VHA) system, including an RCT, VTH was found to be more cost effective than in-person treatment for patients when they used their own personal devices (Bounthavong et al., 2018). Further, it was reported that VTH delivery could save money for the VHA Healthcare System in the form of travel reimbursements for Veterans (Shore, Goranson, Ward & Lu,, 2014). A more future-oriented study found that mental health treatment via VTH may, in fact, be more costly long term, potentially due to increased engagement with the healthcare system (Egede et al., 2017).

In terms of patient satisfaction, VTH has been considered satisfactory across several factors, including comfort, ease of use, and video and audio quality. Although patients do experience technical difficulties, VTH may still be a preferred form of delivery for mental health treatment. This might especially be the case during times of need, such as now. At the height of positive COVID-19 cases in the United States, it was likely that patients were willing to withstand technological problems to receive mental health services remotely in service of public health and safety. Provider reports about satisfaction delivering care through VTH were more varied, seemingly dependent upon VTH experience. On the other hand, some providers practicing in specialty mental health clinics within the VHA voiced concerns about VTH reinforcing treatment-interfering behaviors; while others expressed a willingness to incorporate VTH delivery into routine practice (Fletcher et al., 2018).

Personalized Implementation of Video Telehealth

Implementation of VTH or any telemental health practice calls requires a strategy or plan. We have developed a tailored strategy, referred to as Personalized Implementation of Video Telehealth (PIVOT) to increase adoption of video telehealth among mental health providers and promote patient-center mental healthcare delivery. PIVOT's guiding framework and multi-level communication pathways that involve health system leadership, clinicians, and patients allow for flexibility and rapid responses to the needs of providers and patients. We were able to quickly respond to the needs of our local and national partners in response to the COVID-19 pandemic. We were identified as rural consultants by national leadership, created a COVID-specific training for clinicians using VTH delivery, and provided recommendations on alternative technologies for VTH. Implementation of the PIVOT strategy years prior equipped our partners with the ability to also rapidly response to the changes in clinical practice due to COVID. Based on our experience developing PIVOT, we suggest adopting an implementation strategy that will allow you to address barriers specific to your practice and create a sustainable VTH program. We recommend starting small, involving experienced facilitators, and evaluating your implementation efforts using quantitative methods and qualitative feedback (Lindsay et al., 2019).

Lessons Learned and Clinical Considerations for Telemental Health

Our VTH implementation efforts have taught us many lessons that may be of interest to new VTH users or practitioners experiencing common VTH pitfalls. First, pre-existing tech savviness is not necessary for VTH use. Some patients may be fit candidates for VTH services once they overcome technological barriers. Practitioners may support them by providing limited technical help to overcome technological barriers to receiving mental health care. In the same vein, practitioners should be mindful of the language used to describe VTH, as their role as the provider may influence their patient's decision to engage with the VTH approach. Second, VTH is an excellent delivery tool to connect patients with specialized care in the absence of local providers with comparable expertise. Similarly, VTH lends itself to promoting continuity of care. Again, VTH can be used to help patients, especially those belonging to marginalized populations, overcome barriers that prevented them from receiving adequate mental health care. Fourth, VTH addresses the issue of stigma and allows patients to receive mental health care in a comfortable, natural environment that allows them to fully engage in treatment. Some forms of treatment, such as an exposure therapy, may particularly benefit from VTH delivery because it presents the possibility of in vivo experiments in a natural environment. Lastly, VTH might mitigate treatment-interfering behavior that occurs during in-person sessions. Although, it could also be

difficult to identify such behavior over VTH, given the lack of typical nonverbal cues, this can be managed with a collaborative therapeutic approach with patients (Hogan et al., 2019).

Recommendations for Clinical Practice

In response to the COVID-19 pandemic, we encourage you to consider implementing a VTH program to engage with patients in a way that goes far beyond what can be achieved by a phone call. We have conducted numerous qualitative interviews with patients who have received mental health treatment via VTH who enthusiastically endorse VTH and explicitly note the importance of being able to see their provider. Regulatory guidelines and federal mandates have been modified to facilitate use of VTH, making this an opportune time to explore how to incorporate it into regular practice and preferred videoconferencing and/or communication platforms. Not only is this pandemic likely to impact mental health, but it will likely widen mental and healthcare disparities. Learning to implement VTH is an effort towards increasing access to care for patients disproportionately at this time. We recommend the following for mental health professionals interested in using VTH or other forms of telemental health in their practice:

- Increase patient choice by regularly offering to deliver services by VTH, or consider a hybrid approach (in-person combined with VTH).
- To determine fit or eligibility for VTH, consider both patient- and practitioner-related factors, such as practitioner clinical expertise and the experience and resources of both patient and practitioner.
- Encourage patients who regularly experience barriers to receiving in-person mental health services to consider VTH as a delivery option.
- Consult with experienced implementation facilitators to develop a tailored VTH implementation approach.
- Get involved in a community of practice with other providers interested in or currently delivering mental health services by VTH.
- Develop an empirically based risk management plan.
- Become familiar with peripheral or assistive devices that patients with disabilities may need to receive services via VTH.

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Focus on Diversity

Eugenics in the Time of COVID-19

Krystal Stanley

Well, 2020 escalated quickly. The Spring 2020 IP was published on March 8th, and the week after that, many of us were preparing to quarantine in response to growing cases of COVID-19 in our communities. I spent the first couple of weeks of the quarantine preoccupied with transitioning my group practice from 100% in-person to 100% telehealth, and in the midst of that, I missed the memo that I also needed to be stockpiling enough food and toilet paper to last at least a month. It was surreal to encounter empty shelves at multiple grocery stores, and I anxiously ordered 60 rolls of toilet paper from Amazon.

As the initial dust started to settle on the quarantine, a variety of interesting sociocultural phenomena began to play out around COVID-19, body size, and race/ethnicity. Early into the quarantine, people began complaining on social media about their inability to control their eating while stuck at home with their snacks, and many memes about the "COVID-15" (similar to the "Freshman 15") began to circulate on the internet. This distress was seemingly exacerbated as gyms and fitness studios were ordered to close to facilitate social distancing (Brenan, 2020). An ABC News article entitled *Shelter in place does not mean shelter on the couch: How to stay healthy when COVID-19 sheltering* (Kumar, 2020) encouraged people to avoid unhealthy habits while quarantining, but made little to no mention of the psychological

toll of social distancing and how this might impact their habits. The title of Claudia Cortese's article about this is fitting: *Even during a Pandemic, Fatphobia Won't Take a Day Off* (2020).

Additionally, very early into the pandemic, as it became evident that there would likely not be enough ventilators to adequately treat all of the COVID-19 patients, there was scuttlebutt around preliminary guidelines about who might be prioritized to receive treatment, and the exclusionary criteria read like a eugenics playbook. Initially individuals with preexisting health conditions, older adults, individuals with disabilities, and people who are considered "obese" were among those who might be denied a ventilator if the choice had to be made between them and an otherwise healthy adult (Baker & Fink, 2020; Cha & McGinley, 2020; Stryker, 2020). Some of these state-specific guidelines have been modified or retracted in response to public outcry, particularly from disability and fat activists (Gardiner, 2020), but the damage was done: in this pandemic, some lives might be valued more than others.

Around the same time, "obesity" started to be mentioned more frequently in the media as a factor that exacerbated the symptoms of COVID-19. Although there is some preliminary and non-peer reviewed data that shows an association between higher BMI and severity of COVID-19 symptoms (Clopton, 2020; https://www.medicalnewstoday.com/articles/latest-evidence-on-obesity-and-covid-19), it is important to remember that association does not imply causation. I've written previously about how higher weight individuals often receive sub-par medical care due to weight-based stigma, and that they are more likely to avoid seeking medical treatment as a result (Stanley, 2019-2020). It would follow, then, that higher-weight individuals may be more likely to have untreated or undetected health conditions that might be impactful if they were to contract COVID-19.

Finally, several weeks into the pandemic, data showed that Black Americans were (are) disproportionately dying from COVID-19. For instance, I reside in Washington, DC, and as of May 11th, African-Americans die from COVID-19 at a rate 6 times higher than that of European-Americans, and data combining mortality rates across the country show African-Americans dying at a rate of 2.6 times higher than European-Americans (https://www.apmresearchlab.org/covid/deaths-by-race). While there are many sociopolitical reasons for this (e.g., access to healthcare, living and working conditions, etc; https://www.cdc.gov/socialdeterminants/index.htm), on Friday, April 10th the Surgeon General Jerome Adams made the following statement directed at African-Americans and other minority populations:

> "Do it for your abuela, do it for your granddaddy, do it for your big mama, do it for your pop pop. We need you to understand, especially in communities of color. We need you to step up and stop the spread so that we can protect those who are most vulnerable." (https://www.youtube.com/watch?v=54Phdg0UOYo)

Many were critical of the Surgeon General as this statement was perceived as condescending and did not address the many factors that might impact why Black Americans might be more likely to be exposed to, and die from, COVID-19.

Taken together, these incidents highlight our society's reinforcement of the myth of personal responsibility: that behaviors at the individual level are responsible for health and economic outcomes. While this myth has been debunked by the CDC (e.g., https://www.cdc.gov/socialdeterminants/index.htm), society and institutions continue to uphold this belief and treat individuals accordingly. My hope is that we as clinicians can be a safe space for our clients, especially those who are members of marginalized communities, and that we not reinforce this myth in our work with them during this very difficult time. Here are some questions to ponder for your work with clients:

- Have you confronted your own biases around the myth of personal responsibility?
- How will you address your clients' concerns about weight without reinforcing fatphobia?
- Will you honor the humanity of clients in marginalized communities as they navigate fears and concerns around COVID-19?

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Focus on Clinical Practice

Telepsychology: It's not the Wild West

Eileen A. Kohutis

Prior to COVID-19 pandemic, most psychologists had little experience with telepsychology even though the American Psychological Association (APA) developed guidelines for its use in 2013, Guidelines for the Practice of Telepsychology (2013). In fact, research in telepsychology, or telemental health or telemedicine has been going on since the 1950s. The pandemic has catapulted most of us into the world of telepsychology and telepsychology is more than just talking to patients using a telephone or camera on the computer. The Guidelines defined telepsychology as the "provision of psychological services using telecommunication technologies" (p. 792). The services may supplement traditional face-to-face in-person therapy sessions or may be stand-alone services and these technologies include all manner of electronic communications, such as telephone, email, internet, text, and videoconferencing. In this brief essay, I will provide a summary of a telepsychology program sponsored by

the APA, Telepsychology Best Practices: 101 https://apa.content.online/catalog/product.xhtml?eid=15132&eid=1921. Because of the amount of material presented in the webinar, I am only going to highlight certain aspects of the program. At the time of this issue, the program is free and, after passing the tests for each of the four tow-hour segments, the psychologist earns eight (8) Continuing Education (CE) credits. Because this is not like a face-to-face session, it is important that a psychologist receive training by attending webinars, taking live on-line courses, and reading to improve his or her level of comfort, efficacy, and competence with this method. In doing so, providers will feel better prepared for any unusual circumstance that may arise and will learn ways of engaging with their patients and maintaining the therapeutic relationship.

Telepsychology gives us the opportunity to provide services to both our pre-COVID-19, (current) patients and to maintain continuity of care, as well as to people (new patients) who might not be able to receive services due to geographic, financial, physical, or other barriers. To do so effectively, we need to assess each patient's appropriateness for telepsychology and comfort level with the technology.

The use of telepsychology requires many changes in how we do the business of psychotherapy. Because we do not have the same type of environmental control when working remotely (compared to when working in our offices), we need to alter our policies and forms accordingly. For instance, informed consent, along with confidentiality and privacy issues, need to be modified. A comprehensive assessment of the prospective patient needs to ascertain whether telepsychology is appropriate and whether or not the patient and psychologist feel comfortable with telepsychology. We also need to develop backup and safety plans for any unusual events that may occur and to have a list of relevant resources available to us. For example, if someone appears inebriated in our office, we have a plan. But, what about if someone uses a computer for their session and appears inebriated? What plan is in place? What about a situation where a person has told you of intimate partner violence and in mid-session, there is banging on that person's door? What would you do?

We also must monitor the therapeutic relationship because factors, such as the type of device on which the telepsychology is being conducted, band width, and camera, which are not present in a face-to-face in-person setting, can become obstacles. If a patient is speaking to the psychologist on a phone, that person's experience will be different than someone who can visually see the clinician. Similarly, if band width is slow, the psychologist will not be able to readily notice subtle body movements and affect in the patient. These types of misattunements can result in a patient feeling frustrated and not understood in treatment.

Some patients may not feel comfortable with telepsychology and it is not appropriate for every person. For example, people with have a history of acting out or who are chemically dependent may not be suitable candidates for this type of intervention. The psychologist treating a patient who chronically acts out will need to establish and maintain firm boundaries which would include having backup resources and possibly a collaborator who can assist with the treatment plan and call 911 if necessary. A person who has chemical dependency issues may similarly need a collaborator to help facilitate the treatment but the psychologist will need to have strategies in place to deal with potential triggers for that patient. On the other hand, a person who has a hoarding disorder has the opportunity to literally show the psychologist what his or her living conditions are so that the psychologist can develop a suitable course of action. In face-to-face treatment, unless that patient brought in photographs of the conditions, the psychologist could only surmise what they were like.

With all of the above considerations and questions in mind, I interviewed Marlene Maheu, Ph. D., one of leaders in telepsychology and also the presenter in *Telepsychology Best Practices: 101*.

I. Intimate Partner Violence.

I asked Dr. Maheu about handling a situation in which the client is a victim of intimate partner violence. She suggested that the psychologist have a list of protocols outlining what to do for such a circumstance in the "waiting room" of the software program through which telepsychology is offered and to review them with the person. To increase privacy, the client needs to wear ear buds so that other people cannot hear what is being asked. Dr. Maheu also suggested having a radio play in the background to act as a white noise machine. If the person was unable to speak privately or if something has happened to alter the privacy of the session, then the use of a codeword that was previously agreed upon by both the patient and the psychologist would be a signal to end the session. The psychologist could then call 911 to assist the patient and to ensure the safety of the patient.

II. Child Abuse Evaluations.

I asked Dr. Maheu about conducting child sexual abuse evaluations in the context of a child custody evaluation. She said that prior to doing so the situation needs to be carefully thought out and that in some instances, such as with young children, such an evaluation may not be possible. For example, one consideration is for the parent to pan the room where the interview will occur with the camera so that the psychologist can make certain no one else is in the room. When assured that no one else is present, the parent leaves the room and closes the door so that the interview with the child can begin. In the case of interviewing a young child, multiple cameras need to be set up so that the clinician can see the child's behavior because some children may not be able to sit still for long periods of time. When the interview is over, the psychologist calls the parent on the telephone to indicate that the session has ended.

III. Psychologist In-Session Presentation.

Working remotely means that we can work from home, but working from home does not absolve us from any of our professional responsibilities, including our style of dress. While it may be tempting to only look professional from head to waist, it is important that our clothing beneath the waist is also appropriate, as it is easy for other parts of our bodies or our home settings to come into view during any given session due to a shift in the position of our device or its camera. Likewise, the patient needs to be dressed appropriately for similar reasons. Because patients will be coming into our homes, our "office" needs to be set up appropriately. This includes having the proper lighting for both you and your patient so that it illuminates your face and your client's face rather than either one of you being in shadows. The angle of the camera needs to be set so that you can have a face-to-face interaction with the patient rather than looking as if you are asleep or inattentive because the camera is not at the right level. Fixing the camera angle may be remedied by simply placing a few books under the camera. Ensuring privacy for you and your patient may require nothing more than a sign on the door saying "quiet please." In other words, the psychologist needs to maintain the professional and environmental boundaries conducting a telepsychology session in the same way as in their own office.

IV. Practicing "Out of State."

Although telepsychology enables us to provide services to people not in our immediate geographic proximity, we need to be aware of practicing across state lines. It is important to know the laws for the state in which the psychologist is practicing, as well as for the state where the patient is. For example, a patient could be a resident of Kentucky, but now "sheltered in" in Indiana. While we are in this pandemic, many states have relaxed their licensing laws and allow us to see people who live in another state. It is unknown whether the states will keep this policy in effect when the pandemic is over or how it will change.

V. Use of Social Media.

Dr. Maheu said that most licensing board complaints are due to purported professional boundary violations. These violations can come from what the psychologist has posted personal information on various social media

platforms, such as linking your personal *Facebook* page linked to your business *Facebook* page. Likewise, sending a text message to a patient with an emoticon in it could raise questions about if/how emoticons are good practice. These "cutesy text messages" with patients are typically considered professional boundary violations.

VI. HIPAA Compliance

Because telepsychology is technology-dependent, we need to be certain that the technology we use is HIPAA-compliant. Many of the pre-installed apps on our smart devices are not HIPAA-compliant and neither are most text messages. It is incumbent on the psychologist get a Business Associate Agreement (BAA) from each vendor because protected patient information could be shared between you and your patient. Some free email programs, such as Gmail, Outlook, and Yahoo are not secure but a paid version, such as GSuite and Office 365 may be if the psychologist gets a signed BAA. Encryption is required in transmitting patient information and vendors offering BAAs will explain the encryption method.

VII. The Business of Telepsychology.

Telepsychology is becoming a business venture. Companies such as *Google*, *Amazon*, *Walgreens*, and *Facebook* offer psychological services, but who is actually providing the clinical service? What is the level of education and training of the providers in those companies? While it may be tempting for a psychologist to consider signing up to be a provider for one of these businesses, the clinician must find out what is involved and to fully understand professional/clinical expectations, as well as what the professional liability is for the psychologist. Further, it is likely that each company's agreement is different. Most importantly, the psychologist needs to check with their malpractice carrier before venturing into this endeavor and checking with your own state's licensing board regulations to make certain that you are practicing within the law. Your state's professional association may also have information about clinical, ethical, and legal responsibilities as well as risks for you to consider. For example, you may be licensed to practice in Kansas, but if you enter into an agreement with one of these companies and a caller is from England, are you covered for international practice? Checking these businesses needs to include your thoroughly vetting them.

Closing Remarks

COVID-19 is drastically and dramatically changing how most of us practice, in particular launching us into the world of telepsychology. Exciting as telepsychology may be as a viable option for clinical services during this time of COVID-19 (and otherwise), it is not without its own limitations. The prudent psychologist who wants to pursue telepsychology needs to weigh all the options to make an informed decision about its suitability for his or her own practice. I also strongly recommend the APA's CE program on telepsychology as a starting point.

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Focus on Early Career Professionals

Staycation: How to Vacation During the Era of COVID-19

Tori K. Knox-Rice, Lucas Zullo & Mona A. Robbins

As we navigate through all of the recent societal and professional changes associated with the novel COVID-19 virus, we must consider our own self-care in order to adequately cope with the demands of ongoing stress. This commentary evolved from discussing the concept of vacationing and the guilt so many can feel from taking time for themselves. Our current ability to travel may be limited, but the importance of taking time off remains.

One of the first topics discussed during any initial intake session with a new patient is to screen for how much they prioritize their own self-care. This can include issues such as whether a patient has a healthy sleep routine, a strong social support system, or engages in pleasurable activities. During times such as the current one, it may be beneficial to pause and ask ourselves the same questions. We have the professional training to quickly assess for key risk and protective factors, but when was the last time you used those skills to take stock of your own well-being? We, just like our patients, need to engage in self-care and this will probably look different now due to the present social distancing guidelines. Some of us might even feel like it's time for a much needed vacation now! While it may not be feasible to physically get away right now, a staycation, an at-home vacation experience, may be an unexpectedly rejuvenating alternative.

It goes without saying that as mental health care providers, we are especially aware of the importance of helping our patients avoid burnout. The academic literature even indicates a relationship between a period of overwork and impaired cognitive functioning and physical illness (Dembe et al., 2005; Virtanen et al., 2009). Therefore, one might assume that clinicians would be adept at monitoring their own levels of burnout and take the necessary time to rest and recharge as needed. However, many mental health care providers instead struggle to apply the same recommendations to themselves for a variety of reasons.

What Stops Us From Taking Time Off?

In 2018 the U.S. Travel Association began an initiative titled "Project: Time Off" to learn more about how vacation days are utilized in the United States. A report documenting vacation days used in 2016 indicated that workers sampled from diverse careers forfeited 206 million vacation days, totaling $66.4 billion in benefits (The State of American Vacation,

2017), demonstrating that this phenomenon is widespread across professions. Another source described top reported barriers to taking time off including fears of "feeling guilty using time off," "no one else can do the job," and "want to show complete dedication" (The Tethered Vacation, 2017). Each of these reasons are relevant to clinicians in different ways.

Feeling Guilty Using Time Off - Nowadays there is a cultural expectation to be available for work-related emails or texts on a 24/7 basis, and the field of mental health is no exception. In a clinical setting, there will undoubtedly be emails and texts sent after the working day has concluded and it will be up to you as to when they will be addressed. This is compounded significantly when the question is not whether to wait until the start of tomorrow's work day but whether to wait until the end of one's vacation, which may be several days. There might be fears of how going on a vacation may be viewed by one's coworkers or supervisor or even how this time away might impact one's self-image as a competent professional. This concern is especially relevant to the current need to work from home, as we establish the boundary of when the work day ends and we instead turn to investing energy in leisure activities.

No One Else Can Do the Job - One of the joys of clinical work is being able to get to know your patients, establishing a strong rapport, and working together on building a life worth living. For example, patients may seek out clinical care instead of just reading a self-help book, because they want the regular human interaction and personalized treatment that comes with establishing care with a mental health care provider. By going on vacation for a period of time (whether that be a staycation or a travel vacation), some clinicians may think they are abandoning their patients. Even when ensuring that a trusted colleague is available to your patients in the event of an emergency, there may still be the fear that it will not be enough because of all the time that has been spent on developing a therapeutic relationship, which may impact clinical decisions made in your absence.

Although this line of logic comes from a place of concern and may even have an element of truth, it also runs the risk of "fragilizing" your patients. This concept is a core part of Dialectical Behavioral Therapy and emphasizes the importance of being aware of any urges to become over-involved in a patient's care that may hinder their progress towards healthy independence (Linehan, 1993). As a key tenet of any evidence-based therapy is eventual termination of treatment, it is by no means unreasonable to place patients in a situation where their primary clinician is unavailable for a temporary amount of time. In fact, a clinician's vacation may be a catalyst for unexpected growth on the patient's behalf as they practice implementing lessons from therapy on their own.

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Want to Show Complete Dedication - While the fears already outlined primarily stem from the pressure a clinician places on themselves around a vacation, there also may be consideration of a patient's reaction. Particularly demanding patients with complex cases may add tension to the idea of a clinician taking time off. There are patients who may have difficulty viewing the clinician as an actual person with their own life and needs; these patients may make inappropriate and hurtful comments when informed about a provider going on vacation. In these instances, a clinician may feel compelled that they always must be available to provide care, despite potential burnout, with belief that this sacrifice comes with the "territory." When taken to extreme length, a clinician might internalize that the ultimate form of dedication to patient care is to neglect one's own needs in order to ensure uninterrupted clinical availability. Each of these barriers are reasonable, just as each can be questioned or even revisited when considering the benefits that time away from work can have on overall wellness and productivity.

The Vacation Effect

The physical and mental health benefits of taking a vacation have been identified and are well documented within the field of occupational health (De Bloom et al, 2009; De Bloom et al, 2010). These benefits can be physical, emotional, or directly related to life satisfaction and improved productivity at work (De Bloom et al, 2009). Some evidence indicates that the effect of taking time off endures for several weeks to a month post-vacation (Kühnel & Sonnentag, 2011). A core component of what allows vacations to have such beneficial effects is the opportunity for mental and physical recovery. Without recovery periods, our ability to continue performing at high levels diminishes significantly. Recovery during non-work hours is a crucial defense against job stress. Although it may seem possible to obtain enough recovery during non-work periods (e.g., evenings after work, weekends) to justify avoiding or postponing a vacation, some research has shown recovery to be insufficient in short spans of time (Fritz & Sonnentag, 2005).

A Case for Staycations

The COVID-19 pandemic has created the need for adjustment. It can be overwhelming to keep up with all the new information, altered work schedules, and the need to care for yourself and your family (e.g., distance learning, homeschooling) in new and different ways. There is no better time to reap the benefits of a vacation while in the safety of your own home environment. As the name would suggest, a *staycation* refers to a stay-at-home vacation experience; the act of engaging in leisure activities at home in lieu of traveling for enjoyment. This option can be chosen for a number of reasons, in addition to a social distancing mandate, which may be associated with more time at home or away from others. Staycations are much cheaper than traveling and have the added benefit of coming with no travel-related stress. The risks of vacationing at home are low, especially since you remain in a familiar environment.

It is entirely understandable if the immediate reaction to the term "staycation" is not one of excitement. The word itself does not fully align with the common image of what a vacation "should" be. However, we highlight that the key components of what makes a vacation exciting can still be obtained at home or in your neighborhood, while also effectively avoiding potential stress related to the act of traveling.

Planning for a Home Vacation

So, you've decided to try a staycation, but how do you do it and obtain all the positive benefits? Vacations and travel offer us the opportunity to detach from work, recharge, and utilize our downtime to the best of our abilities. At home, it is easy to be overwhelmed by the compulsion to remain "plugged in" to work demands, making us susceptible to maintaining the same level of stress we experienced while working. This is especially true if/when online working from home is becoming the "new normal," making the need for a "digital detox" all the more apparent.

As technology continues to evolve and become a staple in our daily life, more studies point to the importance of unplugging (Derks & Bakker,

2014). Whether instilled in us through organizational expectations or personally developed over time, we are often compelled to respond to work-related messages even during leisure time. Given that there is a strong link between work demands interfering with home life and symptoms of burnout (Derks & Bakker, 2014), this blurred distinction between professional and private time would benefit from being more clearly defined when working from home and while on a staycation.

If you are able to successfully adhere to the idea that staycations should be treated as a vacation, it also remains important to plan how you intend to spend your time. Some evidence points to poor planning as a contributor to stressful vacations and reduced positive effects (Achor, 2014). It is, therefore, likely that the less stress there is in planning a vacation, the greater likelihood there is for a positive benefit. This principal presumably holds true for staycations as well. Being able to savor a well-planned break, regardless of the location, offers a much-needed respite from routine and schedules, ultimately benefitting our mental health and work performance.

Tips for A First Time Staycation

There is no "one size fits all" approach to taking time off. What one person finds relaxing and reinvigorating may be unappealing to others. The mere act of planning for relaxation has been associated with reduced stress (Etzion, 2019). Match your plan with your personal preference for what feels restorative and fits with the available resources. If you're still struggling to find a way to embrace the staycation frame of mind, we provide the following suggestions for a first-time staycation:

Avoid Social Comparisons. At the end of the day, if you are relaxed and enjoying yourself, you are on a vacation.

Reorganize & Reset. Part of a staycation can involve planning for an easy return to work. Returning to high work demands after vacation has been shown to eliminate positive vacation effects and quickly reverse the recovery gains made (Kühnel, & Sonnentag, 2011). Preparing to gently ease back into work, and preventing overwhelming workloads, is an excellent use of some of your staycation time.

Find Ways to Engage Your Mind. Learning and experiencing new things can be an excellent way to utilize free time. Completing puzzles, finishing books that have been stranded on a bookshelf for ages, or engaging in non-passive activities (e.g. crafts, cooking, learning a new skill) are all great ways to stimulate the mind during downtime.

Change Your Routine. Being stuck at home makes it easy to fall into patterns typical in your daily life. Finding a way to get out of your usual schedule is what sets a staycation apart from merely being stuck at home. Don't be afraid to stay up late to finish an enjoyable project or television show or skip an early breakfast in favor of a mid-morning brunch.

Get Active. You may not be able to go scuba diving in paradise, but it's possible to find a way to get the blood pumping from home. Take a moment to download a new fitness app, browse *YouTube* for online workouts, or even get creative with outdoor activities. Now may be the time to go on runs more regularly or even finally learn how to ride a bike.

Don't Overdo It. Much like a travel vacation, your downtime can begin to feel more like work when you feel driven to overdo your involvement. The goal is to relax and recharge. If what you're doing isn't taking you one step closer to that goal, it might be worthwhile to rethink things.

Final Thoughts

Reframing is a basic skill in our line of work, and it is something that can be directly applied to the idea of going on a staycation. A staycation can be successful if you are able to adjust your perceptions and preexisting assumptions of what a vacation *should* look like. Think about your own judgements that come up when considering a vacation at home. For many, a staycation may be synonymous with a period of laziness occurring in the home. Being in a new environment is often where the thrill of vacationing comes from; thus, the challenge in planning a staycation then becomes bringing new aspects into a space typically governed by standard routines. Find a way to add a twist to what has become mundane or to entirely reinvent what is possible at home. Frame your staycation as an intentional recovery period rather than a "lesser" alternative to taking a trip away from home.

And, if you decide to continue working in some capacity while on break, it is important to recognize how quickly habits can return. Decide in advance how much you will work, set boundaries, and stick to them. Maintaining a firm work barrier can further boost the feeling of a true vacation.

Improving our health, increasing motivation, and lifting away daily life stressors are the primary intended goals of taking time off. In order to avoid the effects of stress and burnout, taking time to recharge is essential. Being able to "switch off" does not have to include a tedious, albeit lovingly constructed, vacation plan with travel and hotel stay. All we need is a break that keeps us refreshed and better able to manage the daily grind. If we can achieve this at home during a time when a vacation is most likely needed more than ever, why not try?

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Focus on Risk Management

More thoughts on Psychotherapist – Patient Privilege

David Shapiro

In a previous column, I had addressed the need to maintain a separation between clinical and forensic work with the same client or patient. I had alluded to, but not fully discussed the breadth of attorney client privilege and the fact that psychotherapist patient privilege has far more exceptions.

A frequent exception to privilege is sometimes referred to as the "patient as plaintiff " exception. This one has several very interesting wrinkles; for that reason I will discuss this exception to privilege in a fair amount of detail. Generally, if you are treating a patient who has "put their mental state into litigation," in other words, has sued someone for mental or emotional damages, your records may not be as private as you think. Frequently, this suit represents a waiver of the psychotherapist patient privilege, though the waiver often is limited to records that are relevant to the litigation; the problem, of course, is what is relevant to the litigation? The plaintiff, of course, will see only the symptoms that have developed subsequent to the accident or injury as "relevant", while the opposition (the defense in civil cases) may see the patient's entire life history as relevant, since there may well have been treatment in the past for some mental or emotional disorder. By bringing out that history, the defense might seek to "cut their losses" arguing that the patient's current mental condition is due primarily to pre-existing problems rather than to the current accident or injury, and that, at most, the current symptoms only represent a slight exaggeration of previous symptoms. Ultimately, it is up to the judge to determine what, if any, aspects of prior treatment history may be admitted. While a therapist may seek to quash the subpoena, once there is a court order, the therapist needs to follow it.The therapist and/or patient may need to carry the burden of proving why the past material is unrelated. Courts will often "bend over backwards" to admit any material that has potential evidentiary value.

Of note is the fact that you may need to reveal records only if the patient has put their mental state into litigation. If they have not, you have no need to disclose the records. It would be prudent, then at the outset of treatment to find out whether the patient is involved in litigation, and, if so, let them know, as part of the informed consent, that their records may be legally discoverable, and obtain their voluntary consent to that fact. Some psychologists have been sanctioned by state licensing boards for failure to obtain such consent, or obtain a court order before releasing the records. On some occasions, you may receive a subpoena for the records of a patient , and, especially if you are no longer seeing the patient, you do not know whether or not they are in litigation regarding their mental state. In such cases, it is recommended that you request, from the party who issued the subpoena, a copy of the pleadings, to make sure that they had indeed put their mental state into litigation. If they had not, there is no justification for revealing the records. You may wonder how your name even came up. On some occasions, the plaintiff, in interrogatories (questions asked by opposing counsel) will be asked a broad question such as "list the names of all health care providers you have seen in the past ten years", and your name may come up, even though your treatment had nothing to do with the accident or injury.

In summary, when confronted with a situation when you receive such a request for records, consider your possible responses carefully; If you had not previously discussed the possible disclosure with the patient, be sure to do so now; of course, be sure to consult with an attorney skilled in these mental health/legal issues when uncertainties arise.

This is just one of the areas that need to be understood regarding waiver of psychotherapist-patient privilege; I will cover others in future columns.

Opinions and Policy

A Pessimist Sees the Difficulty in Every Opportunity

Pat DeLeon

The Chinese word for crisis – *wēijī* – is composed of two characters that have often been described as signifying 'danger' and 'opportunity.' While some scholars argue that this interpretation may not be linguistically accurate, the notion is certainly consistent with my experiences over the last month since attending the inspiring APA Practice Leadership Conference (PLC). Like many other State Psychological Associations, the Hawai'i Psychological Association (HPA) has been scrambling to respond to the varied and tremendous impacts the COVID-19 pandemic is having on our communities, our association members and the practice of psychology. In addition to the tremendous stress that exploited the vulnerabilities of our medical system, Hawaii is turning out to be the #2 most economically impacted state as a result of the pandemic.

"In response, HPA has launched a statewide pro bono program to provide services to those who have been financially impacted by the loss of jobs and insurance coverage. We offer stress management and support services to all healthcare professionals in the State. HPA psychologists are regularly on the evening news providing practical guidance to individuals and families on a wide range of relationship and mental health issues affected by the pandemic. In addition to changes mandated at the federal level, we have advocated for local insurance company expansion of telehealth services and, with the assistance of APA's Jared Skillings, Deborah Baker and others, we have made significant inroads in this area. Our Association listserv has had a tenfold increase in postings, many related to the do's and don'ts of providing telehealth services. Our efforts are also being recognized and promoted at the highest levels of our state government.

"Last week, in the midst of all this, HPA held an all-day workshop. When it was originally scheduled at the beginning of the year, participants were offered the option of attending on-site or remotely via webinar. Approximate-

ly 60% signed up to attend on-site. When the COVID-19 pandemic made it unsafe to hold the event in this manner, we considered canceling the event but, instead, shifted all on-site attendees to the webinar format. Given that some may have found the thought of six hours on the computer – looking at slides and a talking head – to be too much to handle, we offered full refunds to those who did not wish to participate. To our surprise, not a single on-site registrant cancelled when we moved the program to web only. With full membership participation and funds recouped by not needing a hotel venue or food, a potential financial disaster for the Association was averted.

"In the last month, I've seen our psychology community come together like never before and with it comes positive change, both big and small. Were it not for current crisis, it may have taken another 5-10 years to get the same number of psychologists to embrace telehealth as a viable treatment modality. Without our collective efforts, insurance companies would not be nearly as open to expanding their telehealth coverage. It likely would have taken the better part of a year, rather than two weeks, to launch our pro bono program. We have received more requests for TV appearances in the last two weeks than we did the previous 12 months. As former APA President Phil Zimbardo notes, we look to do whatever is needed during times of crisis and, at the same time, cannot help but demonstrate how and why psychology makes a difference" (Ray Folen, HPA Executive Director).

Reflections from the Past: "My Presidency of APA was a challenging time, a tumultuous time, but most of all; it was a terrific time in my life. Why challenging? After a rather intense period of actively campaigning for this position, I won the prize, but then realized I had no experience at all presiding over the huge organization that APA is! There are tens of thousands of members around the world, and an in-house staff of more than 500 people. I had to head a Board of Directors, orchestrate meetings of our large Council of Representatives of over 50 distinct divisions, be the liaison with other national and international organizations, oversee APA's substantial publishing empire, write monthly columns for *The Monitor On Psychology*, and soon to help plan my 2002 APA convention in Chicago. Feeling overwhelmed? Understatement!

"To make my situation even more difficult was the fact that I had no prior involvement in APA organizational affairs, never having been a council member nor even served on any APA committees. Because of my lack of prior organizational commitment there was a lot of resentment expressed in various ways against my being APA's new President. That negativity was especially strong from the leaders of several clinical divisions, who felt that my focus on promoting education and science would not recognize or promote adequately the contributions of clinical psychology.

"I appreciated those positions and actively worked to change those views by espousing new collaborations of science and clinical practice, as well as seeking mentorship from APA seniors, CEO Ray Fowler, and former President Pat DeLeon, who was politically savvy, from his usual job as chief aide to Hawaii Senator Inouye. Ray took me under his broad wing with wise advice about first observing what my predecessor did right and not OK, who might be allies, and who would be foes, and how to win friends with the staff that held power, unobtrusively.

"My first attempt to warm some clinical hearts was by means of working with key members of Div. 42, Psychologists in Private Practice, notably Elaine Rodino, to collaborate on creating an attractive, informative public service brochure on *Painful Shyness in Adolescents and Adults*. One bit of clear advice throughout was, 'Talk to Someone Who Can Help.' It also outlined how psychologists can help with this and other problematic behaviors. It also linked up to the Shyness Clinic and Institute that I had founded earlier at Stanford University with Lynne Henderson. The 8-page fold out brochure was widely disseminated to schools and clinics around the nation.

"Another challenge my first year on the job was dealing with the fatigue from cross-country all-night flights from my home in San Francisco to Washington, D.C. I had to go from my Stanford teaching a large lecture, late afternoon course on 'The Psychology of Mind Control' to an early morning Board meeting, and seem fresh and alert, all day long since, as the new kid on the block, I was under scrutiny by my new colleagues.

"Why Tumultuous? On September 11, 2001, America was shown vulnerable to terrorist attacks, as we all experienced vividly via TV portrayals of two commercial airliners being ballistic missiles exploding the World Trade Towers. Terrorism had hit the home front, creating new fears and spreading anxiety far and wide throughout the nation. The first NY Fire Department on the scene was from Brooklyn Heights coming over directly across the Brooklyn Bridge into downtown Manhattan. However, the collapsing building destroyed its engine and killed nine of its firemen; among the 343 who died in the collapse of the twin towers. I sprung into action to visit first that fire station, talking with its Chief, and then with the Superintendent of the Brooklyn Fire Department about setting up free counseling services for these first responders and their families. With the help of local therapists, Ellen McGrath and her husband Harry Wexler, I organized a series of counseling teams involving a number of resident clinical psychologists and psychiatrists who agreed to offer extended services pro bono. I spent time getting to know one young fireman, Richie Murray, who arranged for our visit to 'the Pile,' the debris-strewn mound at Ground Zero. I later arranged to honor those fallen heroes by having Richie accept an APA award at our Chicago convention on behalf of his buddies, living and deceased heroes. The prevailing fear of flying among psychologists reduced attendance at that convention by almost 50% from usual numbers, despite our energetic attempts at promoting the uniqueness of Chicago-2002.

"In addition to actively promoting and funding an APA task force on the prevention of terrorism, I subsequently founded and presided over a new non-profit foundation (along with Jim Breckenridge) which was named the *Center for Interdisciplinary Policy, Education and Research on Terrorism*, or CIPERT for short.

"The next tumult, on a less dramatic level, was the unexpected resignation of Ray Fowler from his long-held CEO post. That meant I had to set up a search committee for his successor, help hire an executive search agency, and fly to Washington repeatedly for personal interviews with candidates in that pre-Skype era. After a number of months of frantic activities, we were able to hire the most outstanding candidate, Norman Anderson. Not only was Norm the first African American CEO of APA, he proved to be a gifted administrator over the fourteen years that he presided over our organization.

"Why Terrific? In retrospect, my total engagement with APA during my Presidential tenure is best described as 'terrific.' I was able to make many new friends, create a new positive social-motional climate among APA staff, influence policy in part by sharing original ideas in my monthly columns in the *Monitor*, and also impact operations and new agendas through my ideas and actions on the Board of Directors (BOD) and Council of Representatives (COR). Let me briefly outline what I did that I think made a difference, locally and globally, some passing and many enduring.

"At Board of Directors meetings in the main APA office, staff usually sat at one end of the large table and board members sat down the other end. I changed that by having everyone sit in alternate places so as to create a more unified team/family feeling. At the first Council of Representatives meeting, I encouraged each of the hundred plus delegates to give a personal introduction and their main goal in representing their division or program. On each of my monthly visits to APA central, I arranged for all staff to learn more about basic psychology via my brief lunch time lecture accompanying showing some of my *Discovering Psychology* videos, along with Q & A, and, of course, with hot popcorn and crackerjacks. I also introduced the senior staff to the joys of TGIF by hosting a wine and cheese tasting after work Friday afternoons (supplying fine wines from California, Italy, and France).

I loved writing the monthly *Monitor* columns because unlike traditional academic publishing, they don't get rejected or must be revised and resubmitted, they are just accepted as is. So, I was able to use that forum to present a number of ideas that had been percolating about what psychologists should be doing differently as well as how we can promote the importance of psychology for our society. In rereading those columns for this reflection, the following themes emerged:

- Be passionate and proud about psychology;
- We need to demonstrate how and why psychology makes a significant difference in our lives;
- It is vital for us to show how psychology, its science and applications, improves the quality of lives of people, organizations, communities, and education;
- We need to work with the media more productively to help us give away the best of psychology to the general public;
- My love affair with going to psychology conventions, regional, national and international, since my first one as a student in 1954;
- Highlighting the super convention I was preparing for Chicago, August, 2002, that included *The Second City* Improv comedy group doing parodies of famous psychologists, storyteller Studs Terkle accompanied by folk singers, and dynamic superstar lectures by Dean Ornish, Gail Sheehy, and the young *Tipping Point* author Malcolm Gladwell, along with a dozen of the top psychologist stars, senior friends like Marty Seligman and upcoming ones like Jonathan Haidt.
- "In reviewing the minutes of the two COR sessions I presided over during the 2002
- Presidency, the following contributions stand out for me:
- I added the word 'education' to APA's mission statement, along with promoting health and human welfare;
- Endorsed full participation and recognition of the role and importance of women in psychology by ensuring that women are treated equally as members of the psychology community, and that access to all human resources in psychology be fully actualized for them;
- Promoted support for funding for teachers of psychology in the secondary schools TOPPS;
- Supported the role of the graduate student association, APAGS, both at COR and, with a seat at the table of the Board of Directors;
- Increased media staff in scientific writing;
- Increased the Science Directorate public policy staff;
- Enhanced diversity in all aspects of our psychological profession;
- Encouraging greater awareness of culture and gender in International Psychology;
- Supporting funding for the Archives of the History of Psychology;
- Supported APA journal editors to enhance dissemination of psychological knowledge to the public;
- Supported APA's commitment to full utilization of the representation of the diversity in our culture by gender, race, and ethnicity in improving children's mental health.

"Finally, during my Presidential term, I was also actively involved in the meetings of the *Council of Scientific Society Presidents, CSPP*, held quarterly in Washington, DC, with a combination of exciting lectures, debates, workshops and visits to Congress to appeal for more funding for scientific and science education. Apparently, my presentations and involvement in fund-raising efforts led the majority of members to elect me to be its Chair for a two-year period, under Marty Apple's Presidency. So as my APA term of office ended, I headed this mega organization of 150 scientific disciplines representing over 1.4 million members! To make this final memory even sweeter, I received the CSSP *Carl Sagan Award for Public Appreciation of Science* (2002).

"The 2002 APA Chicago Convention: I did all in my power to make this event unique in the memory of all the members who overcame their fears to attend. Briefly, I'll highlight a few special experiences:

- Our convention opened with the Black Gospel Choir singers from the Chicago Baptist Church with prayers for the departed victims of the terrorist attack;
- A Scottish bagpiper marched down the aisle playing a familiar melody of sadness and survival;
- A Brooklyn Fire Department hero, Richie Murray, who was my guest of honor, followed the piper onto the stage;
- After my opening greetings and State of the Union address, I conducted an onstage conversation with Studs Terkel, Chicago raconteur known as the voice of the working-class Americans;
- A lighter note was provided by Chicago's Second City comedy team, who had teamed up with me earlier to find some comic ways to challenge many of our leading psychologists in the audience;
- I ended by highlighting special presentations of my invited speakers in the President's Corner: Malcolm Gladwell, Bob Cialdini, Christina Maslach, Robert Sternberg, and, of course, me;
- I also added for the first time a closing ceremony that included a video montage of the highlights of the 2002 convention in the anticipation of the 2003 convention to be headed by our new President Robert Sternberg;
- We all exited to a wine and cheese reception and made our farewells with a 'safe travels' postscript" (Phil Zimbardo).

"An optimist sees the opportunity in every difficulty" (Winston Churchill). Aloha,

Pat DeLeon, former APA President – Division 42 – May, 2020

Good Books!

Read any good books, lately? Was it engaging? Or old wine in a new bottle? Was the book about a new technique? Ground-breaking? A big yawn? We, at the IP, would love to know what you thought about it. Why not write a book review?

For more information, contact Eileen A. Kohutis at eileen@drkohutis.com.

Stay up to date with the latest changes to the Annual APA 2020 conference.
Go to:
https://division42.org/news/division-42-at-the-2020-apa-convention/

The Community for Psychologists in Independent Practice
WWW.DIVISION42.ORG

New Member Resource Area on Division website

Do you have a favorite Form, or practice Template that you would like to share with your colleagues. How about an online resource that you frequently utilize?

You are invited to contribute forms, templates and other documents to share with colleagues, and to download documents that others have contributed.

You are also invited to submit annotated links of books, movies, TV series and other media that you have found helpful in your work, or that you have enjoyed in your leisure time.

If you would like to share a resource or take advantage of what others have shared, log in to the Division website and go to the Member Resource page under the Resources tab.

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