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LOSS OF FACE-TO-FACE INTERACTION IN TELEHEALTH

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

Steven Lu

May 2022

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May 2022

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ABSTRACT

Telehealth usage has increased dramatically due to the COVID-19 pandemic. The loss of face-to-face interaction may have an impact on rapport building, noticing verbal and nonverbal cues, and attitudes towards telehealth which may negatively affect the quality of mental health services. The study aimed to determine if the loss of face-to-face interaction has any effect on the quality of mental health services through telehealth. The study employed an exploratory qualitative research method design using interviews. Audio recordings were transcribed to written form to analyze themes that were present. The study found that the loss of face-to-face interaction can influence rapport building, noticing nonverbal and verbal cues, and attitudes towards telehealth which negatively impacts the quality of services when delivered through telehealth. The findings of the study have major implications on the micro and macro level. The findings help social workers understand how the loss of face-to-face interaction has impacted the delivery of services. Additionally, trainings can be developed to address barriers that impact the quality of services.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Telehealth is the use of electronic technology to obtain information so that accurate diagnosis, efficient treatment, and ongoing care can improve access to care and efficiency (Haque 2021). Traditionally, telehealth had been used to provide mental health services to rural areas and underserved communities (Gajarawala & Pelkowski 2021). This allows individuals to have access to mental health services that they may not otherwise have due to where they live. This has caused telehealth's popularity to rise over the last few years and has been found to be as effective in treating mental health disorders as in-person services (Wootton et al. 2020). Even with the increased popularity of telehealth, in-person service is still the common way to provide mental health services. However, a nationwide pandemic would change how mental health services would be delivered.

Due to COVID-19, in-person services are currently suspended or provided in limited capacity to reduce the spread of virus. This resulted in a significant increase in usage of telehealth. For example, Koonin et al (2020) found that telehealth visits in the first quarter of 2020 increased by 50% compared to the prior year. Due to this, developing and experienced social workers are now expected to provide telehealth services even though they have little to no

experience with using telehealth. One of the populations that have been greatly impacted by the pandemic are adults. The Czeisler et al. (2020) states that during June of last year, 40% of adults stated that they struggled with mental health or substance use due to COVID-19. Anxiety, depression, trauma, usage of substance use to cope, and suicide ideation had increased dramatically due to the pandemic (Czeisler et al. 2020). Job loss, fear of themselves or their loved ones getting COVID-19, and social isolation are some of the stressors that adults faced. Adults may also miss or see key events canceled such as their child's graduation, weddings, or social events that they planned to attend. The drastically increased usage of telehealth brings an important discussion of how face-to-face interaction will be affected. Face-to-face interaction is often the most important process in building rapport with clients.

A social worker can identify discrepancies between what a client is saying and what the client truly feels. However, body language, verbal, and nonverbal cues are harder to pick up through telehealth compared to in person. Yuel et al. (2012) states that body odor or pupil dilation are uncapturable by telehealth and the ability to notice body language such as fidgeting, eye contact, and posture are affected by the limited camera video. This may cause social workers to miss important cues that signal what the client may be feeling. For example, the client enters the calls and tells the social worker that he is doing good but has begun to tap their foot. It would be very difficult to notice that the client is foot tapping,

which signals signs of anxiety, through telehealth because the video only shows the client’s face and upper body.

The loss of face-to-face interaction may also have a negative effect on how the client views the social worker. Perle & Nierenberg (2013) states that if actions such as taking notes are not relayed to the client, the client may feel that the social worker is invalidating their feelings. This negatively effects the trust that the client has in the social worker because the client believes that their emotions are being rejected when, the social worker was taking notes to either review or get support from their supervisor after the session is over. Similarly, Gordan et al. (2020) states that the placement of the camera may affect the perception that there is lack of eye contact. If the social worker is looking at the computer screen during an assessment, the client may feel that the social worker is not paying attention to them. The client might feel that the social worker is being cold to them. The loss of face-to-face interaction can have negative consequences in rapport building between the client and social worker.

Purpose of the Study

The purpose of the study is to investigate how the loss of face-to-face interaction affects the delivery of mental health services through telehealth. Due to the pandemic, telehealth usage has grown tremendously. However, the loss of face-to-face interaction makes it more difficult to notice nonverbal cues. The social worker may fail to notice body language that signals distress due to

telehealth. This may negatively impact the client's participation in services because the client may feel that the social worker is not paying much attention to how they feel.

Significance of the Study

The need to conduct this study arose from the increased usage of telehealth during the pandemic and these findings from this study would have major implications on the micro and macro level. At the micro level, the findings would assist social workers in understanding how the loss of face-to-face interaction has impacted how services are currently being delivered. Additionally, trained supervisors in telehealth can observe inexperienced social workers and point out misinterpreted or missed cues during individual supervision. This would lead to better quality of care and decrease misinterpreted or missed cues. At the macro level, social work agencies can develop trainings that address how social workers can build rapport and implement interventions effectively through telehealth.

Even when the pandemic is over, telehealth will continue to be utilized. In fact, there is a possibility that clients may prefer telehealth due to eliminating some of the barriers that in person services currently have. Social work agencies may begin to offer telehealth services permanently after the pandemic is over as an alternative or to supplement in person services. It is important for developing and experienced social workers to be familiar with telehealth and how to effectively deliver services through telehealth. Thus, the study addressed the

following question: How has the removal of face-to-face interaction impact the effectiveness of mental health services being delivered through telehealth?

CHAPTER TWO

LITERATURE REVIEW

Introduction

The current issue facing telehealth is whether the loss of face-to-face interaction affects the quality of mental health services being delivered. Telehealth is defined as the delivery of health-related services and information through technology. Verbal and nonverbal communication, rapport building, and attitudes towards telehealth can all be impacted with the removal of face-to-face interactions. All three of these can influence how effective mental health services can be through telehealth.

Verbal and Nonverbal Communication

Verbal and nonverbal cues are the most important aspects for mental health services that may be negatively impacted due to telehealth. As mentioned before, it is more difficult to pick up verbal and nonverbal cues compared to in-person. Gordon et al. (2020) states that patients felt unheard and neglected due to the lack of eye contact with the provider during videoconference. This shows that the lack of face-to-face interaction impacted how patients felt when receiving services. They felt that there were just a number that the doctor had to see before moving on to the next client. Similarly, Agha et al. (2009) found that telehealth patients receiving consultations were more passive and less engaged with their doctor due to the doctor using a physician-centered approach. A

physician-centered is a communication style where physicians are less focused on the client's concerns and more focused on testing their hypothesis on what the medical issue is. Clients are less likely to be engaged to participate in treatment if health care workers are not taking into consideration their concerns. Research also found that it is difficult to notice nonverbal cues through telehealth (Chadi et al, 2020; Disney et al., 2021). Providers who are not being attentive may miss nonverbal cues that negatively affect services being provided. This may especially impact cultures that value nonverbal communication over verbal communication. For example, Zwi et al. (2017) states that high context cultures communications rely heavily on verbal cues, body language, tone, and gestures. If social workers are not culturally sensitive, cultures that value nonverbal communication may become less likely to participate in session or return for future sessions.

However, there are findings that conflict with other studies that say the loss of face-to-face interaction does not affect the delivery of services. King et al. (2020) found that regardless of face-to-face or telehealth, alcohol consumption decreased in college students and that there was an overall satisfaction with treatment. Additionally, Bennet et al. (2021) found that telephone telehealth sessions were beneficial for dating and sexual violence clients even though there were missed non-verbal cues. This shows that the intervention being delivered to participants does not affect the quality of the treatment. It did not matter if there was no face-to-face interaction, clinicians were still able to communicate the

intervention to students and provide quality mental health interventions to their clients. Similarly, Chadi et al. (2018) states that the participants in both the in-person and telehealth group were able to practice mindfulness in their daily routine which led to an increased sense of well-being in both groups. The telehealth group was able to learn and implement mindfulness just as well as the in-person group. The lack of face-to-face interaction did not affect the participant's ability to learn, practice, and utilize mindfulness in their daily lives.

Rapport Building

The removal of face-to-face interaction can also affect rapport building between client and clinician. Rapport building is the process of establishing a connection and trust between client and clinician to create a safe space for the client to be open about their concerns and emotions. Wootton et al. (2020) stated that rapport building between client and clinician can be negatively impacted if there are constant technological issues during telehealth. Additionally, Disney et al (2021) found that refugees had little or no knowledge of how to utilize technology which made engagement difficult. Both cause the therapeutic relationship to be negatively impacted because the client might feel that their session time is being wasted trying to fix technological issues. If connection were to be stable, would rapport building be able to be successfully replicated as if clients were in-person?

Unfortunately, this might not necessarily be the case. Gordon et al. (2020) found that clients felt that the physical distance and the reduced amount of small

talk affected client's ability to develop rapport with the clinician. In this case, clients felt that by not sitting in front of the clinician, their clinician cannot provide the same support as in-person. This may be because some treatment may require physical actions that may be difficult to learn through telehealth compared to in-person where the clinician can help physically assist the clinician to practice these techniques. Additionally, clients may feel that they do not get to build a relationship with the clinician because there is no downtime to talk. Clinicians may jump into the problem without engaging in small talk and seeing how the client is doing. This makes it hard to establish a trusting relationship which makes it difficult for the client to buy into the clinician's attempts to assist the client.

Yet there are findings that say the rapport building is not affected by the removal of face-to-face interaction. Germain et al. (2010) found that rapport building was not negatively affected by telehealth in individuals with PTSD and that the therapeutic relationship in both in person and telehealth developed at the same rate. Participants felt that they were still able to make that connection with their clinician through the telehealth model. Even though clients may feel uncomfortable with telehealth due to unfamiliarity, clients were still able to develop rapport with the clinician and feel supported when discussing their trauma. Similarly, Chadi et al. (2018) found that participants in both the in-person and mindfulness telehealth group felt a sense of connectedness with each other. Even though the group was meeting online, they were still able to develop relationships and trust with each other like the in-person group. For in-person,

there may be opportunities to chat before the meeting for those who arrive early or are waiting for the facilitator to arrive but that is not the case for telehealth. For telehealth, they could only join the meeting when the facilitator starts the meeting so there is unlikely the chance to have informal interactions outside the meeting like in-person. Even so, students were still able to relate to each other with the struggles that they were going through.

It is important to note that these findings reflect when telehealth was still unknown to most people. Showalter (2020) stated that in 2018, 7.8 million Medicare beneficiary who lived in rural areas were able to use telehealth compared to the 36 million beneficiaries who can now use telehealth regardless of where they lived in 2020. Many people were unfamiliar with telehealth prior to the pandemic and at when the pandemic started. They may have expected clinicians to be experts at telehealth when they were also trying to figure out telehealth. Now that it has been two years since the pandemic began, agencies may have developed better supervision, provided trainings on how to replicate rapport building, and allow appointments to be held longer so that clinicians and clients can engage in small talk. It is important to see how the loss of face-to-face interaction affects rapport building after a year and half of using telehealth.

Attitudes Towards Telehealth

An important aspect of telehealth being successful is the attitudes toward telehealth. Are healthcare workers receptive to the idea that telehealth can be beneficial? Shuvler et al. (2016) found that while developing urban healthcare

workers saw the benefits of telehealth, they believed face-to-face interaction was the best method of delivery. While urban clinicians entering the health care system may keep an open mind towards telehealth, they believe that the only way to provide health care services is through face-to-face interaction. This may especially be the case for issues that they believed would be difficult to solve through telehealth. Similarly, Shuvler et al. (2016) found that experienced urban healthcare workers thought that telehealth could not replace face-to-face interactions and that interactions between patient and clinician would suffer due to telehealth. Unlike developing clinicians who are entering the field, experienced clinicians believe that telehealth is extremely limited on how to support clients who are recovering. For them, telehealth puts a barrier on the ability to notice social cues and have direct involvement in supporting the client.

Both developing and experienced urban health care workers believe that face-to-face interaction is the only way to provide services to their population yet those who are experienced in telehealth think otherwise. Shulver et al. (2016) found that experienced telehealth workers believed that telehealth interactions are equal to face-to-face interactions. In contrast with developing and experienced urban workers, those who have experience and knowledge about telehealth understand the benefits of telehealth and believe that the quality is on par with in person. What about providers who had no prior knowledge or training that had to use telehealth during the pandemic?

After utilizing telehealth during the pandemic, providers would like to see telehealth stay as a permanent option. Guinart et al. (2021) found that most providers had positive experiences and would like telehealth to remain as an option after the pandemic. Even though they never expected to use telehealth before the pandemic, providers were positive about their experience. Additionally, providers felt more comfortable utilizing telehealth during the pandemic than before (Zhu et al., 2021). Additionally, a majority felt that they would like to utilize telehealth for a portion of their caseload after the pandemic is over (Guinart et al. 2021). This shows that providers are open to the idea of utilizing telehealth beyond the pandemic. They see the benefits that telehealth provides such as flexible scheduling and having appointments start on time (Guinart et al., 2021).

Theories Guiding Conceptualization

A major theory that has guided telehealth studies that I will be using is normalization process theory. May & Finch (2009) states that normalization process theory aims to understand what factors affect how successful the implementation, embedding, and integration of complex healthcare interventions. Furthermore, May & Finch (2009) state that there are four concepts that help or inhibit the implementation of an intervention which are coherence, cognitive participation, collective action, and reflexive monitoring. One concept that can explain how the loss of face to face interaction is affected is coherence. May & Finch (2009) define coherence as what individuals or people do when faced with

the challenge of operationalizing practices to different settings. For example, understanding the differences of communication between in person and telehealth. During in person, clients may find it easier to jump in when their clinician is speaking to ask questions or offer concerns. In contrast, the loss of face-to-face interaction may cause clients to find it more difficult to ask questions or concerns over telehealth. This may be due to fear of speaking over the provider during telehealth or the clinician not noticing cues signaling that the client wants to speak due to the limitations of the camera. While coherence is an important part of the loss of face-to-face interaction, all four concepts are integral in utilizing telehealth successfully.

If health care providers are unable to be successful in these four concepts, it would be extremely difficult to utilize telehealth successfully. The loss of face-to-face interaction would become more prominent and negative affect the quality of mental health services delivered through telehealth. For example, May& Finch (2009) state that one key component in collective action is interactional workability, the rapport relationship between clinician and client. If clinicians believe that interactional workability, cannot be replicated through telehealth due to the loss of face-to-face interaction, then it is difficult to implement these interventions to telehealth because the relationship between client and clinician is not developed properly.

The theory helps us understand why some studies have been able to implement interventions using telehealth while others have struggled to do so. It

could be that for some clinicians, it is difficult to translate skills such as empathy, active listening, and effective communication, to telehealth because there is no face-to-face interaction compared to in person services. It may be a lack of training or support from the organization on how to build rapport and implement interventions through telehealth. This theory helps explore why some mental health services were able to be replicated through telehealth while others were not able to when the face-to-face interaction is removed.

Summary

The study explored how the loss of face-to-face interaction affects the quality of mental health services during telehealth. Past barriers that impacted services were rapport building, nonverbal and verbal communication, and attitudes towards telehealth. However, others felt that those barriers did not impact the quality of services. The normalization process theory can help social workers understand how the loss of face-to-face interaction impact the quality of mental health services when delivered through telehealth.

CHAPTER THREE

METHODS

Introduction

This chapter will cover how the study was carried out. The sections that will be covered in this chapter are study design, sampling, data collection, procedures, how participants are being protected, and data analysis.

Study Design

The purpose of this study was to explore how the loss of face-to-face interaction affects the delivery of mental health services through telehealth among adults in the United States. Specifically, the study aimed to examine if rapport building, attitudes towards telehealth, and verbal and nonverbal communication were affected when there is no face-to-face interaction via telehealth. Building rapport and noticing verbal and nonverbal communication are integral pieces in delivering successful mental health services that may be affected by the loss of face-to-face interaction. Clinicians may not know how to replicate building rapport over telehealth. Additionally, it may be difficult to notice nonverbal and verbal cues during telehealth. Tapping the foot, moving around, or tone of voice may not be easily picked up depending on the quality of the camera or microphone. Lastly, the attitudes towards telehealth greatly impact how the quality of mental health services will be when delivered through telehealth. If clinicians have a negative views or concerns that in person services cannot be

replicated via telehealth, the quality is likely to be negatively affected. Similarly if the clients do not believe that clinicians can be as effective over telehealth as in person, they are likely to discontinue services until they can go back to in person services. It is important to see how rapport building, attitudes towards telehealth, and noticing nonverbal/verbal cues is affected by the loss of face to face interaction.

This is an exploratory research project because there is a limited amount of information regarding how the delivery of mental health services through telehealth is impacted by the loss of face-to-face interaction. This study is also a qualitative study and utilized face-to-face interviews to collect data. An exploratory, qualitative study utilizing face-to-face interviews allows participants to provide an in-depth look into their personal experience utilizing telehealth during the pandemic. Since there is limited research regarding telehealth, participants will be able to provide details of barriers that they experienced when using telehealth. Additionally, participants provided insight on what worked and what improvements can be made to improve the quality of mental health services through telehealth if any.

The limitation to conducting face-to-face interviews is that participants were asked intrusive questions with a researcher that they have not met before. This may cause participants to not want to answer or answer truthfully and instead give socially desirable answers. Another limitation is due to time constraints, the sample size is small and thus, the results will be difficult to

generalize to multiple populations. It would not be accurate to say that the personal experience of 10 people can represent mental health users' experience with telehealth during the pandemic.

Sampling

The study used nonprobability availability sampling with adults from social media sites such as Facebook and Reddit. Participants consisted of those who use telehealth for mental health services after March 2020. Additionally, one participant gave their experience providing telehealth services during the pandemic. Due to the increase usage of telehealth, this study wanted to hear personal experiences during the COVID-19 pandemic. Before the pandemic, telehealth was limited to certain rural and underserved areas. It is important to explore the personal experiences that were unique to individuals using telehealth during the pandemic. Approval was gained from the moderators of mental health subreddits and Facebook groups to recruit participants that are subscribed to those groups to participate.

Data Collection and Instruments

Qualitative data was collectedfrom December 2021 to January 2022 using live audio-recorded face-to-face interviews through Zoom. Demographics were acquired prior to the interview using a survey distributed via Qualtrics. Demographic information included age, ethnicity, gender, education level, and income. Some of the questions that were asked involved topics such as the quality of mental health services during telehealth, rapport building, and attitudes

towards telehealth. For example, describe if any connection or technology issues during your session affection rapport building. Describe your attitude towards telehealth before the pandemic and after utilizing telehealth during the pandemic. How likely are you to use telehealth again? Did the lack of face-to-face interaction affect rapport building? Questions like these were asked to get the participant's personal experience utilizing telehealth during a pandemic. These questions are based on past barriers that were present in the literature review.

Procedures

Participants were recruited from social media sites (Facebook and Reddit). To be eligible for the study, participants had to be over 18 years old and had received mental health services through telehealth after March 2020. Participants were solicited through posts on social media. Once participants expressed interest in the study, the researcher contacted the individual by email. The researcher described what the study is about, answered any questions or concerns, and asked if participants would be willing to participate after hearing about the study. If the individual agrees to participate, the researcher scheduled a date and time for the interview to take place. Additionally, the researcher sent by email an informed consent form for the participant to fill out and return to the researcher prior to the interview.

The interview took place via Zoom, a video teleconference app, due to the current situation regarding COVID-19. The researcher and the participant used headphones during the interview and used a private room to ensure

confidentiality. Before each interview, the researcher locked his door and put a sign that stated do not disturb to ensure that the confidentiality cannot be breached and asked the participant to do the same as well. The interview lasted approximately 30-45 minutes. Before each interview, the researcher asked to confirm if participants were okay to be audio recorded. Once consent is confirmed, the researcher began the interview. Once the interview concluded, the research allowed participants to share any questions or concerns regarding the study. After, participants were thanked for their time. A total of 10 participants were interviewed.

Protection of Human Subjects

The identity of the participants were kept confidential. Informed consent is kept on google drive provided by the researcher's university. Participants consent to both the study and being audio recorded. Audio recordings are stored on a password protected USB Drive and locked in a file cabinet inside the researcher's room. The key is kept with the researcher on his personal keychain. Informed consent and audio recordings are kept secured for three years. After three years have passed, informed consent and the audio recordings will be destroyed. The participants were given pseudonyms that were used as participant ID and during audio transcription. Discussion of audio transcriptions were discussed with the research supervisor in their office and pseudonyms names were used when discussing the content of the audio transcription. Email communication with the participant was done in a private location to ensure

confidentiality. Before the interview begins, the researcher ensured that both the researcher and participant utilize headphones and that the interview occurred in a quiet and safe space to ensure confidentiality. Once the interview is completed, the researcher thanked the participant for their time. After, all email communication with the participant was deleted.

Data Analysis

All audio recordings were transcribed to written form to analyze themes that were present. Participants were given pseudonyms as their ID number as well as to protect their identity. All instances of verbal utterances were transcribed. Additionally, noteworthy non-verbal communication was also documented. Once the audio recording was transcribed, the researcher listened to the recording again and made necessary edits to correctly match the audio recording. Then, the transcriptions were imported into Dedoose for coding. Codes were made based on statements that the participant made throughout the interview. Codes were put into categories based on their answers such as challenges faced during telehealth, likely to use telehealth again, benefits to telehealth, and how to improve mental health services when delivered through telehealth. Themes that emerged include quality of mental health services, rapport building, attitude towards telehealth, barriers, and improvements to mental health telehealth services. Secondary themes were also coded. Frequencies were measured to determine how often themes appeared. Lastly, demographic data were analyzed using descriptive statistics.

Summary

The study utilized an exploratory, qualitative design method with face-to-face interviews. Interviewees consisted of individuals from social media sites such as Reddit and Facebook.

CHAPTER FOUR

RESULTS

Ten (8 female, 1 male, 1 Transgender) participants were recruited during a two-month recruitment period (December 2021 to January 2022). Ten participants completed both the demographic survey and in-depth interview. Six participants identified as Caucasian, four as African American, and 1 as Asian. The majority of participants had at least some college education. Qualitative data was analyzed using Dedoose. Interviews were imported into Dedoose and coded. Four major themes emerged from the data which were challenges faced during telehealth, participant's attitudes towards telehealth, telehealth benefits, and how to improve the quality of mental health services through telehealth. Table 1 displayed below discusses the major themes as well as quotes from participants showing positive and negative viewpoints.

Table 1 Four Major Themes

Major Themes	Positive	Negative
Challenges Faced During Telehealth	**Privacy during session** And I didn't really think about kind of these confidentiality issues. Even because what I was talking about Like a I don't mind, other people if it's by accident, obviously, like hearing something a little something little detail. **Internet Connection** Ehh no, It actually didn't. No, it was just a little awkward moment, but then it didn't like create any issues for me like talking to her. No, I was able to just carry on. But yes, feel that maybe could have been a little bit more, dunno less awkward and a bit more like natural was like face to face.	**Privacy during session** Um, but like I said I'm not afraid of the whole privacy like HIPAA thing is just kind of like, I don't know, maybe I am afraid of the privacy thing because why else would I be so concerned about talking too loud, but I mean my family knows everything but still it just feels weird to just like want to talk more detail but then I'm trying to like keep my voice down because like, maybe I don't want my husband to hear something like a specific detail. **Internet Connection** So sometimes it was just like there'd be 5-10 minutes of trying to connect with each other, you know technology

	Yeah.	issues. So. Its hard to get in the mood for talking when you're like I don't know why it's not working, I tried connecting on my laptop. I tried on my phone. You know.
Participant's Attitudes Towards Telehealth	And I think my, I think I've become more and more impressed with it over time, because I think I've gotten used to it. Before it was just like a glorified phone call and now I think it's just as functional to me as a therapist working with my clients and it's just as functional for me as a client, working with my therapist because I've gotten so used to it. I mean I've been working on on five, I've been doing zoom for five days a week for two years now so all day long.	And I don't know and I feel like the telehealth, is that like you don't have a choice. Even when you know I have it for work and when I am with my co-workers. And I always talk to them about how I want to see them in person. When we come on, we are like we don't want to talk. We just want to get off of here. So that's another feeling. Doing it this way is not a choice in a sense. You know, and then when it becomes not a choice then you're like... Kinda just want to get it over with.

	Ive seen the downsides of it. But since it's still effective and it's still allowing us access to services. I still saw a nice opinion about it because it's allowed us not to like stop everything because of the pandemic.	But you know, I bet extroverts have a hard time with teletherapy. Introverts probably enjoy it. And that might be, it's, it's like introverts find all that extra information to be overstimulating. And it's distracting.
Telehealth benefits	Oh my gosh that is so true. I'm in a rural area. So one of the problems with rural areas, is people feel stigmatized being seen walking into, I work at a community mental health center for a number of years. And people would not want to go in.Or find some way of sneaking in or park thier car couple blocks away or whatever it might be, they don't want to be seen,	

	because everybody knows everybody. So teletherapy has opened up for rural areas has opened up, I think access of care, because people aren't worried about anybody finding out. I don't feel like it's a barrier at all. I actually feel like I've seen into people's lives better than before like they would have to relay to me everything. But now I'm in their house and I could see what's going on. I can see their interactions with their children or their spouse, or how messy their houses or how clean it is or, so it's actually been additional information for me as a clinician.	
How to Improve Mental		I mean, you would think of all

Health Services		the neat technology advances, you know, why are we still experiencing lag. Yeah, frozenness you know yeah yeah so that can be like a thing of the past. Cause if someone is hard of hearing, you should have closed captioning on like all the video meet program so somebody started hard of hearing that they could read because I've had people who are hard of hearing and that's a little tricky over televideo. So finding a way to help people who are hearing impaired and visually impaired, because obviously somebody's visually impaired and can't see really clearly that wouldn't help at all would it.

Challenges Faced During Telehealth

Some of the major challenges that participants expressed was how it was more difficult for the provider to notice their nonverbal cues and vice versa. Participants expressed the quality of their screen device and the limitation of how much the camera can capture as barriers for noticing their nonverbal cues which in turn affected their ability to connect or share with their provider. Some also expressed that their provider did not communicate their own nonverbal cues such as looking off to the side due to someone entering the room or taking notes and that it made them feel that the provider was not paying attention to what they were saying. Another major barrier to telehealth was stable internet connection. Participants expressed that the lack of stable internet connection affected their ability to connect with their provider. That the lack of stable internet connection made it difficult for participants to share as it felt awkward to repeat themselves regarding their concerns. Some also expressed frustration that their sessions had to be canceled due to poor internet connection on the provider's side. In contrast, others expressed that if there were technical issues in their session, it was just a minor inconvenience. One participant stated, "Yeah, I'm not crazy about repeating myself but, um, but again it's like it's more like an inconvenience. It's kind of an irritation. And then I get past it. Maybe I have to say what I said over again". They felt that even though they had to repeat themselves, it did not affect their ability to establish a connection or share how they felt with their provider.

Participant's Attitudes Towards Telehealth

Many participants expressed that it was difficult for providers to replicate in person services through telehealth. Some participants stated that even though they had the same provider as in person, they were not able to connect at the same level as they did in person. Lastly, the potential lack of privacy made it difficult for participants to share concerns via telehealth. One participant expressed concern that family members or significant others would walk near or enter the room and hear their conversation. Others expressed that the lack of privacy on the provider's side affected their desire to share their concerns or participate during their sessions. Even though participants preferred in person services, the participants acknowledged that there are benefits to telehealth and that some would still use it if it was an option. One participant who was in favor of in person stated, "But I would want to, there are times I would be happy to use telehealth if we had a snow storm like we just did, and you know my therapist was from stuck at home, and I was stuck at home if we could still do our session. That would be great." Because of these benefits, participants were open to either using telehealth in some capacity alongside their in-person session or trying it again in the future.

Benefits of Telehealth

In terms of the benefits of telehealth, all of the participants expressed numerous benefits that telehealth has over in-person. Major sub-themes that

were expressed were convenience, greater access to care, ability to have sessions even when feeling sick, and ability to save resources such as money. Some participants shared how some days they were not feeling 100% and would have canceled their session if it was not done via telehealth. Other participants shared how telehealth allowed them to access mental health services due to fitting into their schedule and not having to miss work.

How to Improve Quality of Mental Health

Lastly, participants gave suggestions on how to improve the delivery of mental health services through telehealth. All of the participants expressed that there needed to be significant improvements to the provider's internet connection. Some participants also expressed simplifying the number of steps to log in. Participants also suggested that providers conduct telehealth sessions from their office compared to at home to protect privacy. In terms of training, participants suggested that providers be trained on how to build rapport, notice nonverbal/verbal cues, and be more expressive during telehealth.

CHAPTER FIVE

DISCUSSION

The emergence of four key themes when delivering mental health services through telehealth were barriers faced during telehealth, participant's attitudes towards telehealth, benefits that telehealth bring, and how to improve the quality of mental health services through telehealth. In terms of sub-themes under barriers faced during telehealth, participants stated that the lack of internet connection, privacy, and ability to notice nonverbal cues affected their ability to connect and share with their provider. Additionally, this has also led to half of the participants to prefer in person services. However, other participants shared that their clinician was able to successfully address their concerns and provide adequate interventions via telehealth. Even though they may not have been as attentive as they were in person or make small talk due to the possible lack of time, they still felt that their concerns were addressed properly. Results confirms both viewpoints from the literature review in that some would be affected by the lack of face-to-face interaction and technological issues while others would not.

One explanation can be that every clinician is different in terms of building rapport and noticing nonverbal/verbal cues. One participant expressed how it may be the clinician's style to not be as attentive to nonverbal or verbal cues

while another participant shared similar feelings in terms of rapport building and making small talk. In social work, we work with a diverse population. This means that some clients may not be affected by the lack of noticing nonverbal/verbal cues or small talk. Some can move past that barrier and still buy into what interventions are being taught. In comparison, others may need the rapport building to build trust with their clinician. Additionally, the noticing of nonverbal/verbal cues may signal that the clinician is being attentive which allows some clients to be more open and trust their clinician. Social workers need to be adaptive in their style and adjust accordingly with different clients.

Another explanation can be that clinicians' attitude towards telehealth can play a negative influence. Previous research stated that clinicians in urban settings believed that telehealth cannot replicate in person services. Most clinicians did not have prior training or experience in providing mental health services through telehealth, it could be that they had a hard time replicating how they did in person services to telehealth. Additionally, some may not be as experienced using technology or telehealth applications such as Zoom which may also play a factor. Things like forgetting to send the link to the client, forgetting to unmute or mute, and forgetting to allow participant into the session can affect the delivery of services due to frustration from both the provider and the client. One participant shared that she knew some clinicians who have quit their job because they were unfamiliar with technology and did not want to do telehealth. In contrast, another participant shared that as a therapist and as a

client, she sees telehealth as effective as in person services and that telehealth has allowed her to see things that she was not previously able to see such as family dynamics. This is also seen in previous research in which clinicians who have experience with telehealth believe it is effective as in person services and that telehealth should remain permeant after the pandemic is over. Future research should interview clinicians on their experience providing telehealth services as well as their perception on telehealth before and after the pandemic.

Regardless of the barriers that some participants felt that led to having a preference for in person services, all of the participants expressed interest in still having some form of telehealth sessions whether it is giving it another chance or having a hybrid model with the majority of sessions being in person while telehealth sessions as supplemental. Additionally, all of the participants shared that telehealth brought benefits over in person services. Muhorakeye and Biracyaza (2021) state that the most common barriers for in person services are lack of financial resources, lack of geographical accessibility, fear of stigmatization, lack of awareness that mental health services exist, and cultural or religious influences. There are a lot of barriers that can cause many to not seek out in person services. However, many participants stated that the convenience, saving of money, accessibility and lack of travel allowed them to access mental health services via telehealth. One participant shared that telehealth has increased access in her area and adolescents who had to rely on parents to take them to in person sessions, no longer had to worry about missing

sessions. Others shared that they were able to do other tasks that they would not have otherwise done due to no travel time. Additionally, some expressed how the lack of travel time and convenience of telehealth allowed them to not miss work or other daily life activities. Even though there were some drawbacks that led to some participants preferring in person services, participants do recognize the benefits of telehealth, want to see it improved, and stay permanently as an option for everyone even when the pandemic is over.

Something that was not expected was how big of an impact the different environment between telehealth and in person played in the preference for in person or telehealth. Some stated that the in-person environment of checking in, listening to the office music, walking to the clinician's office, and being in the proximity of the clinician when discussing concerns as things that were missed in the telehealth environment. One participant shared how they were able to check in and relax with the music that the agency played while waiting for the clinician. In contrast, they stated that they opened their laptop 2 minutes before their telehealth session to login. While telehealth offers convenience to do other activities before the meeting, it may lack a routine or steps to orient into the proper mindset before their session compared to in person. Another participant shared how the in-person environment can be overwhelming for those who are used to the telehealth environment. If someone who has done telehealth primarily and is experiencing in person session first time or is more conscious of their surroundings, stimuli like the smell of the clinician’s office, how tall the

clinician is, the fear of getting sick, and how the clinician's office looks can greatly cause the client to feel more anxious compared to how they would feel during telehealth sessions. For some that may have social anxiety or can be easily overwhelmed with numerous stimuli, it may be difficult for them to do in person services.

Additionally, three participants shared that telehealth also brought anonymity as these sessions took place from the comfort of their homes. One rural participant shared that the anonymity allowed to destigmatize mental health in her area as people would not have to be afraid of being noticed by members of the community compared to in person. Telehealth has allowed those that fear being spotted in their community by people they know by doing sessions from the comfort of their home. They do not have to fear having to explain why they are using these mental health services because sessions are taking place in the home. For those who are afraid of being stigmatized, the anonymity can be the difference on whether they will reach out to receive services.

However, there is the lack of privacy in the client's household that can occur if clients are living with other family members or significant others. Half of the participants shared concerns of privacy for themselves which affected their ability to share. Providers should be aware of nonverbal cues that clients may display that may signal that someone might be listening in and find methods to allow their clients to share even if there are others who could potentially listen.

This can be utilizing a chat function for the client to share their thoughts or asking the client to move to a more private location if possible. The lack of privacy was also shown on the provider side as well. Participants shared how clinicians were distracted by their pets or family members walking into the room. This causes clients to feel that their clinicians are not being attentive and are less likely to share. Furthermore, this breaks the confidentiality agreement that clinicians set before beginning therapy. If social workers need to provide telehealth services from their home, they need to ensure that there is minimal disruption from pets or family members to ensure that confidentiality is kept. Otherwise, social workers should conduct their sessions from the agency's office.

Lastly, some participants felt time constrained during their sessions compared to in person services. One participant discussed how their clinician cut them off when they were discussing their concerns and did not resume from where the previous session left off. In contrast, the participant stated that there was more time flexibility for in person sessions such as getting extra time if the next client had not arrived yet. Another participant shared that her sessions lasted about 10 minutes when discussing interventions for her treatment. This led to the participant not wanting to share her concerns or ask questions because there was no time to build rapport with the provider. The lack of time flexibility is a concern especially if the clinician does not pick up from where the client left off or does not give a courtesy notice that they have a couple of minutes left before the session needs to end. If participants cannot properly express their questions or

concerns, it is quite possible that they are less likely to attempt to use these interventions outside of session. They may just feel like a number that the clinician just had to get through for the day instead of treating each client as an individual.

Limitations to this study were the small sample size, time constraints during interviews, and lack of viewpoints from the clinicians side to compare with how participants in this study felt. Future research should have an increased sample size with a diverse group of participants. Additionally, in-depth interviews should be 45-60 minutes to get more in depth information especially when participants bring up sub-themes that were possibly not expected. Lastly, future research should be done to see how clinicians feel about the loss of face-to-face interaction, if agencies that there are at still utilizing telehealth, and if so, how are they being supported.

Recommendations for Social Work

Mental health providers that will continue to utilize telehealth need to upgrade their internet connections. Of course, there will be small disruptions during the session every once in a while in terms of internet connectivity. However if they become daily occurrences that happen multiple times, it will negatively affect the rapport building and willingness for the client to share their concerns. Furthermore, sessions that have to be canceled due to poor internet connection will greatly affect the motivation to continue to have telehealth

sessions. Additionally, agencies should continue to monitor and upgrade their cybersecurity to protect their client's data and ensure that their telehealth sessions are password protected to avoid unwanted users disrupting their session. As mentioned earlier, anonymity is one of the advantages that telehealth brings. However, that anonymity disappears if unwanted users join the meeting to disrupt the session by posting the session link or a screenshot of the client using these mental health services onto social media. It is important that agencies improve their broadband connection and ensure that the client's data and identity is protected.

In terms of training, mental health providers should train social workers on ways to build rapport with clients via telehealth. About half of the participants stated that their provider made little to no effort to make small talk during their sessions and that they jumped into talking about their concerns. Participants shared that the lack of small talk affected their ability to build a connection with their provider. Clinicians should develop creative ways to build rapport via telehealth especially in the beginning stages. This could be developing worksheets that clinicians and clients do together and sharing their answers so that both get to know each other more. Another option could be finding creative icebreakers that both can do. Clinicians should also be aware that it may take longer to develop that connection over telehealth compared to in person and adjust accordingly. If it takes an extra one or two sessions to build that

connection, then so be it. Early investment in building rapport will pay off in terms of effectiveness of treatment.

Additionally, mental health providers should train social workers on how to be emotionally expressive during telehealth sessions. About half of participants stated that they felt like they were talking to a robot. One participant expressed how even though their provider was effective in addressing her concerns, she was also always emotionally cold or neutral which affected her ability to connect with her provider. Others talked about how the lack of emotional support from providers made it seem like they were talking to a robot which made it difficult to want to ask questions or share their concerns in terms of interventions. It is important that social workers are emphasizing with their clients when they are sharing difficult moments.

Lastly, mental health providers should train their social workers to notice nonverbal/verbal cues and communicate their own nonverbal/verbal cues via telehealth. Participants felt that due to the lack of nonverbal/verbal cues being noticed, they felt that their clinicians were less attentive to their concerns. They felt less inclined to share or even lie about how they are feeling because the clinician did not point out nonverbal/verbal cues as they would in person services. Trainings should be developed to help clinicians better notice nonverbal/verbal cues during telehealth sessions. Additionally, social workers should be aware of any nonverbal/verbal cues that they may display such as

looking down or off to the side when taking notes or hearing someone at their door. Social workers should communicate these cues to their client so that they are aware and not left thinking that their clinician is distracted or on doing something else when the client is talking about their concerns.

Conclusions

In conclusion, the loss of face-to-face interaction can impact the quality of mental health services when delivered through telehealth. Results from this study showed that half of participants were affected by the loss of face-to-face interaction while the other half was not. Trainings should be developed on how to build rapport over telehealth, notice nonverbal/verbal cues, and communicate their own nonverbal/verbal cues.

APPENDIX A

INTERVIEW GUIDE

Describe if any connection or technology issues during your session affect rapport building?

Describe how thorough can your therapist be in addressing your concerns via telehealth?

How effective was your therapist in noticing nonverbal/verbal cues that may impact their understanding of you or your concerns?

Describe your attitude towards telehealth before the pandemic

Describe your current attitude towards telehealth after using it

Did the lack of face-to-face interaction affect rapport building? Describe your response

How likely are you use to telehealth again?

Describe if any, how the delivery of mental health service through telehealth can be improved?

APPENDIX B

DEMOGRAPHICS SURVEY

What gender do you identify as?

Please specify your ethnicity

What is your age?

What is the highest level of education or degree that you have completed?

What is your annual household income?

APPENDIX C

INFORMED CONSENT

The study you are being asked to participate is designed to examine how the loss of face-to-face interaction affects the quality of mental health services through telehealth. The study is being conducted by Steven Lu, a graduate student, under the supervision of Dr. Yawen Li, Professor of Social Work at California State University, San Bernardino (CSUSB). This study has been approved by the Institutional Review Board at CSUSB.

Purpose: The purpose of the study is to examine how the loss of face-to-face interaction affects the quality of mental health services through telehealth.

Participation: Participation in this study is voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

Confidentiality: Your responses and data will remain confidential. No names will be included. Any mention of your name will be removed and replaced with a pseudonym.

Duration: It will take 45 to 60 minutes to complete the interview.

Risks: Although there are minimal risks, there may be some discomfort when answering some of the questions. You are not required to answer and can skip the question or ask to end the interview without repercussion.

Benefits: While there is no direct benefit from participation, the findings from the study will contribute on how to improve telehealth services.

Contact: If you have any questions regarding the study, please free to contact Dr. Yawen Li at yawen.li@csusb.edu

Results: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after May 2022.
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I agree to have this interview be audio recorded: _____ YES ____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

_______________________ ___________
Place an X mark here Date

APPENDIX D

IRB APPROVAL LETTER

November 7, 2021

CSUSB INSTITUTIONAL REVIEW BOARD

Administrative/Exempt Review Determination

Status: Determined Exempt

IRB-FY2022-69

Yawen Li Steven Lu

CSBS - Social Work

California State University, San Bernardino

5500 University Parkway

San Bernardino, California 92407

Dear Yawen Li Steven Lu:

Your application to use human subjects, titled “Examining Loss of Face to Face Interaction in Mental Health Services Through Telehealth” has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has weighed the risks and benefits of the study to ensure the

protection of human participants.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses. Investigators should consider the changing COVID-19 circumstances based on current CDC, California Department of Public Health, and campus guidance and submit appropriate protocol modifications to the IRB as needed. CSUSB campus and affiliate health screenings should be completed for all campus human research related activities. Human research activities conducted at off-campus sites should follow CDC, California Department of Public Health, and local guidance. See CSUSB's COVID-19 Prevention Plan for more information regarding campus requirements.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have

completed your study.

Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.

Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.

Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2022-69 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair

CSUSB Institutional Review Board

ND/MG

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