Mental Health Clinicians' Experiences in Transitioning to Telehealth Service Delivery During the COVID-19 Pandemic

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Abstract

The COVID-19 pandemic necessitated an abrupt, unexpected shift of outpatient mental health services to Internet-based telehealth platforms. This study sought to explore how mental health clinicians experienced this dramatic change in their mode of service delivery. The study addressed the following research questions: (1) Were there significant changes in mental health clinicians' compassion satisfaction and symptoms of burnout between the outset of the COVID-19 pandemic and one year later? (2) Was there a significant shift in clinicians' comfort/discomfort with telehealth technology between the outset of the pandemic and one year later? (3) How do clinicians perceive the positive and negative aspects of online service-delivery? (4) To what degree do clinicians experience challenges related to establishing eye contact and detecting subtle nonverbal cues during telehealth sessions? An electronic survey was administered to a convenience sample of clinicians from four regional mental health clinics in northwestern Wisconsin. The Professional Quality of Life Scale (ProQOL) (Stamm, 2010) was used to measure clinician compassion satisfaction and symptoms of burnout. In addition, the researchers developed qualitative survey items to more fully explore clinicians' experiences during the transition to telehealth due to the pandemic. Paired samples t-tests were used to evaluate changes in compassion satisfaction and burnout before and one year after the transition to online service delivery. Qualitative methods were used to analyze responses to the open-ended survey questions. It was hypothesized that the abrupt transition to telehealth service delivery would be associated with decreased compassion satisfaction and increased risk of burnout. The results of paired samples t-tests suggested support for both hypotheses. Specifically, clinicians reported that their compassion satisfaction at one year into the pandemic was lower than immediately before the onset of the pandemic, and they reported more symptoms of burnout one year into the pandemic than before the pandemic began. Findings regarding clinicians' comfort with telehealth, positive and negative perceptions of online service delivery, and challenges with eye contact and detection of subtle nonverbal cues are also reported.

Review of Literature

General Introduction

The COVID-19 pandemic has necessitated sudden and sweeping changes to the delivery of outpatient mental health treatment. Because the pandemic has been unprecedented in this regard, no corpus of literature from prior research on similar situations was available at the time this study was initiated. The available literature regarding the key variables of interest and

the definition, history, and positive and negative attributes of Internet-based health services in general, serves as the foundation for this study.

Online mental health services offer clients an additional avenue through which to access treatment. Internet-based mental health services allow clients to speak with their mental health professional from the convenience and comfort of their own home (or other private location) through the use of a computer, tablet, or smartphone. The delivery of mental health services via technology is referred to in the literature by numerous names, including "online therapy," "e-therapy," "telemental health," "telehealth," and "Internet-based therapy." Internet-based mental health treatments have been found to be effective in the treatment of numerous mental health conditions including obsessive-compulsive disorder (Brand & McKay, 2012), anxiety disorders, bipolar disorders (DelliFranie & Dansky, 2008), substance abuse (Bensink et al., 2006), depression and schizophrenia (Bensink et al., 2006; DelliFranie & Dansky, 2008).

Mental health providers are primarily concentrated in larger urban areas across America; less than 7% of all psychiatrists live in rural areas (Hartley et al., 2002). In areas with the lowest numbers of mental health providers, only 41% of Americans with a diagnosed mental illness reported receiving any treatment in 2014 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). With this scarcity of mental health providers in many outlying areas, Internet-based mental health services are invaluable to clients who might not otherwise have feasible access to a provider.

An Abbreviated History of the Use of Technology for Mental Health Service Delivery

The use of technology to deliver mental health services began in 1955 at the Nebraska Psychiatric Institute when Van Lear Johnson began providing group psychotherapy and psychiatric consultation via closed-circuit television (Institute of Medicine, 1996). The use of early forms of telehealth continued through the 1960s, but in those early stages, the hardware was expensive and difficult to use, and services remained very limited geographically because the technology could only reach distances up to 20 miles (Dwyer, 1973). In 1968, Veterans Administration (VA) hospitals throughout Nebraska began providing the first interhospital online therapy; other VA hospitals soon developed the capacity to connect online with the central resources available at Massachusetts General Hospital (Godleski et al., 2008).

By the 1990s, technology-based mental health service delivery had become much more efficient and advanced, enabling mental health professionals to provide virtual medication management services and conduct virtual patient evaluations, treatment planning, and both individual and group psychotherapy (Smith & Allis, 1998). As computers and Internet service became available to the public, the delivery of mental health services via technology became increasingly prevalent, though it was still available only to a small subset of affluent Americans. The Telecommunications Act of 1996 mandated that high-speed Internet service be made available to citizens in rural areas at costs comparable to those in urban areas (Adams et al., 2018). Although this legislation was an important step forward, it remains the case – even today – that many Americans cannot access online mental health services due to their inability to afford Internet service and/or electronic devices such as computers, tablets, and cell phones.

Benefits and Limitations of Online Therapy

Prior research has identified both benefits and concerns regarding the delivery of mental health services via the Internet. In terms of benefits, telehealth technology provides access to mental health treatment for many clients who may feel uncomfortable with in-person sessions (Simpson et al., 2005), or who live in geographic areas that lack any mental health service providers (Hilty et al., 2007). Online service provision has the potential to improve client attendance and satisfaction by reducing or eliminating travel (Simpson et al., 2005). The telehealth option can provide needed treatment for clients who may be unable to attend in-person sessions due to physical or psychiatric disability (Institute of Medicine, 1996). The ability to provide services online also benefits clinicians, by reducing or eliminating travel-time, and by making it feasible for them to work from home if they have childcare or eldercare responsibilities.

Research has yielded evidence that telehealth services can help to prevent impatient rehospitalization and can improve compliance and overall satisfaction with treatment (Godleski et al., 2012). Simpson and Reid (2014) reviewed 23 studies which found that the quality of therapeutic alliance between the client and counselor in telehealth is comparable to in-person psychotherapy. Systematic reviews of service delivery via telehealth have shown that its efficacy when used for assessment, diagnosis and treatment is comparable to in-person service delivery. Some studies have suggested telehealth may even be more effective for treating older children, adolescents, adults, and clients with differing cultural backgrounds (Hilty et al., 2013; Molfenter et al., 2015).

Conversely, there are also several concerns regarding Internet-based psychotherapy. One such concern is related to protecting the security of sensitive client mental health information. Practitioners may experience discomfort about offering online therapy (as compared to in-person therapy) due to concerns about client privacy and confidentiality, security of telehealth sessions, and potential professional liability in the event of a data breach in which protected health information is inadvertently disclosed to unauthorized entities.

Health Insurance Portability and Accountability Act (HIPAA) Rules for Telehealth

The privacy of patient health records in general was first formally protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In 2003, HIPAA rules were expanded to address the protection of *electronic* health information (CMS, 2011). HIPAA legislation outlines stringent requirements that must be followed to protect patient privacy and confidentiality when transmitting any form of protected health information (including mental health information).

With the onset of the COVID-19 pandemic, many HIPAA policies were temporarily revised or suspended. On March 17th, 2020 the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) declared that it would utilize its enforcement discretion to ease penalties for HIPAA violations of privacy and security during the CAVOID-19 public health crisis. The OCR also relaxed its breach notification rules for health care providers using technology to communicate with patients during the COVID-19 pandemic (hhs.gov, 2020).

Ideally, of course, psychotherapy sessions should be conducted in a private setting with minimal distractions and interruptions. However, the realities of the COVID-19 pandemic have, in many cases, rendered this ideal impossible to achieve. For example, in the early stages of the pandemic when entities such as businesses, schools, and mental health clinics were in lockdown, both clients and clinicians often found themselves connecting for telehealth sessions in environments that were anything but private. Many clients and clinicians were simultaneously attempting to care for elders or young children and/or facilitating at-home learning for their school-age children. Such contexts posed major challenges for clinicians and clients alike. The U.S. Department of Health and Human Services (DHHS) formally recognized that it might not be feasible to adhere to all usual HIPAA standards during COVID-19, but indicated that health care providers should continue to implement HIPAA safeguards to protect patient health information. When a private setting was not available, DHHS suggested precautions such as lowered voices and refraining from using speakerphone.

Members of the general public use myriad online platforms for personal communication purposes (e.g., Instagram, Facebook, Snapchat, Skype, etc.). However, these social media platforms are considered public-facing, and are not sufficiently secure for confidential medical and mental health conversations with patients. HIPAA mandates that any online communication with patients/clients must be conducted only via secure, HIPAA-compliant platforms designed expressly for telehealth purposes. Examples of such platforms include, but are not limited to Zoom for Healthcare, doxy.me, Microsoft Teams (with specific security controls enabled), and Spruce Healthcare Messenger (hippajournal.com. n.d.). Secure telehealth platforms have proliferated under the increased demands posed by the COVID-19 pandemic.

The Importance of Visual Cues in Psychotherapy.

Visual cues such as eye contact, body language, and facial expression provide clinicians with invaluable clues about the client's current affect, how the client is reacting to discussion of a difficult situation, and whether the client is displaying symptoms of psychopathology. When conducting therapy online, it is sometimes more difficult to detect these subtle facial expressions and nonverbal cues due to deficient image quality or the fact that only the client's face is visible (in contrast to visibility of the whole person as would be the case during in-person sessions). An additional limitation is that some of the experiential approaches used during in-person sessions are not feasible in the online environment (Alleman, 2002). Clients may experience parallel concerns because they also rely heavily on visual cues such as therapist eye contact, body language, and facial expression as signals of attentive listening and empathy on the part of the clinician. (M. K. Crothers, personal communication, June 11, 2020).

Compassion Satisfaction among Mental Health Clinicians

Stamm (2010) describes compassion satisfaction as "the pleasure one derives from being able to conduct one's professional work well, and feeling satisfied after doing so" (p. 12). People who have high compassion satisfaction feel "successful and invigorated by their work and believe they can make a difference" (Stamm, 2010, p. 21).

Senreich and colleagues (2019) found that the likelihood of compassion satisfaction increases when clinicians have a manageable caseload, believe their training has adequately prepared them for their work responsibilities, and feel their work is valued. The first two of these factors have been impacted significantly by the COVID-19 pandemic. Clinicians' caseloads have risen sharply due to the dramatic increase in the number of people seeking mental health care in response to the anxiety and isolation ensuing from COVID-19. In terms of clinicians' perceptions that their training has adequately prepared them for their work, the pandemic may have adversely affected compassion satisfaction because the majority of mental health professionals had no experience with Internet-based therapy prior to the pandemic. Further, to avoid prolonged disruptions in treatment at a time when client stress was particularly intense, the transition to online service-delivery had to be accomplished very rapidly. There was virtually no advance warning and very little time to obtain training and master the technology required for online therapy, thereby thrusting clinicians abruptly into a work environment for which they felt inadequately prepared. It is therefore plausible to imagine that clinicians' compassion satisfaction may have declined during the pandemic.

Burnout among Mental Health Clinicians

Maslach (1982) defined burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment'' (p. 3). Other researchers have further developed the description of burnout, reporting that it tends to be characterized psychological distress, feelings of dissatisfaction, impaired interpersonal functioning, cynicism, physiological symptoms, and emotional numbing (Fothergill et al., 2004). Stamm (2010) reported that people who experience burnout express feeling "unhappy, insensitive, and disconnected regarding their professional work" (p. 21).

Factors that increase the likelihood of burnout for mental health clinicians include limited time to meet deadlines or perform duties, the psychological weight of responding to the emotional needs of clients, and peripheral administrative responsibilities (Dillenburger, 2004). Previous research has shown that heavy workloads and pressure to meet productivity targets (as measured by billable client hours per week) contribute to work-related stress (Collings & Murray, 1996). As soon as the COVID-19 pandemic began, mental health services were quickly overrun, with the need for treatment far exceeding the capacity of clinicians. This resulted in stress from increased workload and from having to turn away prospective clients who were in desperate need of support. In addition to other work-related and personal stressors, the sudden shift to entirely online service-delivery posed unique challenges, as many clinicians had no previous experience with telehealth. These factors likely increased levels of stress for clinicians, potentially contributing to decreases in their compassion satisfaction and increases in their risk for burnout.

Purposes of the Study

The purposes of the study reported here were twofold: First, the study investigated whether the sudden shift to online mental health service-delivery was associated with changes in clinician compassion satisfaction and risk of burnout. Second, the researchers sought to explore clinicians' subjective experiences and perceptions regarding the abrupt shift to telehealth during the COVID-19 pandemic. Specifically, the study explored clinicians' comfort/discomfort with telehealth, their perceptions of the positive and negative aspects of online therapy, and challenges

related to eye contact and their ability to detect subtle nonverbal cues during telehealth sessions.

Method

Participants

Participants were recruited from four mental health clinics in a circumscribed midwestern region. The recruitment process yielded 26 fully completed surveys. All participants were direct-service mental health or AODA (Alcohol and Other Drug Abuse) clinicians. Experience levels ranged from participants who were completing pre-credential internships, to seasoned clinicians with more than 20 years of professional experience.

Measures

To measure compassion satisfaction and burnout, the researchers employed a subset of items from the Professional Quality of Life Scale (ProQOL) (Stamm, 2010). The ProQOL measures the positive and negative aspects one may experience in a helping profession. It is widely used to measure the quality-of-life experiences of mental health therapists, medical health professionals, and social service employees. Selected items from the ProQOL were utilized to compare counselors' recollections of their compassion satisfaction and burnout levels before the pandemic began, with their levels of the same two variables at the time data were collected, one year into the pandemic.

The ProQOL includes three, 10-item subscales (Compassion Satisfaction, Burnout, and Secondary Traumatic Stress), each rated on a 5-point scale (1 = never; 5 = very often). Because this study did not include exploration of secondary traumatization, only the items from the Compassion Satisfaction and Burnout subscales were utilized. Subscale scores on the ProQOL are computed by summing the ratings for the items loading on each factor. For both subscales, scores ≤ 22 are considered low; scores from 23-41 are considered to fall in the medium range; and scores ≥ 42 are considered high (Stamm, 2010). The ProQOL has shown good internal consistency for both subscales, with the following Cronbach's *alpha* levels: Compassion Satisfaction $\alpha = .88$; Burnout $\alpha = .75$ (Geoffrion et al., 2019). One aim of the study was to determine whether clinicians' Compassion Satisfaction and levels of Burnout had changed across the first year of the COVID-19 pandemic. To achieve this aim, participants were asked to give two separate ratings for each ProQOL item – one retrospective rating reflecting how they were feeling when the pandemic first began and they were first starting to use telehealth, and a second rating reflecting their current feelings at the time of data collection, almost precisely one year into the pandemic.

In addition, the researchers developed a novel scale to measure the effects of the sudden, forced shift of mental health service delivery to the online environment as necessitated by the COVID-19 pandemic. This researcher-generated measure was composed of 30 items – some rated on a Likert-type scale and others worded as open-ended questions with free-response comment fields. The measure included questions about participants' perceptions of the positive and negative aspects of online therapy, their comfort (or discomfort) with telehealth, and their perceptions of their ability to establish eye contact effectively and to detect subtle nonverbal client cues when conducting psychotherapy in the online environment.

Items from the ProQOL and the novel researcher-designed measure were combined into a single Qualtrics survey. The survey design employed the "skip logic" function so that participants were asked to respond only to those items that were directly related to their specific work experiences. Basic demographic information (e.g., age, years of professional experience, and type of credential) was also gathered, but was not ultimately used in the analyses due to small sample size and potential concerns about anonymity.

Procedure

The first step in recruitment entailed contacting (by phone) the directors of four mental health clinics. The researchers expressed the desire to recruit clinical staff members to participate in an online survey exploring clinicians' experiences with delivering client services via telehealth during the COVID-19 pandemic. The researchers provided a general description of the study procedures, offered opportunities for questions and clarification, and requested permission to contact clinical staff members to invite their participation. If the director gave permission to recruit, a list of staff names and email addresses was requested.

Each prospective participant received an individualized email invitation (and two reminder emails, at one-week intervals). The initial email included a brief description of the purpose and nature of the study and invited them to participate. Those interested in participating were directed (via a link embedded in the email) to more detailed informed consent information, which was followed by a yes/no question asking whether the potential participant understood the information and gave their informed consent to proceed with participation. Those who answered "No" to this question were thanked for their consideration and exited out of Qualtrics. Those who answered "Yes" to this question were directed automatically to the survey items. The *"anonymize response"* feature in Qualtrics was employed to ensure that no personal information about the participants was recorded. Upon completion of the survey, participants were thanked, provided with contact information for the researchers, and given the opportunity to request a summary of the findings of the study, if desired.

Results

Descriptive statistics showed that clinicians experienced decreases in compassion satisfaction between the start of the pandemic and the time of data collection one year later. Specifically, the mean of the clinicians' retrospective ratings of their compassion satisfaction just prior to the beginning of the pandemic was 43.65, as compared to a mean of 40.50 one year into the pandemic. A paired samples t-test showed that this change in compassion satisfaction was statistically significant ($p < .001$). Cohen's D indicated a relatively large effect size of 0.756. This decrease in compassion satisfaction is presented graphically in Figure 1, below.

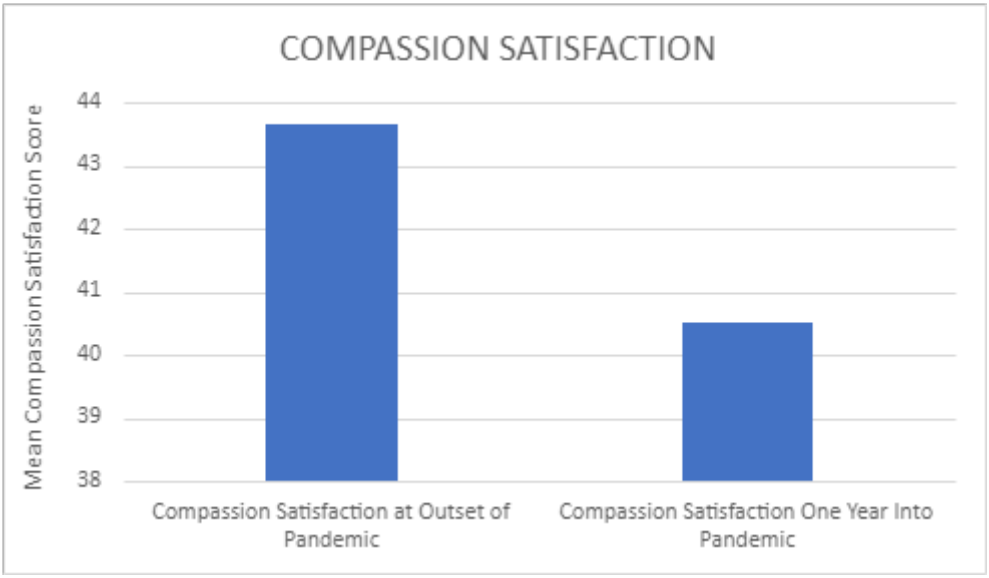

Figure 1. *Clinician Compassion Satisfaction at Outset of COVID-19 Pandemic and One Year Later*

Descriptive statistics showed that clinicians experienced increased symptoms of burnout increased between the start of the pandemic (M = 18.73) and one year later (M = 21.96). A paired samples t-test revealed that this increase in burnout symptoms was statistically significant ($p <$ .001). Cohen's D indicated a relatively large effect size of 0.756. This increase in symptoms of burnout is represented graphically in the figure below.

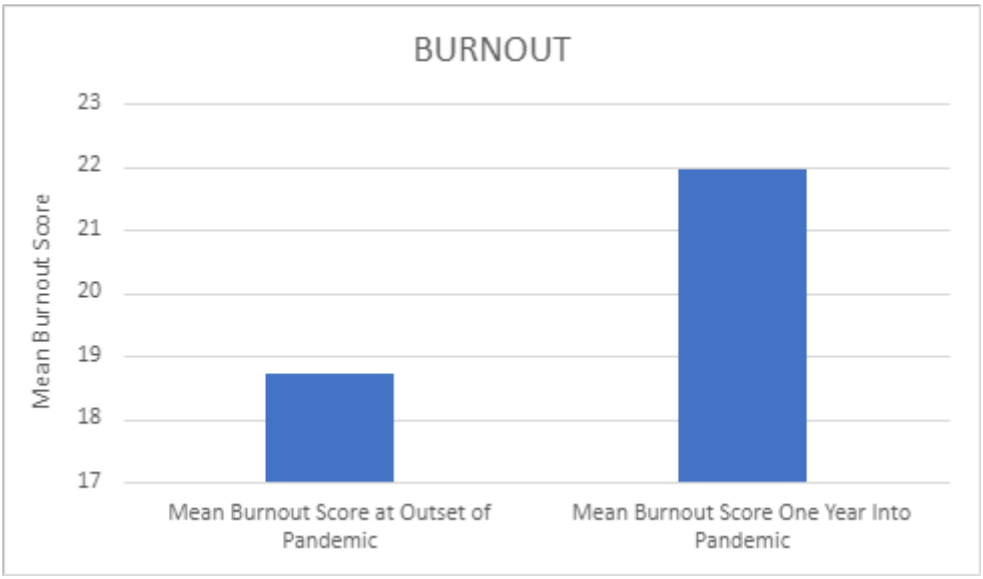

Figure 2. *Clinician Burnout at Outset of COVID-19 Pandemic and One Year Later*

Participant responses to the question about their comfort with using telehealth technology at the start of the pandemic versus one year later indicated that, in general, their comfort had increased markedly. Specifically, at the outset of the pandemic approximately 28% of

clinicians were somewhat or very comfortable using telehealth, as compared to 79% one year later. This corresponded with a decrease in the percentage of clinicians reporting some degree of discomfort, from 38% initially to only 3% one year later. These findings are represented graphically in Figure 3, below.

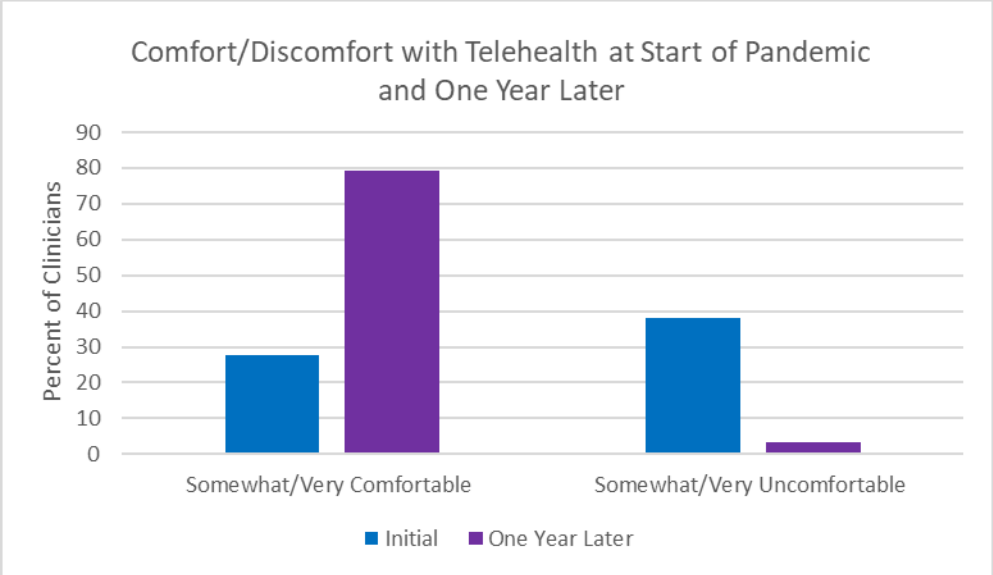

Figure 3. *Clinician Comfort with Telehealth Technology at Outset of Pandemic and One Year Later*

At the time of data collection (almost precisely one year after the start of the pandemic), only a very small proportion of clinicians (3%) had resumed fully in-person service delivery; 76% were still conducting sessions exclusively via telehealth, and 21% were still using telehealth with some clients, but had returned to in-person service delivery with others. Slightly more than half (54%) of the clinicians reported that they found conducting virtual sessions more tiring than in person sessions; however, nearly half (45%) reported enjoying interacting with clients via telehealth more enjoyable than they had anticipated would be the case.

An open-ended question asking participants to describe either positive or negative aspects of conducting online therapy yielded some interesting responses. In terms of negative aspects, some clinicians reported experiencing difficulty with eyestrain. On the positive side, clinicians noted that telehealth service delivery increases access to treatment for some clients (e.g., those who are geographically distant, or have limited mobility, or experience anxiety about driving in inclement weather). Approximately two-thirds of the clinicians reported having clients who were reluctant to meet with them over video telehealth, and 90% of those clinicians worked with video-reluctant clients via telephone. Sixty-nine percent of clinicians reported that some of their clients were unable to meet with them via video telehealth because they did not have Internet service and/or did not have an electronic device through which to connect.

The researchers were interested in exploring challenges relating to eye contact when conducting telehealth sessions. One of the most important and effective ways to communicate empathy and undivided attention is for the clinician to make direct eye contact with their client. In order

for the client to subjectively experience this type of eye contact during telehealth sessions, the clinician must look directly into the camera. However, doing so means that the clinician cannot see the subtle nonverbal facial signals that are invaluable in psychotherapy (e.g., furrowing of the brow, tears welling up, etc.) It is impossible for the clinician to simultaneously look into the camera and detect these subtle cues. Participants indicated a moderate degree of initial worry about this challenge, but indicated that it interfered only slightly with their ability to communicate empathy and attentiveness successfully, and to detect subtle nonverbal cues.

Limitations

The limitations of this exploratory study include its small sample size, circumscribed geographic region, and the limited variety of mental health settings from which the sample was recruited. Further, the novel survey items developed by the researchers have not yet been subjected to rigorous psychometric validation. The design of the study does not explore the many additional variables that contribute to compassion satisfaction and burnout. Future studies will be strengthened by addressing these limitations.

Discussions

As expected, clinicians reported decreases in compassion satisfaction and increases in symptoms of burnout across the course of the first year of the COVID-19 pandemic. Although the present study focused on clinicians' experiences with the sudden shift to telehealth, and that shift quite likely had an impact on compassion satisfaction and burnout, it is essential to emphasize that the findings reported above do not support causal inferences. Myriad factors other than the shift to telehealth almost certainly influenced the decrease in clinician compassion satisfaction and the increase in clinician burnout symptoms.

Although more than a third of clinicians reported initial discomfort with the prospect of shifting to telehealth service delivery, only three participants reported any lingering discomfort one year into the pandemic. Further, although the clinicians experienced more fatigue and eye strain in the online therapy environment than when conducting in-person sessions, many of those who were initially reluctant about telehealth found it more enjoyable than expected. Taken together, these findings reflect remarkable clinician adaptation under challenging circumstances.

Caveat

While online service delivery increases convenience and the accessibility of mental health treatment for *some* clients, it is essential to recognize that it can potentially introduce barriers for others, sometimes rendering treatment completely inaccessible. For example, many remote geographical areas lack reliable Internet service and people living in poverty may not have equitable access to electronic devices. These barriers may reduce access to mental health care for some of the very individuals who most urgently need it. It is imperative that we not allow enthusiasm over the convenience of telehealth technology to overshadow the inherent access disparities. Future research should focus on identifying these and other potential disparities and

barriers, as well as developing and measuring the efficacy of programs designed to address them.

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