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TELEHEALTH SATISFACTION ADMIST THE COVID-19 PANDEMIC

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota
August
2022

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July 18, 2022

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ABSTRACT

The COVID-19 pandemic caused substantial disruptions and changes in mental health service delivery as community mental health clinics had to scramble to implement telehealth services to provide continuity of care under quarantine. For the current study, I conducted in-depth video interviews with ten clients from a community mental health training clinic who transitioned from in-person services to telehealth services. Twenty-one factors related to clients' satisfaction with telehealth services and their perceived barriers to the treatment modality using a grounded theory framework. The majority of participants reported they were satisfied with telehealth but preferred to return to in-person therapy sessions with supplemental telehealth services as needed. Various benefits of telehealth were noted throughout the interviews, including increased ease of access, convenience, and having means of personal comfort during session (e.g., pets, musical instruments, etc.). Participants also identified ways in which telehealth can create barriers to effective therapy, such as privacy concerns, distractions, and technology challenges. Nine guidelines to enhance the effectiveness of telehealth services in the future are provided based on data collected in these interviews.

INTRODUCTION

In the early months of 2020, the Coronavirus Disease (COVID-19) led to rapid changes in the social structures, routines, and daily life in the United States. Quarantining, stay-at-home orders, social distancing mandates and other factors to promote public health affected schools, businesses, gyms, hospitals, and medical clinics among others. To limit the spread of the virus, many mental health care providers were faced with the challenge of quickly identifying ways to adapt and implement therapy and assessment services virtually through telehealth. Individuals receiving mental health services had to adjust as well, as their scheduled in-person appointments were halted and transitioned to a telehealth treatment modality. In this introduction, I will provide an overview of challenges COVID-19 posed to mental health service provision and outline a qualitative study aimed at identifying clients' perspectives on telehealth services.

COVID-19 and Mental Health Care

The World Health Organization declared the novel, rapidly spreading, Coronavirus Disease (COVID-19) a global pandemic in March 2020 (Whaibeh et al., 2020). Shortly after, the United States declared COVID-19 a public health emergency (U.S. Department of Health & Human Services, 2020). COVID-19 has already been associated with some of the most significant social, economic, and medical challenges in the 21st century (Gruber et al., 2020). COVID-19 may also present unique mental health challenges. In an effort to manage the spread of COVID-19, various guidelines were put in place such as stay-at-home orders, social distancing, closing down businesses, and limiting the number of people permitted in locations and at gatherings/events (Centers for Disease Control and Prevention, 2020). These necessary safety precautions, however,

disrupted social support networks and created significant economic instability and uncertainty for many Americans (Osofsky et al., 2020). Families across the United States were quickly faced with numerous challenges, some of which included dealing with temporary or permanent layoffs, financial stress, providing remote learning for children, and worries about the virus (Osofsky et al., 2020). Rosen et al. (2020) identified preliminary data which suggested that many individuals in the United States may have experienced high rates of fear, helplessness, loss, and economic hardship due to COVID-19. Reports demonstrated that COVID-19 has impacted mental health with increases in anxiety, depression, substance use, and isolation as well as exacerbating previous mental health problems (Osofsky et al., 2020). These emerging and troubling mental health needs greatly emphasized the importance of continuity of care during the pandemic as well as highlighting the potential of a greater need for services during the time of COVID-19.

The severity of the COVID-19 pandemic necessitated sudden changes within health care delivery, especially mental health care (Feijt et al., 2020). Clinics and practices around the country were closing down their physical offices in accordance with strict lockdown measures put into place. This required mental health care professionals to transfer their face-to-face care to online telehealth services quickly. While telehealth has been around for quite some time, it has not been technology that has been widely adopted in the field. Literature suggests that most clinicians have not used telehealth as part of their daily work and the adoption of telehealth tools were relatively low prior to COVID-19 (Wright & Caudill, 2020; Feijt et al., 2020). Telehealth has largely been viewed as a

treatment option particularly in rural settings; however, with the dramatic changes of COVID-19 telehealth services became an essential tool (Rosen et al., 2020).

Telehealth

According to Schopp and colleagues (2006), telehealth programs emerged in the 1960's and 1970's. These initial programs were grant funded and were unsustainable as grant funding expired. Interest in telehealth rose again during the 1990's as the internet offered the possibility for clinicians and clients to connect through broadcasted networks and clinicians launched numerous behavioral telehealth applications seeking to meet client needs in diverse geographical locations. The innovation of telehealth gathered wide interest among clinicians but was met by relatively low rates of telehealth adoption. Until recently, this pattern of interest in telehealth but low rate of use, appears to have been a consistent pattern. In a study published a couple of years before the emergence of COVID-19, Glueckauf and colleagues (2018) surveyed 164 psychologists and found that most had never delivered online services. Nevertheless, 51% of their sample indicated that they would like to deliver the majority of their services online and 73% reported they viewed videoconferencing as a useful tool for service delivery.

Traditionally, telehealth had been limited to rural areas where it was beginning to emerge as a way to overcome geographic barriers to care. Due to the maldistribution of mental health clinicians in metropolitan areas and underserved populations living in rural settings, rural areas have become a common place for use of telehealth services (Nelson & Bui, 2010). Telehealth has proven to be an efficient and effective answer to the need of mental health services in rural settings (Rainer, 2010), especially when it is viewed as acceptable by clients and their families (Schopp et al., 2006). With the emergence of

COVID-19, many mental health care providers were required to quickly identify, learn, and implement telehealth with little to no experience as it became a necessary tool for maintaining continuity of mental health care.

Barriers and Conveniences of Telehealth

Despite the promise of telehealth, barriers remain for both clinicians and clients. The barriers surrounding the use of telehealth have been widely studied from the perspective of barriers encountered by clinicians. Multiple studies have shown that clinician acceptance is the most important factor on the successful implementation of telehealth services (Wade et al., 2014; Smith et al., 2020; McClellan et al., 2020). Other barriers identified by clinicians include lack of training for both clinicians and clients, unreliable technology/technology failures, challenges with rapport, difficulty communicating their intended message clearly, likelihood of miscommunications, a lack of nonverbal cues/behavioral observations, among privacy, security, and ethical concerns (MacMullin et al., 2020; Perry et al., 2020; Schopp et al., 2006; Feijt el al., 2020).

While several studies have been published on mental health care providers' perspectives of barriers to care to telehealth, few studies have focused on clients' perceptions of these barriers. In an article calling for improved telemedicine during the COVID-19 pandemic, Zhai (2020) identified a number of potential barriers to telehealth, which included financial barriers, lack of and/or unstable internet connections, and accessibility and usability of technology. However, these barriers were based on assumptions made by clinicians and researchers. Few studies have focused on client perspectives of telehealth-related barriers to treatment, and the few studies that do exist focus on rapport between telehealth and in-person services (Jenkins-Guarnieri et al.,

2015). While rapport is important, there may be additional important factors and barriers worth consideration, some of which might be unique to the context of the COVID-19 pandemic.

Accessibility and familiarity with the internet might be a barrier for some clients. As recently as a decade ago, as many as one quarter of the American population did not identify themselves as internet users (Yuen et al., 2012). In a more recent study, 22% of New Orleans residents reported not having access to a computer, while 17% of residents only have cellular connectivity which limits their ability to access telehealth services (Osofsky et al., 2020).

In addition to the barriers commonly associated with telehealth, the stressors of COVID-19 may have presented new challenges and unique barriers related to telehealth in the pandemic. The pandemic along with manmade and natural disasters result in large-scale changes in everyday life. These can cause disruptions in social support networks, and place individuals at increased risk for anxiety, depression, and other poor mental health outcomes (Rosen et al., 2020; Silverman & Le Greca, 2002). The disruptions in healthcare during a disaster can have negative consequences, exacerbating mental health symptoms and impairment (Whaiben et al., 2020). Similar barriers and risk factors may be present for clients seeking to continue mental health services during the COVID-19 quarantine. As in other manmade and natural disasters, clients may feel the need to place their mental health needs on the back burner and prioritize more immediate needs such as financial obligations, employment, and childcare (Legerski et al., 2012). Continued research and exploration of client satisfaction and client barriers with use of telehealth services is necessary to account for these COVID-19 pandemic challenges.

Along with barriers, there may be important advantages to telehealth for clinicians and clients. Telehealth may offer a level of convenience. Clinicians have reported flexibility and a lack of travel time as advantages to telehealth (Feijt et al., 2020). Telehealth services may also provide increased accessibility of services by reducing various barriers to client attendance, which may include time and expense for traveling (McClellan et al., 2020; Nelson & Bui, 2010). Some preliminary research has compared telehealth treatment with in-person treatment and initial findings suggest that client satisfaction is comparable (Jenkins-Guarnieri et al., 2015). However, more research is needed to determine changes in client satisfaction which may occur as clients transition from in-person therapy to telehealth during an international pandemic such as COVID-19.

Purpose of Study

At present little is known about how established clients are responding to the use of telehealth services in place of in-person services in the context of the COVID-19 pandemic. As an exploratory study, I interviewed clients at a community mental health training clinic about their experiences transitioning to and utilizing telehealth services. Using a grounded theory framework, I identified factors that contributed to clients' satisfaction with telehealth services, as well as factors they perceived as barriers to the treatment process. The identification of these factors may help inform practices that can be used to enhance the effectiveness of telehealth services in the future.

This study was conducted in partnership with a training clinic on the campus of an upper Midwest university. During the 2020 pandemic, many of their clients had to transition from traditional in-person therapy to telehealth video conferencing. The aims of

this study were threefold. First, I wanted to identify the overall impact of COVID-19 on mental health and accessibility to treatment services. Second, I wanted to evaluate and learn about clients' engagement in telehealth services and any perceived benefits or barriers. Third, I wanted to assess clients' satisfaction with telehealth care. The ultimate goal of this study was to create client-based recommendations that mental health providers could use to enhance their telehealth services in the future.

CHAPTER II

METHODS

Participants

Participants were recruited from a community clinic located on a university campus in the upper Midwest which serves as a training clinic for clinical and counseling PhD graduate students. To be eligible for the study, participants were required to have been engaged in in-person therapy prior to transitioning to telehealth services. Therefore, each had pre-existing diagnoses and symptoms prior to COVID-19. Participants were also required to have access to zoom to engage in an interview. Clients who were younger than 18 years old, receiving couples therapy, and/or received therapy services from the primary investigator in the study were ineligible. These exclusionary criteria were used to keep the participant pool homogenous and to reduce the risk of introducing any potential bias.

From a list of sixteen eligible clients in the clinic, participants were randomly contacted and invited to participate in the study. Those who elected to participate scheduled a time with this interviewer and completed the demographic questionnaire prior to the interview. All sixteen eligible clients were contacted and invited to participate. The number of participants was not decided at the outset. Instead using constructivist grounded theory, data collection in the form of interviews continued until saturation occurred. In the current study, saturation occurred after interviewing 10 participants, which is a sample size that is consistent with other studies using grounded theory (Charmaz, 2014).

Demographic information can be found in Table 1, including gender, age, race, and education. Prior to the transition to telehealth services, five (50%) had received treatment services for 12+ months, three (30%) had been receiving services for 6 months, and two (20%) had been receiving services for 3 months or less. The combined family/household for the year 2019 (pre COVID-19) was variable. Two participants (20%) reported a 2019 income of <25,000; four participants (40%) reported a 2019 income of 25,000 - <50,000; three participants (30%) reported a 2019 income of 50,000 - <75,000; and one participant (10%) reported a 2019 income of 75,000 - <100,000. Eight participants (80%) reported being currently employed at the time of interview. Most participants (60%) denied that COVID-19 had a negative impact on their income, while four participants (40%) reported that COVID-19 had a negative impact on their income. Many participants (70%) reported they have not experienced reduced hours since COVID-19, while three participants (30%) reported experiencing reduced hours related to COVID-19. Only one participant (10%) reported experiencing unemployment related to COVID-19. All participants (100%) denied receiving unemployment benefits.

Table 1

Participant Demographic Data (N = 10)

	N	%
Gender		
Male	2	20%
Female	7	70%
Transgender Female	1	10%
Age		
18-29	5	50%
30-39	2	20%
40-49	3	30%
Race		
Caucasian	9	90%
Latinx	1	10%
Highest Education		
High School or GED	2	20%
Associates Degree	2	20%
Bachelor's Degree	3	30%
Master's Degree	2	20%
Doctorate	1	10%

Materials/Measures

Aside for the brief questionnaire created by the researcher to collect the demographic data above, no additional formal measures were administered. Interview questions were utilized to promote discussion of participants views of and experiences with telehealth services during COVID-19 (see Table 2). Follow-up questions were used during the interview as they naturally emerged in response to the information that was learned throughout the process.

Table 2

Interview Protocol

Interview Questions

1. In what ways, if any, has COVID-19 affected your mental health?
2. How has COVID-19 affected your ability to access treatment services?
3. What has receiving mental health services been like for you with COVID-19 and can you describe what the transition of services has been like for you?
    a. If you recall, could you tell me about your thoughts and feelings when you learned services would be offered only via telehealth?
4. What has your experience been like with telehealth?
5. What was receiving telehealth like for you?
    a. What, if any, are some challenges that make it difficult to participate in treatment/therapy?
    b. What, if any, are some factors that make it easier to participate in treatment/therapy?
6. Do you feel that you have been receiving the same benefit/quality of care through telehealth?
    a. How satisfied are you with this mode of treatment/therapy?
    b. What, if anything, has been the most/least helpful aspect of telehealth?
7. Given the current restrictions and risk if you had a preference would you choose to do in-person treatment/therapy or telehealth currently?
8. In the future when the risk has subsided/become minimal given the option would you chose to resume treatment/therapy in-person or continue telehealth?
9. What, if any, recommendations would you have for mental health providers?
10. What, if any, recommendations would you have for people receiving telehealth services?
    a. What do you think are the most important ways to make telehealth services effective/comfortable/client friendly?
    b. After having these experiences, what advice would you give to someone who is new to experiencing therapy via telehealth?

Procedure

Prior to each interview, each participant completed an informed consent through the Qualtrics Research Suite, which was later emailed to them for their records. Participants then completed the demographics questionnaire through Qualtrics and proceeded with the video interview. Interviews were conducted, and recorded, on Zoom (online), in a password protected zoom session. Prior to beginning the interview, the

researcher verbally reviewed the informed consent with the participant. The duration of interviews ranged from 36 to 64 minutes. The interviews were transcribed for analysis, removing any identifying information. To ensure accuracy, a copy of their transcript was e-mailed to each participant to allow the opportunity to make any edits to clarify or add information. No participant elected to edit their transcript.

CHAPTER III

ANALYSIS PLAN

Grounded theory

The current study was conducted using constructivist grounded theory (CGT). Grounded theory is a commonly used qualitative data analysis process used for coding themes that emerge in interviews and focus groups (Mills et al., 2006; Hallberg, 2006; Glaser & Strauss 1967). Charmaz (2014 & 2017) provides a detailed, but flexible, approach to conducting a study using CGT which focuses on ongoing awareness throughout the research process. Charmaz emphasizes that, when using CGT, researchers are active participants in the world that is being studied where data is collected and analyzed. As a result, the perspectives and experiences of researchers and participants form constructions of reality, rather than objective realities. The process of using CGT to code qualitative data is outlined below.

Data Analysis

For this current study, all interviews were recorded through zoom. These interviews were reviewed along with the transcription, ensuring the accuracy of the transcription for analysis which allowed for clarification of any unclear dialogue. The transcripts were analyzed by identifying and indexing themes that were coded and recorded using NVivo, a qualitative software program used to organize and interpret data from transcripts. The multistep process for coding the transcripts is outlined below.

Initial Coding

The first step in data analysis is initial coding, which is examining the data (i.e., transcriptions) and working to create codes by defining what is observed in the data.

During initial coding, the researcher recorded themes and patterns that emerged from the data, while mindfully being open to all the themes that emerged and attempting to limit preconceived notions or biases.

Constant Comparative Methods

Constant comparison was an ongoing process throughout data analysis at each level of coding. This involved making comparisons within and across interviews. Comparison began by identifying similarities and differences within a single interview. These comparisons then continued with other transcripts to identify similarities and differences across participants.

Focused Coding

The second step in data analysis was focused coding, during which codes are used to examine and organize large amounts of data. At this stage, the researcher was required to decide what codes to focus on for further analysis. Focused coding involved scrutinizing and analyzing initial codes to determine the codes that appeared most frequently and/or were most significant for the topic of interest. These codes are presented in the results section.

Memo-Writing

Memo-writing is a critical method in the grounded theory analytic process. Memo-writing provided an informal way for the researcher to actively engage with the data and document thoughts, questions, and comparisons throughout the study. Memos can include reflection, new ideas, or content related to the emerging coding process. In this study, memo-writing included notetaking during research meetings and informal writing during the transcription and coding processes.

Theoretical Sampling, Saturation, and Sorting

Theoretical sampling is a process of gaining more information to expand and refine categories with the aim towards theory construction. The basis of theoretical sampling is to obtain data to help elucidate these emerging categories. Through the use of theoretical sampling, asking more specific questions allows for identification and clarification of emerging categories and themes (Charmaz, 2014). Throughout this study, the semi-structured interview allowed for focused questions to provide information about categories and themes which had begun emerging.

Saturation is the point at which gathering new data about a category does not reveal "new properties" or "any further theoretical insights about the emerging grounded theory" (Charmaz, 2014, p. 345). Grounded theory uses saturation as the criterion for data collection for emerging categories, when new data does not further elucidate a category data collection is completed. Grounded theory emphasizes sampling adequacy rather than sample size. In the current study, it was determined after transcription and coding that saturation was reached at the tenth interview.

Theoretical sorting is one of the strategies used in the theoretical development of grounded theory analysis (Charmaz, 2014). This step involves comparing your categories to find how they are related and ordered. Theoretical sorting can be done in a variety of ways that provide visual representation of categories and the relationships among them. In this study, I used visual representations and diagrams to find the order and relation between categories.

Constructing Theory

The goal of grounded theory data analysis is the construction of a theory. The constructivist grounded theory approach evaluates how, and why, participants construct meanings and actions in situations. The CGT process acknowledges that both the researcher and participants are constructing meaning which together shape a theory. Constructivists seek to be actively aware of their assumptions and values and frequently contend with how they affect the research. This approach encourages ongoing reflection and awareness on the part of the researcher. While tools may be helpful in constructing a theory, it is not a step-by-step regulated process. Charmaz (2014) emphasizes analyzing actions and processes rather than analyzing individual participants when constructing theory. The aim of the current study was to develop an initial theory of client-based recommendations that could be used to enhance telehealth services in the future.

Auditing

Auditing is an important part of qualitative data analysis as it allows for multiple points of view to be taken into consideration. Generally auditing is comprised of two different levels, including a peer debriefing and an inquiry auditing (Fassinger, 2005). Peer debriefing involves critically evaluating the researcher's analysis including coding, categorizing, and theorizing of data; this process remains very close to the content of the data. Whereas inquiry auditing involves monitoring the overall process and product. The auditing process allows for monitoring of the overall process and progress as well as the monitoring of individual biases and provides different perspectives throughout the stages of data analysis (Fassinger, 2005). In this current study the primary investigator reviewed all transcripts and applied initial codes to data. This was done continuously and there was

constant comparison taking place across individual interviews to determine how the codes were best categorized based on the emerging data. As this was occurring, the primary investigator wrote memos to document questions and insights that came up. This process was monitored by an inquiry auditor who provided feedback throughout all stages of data analysis.

CHAPTER IV

RESULTS

A total of 25 themes were identified ranging from diverse topics such as convenience, necessity of services, and mental health stigma. Twenty-one of these themes were most relevant to the use of telehealth during the COVID-19 pandemic and fell into these main categories *(1) Impact of COVID-19, (2) Accessibility to Services, (3) Engagement in Telehealth,* and *(4) Service Preference and Satisfaction.* Due to their relevance to understanding telehealth and long-term implications for widespread use of telehealth services, these 21 themes were the focus of data analysis. To organize findings, information in the results sections has been divided into four parts, *(1) Impact of COVID-19, (2) Accessibility to Services, (3) Engagement in Telehealth,* and *(4) Service Preference and Satisfaction* with a summary of each of the included major themes.

Main Category 1: Impact of COVID-19

Participants reported that the COVID-19 pandemic effected their lives in many ways. When participants discussed the effects of COVID-19 two themes emerged including: Impact of COVID-19 on Mental Health and Impact of COVID-19 on Mental Health Services (see Table 3).

Table 3

The frequency of references to the Impact of COVID-19 (N = 10)

	Total Number of Participants	Total Responses
1. Impact of COVID-19		
1.1 Impact of COVID-19 on Mental Health	10	26
1.1a Negative Impact of COVID-19 on Mental Health	*(10)*	*(18)*
1.1b Positive Impact of COVID-19 on Mental Health	*(7)*	*(8)*
1.2 Impact of COVID-19 on Mental Health Services	6	13

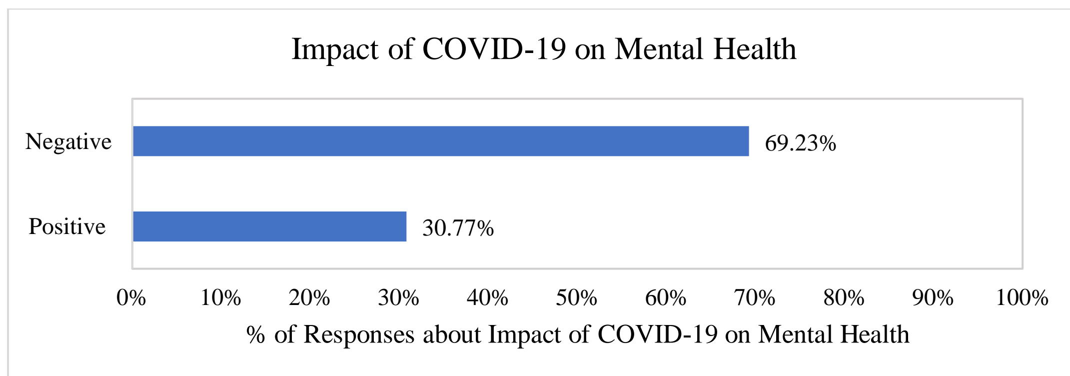
Note. Parentheses indicate number of unique participants and responses included in each sub-theme identified within a larger theme.

1.1 Impact of COVID-19 on Mental Health

Individuals in this current study reported that COVID-19 had both positive and negative impacts on their mental health. However, the negative impacts appeared more salient. The distribution of positive and negative impacts can be seen in Figure 1.

Figure 1

Percentage of Responses in Impact of COVID-19 on Mental Health Subcategories



1.1a Negative Impact of COVID-19 on Mental Health. All participants endorsed negative impacts of COVID-19 on their mental health. One participant said, "I would say it's definitely made me more unstable emotionally and it increased my levels of anxiety and depression." Another participant said, "I think it has increased anxiety, for

you know the future… everything seems far more unpredictable." Participants endorsed increases in anxiety due to the uncertainty of the pandemic, worrying about friends and family, and increased awareness of physical health, physical space, and interpersonal interactions.

Disruptions in social support networks caused by quarantining, stay-at-home orders, and social distancing during the pandemic may have also exacerbated depression and anxiety symptoms that were present prior to the pandemic. One participant reported "it was difficult not being able to reach out to your social groups for support" and "I have depression … being in contact with people … is helpful." Another participant described coping with depression, "It was a little more challenging to try to find ways to alleviate some feelings… I didn't have as many options due to the pandemic." Not only did participants identify disruptions in social supports, they also spoke about the ways that COVID-19 contributed to poorer emotional adjustment and impacted their day-to-day routines. As one participant reported, "obviously makes it a little bit harder to keep up a regular routine and do things that make me feel better like getting dressed up or cleaning my house, there weren't as many reasons, because I couldn't invite my friends over to see it." Although each of the participants in the study presented with mental health challenges prior to the lockdown, they indicated that circumstances associated with the pandemic appeared to have a negative impact on their social emotional functioning in various ways.

1.1b Positive Impact of COVID-19 on Mental Health. Surprisingly, seven out of ten participants also identified positive outcomes resulting from the COVID-19 pandemic. Finding a silver lining, one participant endorsed specific positive mental health impacts related to COVID-19, "I think in a weird way it's kind of been better for

my mental health… I can see that there were benefits from it." This participant described benefits such as being able to "take more time off work to focus on my mental health and the issues that I had been having." For this participant, they were able to take more time and more preferred hours off work due to the increased work environmental flexibility, which allowed the individual to take steps to prioritize their mental health (e.g., scheduling consistent exercise). Further, another participant reported that COVID-19 resulted in a new perspective that emphasized appreciation and gratitude, stating, "I don't take things for granted as much and it's helped me develop a sense of hope and positive outlook." Another participant found that these circumstances adaptively fostered a sense of self-reliance by forcing him to "build up [coping] skills that didn't require many people around." Most positive benefits identified included finding new ways to cope by maintaining interpersonal relationships and connections with family members at home. Although these positive impacts were mentioned, the negative impacts of COVID-19 were much more salient as participants identified how COVID-19 increased their anxiety, stress, depression, and health concerns.

1.2 Impact of COVID-19 on Mental Health Services

The majority of participants denied that COVID-19 significantly impacted their use of mental health services. This is likely due to access to services prior to the pandemic and their ability to transition to telehealth when the clinic was closed to the public. Participants reported that occasionally COVID-19 would be discussed in telehealth services as it was applicable to their experiences and having peripheral impacts on their treatment needs and therapy. For example, a participant stated, "It's not so much

that telehealth affected what I was working on, but the pandemic caused changes in my life that I had to work on."

Main Category 2: Accessibility to Services

Participants reported that they were able to continue accessing services during COVID-19 with limited challenges and barriers. Furthermore, most participants were able to recognize new ways in which telehealth increased accessibility to services. When participants discussed their experiences regarding accessibility to services two themes emerged including: Transitioning to Telehealth and Access to Services (see Table 4).

Table 4

The frequency of references to Accessibility to Services (N = 10)

	Total Number of Participants	Total Responses
2. Accessibility to Services		
2.1 Transitioning to Telehealth	10	26
2.2 Access to Services	10	48
2.2a Convenience and Increased Access	*(10)*	*(43)*
2.2b Restricted Access	*(3)*	*(5)*

Note. Parentheses indicate number of unique participants and responses included in each sub-theme identified within a larger theme.

2.1 Transitioning to Telehealth

All the participants that were interviewed indicated they experienced a range of thoughts and emotions when transitioning to telehealth. During the beginning of the pandemic the clinic shut down and there was a two-week delay until telehealth services were operational. When describing this period, one participant shared, "I knew it would take a minute… maybe was a little longer break than I would have liked", adding that "all it was, was an inconvenience. It wasn't a major hassle." Other participants reported initial

feelings of trepidation and ambivalence during the transition period and expressed feelings of frustration, nervousness, and annoyance. As one participant recalled,

> "It was, because it was a forced transition, I think it was just accepting that there aren't any other options, so if I want to meet this is the format, this is what we can do, rather than you know this wasn't my choice to meet over telehealth, so I think that for me personally if I'm forced into decisions I automatically just don't like things that aren't my choice, but I can accept them."

Despite some initial adjustments and feelings of awkwardness, most participants reported that the transition to telehealth was relatively smooth. Participants reported getting used to the new telehealth platform over time with repeated/increased use. As one participant said,

> "I feel like I was kind of apprehensive about it in the beginning, and it was just a weird change to go from being in-person to trying to do the exact same thing over the computer, but it's felt better and like I said just more natural the longer that I've done it."

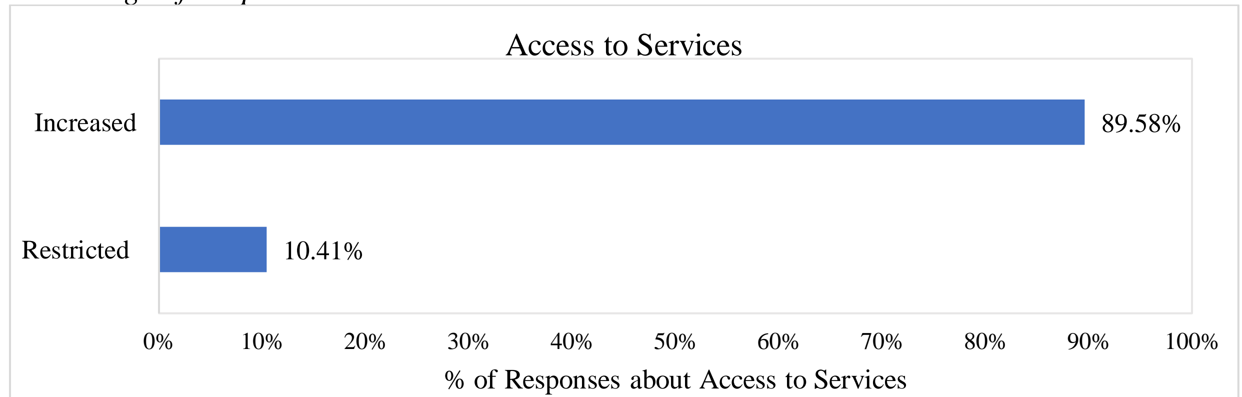
Some participants shared positive aspects of transitioning to telehealth. Specifically, it was reported that transitioning to telehealth was an opportunity for clients to utilize their coping skills and challenge themselves. For example, when describing how she responded to the transition to telehealth, one participant shared, "I really struggle with this change, so it's pushed me out of my comfort zone and help me grow as an individual that way."

2.2 Access to Services

Many participants noted little to no disruption in their ability to access services, in fact multiple participants noted positive aspects of accessibility to services through use of telehealth. When speaking about ability to access services participants identified ways that telehealth increased their access as well as ways telehealth restricted their access to services. Participants perceived increased access to services and restricted access to services can be seen in Figure 2.

Figure 2

Percentage of Responses in Access to Services



2.2a Increased Access and Convenience The majority of participants identified benefits telehealth; the most salient benefits of telehealth were increased access and convenience. The accessibility of Zoom teleconferencing allowed clients and clinicians to see each other face-to-face despite being in remote settings. As one participant illustrated, "it's a connection thing just being able to see the person you're talking to even if it's not in-person makes a difference." Participants reported experiencing easier access to therapy services, specifically being able to stay at home. For example, one participant discussed how the symptoms of depression can make it challenging to get up and go somewhere and stated, "it has been nice to just grab my laptop… and go to a therapy session." Other

participants reported how telehealth increased access to therapy when medical issues, like chronic illnesses, had interfered with in-person sessions in the past. As one participant reported, "the most helpful benefit of telehealth has been the access of it." Furthermore, ninety percent of participants spoke about the convenience as an advantage to telehealth. Participants identified aspects of convenience which included: flexibility, flexibility in scheduling, not having to account for travel time, portability, and ability to engage in therapy remotely. Participants were already identifying the convenience of continued telehealth use after the pandemic. As one participant identified, "when travel becomes available again it [traveling] wouldn't mean that I have to cancel a session." Many participants identified another convenience of telehealth as the ability to engage in therapy regardless of weather conditions, chronic health problems, and unplanned emergencies. Another participant stated, "if I need to be out of state or if I can't leave my home because I'm snowed in or my car is broken down, I can still make it to a session." Participants consistently identified convenience as a major benefit of telehealth services.

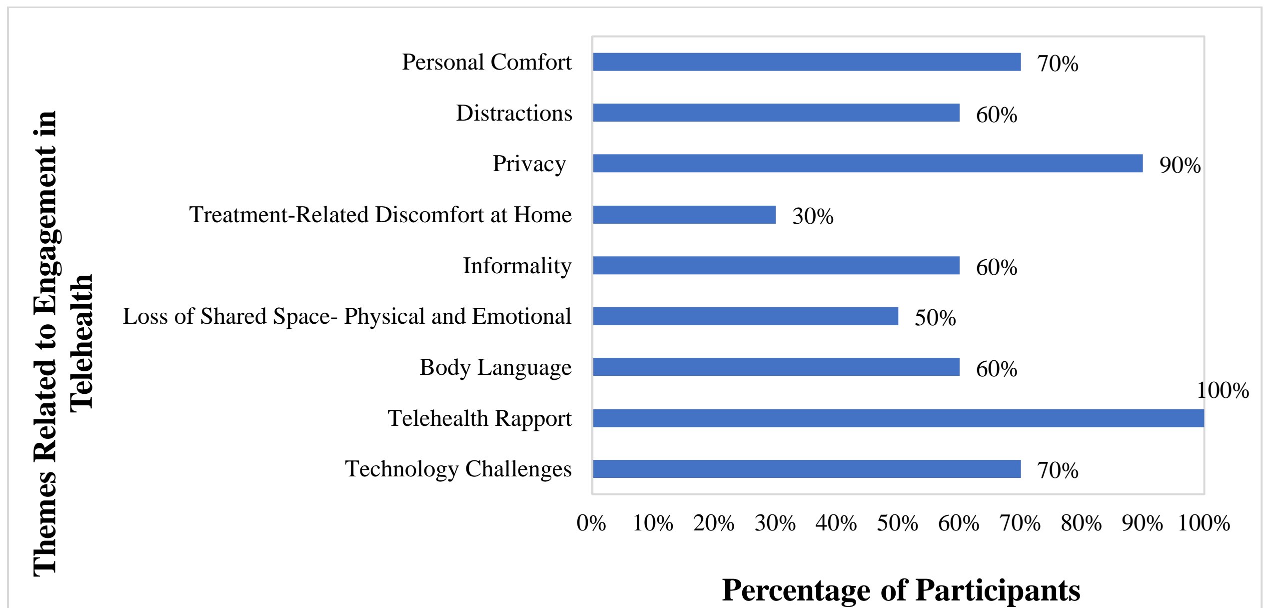
2.2b Restricted Access. Participants also recognized that restricting services to telehealth limited access to some specific services. For example, one participant reported that due to logistic challenges they were unable to engage in dialectical behavior therapy group sessions. Another participant reported she was unable to receive a comprehensive ADHD assessment because it required the use of hands-on testing materials within the clinic. Despite these limitations, many participants appeared to take these challenges in stride, as one reported "we just have to be more creative about ways we can think around problems or treatment ideas and stuff like that."

Main Category 3: Engagement in Telehealth

Throughout the interviews, participants discussed ways in which telehealth enhanced and hindered their engagement in therapy in different ways. Nine themes emerged when participants discussed their experiences regarding engagement in telehealth, including: Personal Comfort, Distractions, Privacy Concerns, Treatment-Related Discomfort at Home, Informality, Loss of Shared Space- Physical and Emotional, Body Language, Telehealth Rapport, and Technology Challenges. The percentage of participants who contributed to the themes within Engagement in Telehealth can be found in Figure 3.

Figure 3

Participant's Identified Engagement in Telehealth (N = 10)



After reviewing these nine identified themes, it was evident that subcategories had presented in the data within some of the themes revolving around engagement in

telehealth. Subcategories were identified for Distractions, Informality, and Technology Challenges. The nine themes and identified subcategories can be found in Table 5.

Table 5

The frequency of references to Engagement in Telehealth (N = 10)

	Total Number of Participants	Total Responses
3. Engagement in Telehealth		
3.1 Personal Comfort	7	19
3.2 Privacy Concerns	9	20
3.3 Treatment-Related Discomfort at Home	3	8
3.4 Distractions	5	17
3.4a External Distractions	*(5)*	*(12)*
3.4b Internal Distractions	*(3)*	*(5)*
3.5 Informality	6	20
3.5a Disadvantages associated with Informality	*(5)*	*(12)*
3.5b Advantages associated with Informality	*(4)*	*(8)*
3.6 Loss of Shared Space- Physical and Emotional	5	16
3.7 Body Language	7	27
3.8 Telehealth Rapport	10	32
3.9 Technology Challenges	9	41
3.9a Clinic Technology Challenges	*(8)*	*(22)*
3.9b General Technology Challenges	*(7)*	*(19)*

Note. Parentheses indicate number of unique participants and responses included in each sub-theme identified within a larger theme.

3.1 Personal Comfort

Another theme that contributed to telehealth engagement identified across 70% of participants was personal comfort. Personal comfort was coded as references to having access to comfort items while engaging in treatment within the home, the familiarity of the home environment, and references to feeling comforted by the distance (physical and emotional) that telehealth offered. A common source of comfort that was seen across many participants was access to their pets during therapy and the comfort that the presence of their pets provided. One participant shared:

> "I am very much an animal person, I do have a dog, it is awesome to sit on my bed with my dog and have that sort of immediate comfort as well as having someone in the room—not technically a body in the room, it is an immediate sort of comfort and familiarity that I do very much appreciate."

Similarly, many participants describe sources of comfort and coping tools that they had access to within their own environment such as cozy blankets, heated blankets, guitars, musical instruments, and other objects like moon sand. Some participants discovered that for them it was easier to engage virtually in part due to feeling safe and comfortable within their own personal, familiar space. One participant reported that receiving services in their home gave them a "sense of privacy, confidentiality, but also just a level of comfort." Another participant stated:

> "I think, for me, being able to have literally what feels like a wall or screen or something between me and that other person, it makes me feel a little bit safer. And I'm also in my home so I'm going to a comfort place, so it just helps with the flowing of what I need to say."

3.2 Privacy Concerns

Another theme that emerged during the interviews was privacy concerns. Ninety percent of participants endorsed experiencing privacy concerns that arose while engaged in telehealth sessions. When participants discussed being interrupted by people during their telehealth sessions, unless explicitly stated, it was often difficult to differentiate whether these interruptions were a concern strictly due to it being an invasion of privacy or because the interruption itself was distracting - or both. Therefore, I coded interruptions by others as privacy concerns only in instances when participants referenced

privacy. Conversely, if no explicit reference to privacy was made, these interruptions were coded as external distractions (see below). Given the similarities in context, there is likely considerable overlap between these themes.

Finding space for privacy was a challenge, as many participants had spouses and children working and learning remotely at home during the first year of the pandemic. One participant shared that, due to these circumstances, finding a private corner was difficult, "I was like in my bedroom in the closet…and I would say that's not a particularly comfortable space." Others were only able to find privacy by holding sessions at their place of employment or even in their car. Furthermore, participants described that simply knowing someone was in the house who could potentially violate their privacy influenced their thoughts and behaviors during their therapy sessions. When discussing this issue, one participant described having to trying their best to "not be aware of what is going on with the other person" within their home. And despite their best efforts, instances of invasions of privacy seemed unavoidable, as one participant shared that there were "times where they forgot… and they'll just come barging into my room… I'll be in the middle of a conversation, and I just almost shut down." Thus it appeared that privacy-related issues were a much more common occurrence in telehealth sessions than they were in participants' previous treatment session held in the clinic.

3.3 Treatment-Related Discomfort at Home

For some participants, having emotionally distressing therapy sessions that occurred within their home was discomforting. One participant mentioned missing the ritual of traveling to in-person therapy and driving home which allowed them to reflect on their session and decompress, this speaks to the value that the time before and after the

appointment held for the individual to separate the emotion work from therapy and their home life. Similarly, one participant stated, "I felt like I was speaking about things in my house that I would never normally speak about you know because I would go to like the therapist's office to talk about that." Recognizing feelings of discomfort with talking about treatment-related issues at home, another participant stated:

> "We worked on some trauma PTSD stuff and I think that it was really important to have those sessions in-person, and then to also have that be the place I went to talk about it, so that I could kind of in a healthy way compartmentalize so that it didn't always leak over everything else in my life emotionally and I think it would be hard for me to do that type of therapy again in my own home, you know I don't think I would be interested in that."

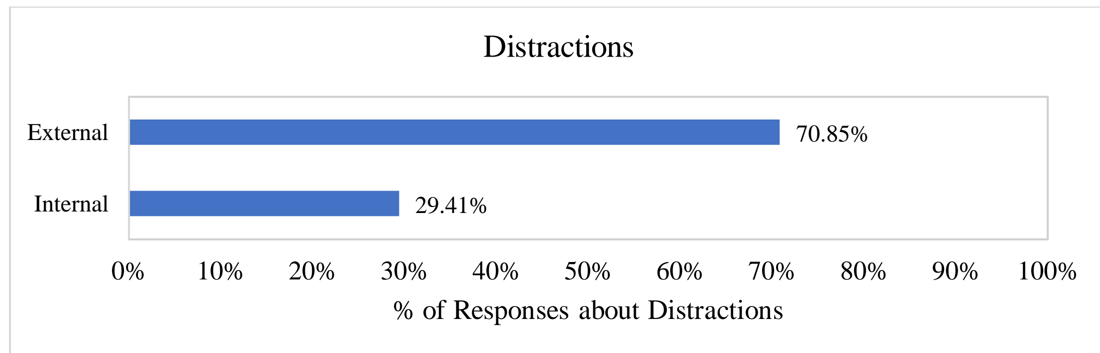
The participant reported they made the decision with their clinician to use telehealth to focus on other treatment goals and to pause the trauma-focused therapy until their return to in-person therapy. For a minority of participants, it appears they felt the need to separate aspects of their treatment work from their home life, reserving the most emotionally taxing treatment work for the clinic.

3.4 Distractions

Participants reported both external and internal distractions that occurred during telehealth sessions (see Figure 4). Distractions, especially external distractions, often included disruption by others during sessions which likely led to an invasion of privacy (see privacy concerns code). All descriptions of disruptions by others during the telehealth therapy session were coded as external distraction unless participants directly referenced privacy.

Figure 4

Percentage of Responses in Distractions



3.4a External Distractions. External distractions appeared to be the most common form of distractions participants experienced during telehealth. One participant reported:

> "There's a lot of external things going on in my environment if my roommates are walking around, if they come into my room without knocking, if my animals are going crazy, it takes away from that engagement that I need to make progress in my treatment."

External distractions within the environment that hindered engagement, including pets running around and making noise, phones buzzing, and roommates/household members entering the room or area where an individual is doing telehealth therapy. When discussing this challenge, one participant stated:

> "Household members being around can be a distraction … I can't expect my roommate to just like hide in her room during the duration of my sessions so she could be cooking and making noise and that's something, like noise, around me is something—that's really distracting to me, which is why in-person worked pretty well."

Participants frequently reported that these external distractors interfered with their engagement in treatment engagement and hindered their treatment progress. Participants also frequently described efforts to reduce these distractions. One participant stated they tried to minimize their own distractions proactively by scheduling sessions during times when interruptions from deliveries, their spouse, and others would be less frequent, as well as by reducing clutter from the room where they would be having the telehealth session.

Many participants also reported that factors within their clinician's environment could equally be distracting. One participant stated, "Again, pets running around like lunatics, and the same can happen on the therapist's end too, if they're at home their pets might be running around as well." One participant added that it was helpful when their therapist had "an environment that [was] created to not have any distractions." For some participants seeing that their clinician was in a distraction free, therapeutic environment enhanced their engagement.

3.4b Internal Distractions. Internal distractions were also mentioned but to a lesser extent. These included references to difficulty focusing and being easily distracted during telehealth sessions. Participants described daydreaming and/or zoning out, having difficulty listening, and needing the clinician to repeat themselves. For example, one participant reported that while at home their thoughts were more readily wandering on other things. One participant shared:

> "I can see things that maybe I've intended to get done that day and so that can be something that I can be half focused on like okay, this is a [mental] to do list that I

> need to get done, which isn't something that shows up when I'm in a therapist's office because that's not the visual that's presented to me."

Participants discussed having to prepare themselves for telehealth services by setting their mentality as to not be distracted and to be presently focused and engaged in therapy sessions. Participants described intentionality in minimizing internal distractions:

> "I felt like I had to think about or try to tune out in order to make it still a productive therapy session because it's kind of a mindset thing you know when I would go there physically, it was you know I walked in with a purpose and knew why I was there and it was a shift in my mind, I had to put more effort in mentally I think to shift my focus to be like okay this is my purpose, right now, and this is what I need to be working hard on."

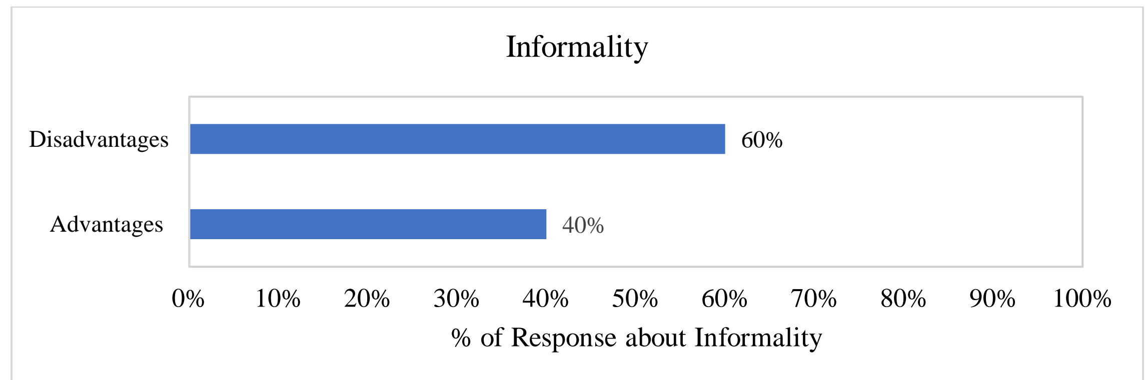
These responses suggest that for many participants, it was more challenging to maintain focus during telehealth sessions than during in-person clinic-based treatment sessions, due to various unique aspects of the telehealth treatment environment.

3.5 Informality

Participants described disadvantages and advantages to the informal aspects of telehealth sessions. Interestingly, aspects of the perceived informality of telehealth were described as disadvantages by some participants and as advantages by others. The distribution of the disadvantages and advantages can be seen in Figure 5.

Figure 5

Percentage of Responses in Informality



3.5a Disadvantages Associated with Informality. Some participants shared that they occasionally felt less committed to telehealth therapy because, ironically it was so easy to access, with no more formality or investment than opening one's laptop. One participant stated it provided "an opportunity to be lazy, logging into my computer and setting up in my own bedroom is a lot less work." Other participants similarly reported without having to travel to the clinic it was "just easier to not do it…I felt like it was a little bit easier to forget." Some participants shared having sessions within the home felt too informal, too comfortable. As one participant put it, "therapy is not supposed to be comfortable…how can I still get the most out of my session while being around all my comforts."

Similarly, a few participants noted that it was difficult to be fully engaged in therapy when their therapist's environment felt informal, cold, and impersonal. One participant recommended that providers increase their efforts to personalize their treatment space to counter the impersonal feeling of a telehealth session, saying "put something up… just to make it seem a bit more personal."

3.5b Advantages Associated with Informality.

Forty percent of the participants mentioned benefits of using telehealth within the informal, and more personal, environment of the home setting. Some participants identified that telehealth allowed clients to address issues in the place where issues frequently occurred - within their home. One participant stated, “being in a place where I can talk with my therapist in the environment where I’m needing help to figure things out in my home environment, that's unexpectedly awesome.”

Telehealth sessions provided many participants with a small window view into the informal aspects of their clinician’s life, as their clinicians conducted telehealth sessions from their own home. As one participant put it, this allowed them to realize that their clinicians “are people too, and it kind of I guess just eases the mood.” Another participant reported that seeing their clinicians in this informal way helped them feel like the pandemic was a shared experience, stating “I think in a way it was maybe a little reassuring that we’re all uncomfortable right now.” Another participant mentioned that it felt reassuring when their clinician was in the same spot with a familiar background each session. Perhaps due to the many stressors during the pandemic, her clinician’s efforts at “maintaining consistency in the environment” provided her with a needed sense of predictability.

3.6 Loss of Shared Space- Physical and Emotional

Participants reported that without in-person therapy, there was a loss of both physical space and emotional space. Many participants reported there was an inherent value being in close physical shared space with their clinician, which could only be provided in traditional in-person therapy settings. As one participant shared that without

speaking one-on-one in-person, there was a “loss of this socially sanctioned space to talk about things in a certain way.” In-person sessions were identified among participants as a unique shared experience being present in the same environment with someone. When comparing the two treatment modalities, one participant made the observation that “it’s just missing being there in-person, you can’t replace that.”

Some participants also reported experiencing more difficulty connecting with their clinician over a screen after sharing very emotionally vulnerable, personal content over telehealth. Specifically, one participant reported “it just felt a little different to be going those places emotionally when you’re not in the room with somebody.” As a result, for some participants this limited the extent to which they were comfortable being emotionally vulnerable over telehealth.

3.7 Body Language

Loss of body language was another reoccurring theme when discussing telehealth. Many participants spoke about how in video sessions it was more difficult to discern non-verbal communications, such as body language and other behavioral cues.

> “I wondered are they seeing enough of me right now to know my full reaction to something that they've asked or to read my body language, all the way. They can't tell that my foot is bouncing right now, they can't tell that my knuckles are white right now.”

Interestingly, because telehealth limited visual cues to a small headshot, some participants reported that they adapted new ways of communicating their emotion that could more easily be conveyed across the screen. One participant stated:

> "I felt like I had to make sure that I was putting everything on the table so that even if they couldn't see that I was biting my nails, or you know picking at it, that I was really tense even if they couldn't see that they would still have all the information they needed."

Given how frequently the theme of body language emerged across participants, participants were also asked what recommendations they would give clinicians working within the limitations presented by telehealth and virtual screen-to-screen communication. Participants recommended that clinician's using telehealth "be aware of the limitations of it [telehealth] and what could stay hidden or undisclosed." One participant stated that "instead of being able to make some of those observations [behavioral] it's just kind of adding additional check ins when there's uncertainty or you need clarification." Many participants recommended that clinicians verbally check-in more frequently throughout the session and specifically at the end of the session. One participant reported that along with their clinician they adapted the loss of body language and cues by using a numerical scale from 0 to 100 to rate physiological symptoms of anxiety, with 100 being the highest anxiety. This participant reported that these adaptations have made the loss of body language easier.

3.8 Telehealth Rapport

One of the main concerns for participants was how the therapeutic relationship may change as a result of the virtual nature of telehealth. Participants in the current study already had established relationships with their providers before transitioning to telehealth and reported that they were glad they had the time in-person with that clinician to get to know them prior to the transition. One participant reported "I got to get the

initial awkwardness of not being super used to the video call, I got to get that over with a person I was already familiar with."

Many wondered how difficult it would be to build rapport with new providers strictly over telehealth. Of the people interviewed in our study, only two participants spoke about their experience transferring to a new therapist after the clinic transitioned to telehealth. One participant shared their experience tackling this challenge in the following way:

> "The fact that I did have a therapist I had met in-person and like had gotten used to the telehealth sessions that way it wasn't like I had to deal with the learning curve of technology, at the same time as the learning curve of a new therapist, that was nice."

Another participant who transferred to a new therapist after a few months of telehealth compared her relationship with her two therapists – the one she met it person, with the one met online, saying, "I think that I'm at the same comfort level with both…which is not what I expected. I wasn't expecting to feel as comfortable with the person that I only met via zoom as I did the person in-person."

Given that therapeutic alliance is such an important predictor of positive therapeutic outcomes, we asked participants for suggestions to aid clinicians to more effectively develop appropriate rapport over telehealth. One participant reported "they [clinician] are meeting me at my level in regard to maybe the language that I use… and that makes it feel a lot more personal." Another participant recommended being available for any questions about telehealth or talking about any kind of reservations the participant had about switching to telehealth. Ongoing and open communication was a common

recommendation among participants. A participant reported that it was particularly helpful when their clinician provided an open environment and invited feedback for each session. This participant stated:

> "From the very beginning, she [clinician] made sure to say if there's anything you don't like about these sessions, if there's something that you need to be fixed, please tell me and she says that every session. Every session she's like is there anything that didn't work for you today, is there something that I can make better, and it makes it a really open environment."

The participant went on to explain that this was an effective way to communicate and build rapport with the clinician, which was especially important in telehealth sessions. She added that the solicitation of feedback empowered her to feel comfortable speaking up about a telehealth challenge they encountered. Once brought to her attention, she reported that the therapist worked with her to identify a collaborative solution, an effort that enhanced her rapport and engagement in treatment.

3.9 Technology Challenges

Technology encompasses nearly all aspects of telehealth, from the platforms used for telehealth, to client portals, internet connections, and knowledge of using it all together to access telehealth therapy services. As a result, it is inevitable that technology challenges will be experienced.

3.9a Clinic Technology Challenges. Some of the challenges that participants reported around technology were specific to the campus clinic and the telehealth measures that were specifically implemented within the clinic services. Some of these challenges were related to changes in communication, specifically being able to contact

front desk staff readily. During the period of transition to telehealth, there were initial challenges as much of the communication was through an online portal. As one participant shared:

> “I prefer to just call in and talk to [Clinic Staff] than the portal, but right away again it was the office was completely shut down, that portal became the only way to communicate— well primary way of communicating.”

Other challenges were related to the platform used for telehealth as one participant stated:

> “I wish that there were maybe other services … that could be used just because sometimes the URLs or the passwords can get really glitchy. There can be issues in that regard, if I mean if you get a wrong password, you can't get on to there and that can create a lot of anxiety and take away from the experience overall.”

Another participant reported, “I was confused there's like click here to check in but then you have to click on the note to get the link … I was a little bit confused by what to do.” The majority of the specific clinic-related technology challenges were the result of a change in communication with staff or related to the telehealth platform and client portals used by this campus community training clinic. These communication difficulties made rescheduling and canceling appointments especially difficult. In addition to communication, the clinic was forced to adopt new payment procedures which were not available previously. One participant shared that before the pandemic, “I would always pay when I got there. And so now I'm getting calls to pay for therapy [online] and I try and call back in and it's like phone tag when it used to be so much easier just to pay there.” Many of these issues arose during the adjustment period, and became less prominent as both the clinic and participants learned to navigate the variety of new tools

and procedures necessary for telehealth. There were, however, more general technological challenges that participants encountered that were not specific to the clinic or this period.

3.9b General Technology Challenges. Participants reported general non-clinic technology challenges that occurred throughout telehealth. Perhaps unsurprisingly, the most commonly reported challenge was an unstable internet connection. Participants identified the importance of a stable internet connection, but also identified the lack of internet access as a barrier to treatment services. Other participants shared brief periods of time where they did not have access to internet. When discussing connectivity issues, one participant shared, “it is glitchy I mean if you don't have access to good quality internet, high speed internet then it's going to create more barriers.”

Some participants reported problems with audio/visual access on their computers/phones, which required creative solutions to continue sessions. For example, one participant described, “there have been sometimes, where it was freezing a lot, so my therapist called me so we just talked on the phone for the rest of the call.” In this instance, having a plan and knowing what was going to happen if the video session disconnected provided the client with a sense of comfort and demonstrated clinician confidence utilizing telehealth and handling challenges that may arise. Another participant reported: “I think there was one therapy session I had to have her up on my computer because I couldn’t get her visual up on my phone.”

Unstable internet was also a frequent technological challenge. One participant described how internet connectively issues interfered with their ability to connect emotionally with the clinician, saying:

"If I feel like I'm going to make a breakthrough or making an intense moment of progress, and then the internet just cuts out, and I have no idea what they're [clinician] saying I'm sitting there emotionally vulnerable … my thoughts are just going crazy in my head and they won't shut up, so I have no way of kind of having my clinician help me bring it back down to ground myself more so I can understand what's happening to me."

Many participants recommended that clinicians providing telehealth experience practice and training with some of the technical aspects of the platform, to ensure the provider is comfortable using the technology during the session. Participants were able to tell when clinicians were nervous and were unfamiliar with the telehealth platform and technology. One participant stated:

"I think she was new, and she was pretty nervous, and I think trying to add on the checklist and the telehealth and stuff probably made her more nervous… you know she was pretty nervous, and I think that made it a little harder to connect."

In contrast, when clinicians were comfortable and confident with the use of telehealth, the participant reported feeling comfortable and secure.

Main Category 4: Service Preference and Satisfaction

All participants were asked about their satisfaction and preference for telehealth preference. When participants discussed their satisfaction and preferences two themes emerged including: Service Preference and Service Satisfaction (see Table 6).

Table 6

The frequency of references to Service Preference and Satisfaction (N = 10)

	Total Number of Participants	Total Responses
4. Service Preference and Satisfaction		
4.1 Service Preference	10	31
4.1a Current Preference	*(10)*	*(15)*
4.1b Long-Term Preference	*(10)*	*(16)*
4.2 Service Satisfaction	10	24

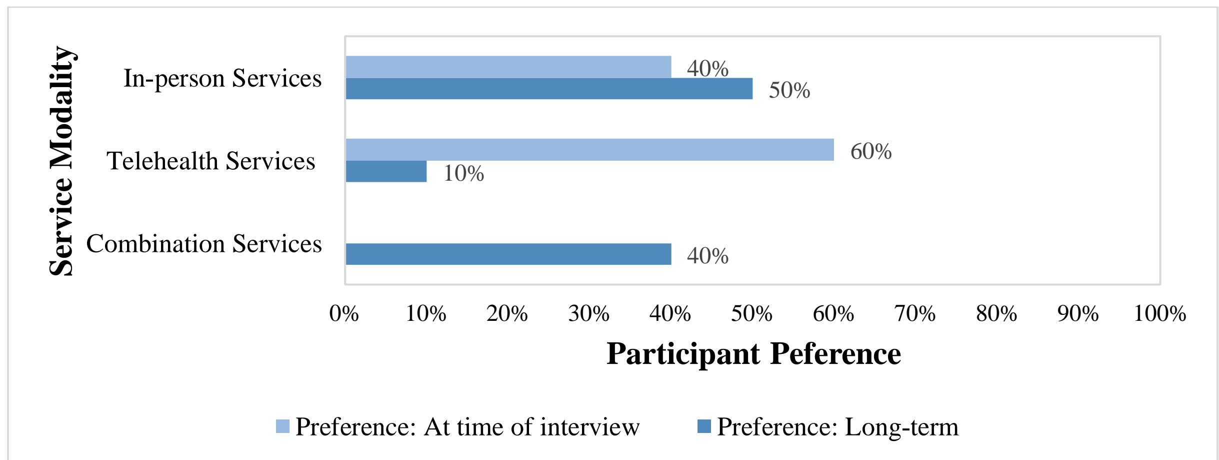
Note. Parentheses indicate number of unique participants and responses included in each sub-theme identified within a larger theme.

4.1 Service Preference

Participant preferences for either in-person or telehealth services were further divided into their current and long-term preference. The service preference of participants can be found in Figure 6.

Figure 6

Service Preference Among Participants (N = 10)



4.1a Current Preference. At the time of the interview, 40% of the participants indicated that they would prefer in-person therapy services, whereas the majority (60%) of participants reported that, had they been given the chance, they would rather continue

with telehealth. Many of the reasons for choosing to continue with telehealth at the time of the interview were related to health and public safety. Regarding health and public safety, one participated stated:

> “I don't think I feel exceptionally comfortable for myself or my provider going into the clinic without masks, or even frankly being masked, in those small spaces I don't know that unless we're like corner to corner you can be six feet apart in there and so I definitely think that given the situation given being asked right now I think I would say continue on telehealth.”

Participants in this study expressed concerns about the ability to be safe and take appropriate precautions in therapy sessions. Other participants also expressed concern about not only the potential of exposing other people to the virus but also the additional concern of unknowingly exposing others to the virus. Another participant said:

> “I don't have to worry about putting other people at risk … maybe you are also just sick and you're near an elderly person or someone with a low immune system, so I feel like I don't have to worry about hurting people going into a clinic.”

4.1b Long-Term Preference. In the long-term, when the COVID-19 risk has subsided and/or become minimal, 50% of participants said that they would exclusively prefer in-person services. Only 10% of participants said that they would prefer exclusively telehealth in the long-term when the COVID-19 risk has subsided and/or become minimal. The remaining 40% of participants indicated that they would prefer a combination of in-person services and telehealth services in the long-term. These participants spoke to the convenience of having telehealth as a back-up option for

situations they could not make in-person appointments. When describing the option of having telehealth as a back-up option, one participant shared:

> "I would probably choose to do in-person, but it would be nice to have the option of say if I was going to be gone somewhere else, or if there were like weather barriers, like bad weather or like I had said with my physical illness, if we would be able to change that [appointment] to a telehealth appointment on kind of a shorter notice, to kind of have both options on the table."

4.2 Service Satisfaction

Participants reported mixed responses to service satisfaction. One participant reported "my whole experience has been positive, I'm very thankful for it." Many participants reported being "completely satisfied" and "very highly satisfied" with services, whereas a minority indicated that they felt less satisfied than they were with face-to-face services. And although 90% of participants reported they were satisfied with telehealth services, two thirds of this group indicated limiting their therapy to telehealth alone would not be their preference. One participant stated:

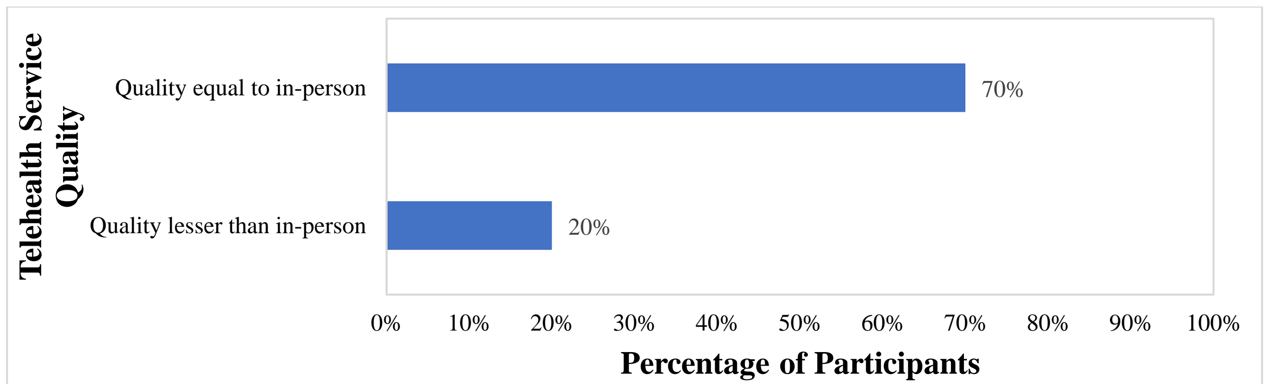
> "I'm right smack dab in the middle. It's not what I would prefer but it's what is needed for this time with the pandemic and what our community needs and that's another core value of mine so being able to help in that process gives me a sense of hope and urgency in order to go forward with my treatment in this style."

The majority of participants described this as "the best-case scenario, in a bad case scenario." While evaluating satisfaction with services overall, we also evaluated if the participants perceived that they were receiving the same benefit or quality of care via telehealth. The results of this evaluation can be found in Figure 7. Most of the

participants indicated that the benefit or quality of care received was comparable to in-person services; however, there were participants who felt it was lesser than in-person services. One participant found the benefit or quality between telehealth and in-person services unable to be compared, stating, “there’s just some things that are different is all, I don’t think it’s a better or worse thing.”

Figure 7

Perceived Quality of Telehealth Services Among Participants (N = 10)



Note. Percentage does not add to 100% because one participant was unable to compare the benefit and quality between telehealth and in-person services.

CHAPTER V

DISCUSSION

Interviews collected during the current qualitative study identified several themes that were grouped in the following four main categories: *Impact of COVID-19, Accessibility to Services, Engagement in Telehealth,* and *Service Preference and Satisfaction.* These themes provide an overview of challenges COVID-19 posed to mental health clients and their providers, factors that contributed to client satisfaction with telehealth services, as well as aspects of telehealth that were perceived as barriers to the treatment process. Understanding these factors may help inform effective telehealth practices. A brief discussion of the findings are provided below, focusing first on COVID-19 specific telehealth findings, then of the findings that appeared most relevant to telehealth services across a wider context. This discussion is followed by nine recommendations for the use of telehealth based on participant responses.

COVID-19 Specific Telehealth Findings

The qualitative data collected in this study supported the notion that COVID-19 presented many novel mental health concerns and stressors. As with most individuals and families enduring the pandemic (Osofsky et al., 2020; Rosen et al., 2020), participants in our study experienced stress and anxiety from uncertainty and disruption resulting from the COVID-19. All participants in this study reported experiencing negative impacts of COVID-19 on their mental health. Participants also routinely endorsed increased depression and social isolation due to COVID-19; social isolation necessitated by the pandemic seemed to exacerbate depressive symptoms by removing access to social support networks. The conditions of COVID-19 contributed to the specific, and novel,

stressors experienced by participants which impacted their mental health as well as the concerns the participants voiced experiencing during COVID-19. Despite these challenges, a few participants were able to identify positive outcomes that resulted from the pandemic (e.g., more time with family); however, these positive outcomes were identified much less frequently than the negative ones.

General Telehealth Findings

Advantages

Ninety percent of participants in this current study identified positive aspects of telehealth use. Participants reported they found many unexpected advantages upon using telehealth. Forty percent of participants from this current study indicated they have an interest in continuing to have telehealth as an option in their treatment. Many participants were satisfied with the use of telehealth services and found these services to be comparable in quality to in-person services.

Participants reported the desire to continue with the use of telehealth for a variety of reasons including flexibility, flexibility of scheduling, not having to account for travel time, and portability of services. Participants quickly identified ways that the use of telehealth would be convenient, for example if they were snowed in or sick the day of the appointment, they could use telehealth. The results of this study indicated that because telehealth allowed people to attend sessions remotely it has been helpful increasing attendance, especially as it decreases several of the barriers to receiving care. These findings are consistent with previous literature regarding what clinicians have found convenient about telehealth, increased accessibility to services, and improved client attendance (Feijt et al., 2020; McCellan et al., 2020; Nelson & Bui, 2010).

Participants frequently identified ways in which telehealth enhanced engagement. For many interviewees, telehealth improved engagement by making therapy more convenient, flexible, and accessible. These advantages are consistent with previously reported advantages to telehealth (McClellan et al., 2020; Nelson & Bui, 2010). Participants also reported feeling more engaged because telehealth allowed access to personal comforts in the homes that would not have been accessible in most traditional clinic-based treatment settings.

Although many participants reported initially feeling unsure how rapport would translate over telehealth, previous research suggested that providers who use clinical video telehealth agree or strongly agree that their level of rapport was equal to in-person appointments (Perry et al., 2020). Current research in this study suggested that those who transitioned with an established clinician were glad they had time in-person with that clinician prior to telehealth. However, having time in-person prior to telehealth did not seem essential to building rapport for some clients as participants reported that therapeutic relationships and rapport were able to be established over time with clinicians they had not known previously.

Disadvantages

Similarly, participants interviewed in this study were able to identify disadvantages and challenges of telehealth that are generalizable to the use of telehealth beyond the context of COVID-19. Previous literature, as well as this current study, demonstrate that privacy is one of the biggest concerns when it comes to implementing teletherapy (Perry et al., 2020; Feijt et al., 2020). Ninety percent of participants in this study identified experiencing at least one privacy concern while trying to engage in

telehealth. Participants in this current study endorsed difficulty finding space to be alone to engage in therapy. In addition to this, participants described that just knowing someone at home could potentially hear them was interfering. Concerns of privacy are not necessarily specific to COVID-19; however, such high levels of privacy concerns may have likely been exacerbated by COVID-19 as family members were often working and attending school from home making it harder to obtain and ensure privacy.

Although many participants described advantages of receiving telehealth sessions within the home, a minority of participants reported emotional discomfort addressing difficult and intrusive topics in therapy sessions within their own home environment. Distractions, both external and internal, at home were another issue that participants described as being unique to telehealth.

Another disadvantage that was repeatedly identified by participants was the ways telehealth limited non-verbal communication and body language. Participants identified concerns that their clinician may not be able to see the expression of their emotions or their behavioral reactions which may inform the clinician about how the client is feeling during an in-person session. Previous literature has expressed concerns that if therapy was done via teletherapy it would be challenging to read body language and be attuned to the client (MacMullin et al., 2020). This is consistent with Swartz (2021) which postulates that nuanced nonverbal communication cues are lost in translation when the therapeutic interaction moves from the therapy room to video.

Despite the concerns raised by participants regarding the loss of full body language, MacMullin and colleagues (2020) have shown that there is evidence that clients and clinicians do engage in meaningful emotional communication via telehealth

by increasing verbal descriptions of emotions, enhancing tone of voice, and other changes in behavior. Participants in the current study identified adopting similar strategies to compensate for reductions in full body language communication. Furthermore, based on participant interviews, there was no evidence that the barrier to body language resulted in significant reductions in emotional connection and rapport.

Another concern regarding the use of telehealth was technology challenges. Previous literature demonstrates that technology concerns were inevitable with telehealth therapy (MacMullin et al., 2020). The most common and enduring technology challenge was unstable internet connections that created a disconnect and disruption as was demonstrated in this current study.

It is clear that participants considered both the advantages and disadvantage of telehealth when asked to their preference to receive and utilize therapy services in the future. Even with the disadvantages noted above, half of the participants expressed an interest in integrating telehealth services into their use of in-person services. This is consistent with literature stating that many individuals will continue to prefer telehealth services, especially when telehealth services minimize barriers to treatment (Swartz, 2021). Furthermore, given its widespread adoption during the pandemic, it is very likely that telehealth services will continue to be available in clinics well into the future.

Recommendations

The ultimate goal of this study was to create client-based recommendations that mental health providers could use to enhance the use of telehealth services in the future particularly as literature and direct client report has indicated that telehealth will continue to be used (Swartz, 2021; Pierce et al., 2021). Based on participant response from data

collected in the current study, a number of recommendations for practice with telehealth and the applied application of telehealth are provided.

1. Recognize the Many Benefits of Telehealth

The COVID-19 pandemic has brought telehealth to clinics throughout the United States well beyond its use in rural settings (Rainer, 2010). With the expansion of telehealth, its important that both service providers and clients understand the benefits of telehealth. The majority of participants interviewed believed that the access to services virtually via face-to-face video conferencing held many advantages, including reducing physical barriers, making it easier for clients to meet with their therapists, helping clients feel more comfortable, and even for some participants, enhancing client-therapist rapport. Sharing these benefits with clients new to telehealth may help reduce an initial concerns or reluctance they might be experiencing.

Given participants willingness to integrate telehealth into clinic-based treatments, mental health providers should seek out novel ways of hybridizing the two modalities. Rather than an alternative to in-person services, telehealth could be used as a back-up option for situations in which clients, or clinicians, are unable to make in-person appointments due to sickness, vacation, etc. Intermittent telehealth sessions could be used by clinicians in more prescribed way to augment existing clinic-based services. For example, clients could host virtual "home visits" to build rapport or demonstrate the use of new treatment skills within the home setting. Offering telehealth as an option may also increase utilization of mental health services for individuals reluctant to come into the clinic due to physical or mental health constraints.

2. Minimize Hurdles for Accessing the Telehealth Platform

With the rapid onset of COVID-19, the rapid implementation of telehealth services was required. As this was the first implementation of telehealth at this clinic, there were challenges that participants encountered using the telehealth platform. Many participants expressed confusion and lack of clarity regarding the telehealth platform and client portal services utilized by this clinic. Other participants expressed the frustration of not being able to pay online, as they would typically pay in person for each session, not having the ability to pay through the client portal services was a factor that complicated our clinic's telehealth process.

The challenges associated with engaging with the technology platforms can hinder client willingness to use telehealth services (Pierce et al., 2021), and can pose an added barrier to treatment accessibility and engagement. The more complex the telehealth platform, the less likely it is to appeal to clients. Accessing the telehealth platform and interface should be a process that is simple and designed to appeal to the ease of client use.

It is important that clinics seek out ways to streamline their online procedures and increase the accessibility of telehealth services. The goal should be to make the telehealth platform as user friendly as possible, this includes minimizing clicks and displaying information clearly. Streamlining the access to telehealth through the client portal is a vital step in making telehealth a sustainable modality of therapy services. In order for clients to engage in telehealth, it is necessary that they are able to confidently engage with the telehealth platform.

Internet connectivity issues was a reoccurring problem mentioned by participants in this current study. Therefore, telehealth clinicians should also be well informed of strategies they and their clients can use to enhance internet connectivity. This may include teaching clients the importance of regularly resetting routers, using ethernet cable connections rather than WIFI, updating internet browsers, and other strategies. Providers should discuss these tips with clients, provide handouts, and make this information easily available on their clinic website.

3. ***Ensure that Clinicians are Adequately Trained in Utilizing the Telehealth Interface***

The level of confidence and comfort that the clinician displays using the telehealth interface can influence client comfort and willingness to use the telehealth interface as well. Participants in this study reported that they were able to tell when a clinician was nervous and that it often made the participant more nervous themselves. Participants in this study also reported that they had more difficulty connecting with and establishing rapport with a nervous clinician.

When clients are attending telehealth sessions and are sharing emotionally vulnerable information, it is necessary that they have confidence in the clinician's ability to interact through telehealth. A clinician who is not comfortable interacting with the telehealth interface is more likely to experience technology challenges and research has demonstrated that recurrent technology challenges are more likely to threaten the therapeutic processes or damage the therapeutic relationship and rapport between client and clinician (Swartz, 2021). Therefore, it is essential that clinicians are well trained, well-prepped, well-practiced within the telehealth platforms they will be providing

services through. This may include mock therapy sessions with another student clinician to familiarize clinicians with programs they may be expected to use. Clinicians will want to continue to learn more than just the technical aspects of the telehealth platforms and familiarize themselves with web applications that can enhance client-therapist interactions, such as screen sharing, shared virtual white boards, and other real-time virtual therapy tools.

4. *Create and Discuss Contingency Plans to Address Technology Issues Before They Occur*

While it is essential that clinicians are familiar with the telehealth platform and the telehealth platform is designed and chosen to be user-friendly, it is vital that clinicians are prepared for real-time technology challenges. The most significant barrier to using technology in psychology via telehealth is the technology itself. Due to the unpredictable and unreliable nature of the technology, almost all clients and clinicians will experience real-time technological issues at one point or another. Therefore, clinicians should establish a contingency plan with their clients to address these issues when they do occur. This might include a telephone call after a few failed attempts. Collaboratively developing this type of plan can convey a level of security and confidence in the provider. Previous literature has demonstrated that psychologists who were well trained in the technology and were quickly able to address technical problems that arose for their clients supported telehealth rapport between client and clinician and improved treatment experience (MacMullin et al., 2020). This demonstrates the importance of being prepared to handle technology problems that may arise during sessions.

5. Work Collaboratively with Your Clients to Reduce Privacy Concerns

Privacy violations, or even clients concerns of them, can be major impediments for therapeutic engagement. Although some privacy violations are easy to recognize, such as roommates walking into a telehealth session, distracting privacy concerns that a client might have are not necessarily apparent. Therefore, it is important that therapists have regular conversations with their clients about privacy. The therapist should explain their efforts to maintain the client's privacy, and work with their clients to identity ways that client might enhance privacy within their home. Possible suggestions may include scheduling appointments when the client is home alone, having the client join the telehealth session from a private office at work, or buying a white noise machine for telehealth sessions at home. Providers investment in making accommodations to promote privacy, as well as their willingness to discuss client privacy concerns, can foster therapeutic engagement.

6. Eliminate Distractions, When Possible

Throughout the interviews, another common concern was distractions that interfered with telehealth sessions. Participants reported that distractors can take away from the engagement that is needed to fully engage in and make progress in treatment. Previous literature has indicated that participants have found being surrounded by daily home distractions as a barrier to engagement in telehealth (MacMullin et al., 2020). It is important that clinicians be prepared for distractions and prepare their clients for potential distractions and collaboratively work on how to minimize distractions in advance. This may include having conversations with clients about what kind of distractions they are most likely to experience and how collaboratively these distractions can be minimized.

7. Adapt Behaviors to Compensate for Communication Limitation

The telehealth interface often makes it difficult to read some body language and other forms of non-verbal communication. It is important the providers acknowledge and discuss this limitation with their clients frequently. Telehealth places greater responsibility on both providers and clients to find new ways to communicate their thoughts and emotions. This might include more frequent emotional check-ins or adopting numerical rating scales to share thoughts and feelings over screens. Something as simple as a "thumbs-down" by the client could be used to convey feelings of being too emotionally overwhelmed by the topic and the need for a break. Providers can collaboratively work with their clients to identify and develop their own novel system for relaying these messages.

8. Rapport via Telehealth/Building Rapport via Telehealth

This study demonstrated that while participants were typically thankful for the time with their provider in-person before transitioning to telehealth, it was possible for therapeutic relationships and rapport to be established solely through the telehealth modality.

It is recommended that clinicians be intentional about rapport building over the telehealth modality and closely monitor the development of the therapeutic relationship. It is also recommended that clinicians find ways to actively involve their clients in adapting telehealth in a way that is successful and effective for that individual, this may include eliciting feedback from the client about the effectiveness of sessions. Involving clients in this process and working collaboratively can help build therapeutic rapport over

telehealth. It is of note that during this current study many participants transitioned from in-person services to telehealth services with the same clinician.

9. ***Open Communication and Acknowledge Ambivalence/Attitude Toward Telehealth***

New clients naturally may have a lot of reservations regarding telehealth, this was seen in the current study as the news of the transition to telehealth was met with trepidation. When working with clients that are new to telehealth, it is important to take time to validate their concerns, apprehension, and anxieties, while also acknowledging the advantages and benefits associated with telehealth. When possible, it may be helpful to begin initial contact with the client in-person prior to beginning telehealth. This approach could be used to walk clients through the telehealth platform and/or set up their patient account with their clinician. This can ease some technology anxieties and provide clients with a level of comfort before navigating the use of telehealth on their own. The level of confidence and comfort that the clinician displays, as well as the attitude clinicians display, around telehealth are likely to influence client's initial impressions as well as their initial experiences.

During the first telehealth session, and throughout, it is important to provide an environment that promotes open communication so that the client is comfortable enough to speak up in session when something is not working that the clinician would not otherwise know. This allows both the clinician and the client to make adjustments to the telehealth services that can strengthen the therapeutic relationship and the quality of services.

Limitations and Future Directions

The current study is not without limitations, which are critical to consider when interpreting these findings. One of the most salient limitations to this study is that this data was collected during a pandemic which brought many unique and difficult challenges to the daily lives to the individuals interviewed. When possible, I attempted to differentiate COVID-19 specific themes from themes that appeared to be relevant to the larger picture of telehealth. Nevertheless, it is important to consider the circumstance in which the data was collected when making inferences.

The sample was also relatively homogeneous, especially with 90% of participants being Caucasian. The location of the campus community training clinic associated with a university campus in the upper Midwest, also provides geographical limitations to the data collected in this study. Furthermore, age range was limited. Future studies may evaluate telehealth therapy success with other age populations, as this may be an important variable when it comes to providing effective and successful therapy services. Furthermore, data was collected from individuals who elected to continue with treatment via telehealth. While the majority of the clinic's clients opted to use telehealth, a small minority did not. As a result, the individuals interviewed in this study may have more positive opinions and experiences with telehealth compared to those who opted to discontinue treatment. More research is needed to better understand the views of telehealth abstainers.

Another limitation of this study is the psychotherapy modality being used within sessions was not assessed, therefore no conclusive statements can be made about the utility of any specific treatments (e.g., CBT) through telehealth therapy. Similarly, this

study did not evaluate the diagnosis/diagnoses being treated via telehealth. Future studies may consider evaluating how different diagnoses respond to telehealth intervention as some diagnoses may respond with more success to telehealth than others. Further, another limitation of this study is that only therapy through means of telehealth was assessed, the campus community training clinic elected to stop psychological assessments during the time of COVID-19. As a result, there is no information about psychological assessments via telehealth. Future research could explore how psychological assessment was conducted via telehealth, or can be conducted via telehealth, as well as the validity of assessment conducted via telehealth.

Qualitative analysis has the ability to provide rich details of participants' experiences and perspectives. But, like many forms of qualitative studies, it relies on participants' retrospective reports which can be influenced by biases. It is hoped that the exploratory findings for the current study may provide a starting point for more systematic quantitative efforts. Future studies may be able to test conclusions derived here, for example, by comparing videos of in-person and telehealth sessions to determine whether distraction, rapport, and other differences are apparent across telehealth and clinic-based face-to-face sessions. This and other more nuanced studies will be needed to further inform telehealth best practices.

Conclusions and Clinical Implications

This study provides a number of potential research and clinical implications. Qualitative research is often a first step that can help pave the way to identify themes that may lead to quantitative research on a large scale. The information collected through this study may allow researchers to identify approaches within telehealth that have been

effective and use this knowledge to help educate and train clinicians in providing telehealth services. Furthermore, it is hoped that this research may help to foster future research aimed at continued improvement of telehealth therapy outcomes. Research has already demonstrated that psychologists plan to continue telehealth therapy at a greater rate relative to telehealth use prior to the pandemic (Pierce et al., 2021).

Additionally, as telehealth is gaining momentum due to COVID-19, the practices adopted will have long-term implications in the use of telehealth services (Perrin et al., 2020). This study provides a list of numbered recommendations for the implementation and successful use of telehealth. The information gained from this study contributes to the practice of telehealth in response to COVID-19 as well as in the process of adapting the widespread use of successful telehealth services post COVID-19.

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