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Review Article

Clinical Psychology and the New Technological Challenges After Covid-19

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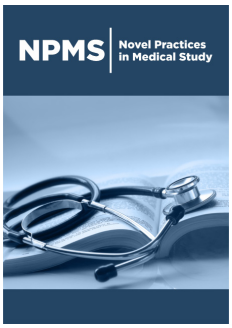

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Abstract

We reflect on the current challenges of clinical psychology practice through a theoretical review of crucial dimensions (e.g., therapeutic relationships, multidisciplinary teams, and the challenges of new technologies in clinical psychology), highlighting the effects and obstacles created by the COVID-19 pandemic. Mental Health has been widely influenced and impacted by the pandemic creating a need for new ways to connect clients and therapists. New technologies have effectively changed how therapists communicate and engage with their clients, with new forms of therapy emerging (through online platforms, for example). However, there is a growing concern regarding their use and effect on clinical psychological practice. Will new technologies create a world where some form of artificial technology replaces therapist? Will face-to-face therapy become obsolete? How can we move forward without compromising critical elements of in-person therapy? We reflect on the scope of clinical psychology and the use of new technologies to complement current practices. We advocate for the intended use of these technologies without compromising the benefits of an interpersonal and therapeutic connection.

Keywords: Clinical observation; Multidisciplinary teams; Therapeutic relationship; Challenges of clinical psychology

Definition of Clinical Psychology

Clinical psychology is a topic involving theory, research, and practice. It has been dynamically maturating since the 18th/19th century [1]. In contrast to strictly academic areas, the scope of clinical psychology is determined by simultaneously solving research problems and promoting educational and practical tasks. The scientific level of clinical psychology is conditioned by developing the clinical psychologist's theory and conducting modern empirical research. This engagement can guarantee the quality of putting into action scientific knowledge in various forms of social practice aimed at solving health problems and minoring mental disorders of people, groups, and communities. Clinical observation is one of the most frequently used methods in clinical psychological diagnosis. Using this method, the therapist attempts to objectively and systematically register the client's nonverbal behaviour at the moment of its occurrence, drawing inferences about their mental state based on a specific theoretical framework. Clinical observation is formalized and divided into different phases of data collection, records, analysis and interpretation, according to the type of observation employed. Clinical observation as a tool for "diagnosis" includes several techniques that distinguish behavioural observation from itself. In this sense, clinical observation applied in a therapeutic setting goes beyond simple behaviour observation and is only effective when supported by a psychological theory. According to Stephen [2], what distinguishes professional psychological observation from non-professional observation is the scientific knowledge and the principles and instruments used.

A person from the environment carries out participant observation, while a trained supervisor carries out non-participant observation. Usually, it is impossible to obtain an overall record of the behaviour, so the researcher determines the observation periods. These can be regular or random periods and samples of events or situational ones. When performing clinical observation, four groups of indicators must be considered: i) constitutional indicators, ii) physiological indicators, iii) behavioural indicators and iv) objective indicators [3]. Concerning the first ones, constitutional indicators are related to body structure, visible disproportions, and various forms of disability. Physiological indicators are externally observable and correlate with symptoms of emotional states. Behavioural indicators are external expressions of behaviours directly linked to observable characteristics of the communication process, like observing specific body language movements. Objective indicators pay attention to how a person displays themselves and the items that help them, such as self-presentation, make-up, and outfit. Even the entrance into a room can be a source of important diagnostic information. On the other hand, the person may lack conscious reflection regarding the first impression and may entail errors of interpretation resulting from unconscious attitudes. To further increase observation methods' usefulness, accuracy and reliability, psychologists need more updated observational systems framed into objective and measurable methodologies.

Evolution and Challenges for the Clinical Psychologist

Clinical psychologists in multidisciplinary teams

Multidisciplinary Teams (MDT) are emerging because of a growing consensus on the need to intervene holistically to help heal people's suffering. Because each case is unique and complex, requiring knowledge from multiple disciplines, psychologists have discovered ways to improve their response by utilizing Multidisciplinary Teams. These teams are composed of professionals who, according to their area of expertise, approach different parts of the problem to achieve a common goal: improving their mental state. The professional literature strongly recommends MDT in mental health care, and policy documents have been elaborated since 1994 [4]. The literature on the topic of MDT in mental health highly recommends a biopsychosocial model of mental health that entails person-centred services adapted to the needs of individuals performed by a range of skilled professionals, delivering integrated care plans. The role of clinical psychologists in these circumstances usually is to perform in-depth assessments of brain functioning, behaviour aspects as well as psychological functioning (i.e., personality or intellectual functioning). The biopsychosocial model views health and illness as the product of a combination of factors, including biological characteristics (e.g., genetic predisposition), behavioural factors (e.g., lifestyle, stress, health beliefs) and social conditions (e.g., cultural influences, family relationships and social support)." Overall, the biopsychosocial model reflects the belief that biological, psychological, and social factors interact to maintain or cause illness in a systemic or interdependent manner.

This approach (biopsychosocial paradigm) has gained universal acceptance, with the World Health Organization endorsing and adopting it [5,6] Psychological ways of critical thinking can be precious in teams. Psychologists can provide a different perspective and identify aspects of patient care that medical professionals may overlook. They can offer alternative hypotheses which can enlighten and guide the care planning intervention, which is very important in this holistic perspective. According to Wood et al. [7], psychologists are valued, multidisciplinary team members. They must, however, ensure that they are fully integrated into their teams, are accessible, regularly promote their skills, educate team members on the role of psychology, and improve dialogue with the team. Indeed, Psychology is seen by MDT members as an integral piece but has yet to be seen as a first-line treatment option in the psychiatric inpatient setting. In the abovementioned paper, the authors state that multidisciplinary staff participants valued direct and indirect work. However, the multidisciplinary team needs to understand psychology's role clearly, and education and dialogue about this role are required. In the context of MDT, psychologists deliver psychological interventions based on scientific evidence to patients in individual or group settings. They support and promote the development of patients' insight and understanding in the context of their symptoms. The patient is also educated about developing healthy coping strategies [7].

Another critical role of the psychologist is supporting the staff team. MDT's strength is made in the diversity of members and their interaction, which enables MDT to achieve its full potential. It is crucial and beneficial to patients. In Belgium, in the case of oncology, for example, the multidisciplinary approach is mandatory and regulated by law. The basis is the evidence-based aim of collaborative and multidisciplinary decision-making for cancer treatment and patient management. The Cancer Plan from 2008 [8] included a specific group of clinical psychologists specializing in oncology (psych oncologists). This study in Belgium supports that MDT is the best-known practice so far in the management and decision-making of cancer patients [8]. Multidisciplinary Team Members are surgeons, medical oncologists, organ specialists, radiologists, pathologists, oncology specialist nurses, and psychologists. Psychologists focus on psychosocial aspects in treatment decisions, which are essential to the treatment [8]. Unfortunately, the authors also point out that worryingly, there needs to be higher awareness of the true character of multidisciplinary among medical disciplines in oncology care. The working culture still needs a change toward a truly integrated care approach. There is a need for more empirical evidence on how to build a composition of a team and how to understand the hospital culture. However, also there is a need to understand how organizational and environmental factors affect MDT performance.

As Horlait et al. [8] state, psychologists need to break barriers and often overload themselves with demands as the teams hardly recognize their functions and their importance, such as:

a) They fight for the principle of integrality with the team.

b) For empathic understanding.

c) For unconditional positive acceptance and trust with patients, family members, and professionals for the excellent functioning of the team [8].

They surely need to take care of themselves (mentally and physically) to exercise their functions. Good training in psychology and post-graduation in a hospital or health center precedes competent performance in the team [3]. The role of psychologists in the psychiatric inpatient setting is valued by the multidisciplinary team, even though Psychology is not viewed as a first-line treatment option but as an add-on to medical treatment [3]. Nevertheless, clinical psychology support is a valued source for skilling up and offering insightful space to the multidisciplinary team. In 2009, some authors already recommended that actions within patient care should involve psychiatry, nursing, occupational therapy, and psychology [9].

Bateman [10], in his article Psychologists in diabetes care, focuses on how psychologists can work with other practices to be wholly beneficial to the patient facing specific challenges in the context of diabetes. He outlines the role of the psychologist, which involves supporting the development of a helpful thinking style and coping strategies to deal with health, understanding the role of the patients' early experiences may have impacted their health in later adulthood, increasing confidence and developing skills in their ability to manage their diabetes. He also reinforces psychologists as a part of the MDT to support the patient in accepting the diagnosis and integrating it into their identity and life [10]. This article also highlights the clinical psychologist's important role towards other MDT members. It is essential to point out actions such as training colleagues on communication skills, using motivational interviewing skills within time-limited consultations, guided self-help and psychoeducation, and individual therapy, usually offering short-term, evidence-based therapies such as Cognitive Behavioral Therapy (CBT), Cognitive Analytic Therapy (CAT), [10] (National Collaborating Centre for Mental Health, 2014). Bateman [10] and Wood et al. [7] focus on how other MDT members perceive psychologists. In their studies, psychologists were seen as marginal or secondary because they were, compared with other professions, in smaller numbers. Psychologists have historically been associated with the most significant ambivalence about teamwork. However, Bateman [10] claims that this picture has changed over the last decade, and there is a clear tendency in the group of researchers and stakeholders to integrate psychologists into the daily life of teams. He argues that psychologists should care for their identity and be flexible between separation and integration. Separation can give, for example, more independent viewpoints while getting different perspectives from other members. The integration allows them more opportunities to influence the team and a greater understanding of the nature of the work from other professionals. An essential aspect of the work of a psychologist in the public state health service in Europe is that a psychologist is part of a larger team consisting of doctors, nurses, and support staff. Organizations have a hierarchical structure to function well, which generates many problems in practice. One of them is that a psychologist is rarely the head of the clinic or health department. As a rule, it is subordinate to doctors in management positions. That is to say that, directly and indirectly, his superiors are people whose level of specific knowledge and scope of work are different from a psychologist's work. Summing up, the situation of a psychologist in these realities is complex, and he is often exposed to various difficult situations. He can become entangled in a conflict between different types of duties.

To enhance this problem, consider designing regulations and guidelines regarding psychologists' work standards as extremely important and needed for practitioners. In the study Multidisciplinary team meetings in cancer care: Is There a Psychologist in the House? the authors argue that for psychologists to report to another MDT member, for example, a psychiatrist, that would suggest a subordinate relationship that is inappropriate and damaging to both parties because it has the potential to engender a false sense of inferiority or superiority [8]. The idea is to work in partnership in a co-constructive way, starting from different points of view, but not necessarily superior or inferior, but complementary.

The contexts where clinical psychologists work

Psychologists and other health care professionals are educated in the paradigm of the biopsychosocial model, which corresponds to the biomedical model but allows for a broader and more holistic view of individuals and their difficulties in the context of their mental processes and the social environment in which they live [11]. Albee [12], argued that clinical psychology entered a paradox of its development in which the problem of identifying and applying its methods was threatened with extinction, and the possibilities of growth seemed endless. This dilemma still exists today. The biomedical model became increasingly present throughout the development of clinical psychology as a profession and scientific field [12]. The current model of practising clinical psychology needs to be more suited to the environment and world standards [11]. Taking this into consideration, we can ask, where does clinical psychology fit today after occurring a pandemic worldwide? Historically, scientists and health authorities have ignored the role of psychological elements in pandemics, despite evidence indicating pandemics are, to a considerable degree, psychological events in which beliefs and behaviours impact the spread vs containment of infection [13]. Psychological factors influence (a) adherence to pandemic-mitigation methods (e.g., social distancing protocols, mask-wearing, vaccine uptake), (b) pandemic-related socially disruptive events (e.g., panic-buying, anti-social-restriction protest rallies), and (c) pandemic-related psychopathology such as anxiety or mood disorders, contamination-related Obsessive-Compulsive Disorder (OCD) [13,14]. Furthermore, the psychological footprint of pandemics, particularly the more severe outbreaks, is larger than the medical footprint because psychological consequences are more pronounced, pervasive, and long-lasting than solely somatic effects of infection [13,14].

According to Saultz et al. [15], clinical psychology could be used primarily in primary care, outpatient, community psychiatric treatment, and public health and mental health intervention platforms. The next level was hospital care (psychiatric, neurological,

and somatic) and specialist care, such as psychotherapy or detailed psychological diagnostics. The psychologist's skills included the assessment of the patient's functioning, mood, motivation, expectations, personality, intellect, and the severity of disease symptoms, as also as the ability to deal with stress, social competencies, and temperament [16]. In their education and specialization path, clinical psychologists receive preparation in clinical evaluation, diagnosis of dysfunctionality and mental health, as well as the basics of psychological help and psychotherapy [17]. Clinical psychology, nowadays, can find its place in several fields, not only in health care contexts (like hospitals and health centres) but also companies, education, and communitarian contexts, and with great potential for growth in e-health services, in particular after the pandemic. Clinical psychology was one of the first to emerge from the womb of psychology as an independent sub-discipline. Clinical psychology gained traction during World War I when practitioners demonstrated the utility of psychological examinations. The American Association of Clinical Psychology was founded in 1917, but it was quickly supplanted by the American Psychological Association two years later (APA). Moreover, for a long time, after World War II, its main task and ambition was psychological testing [18]. Clinical psychologists worldwide devote less and less time to strictly testing and psychometric research and selectively and wisely use psychometric methods according to a comprehensive assessment rather than categorizing mental problems. It is also worth noting that psychometric assessment is less valued by the health company/institution/insurance than, for example, psychological or psychotherapeutic counselling [19].

The psychological assessment should be ecological and comprehensive: it should be short, sufficiently accurate and reliable, and the best possible for the respondent and the researcher (Kinderman & Tai, 2007). The multiplicity of standardized psychological tools available for assessing personality, intellect, temperament, cognitive processes, and many other aspects of the psychological functioning of an individual is widely used in clinical psychology. However, their use without other therapeutic outcomes is only one of the goals of clinical psychology [19]. Some authors argue that psychological tests are as reliable and accurate as most medical tests, such as computed tomography or X-ray techniques [20]. Despite this idea, the essence of clinical psychology should be different from the application and calculation of standardized psychometric tests. In addition to psychometric evaluation, therapeutic evaluation has become increasingly important in clinical settings. In the central area of work and functioning of clinical psychologists, i.e., in health care, their primary duties have not changed for a long time: counselling, psychological diagnosis and assessment, psychoeducation, consultations, interviews with families, and possibly scientific research (Mr djenovuch & Moore, 2004). In this post-pandemic era, e-health support, using video consultations, e-mails, and apps for supporting mental health, has been an increasing economic market that challenges the clinical psychologist's classical skills. These new domains affect the psychologist's work and require adaptation. Nevertheless, the burden of the challenges of new technologies is not on the psychologist's classical skills but on the contexts where they are applied. Even regarding clinical observation, this occurs in the context of video consultations and can offer insights like those obtained in person. In addition, these new domains bring extraordinary advantages for psychologists: they limit the need for a physical space to work; allow the emergence of more services and more accessible access; increase available resources for population empowerment; allow the dissemination of materials that promote health literacy and mental health.

Nevertheless, according to Singh & Sagar [21], there is an urgent need to regulate the practice of these new domains by developing minimum standards for tele-psychotherapy. The authors suggest that the available international and national guidelines for tele-psychotherapy (though not mandatory or legally binding) should be popularized among mental health professionals and the general public to promote awareness about the suggested good practices for mental health issues. Telepsychology and virtual reality have the potential to be increasingly valuable tools to help therapists mitigate the consequences of COVID-19. The authors Sampaio et al. [22] recommend research, development, and training.

Challenges from globalization and culture

The dominant psychological research publications impact the Zeitgeist about globalization on human development, values, identity, and lifestyle [23-25]. These scientific reports and the globalization process have been adjusting our perspective and scientific knowledge concerning human development in adolescence and emerging adulthood. The extension of chronological age and the psychological maturity of these developmental periods are now observed differently than in the early 20th century. Cultural inadequacy, education with multicultural identities, gender identity with multiple identities, and the global world movement are growing among young people. A social phenomenon has been growing under the so-called self-selective culture, markedly based on a cultural foundation [23]. The relationship between theory and clinical practice is a constant topic for reflection and for taking new actions. It includes creating conditions for creative dynamism, mobility, the possibility of competition and cooperation, the rapid dissemination of discoveries in science and technology, information systems and speed of communication, and broad access to knowledge thanks to the constantly improving Internet. These changes stimulate the development of cognitive spheres and human competencies [26]. The process of globalization has become the subject of attention in the scientific psychology community. It entails modifying existing concepts by introducing globalization phenomena into thinking about the patterns of human reaction to universal tendencies in economics, politics, ecology, language, culture, and individual self-regulatory development of human identity and lifestyle, which are additionally characterized by a high potential for unification and commitment [27,28]. The author proposes new concepts and theoretical models that make it possible to understand the relationship between changes in the organization of social life and patterns of psychological reactions. New interactions between a macrosocial organism, like the process

of globalization, and an individual being should be discovered. Even more crucial for a clinical psychologist is the concept of contextualization. Its primary function is to give meaning to one's behaviour regarding the freedom to choose and maintain the direction of one's activity about the identified external macro social conditions. Such an understanding is consistent with the concept of self-regulating human subjectivity related to globalization, proposed by Bandura [27].

Challenges for clinical psychology in the 21st century

One of the most critical challenges for clinical psychology in the future, from socio-cultural changes that generate new problems and tasks in the mental health field, comes from the need to improve and update clinical theories and practice regarding E-health issues. Scientists are expected to undertake theories and research activities necessary for the development, maintenance, and enhancement of mental health, which will result in new theories and models of describing and explaining intrapsychic mechanisms of human functioning, the construction of more accurate and reliable diagnostic tools, and the creation of more effective psychotherapy strategies and psychosocial interactions. On the other hand, clinical psychologists, when in practice, are expected to have the knowledge and specific skills necessary to provide psychological services at the highest level, especially in diagnostic, preventive, and therapeutic procedures.

Challenges in the field of clinical diagnosis

The most significant challenges faced by theory and clinical practice in clinical diagnosis concern developing guidelines on conduct within two models: Epigenetic diagnosis and diagnosis in therapeutic management. The results of longitudinal studies [29-32]. Some childhood anomalies could predict 2/3 to 3/4 of mental disorders in adulthood. In the context of these data, Fonagy et al. [33] put forward the thesis that only the developmental perspective, especially developmental psychopathology, allows for a comprehensive understanding of mental disorders and their determinants. Diagnosing mental health determinants, by the assumptions of developmental psychopathology, requires knowledge about the size (proportion) of biological, mental, and socio-contextual factors in the genesis of mental problems at various stages of an individual's life [29]. Various international and European expert teams [29,34] were formed to promote evidence-based psychological practice. However, further research is required to show the relationship between the initial descriptive and explanatory diagnosis and the objectives and the subject of partial diagnosis in the context of individual interventions. The diagnosis should include not only the analysis of the patient's change process under the influence of specific interventions but the basis for selecting the subsequent intervention in connection with the diagnosis of the patient's response to the intervention in the context of the therapeutic relationship and the strength of the therapeutic alliance. This complex issue has been studied fragmentarily, which needs to give a complete picture of the dialectical interdependencies.

The therapeutic relationship

An interview, and more broadly, any psychological examination, is primarily an encounter between two people. We must meet and interact with a person to clinically observe them. Therefore, in addition to the cognitive dimension, there should also be an interpersonal dimension that affects the course of the therapeutic relationship and its results. Furthermore, a particular psychologist and a specific client are people of a certain age, gender identity, sexual orientation, or nationality, with their worldviews and reactions to each other. Their therapeutic meetings occur at a specific time, often within the framework of the activities of an institution and on its premises. The therapeutic setting is considered an extremely significant factor influencing the course of the therapeutic relationship [35]. Even in a non-standard form as having a conversation on the phone, both parties are specific in space and time, and the remarkable fact that they communicate indirectly undoubtedly influences what they say to each other.

The following reflections related to building up a therapeutic relationship between a clinical psychologist and a client should be further and more deeply studied throughout research studies:

A. The unique ability to critically review the multiple roles and contexts of relationships the client and the psychologist assign and recognize the impact of these roles, contexts, and relationships on the activities undertaken as part of the clinical diagnosis and intervention.

B. The ability to satisfactorily establish, maintain and understand a cooperative

C. the professional relationship between the therapist and the client.

D. Adequately understanding of the complex relationship between accurate diagnosis and intervention planning, the awareness that diagnosis is already an active intervention.

E. Technical diagnostic skills, including:

a) Recognizing the problem/goal and understanding the fundamental essence of the clinical case.

b) Selecting appropriate diagnostic methods that provide both test and non-test data.

c) Practical application of diagnostic procedures, both to the client and to the different social systems in which he participates.

d) Information integration, logical inference, and clinical psychological analysis.

e) Elaboration of results regarding a diagnosis for proper case formulation and clinical recommendations into practice.

f) Providing the client with understandable and valuable feedback that meets his needs regardless of whether the client is an individual, group, or organization.

Key variables that affect the effectiveness of psychotherapy are the resources of the therapist, the patient's pre-sources,

and the theoretical model of the therapeutic process. Although representatives of various therapeutic approaches differ in assessing the therapeutic relationship's importance and influence on the psychotherapy process, they all agree that it is a significant healing factor. This alliance in action is not related to immediate effects in psychotherapy, which means that it does not increase the current satisfaction with life and experiencing positive affect and satisfaction with life. The empirical data obtained from recent research [36] concludes that the alliance in psychotherapy strengthens the person's ability to enter a deep and trustful relationship with others than the therapist. It contributes to well-being and is a long-lasting element of healthy human Development [36].

From the psychological point of view, therapeutic change occurs when the individual recognizes their behaviour and takes responsibility for it, whereby the drive previously directed against himself reintegrates as his own. It is a step towards integrating one's behaviour and promoting actions toward therapeutic change. In contact with the client, the therapist does not force the change to take place but, considering the therapeutic contract goes in the direction that he agreed with the client and creates a psychological space for developing the awareness-expanding process. In this process, the client becomes aware of his ways of dealing with the environment and may learn a new response mechanism to new situations. Change occurs as a product of the consciousness-expanding process. According to Perls [37], the problem of humanity is being dissatisfied with themselves, feeling frustrated, trying to change, and seeking help from a psychotherapist to get rid of defects. The author argues that human beings gain a strong foundation for improving themselves if they accept themselves as they are and become aware of their current situation. Focusing on self-acceptance, instead of the constant pursuit of the ideal self, is the prerequisite for change. Facing the truth about ourselves that we are not perfect, have contradictions within us, and are internally polarized is the beginning of an authentic life.

In Gestalt Therapy, change occurs paradoxically. What is this paradox? One of the therapeutic questions perfectly elucidates it: If a man accepts who he is, why should he change? According to Harris [38], during psychotherapy, the client goes through three phases of self-understanding. In the first phase, the individual realizes what he is, i.e., accepts himself. Only then can he move on to the second phase, when he realizes how to be because he decides so? Responsibility for their actions and the very moment of choosing oneself are significant at this phase. The last step is understanding that change is possible and depends only on the individual's autonomous decision. Also, regarding the responsibility for change in the therapeutic process and introducing the concept of mental health and physical health in 1948, the World Health Organization (WHO) elaborated the concept of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity [39,40]. Beforehand, health was considered under the ancient Latin phrase of the Roman poet Juvenal: Mens sana in corpore sano (a healthy mind in a healthy body) as well as the affirmation made by Leriche in the 1930s: Health is a life lived in the silence of the organs, [41]. After World War II, there was a demand to promote political welfare to people, just like nowadays, there is a high demand to promote mental health politics after the 2020-2022 COVID-19 pandemic. Back then, the WHO elaborated a concept of health as a kind of well-being, introducing the social factor in health. Before the war, health was just considered individually. After the war and considering its precarious social condition, we start to perceive that collectivity crosses over individuals and individuals cross over collectivity [41].

New Technologies and Clinical Psychology

Considering the WHO definition, physical well-being corresponds to an objective process. Conversely, mental well-being is related to a subjective process. Let us reflect on these two concepts, objective and subjective, as Neves [41] argues. In the last decades of the XX century, the objective was more valorized, contrary to the subjective concept. The concept of objectivity is related to the object and subjective to the subject. Thus, society was very pragmatic. Somehow an objectification of the human being took place in addition to humanization, particularly in medicine. Our recent reflection on this is that pandemic consequences are emerging in different areas, in particular in the mental health field, where communication between clients and therapists is changing, new technologies are producing mental health content, and the main question remains to be seen in the future: can technology, artificial intelligence replace a human therapist? We do hope not. Let us hope interpersonal connection, eye-to-eye, verbal and nonverbal actions and decisions are still on the frontline, considered very important in understanding human being psychological suffering. Singh &Sagar [21] acknowledge the critical role of online services in meeting the massive demand for mental health services during the COVID-19 and post-pandemic era. However, they draw the attention of mental health professionals, policymakers, and other stakeholders to the urgent need to discuss ways to make it safer and more reliable for both the client and the therapist. Quality of Human Interconnections (QHI) is how we grow and develop. What matters most is the quality of the relationships we develop and maintain throughout our lives. Technology can help towards that goal but can never replace it.

Conclusion

Mental Health has been widely influenced and impacted by the pandemic creating a need for new ways to connect clients and therapists. New technologies have effectively changed how therapists communicate and engage with their clients, with new forms of therapy emerging. The scope of clinical psychology is clearly increasing with the use of new technologies but let´s not compromise the benefits of an interpersonal and therapeutic connection. Clinical observation, Multidisciplinary Teams (MDT), holistic interventions are essential in the therapeutic process of clinical psychology. However, telepsychology and virtual reality are valuable tools to help therapists mitigate the consequences of COVID-19. Clinical psychology, nowadays, can find its place in

several fields, not only in health care contexts (like hospitals and health centres) but also companies, education, and communitarian contexts, and with great potential for growth in e-health services, in particular after the pandemic [42-47].

References

1. Witmer L (1907) Clinical psychology. The Psychological Clinic 1(1): 1-9.
2. Stephens MW (1970) Training in behavioural observation and clinical inference. Professional Psychology 1(5): 483.
3. Wood L, Williams C, Billings J, Johnson S (2018) The role of psychology in a multidisciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team. Psychology and Psychotherapy Theory Research and Practice 92.
4. Galvin SW, McCarthy S (1994) Multidisciplinary community teams: Clinging to the wreckage. Journal of Mental Health 3(2): 157-166.
5. Smith T, Nicassio P (1995) Psychological practice: Clinical application of the biopsychosocial model. In: Smith T, Nicassio P, (Eds.), Managing chronic illness, USA.
6. WHO (2002) The world health report. WHO, The World Health Organization, Geneva, USA.
7. Wood L, Williams C, Billings J, Johnson S (2019) The role of psychology in a multidisciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team. Psychol Psychother 92(4): 554-564.
8. Horlait M, Dhaene S, Belle SV, Leys M (2019) Multidisciplinary team meetings in cancer care: Is there a psychologist in the House? International Journal of Integrated Care 19(S1): 1-8.
9. Whittington R, Bowers L, Nolan P, Simpson A, Neil L, et al. (2009) Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. Psychiatric Services 60(6): 792-798.
10. Bateman J (2018) Psychologists in diabetes care. Diabetes & Primary Care 20: 161-164.
11. Bray JH (2010) The future of psychology practice and science. Am Psychol 65(5): 355-369.
12. Albee GW (1970) The uncertain future of clinical psychology. Am Psychol 25(12): 1071-1080.
13. Taylor S (2019) The psychology of pandemics: Preparing for the next global outbreak of infectious disease. Cambridge Scholars Publishing, UK.
14. Taylor S (2021) The psychology of pandemics. Ann Rev Clinical Psychol 9(18): 581-609.
15. Saultz JW, Lochner J (2005) Interpersonal continuity of care and care outcomes: A critical review. Annals of Family Medicine 3(2): 159-166.
16. Townsend CO, Bruce BK, Hooten WM, Rome JD (2006) The role of mental health professionals in multidisciplinary pain rehabilitation programs. Journal of Clinical Psychology 62(11): 1433-1443.
17. Geczy B, Sultenfuss JF, Donat DC (1990) Psychologists in state mental hospitals: Problems and recommendations. Professional Psychology: Research and Practice 21(5): 392-397.
18. Schafer R (1948) The clinical application of psychological tests: Diagnostic summaries and case studies. International University Press, USA.
19. Butcher JN (2006) Assessment in clinical psychology: A perspective on the past, present challenges, and future prospects. Clinical Psychology Science and Practice 13(3): 205-209.
20. Meyer GJ, Finn SE, Eyde LD, Kay GG, Moreland KL, et al. (2001) Psychological testing and psychological Assessment: A review of evidence and issues. American Psychologist 56(2): 128-165.
21. Singh S, Sagar R (2022) Online psychotherapy during the COVID-19 pandemic: The good, the bad, and the ugly. Indian Journal of Psychology Medicine 44(2): 177-180.
22. Sampaio M, Haro MVN, De Sousa B, Melo WV, Hoffman HG (2021) Therapists switch to telepsychology to safely continue treating patients during the Covid-19 pandemic. Virtual reality telepsychology may be next. Frontiers in Virtual Reality 1: 576421.
23. Jensen AJ (2002) The psychology of globalization. American Psychologist 57(10): 774-783.
24. Hermans HJM, Dimaggio G (2007) Self, identity, and globalization in times of uncertainty: A dialogical analysis. Review of General Psychology 11(1): 31-61.
25. Nieman MD (2011) Shocks and turbulence: Globalization and the occurrence of civil war. International Interactions 37(3): 263-292.
26. Friedman TL (2000) The Lexus and the olive tree: Understanding globalization. USA.
27. Bandura A (2001) The changing face of psychology and the dawning of a globalization era. Canadian Psychology 42(1): 12-24.
28. Bandura A (2002) Social cognitive psychology in cultural context. Applied Psychology: An International Review 51(2): 269-290.
29. Cicchetti D (2006) Development and psychopathology. In: Cicchetti D, Cohen DJ (Eds.), Development and psychopathology. Theory and method, John Wiley & Son, USA.
30. Fichter MM, Kohlboeck G, Quadflieg N, Wyschkon A, Esser G (2009) From childhood to adulthood: 18-year longitudinal results and prediction of mental disorders in the community. Soc Psychiatry Psychiatr Epidemiol 44(9): 792-803.
31. Goodman A, Joyce R, Smith JP (2011) The long shadow cast by childhood physical and mental problems on adult life. PNAS 18(15): 6032-6037.
32. Wollum AEK, Berdal EK, Iversen JM, Indredavik MS, Evensenet KAI (2022) Outcomes and predictors of functioning, mental health, and health-related quality of life in adults born with very low birth weight: A prospective longitudinal cohort study. BMC Pediatr 22: 628.
33. Fonagy P, Target, M, Gergely G (2006) Psychoanalytic perspectives on developmental psychopathology. In: Cicchetti D, Cohen DJ (Eds.), Development and psychopathology. Theory and method, John Wiley & Sons, USA, 1: 1-10.
34. Harvey AG, Gumport NB (2015) Evidence-based psychological treatments for mental disorders: Modifiable barriers to access and possible solutions. Behav Res Ther 68: 1-12.
35. Pereira A, Goncalves MM, Ribeiro E (2009) Narrative processes of change in psychotherapy: A successful case study of constructivist therapy. Psychologica 50: 181-203.
36. Prusinski T (2021) The working alliance and the short-term and long-term effects of therapy: Identification and analysis of the effect of the therapeutic relationship on patients' quality of life. Psychiatria Polska 56(3): 571-590.
37. Perls FS (1969) Ego hunger and aggression.
38. Harris JB (1989) Gestalt: An idiosyncratic introduction. Manchester Gestalt Center, UK, p. 51.
39. Lee K (2008) The World Health Organization (WHO) 1st (edn), Routledge Publishers, London, pp. 184.

40. Kirton JJ (Ed.), (2009) Global Health 1st (edn), Routledge Publishers, London, pp. 592.

41. Neves AC (2021) An amplified concept of health. Academia Letters.

42. Arnett JL, Jensen AJ (2012) Going global: New Pathways for adolescents and emerging adults in a changing world. Journal of Social Issues 68(3): 473-492.

43. Blount A, Schoenbaum M, Kathol R (2007) The economics of behavioural health services in mental settings: A summary of the evidence. Professional Psychology: Research and Practice 38(3): 290-297.

44. Mollon P (2009) Our rich heritage are we building upon it or destroying it? (or "Why are counselling psychologists not angrier with clinical psychologists?"). Counselling Psychology Review 24(3-4).

45. Mrdjenovuch AJ, Moore BA (2011) The professional identity of counselling psychologists in health care: A review and call for research. Counselling Psychology Quarterly 17(1): 69-79.

46. Salzman MB (2001) Globalization, culture, and anxiety: Perspectives and predictions from terror management theory. Journal of Social Distress and Homelessness 10(4): 337-352.

47. Taylor S (2022) The psychology of pandemics. Annu Rev Clin Psychol 9(18): 581-609.