Continuation of teletherapy post COVID-19: Survey data from licensed mental health professionals

Rashmi Gangamma, Bhavneet Walia, Melissa Luke, Claudine Lucena

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Abstract

Background: The use of teletherapy has exponentially increased in the context of the ongoing COVID-19 pandemic. Studies on teletherapy have documented substantial benefits of accessibility and convenience even before the start of the pandemic. While recent studies show that this modality of therapy delivery is here to stay few, if any, have studied who will most benefit from this trend.

Objective: In this short paper, we report predictors of continued teletherapy usage in a sample of licensed mental health professionals in the United States during a time period when pandemic-related restrictions began diminishing. As such it is one of the first studies to examine factors related to continued benefits of teletherapy post-pandemic.

Methods: Participation from licensed mental health professionals was sought on listservs of national organizations of multiple mental health organizations. Data were collected via an anonymous link to a survey on Qualtrics between January 2021 to April 2021. Participants responded to questions on therapist demographics, practice setting, experiences of shifting to teletherapy, perspectives on continued use of teletherapy, and their client characteristics. Findings related to client characteristics that predicted continued teletherapy usage are presented here.

Results: A total of 186 consented to participate in the survey, with a final sample of 114 with complete data. A majority of participants identified as female (92/114, 80.7%), White (94/114, 82.5 %), having a master's degree (75/114, 65.5%) from a nationally accredited program (106/114, 93%). Data were analyzed using heteroskedastic regression modeling with client related factors as predictors. Two models were run with and without distance travelled by clients as a control variable. Model estimates from both models showed that continued use of teletherapy post-pandemic were predicted by the following factors: higher percentage of clients from rural areas, younger and elderly clients, clients with Medicare, and clients with marginalized gender and religious/spiritual identities. Significantly, having a higher percentage of clients from lower socioeconomic status, those with Medicaid coverage, and a higher percentage of couple and families as clients predicted decreased use of teletherapy post-pandemic.

Conclusions: Findings from the study suggest that while some groups of clients are more likely to continue to receive benefits of teletherapy, vulnerable groups such as those in lower socioeconomic conditions, Medicaid beneficiaries, and those who seek couple and family therapy may be less likely to be served by it. These differences point to a need to address factors driving telehealth care disparities such as access to technology, housing, and childcare issues, as well as need for continued training licensed professionals.

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Keywords: Teletherapy, Relational teletherapy, Post-pandemic teletherapy

Introduction

The novel coronavirus pandemic (COVID-19) and subsequent social measures drastically impacted society [1] shifting education, work, and healthcare [2,3], and mental health [4]. Tele-mental health, referred to as teletherapy, has been used over the past 20 years [5] with demonstrated effectiveness [6, 7]. Teletherapy refers to the use of electronically based communication such as video conferencing, telephone calls and other mobile applications to provide access to mental health services, typically across distances [8]. Rapid legislative changes, training, and guidelines, resulted

in an exponential increase in teletherapy when compared to pre-pandemic levels [9, 10]. The increase in relational teletherapy (therapy with couples and families) has been particularly important given increased risks for distress, anxiety, grief/loss, substance abuse, and family violence in children [11] and adults [12-14] during the pandemic. Pre-pandemic, scholars contended that historically underserved populations derived more benefits from the flexibility and accessibility of teletherapy [15,16]. As COVID-19 related restrictions are lifted, teletherapy will remain part of the mental health landscape [17]. However, given the existing challenges of the need for training, technological advances, and other barriers to effective use [18, 8, 19], we are yet to understand whether teletherapy post-pandemic will be accessible equitably.

In this short paper we present findings from a study on predictors of continued teletherapy practice post-pandemic from a sample of licensed mental health practitioners. Specifically, our research question was, what factors of therapist practice predict their intention for continued use of teletherapy practice post-pandemic? Existing literature suggests that distance from services, client profile, [15,16] and vulnerability of selected client populations [6, 7, 8, 18,19, 20] may influence provision of teletherapy. Clarifying predictors would strengthen recent research on therapists' experiences transitioning to the use of telehealth [18] and may assist in identifying factors in disparities in telehealth care post-pandemic.

Methods

Recruitment

Participation was open to licensed mental health professionals who were currently providing teletherapy. Upon IRB approval, a link to an anonymous Qualtrics survey were posted on multiple listservs including the American Association for Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), as well as professional groups for social workers. Data were gathered between January 2021 to April 2021when increased vaccinations were driving gradual removal of public health reductions [20]. Survey questions included therapist demographics, practice

setting, experiences of shifting to teletherapy, perspectives on continued teletherapy use, and client characteristics. No incentives were provided; instead, a donation was made to a non-profit chosen by participants. A total of 186 consented to participate in the survey, with a final sample of 114 with complete data.

Statistical Analysis

Descriptive statistics and regression analyses were conducted using Stata software v.14 [21]. A residual plot revealed increasing standard deviation of residuals in the independent variables (i.e., heteroskedasticity). Given that errors were normally distributed and mean and variance functions were correctly specified, we ran hetregress regression models with maximum likelihood estimator [21]. Using G* power analysis, setting a medium effect size with 10 predictors in our model, we determined that our final sample of 114 was sufficient for regression analysis [22].

Results

Participants were from 27 states in the US with a majority identifying as female (92/114, 80.7%), White (94/114, 82.5 %), with a master's degree (75/114, 65.5%) from a nationally accredited program (106/114, 93%), and with less than half of them (45/114, 39.47%) reporting pre-pandemic experience practicing teletherapy. Table 1 shows other practice profile of participants and Table 2 shows client profile factors used as independent variables in the regression models.

Table 1: Practice profile of participants (N =114).

Practice profile of participants	**Percentage (n = 114)**
Type of License	
• Marriage and Family Therapy	67.54% (n= 77)
• Mental Health Counselor	18.2% (n = 21)
• Clinical Social Work	4.39% (n – 5)
• Clinical Psychologist	3.51% (n =4)

• Other	6.14% (n = 7)
Geographical location	
• Large metro	31.86% (n = 36)
• Medium metro	28.32% (n = 32)
• Small metro	23.89% (n = 27)
• Rural area	5.31% (n =6)
• Small town	4.42% (n = 5)
Distance travelled by clients	
<25 miles	85.84% (n = 98)
25-50 miles	11.5% (n = 13)
>50 miles	2.4% (n =3)

Table 2: Descriptive of client profile factors used in regression models.

Client profile	**Average Percentage**
Age	
• <30 years	44.05%
• 30-49 years	38.75%
• 50-64 years	10.83%
• 65-80 years	4.20%
• >80 years	.34%
Gender	
• Female	56.42%
• Male	34.81%
• Non-Binary/Gender expansive	5.19%
• Transgender	4.81%
• Other	1.39%
Marginalized identities	

• Marginalized gender identities	15.22%
• Marginalized Sexual identities	17.79%
• Marginalized Racial/Ethnic identities	26.22%
• Marginalized Religious/Spiritual identities	10.01%
• Marginalized Lower SES groups	28.38%
• Marginalized Having a disability	15.91%
• Marginalized Veterans	5.96%
Payer mix	
• Medicaid	13.01%
• Medicare	4.42%
• Private Health Insurance	27.81%
• VA Care	2.19%
• Self-Pay	43.71%
• Other	8.63%
Percentage of couple and families	
• Less than 25%	42.98%
• 25-50%	.34%
• 50-75%	11.40%
• >75%	12.28%

Table 3 shows coefficient values of regression models run without and with control for distance travelled by clients (model 1 & 2 respectively). We controlled for distance from a health setting in model 2 to limit multicollinearity and increase robustness of estimates. Both models were

estimated with therapist gender as a cluster variable.

Table 3: Regression model of client factors predicting therapists' post-pandemic teletherapy usage.

Factors	**Model 1 (n = 94)**		**Model 2 (n = 94)**	
	Coefficient	**SE**	**Coefficient**	**SE**
Practice setting				
• Fringe Large metro	6.792	0.436	9.670	0.499
• Medium metro	7.495***	3.418	5.545*	1.876
• Small metro	6.620***	3.960	5.401	0.928
• Micropolitan	16.804***	2.804	15.939***	3.028
• Rural	39.843**	1.970	38.578**	2.079
Percentage of couples and families in case load				
• < 25%	25.291***	3.518	19.876***	2.993
• 25-50%	39.158***	29.207	32.040***	9.333
• 50-75%	35.416***	5.746	28.927***	4.351
Client age (in years)				
• <30	0.213***	16.047	0.186***	7.052
• 30-49	0.277***	28.157	0.226***	5.083
• 51-64	-0.215	-0.655	-0.135	-0.365
• 65-80	0.661**	2.468	0.634***	2.961
Percentage of clients with marginalized identities				
• Racial/Ethnic	0.089	0.921	0.134	1.129
• Sexual identities	0.005	0.033	0.009	0.079
• Gender identities	0.276***	4.766	0.223***	6.154
• Religious/Spiritual identities	0.109**	2.069	0.153*	1.855
• Lower SES	-0.341***	-3.879	-0.285***	-3.264
• Disability	0.417***	6.261	0.399***	3.734
Client payment modality				
• Medicaid	-0.066	-0.871	-0.143*	-1.649
• Medicare	0.390***	4.139	0.457***	4.823
• Private Insurance	-0.071***	-4.344	-0.079***	-3.712
• Other pay	0.148***	3.151	0.090***	2.787
Constant	-83.033***	-6.727	-87.333***	-6.786
Insigma 2 Constant	6.068***	58.08	6.161***	54.54

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Among factors examined, statistically significant predictors were: a. Higher percentage of clients living further from a metro area, particularly those in rural areas (β =38.578, *P* <0.01). b. Higher percentage of clients who are younger (less than 30 years; β=.186, *P* <0.001) or older (between 65-80 years; β=.634, *P* <0.001). c. Higher percentage of clients who identified with a minoritized gender (β=.223, *P*<0.001) and religious/spiritual identities (β= .153, *P* <0.001), and those with disabilities (β= .399, *P* <0.001), and d. Higher percentage of clients with Medicare (β= .457, *P* <0.001).

Conversely, therapists who had more than 75% of caseload with couples/families were *less* likely to continue teletherapy compared to therapists with caseloads less than 25% (β =19.876, *P* <0.001), 25-50% (β =32.040, *P* <0.001) and 50-75% (β =28.927, *P* <0.001). Similarly, therapists with a higher percentage of clients from lower socioeconomic backgrounds (β= -.285, *P* <0.001) and a higher percentage of clients with Medicaid coverage (β= -.143, *P* <0.05) were *less likely* to continue teletherapy post-pandemic.

Discussion

Results illuminate the potential types of clients most likely to continue to receive teletherapy post-pandemic from licensed mental health professionals in our sample. In addition to supporting earlier literature on use of teletherapy with clients with disabilities and from rural areas [23, 24], our findings suggest that younger and elderly clients, those on Medicare, and clients who identified with marginalized gender, religious/spiritual identities are most likely to continue to receive teletherapy. It is likely that legislative actions leading to waivers of restrictions and increased coverage of teletherapy [25, 26] benefitted elderly clients and those with Medicare coverage. For clients with minoritized social identities who could also access teletherapy, changes during the pandemic may have highlighted the relative safety of seeking therapy via technology.

We also found that therapists were less likely to continue teletherapy when they had a higher

percentage of clients from lower socioeconomic backgrounds and Medicaid coverage or had a higher percentage of caseloads with couples and families. Given the pandemic has disproportionately impacted those who are under-resourced, decreased teletherapy usage with those from lower socioeconomic status suggests that unless structural issues of accessibility are addressed, vulnerable groups may be left behind. Studies report technological difficulties, lack of confidential space, and privacy concerns hinder relational teletherapy [27]. It is possible these barriers are indicative of a need for structural changes (e.g., access to adequate housing, broadband internet, and childcare) to prevent deepening disparities. Although therapists with a higher percentage of Medicare clients were likely to continue its use, those with a greater percentage of Medicaid clients were less likely to do so. Given both Medicare and Medicaid coverage of teletherapy began at the same time, this difference may be a factor of available client resources and/or discrepancies in support between the two programs at State and local levels.

Another significant finding is therapists with the highest percentage of couples and families in their caseload were less likely to continue teletherapy. While we did not ask for their reasons, this is consistent with earlier studies identifying challenges of training [8], difficulties in de-escalating, and simultaneous engagement with multiple family members [28]. While teletherapy presents several advantages for access with partners in multiple locations or families with young children [7, 18, 27], COVID-19 related factors related to remote work and school, limited space at home, and lack of social support may have resulted in intense situations [29] that were challenging to address via teletherapy. Studies have reiterated these challenges, including the possibility of therapist exhaustion [30], moral distress [31], split alliances [18], and lack of training and competencies in teletherapy [8]. Moving forward, competency-based training [19] and best practices for tele-mental health must attend to the unique challenges of working with couples and families [27] along with ways in which therapists can be better supported [32]. Further research is also needed to better differentiate therapists' experiences with telehealth, in general, from their unique experiences of teletherapy

during COVID-19 pandemic [18].

Limitations

While this study recruited from different states and mental health disciplines, and findings are robust, they are still exploratory and tentative. Participants self-selected to take part in the survey, and it is possible they had specific experiences that may not reflect views of the national population of therapists, limiting generalizability. Future research with a diverse sample and increased heterogeneity is needed. Doing so may result in less heteroscedastic data and extend our understanding of how aspects of the therapist, practice context, and clients intersect.

Conclusion

Public health concerns and health safety underscored the shift to teletherapy [33], rather than a structured or clinically-sound plan to increase access with trained practitioners. As we emerge from the pandemic-related restrictions, it is likely that teletherapy will continue [17]. However, few studies have examined mental health providers' perspective on potential inequities of shifting to teletherapy [34] and the resultant disproportionate experiences of those living in under-resourced communities [35]. While access and convenience drive teletherapy use [36], our study suggests post-pandemic, licensed professionals are less likely to continue teletherapy for clients in lower socioeconomic groups as well as for many couples and families. We contend that training clinicians without simultaneously addressing structural barriers may further exacerbate disparities in teletherapy access.

Conflicts of Interest

None.

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