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"Each week feels like a mountain": The impact of COVID-19 on mental health providers' wellbeing and clinical work

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Abstract

The SARS-CoV-2 (COVID-19) pandemic has placed a tremendous strain on healthcare providers. Although there is a burgeoning body of literature on how COVID-19 has impacted frontline healthcare workers (i.e., providers treating COVID-19 patients), little attention has been dedicated to second-line workers (i.e., providers treating the mental health of people impacted by COVID-19). In this paper, we present findings from a thematic analysis of open text responses (n = 136) examining how COVID-19 shaped both the wellbeing of second-line workers, specifically mental health providers, as well as their clinical work in the early months of the COVID-19 pandemic in the United States. Results indicated that mental health providers were experiencing significant COVID-19-related burnout and poor physical and mental health outcomes. Participants described diminished negative effects on the quality of their clinical care from the burnout and trauma associated with COVID-19. Many also demonstrated resilience, identifying the duality of both negative (e.g., exhaustion) and positive (e.g., pride in helping others) meaning derived from their second-line work experiences. We conclude with recommendations for preventing and addressing burnout among mental health professionals in the era of COVID-19 and subsequent health emergencies.

Keywords

COVID-19; teletherapy; mental health provider; second-line workers; burnout

The COVID-19 pandemic continues to be among the most influential global events in modern history. The highly contagious nature of SARS-CoV-2 (i.e., COVID-19), combined with the severity of the COVID-19 disease, have overwhelmed healthcare systems around the world (Moitra et al., 2021). Healthcare workers provided care in impossible conditions, rife with shortages of personal protective equipment (Ranney et al., 2020), rampant

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misinformation (Depoux et al., 2020), rapidly changing knowledge about the virus itself (Seale et al., 2020), the politicization of mask wearing (Kahane, 2020), high transmission risk (Moitra et al., 2020), critical medical supply and provider shortages (Ranney et al., 2020), and unprecedented numbers of patients and colleagues in critical care (Moitra et al., 2021). Consequently, it is not surprising that these coalescing factors inherent to providing care during the COVID-19 pandemic have yielded a significant impact on the wellbeing of healthcare workers (Moitra et al., 2020).

Research suggests that, during the pandemic, healthcare workers are broadly experiencing higher rates of depression, anxiety, problems with sleeping, exhaustion and burnout, and overall psychological distress (Greenberg et al., 2020; Moitra et al., 2020; Pappa et al., 2020). The majority of this research focuses on physical health care providers (e.g., medical doctors, nurses, etc.), also called “frontline workers” due to their proximity to those who contract the COVID-19 disease. Significantly less empirical efforts have been dedicated to healthcare workers, such as mental health providers, who are part of the global response to COVID-19 but not quite “frontline workers” (Fish & Mittal, 2021). Rossi et al. (2020) refers to this category of providers as “second-line healthcare workers”—health care providers who are not always directly working with COVID-19 patients but often treat those (i.e., patients and providers alike) impacted by COVID-19 in some way. Like frontline workers, second-line healthcare providers are considered essential workers in public health efforts, especially during COVID-19. It is imperative that we understand the unique experiences of both frontline and second-line workers during COVID-19, as their public health roles are different. Namely, frontline providers’ work is likely to be short-term and acute (e.g., treating COVID-19 patients in an emergency department or intensive care unit; although some frontline workers also provide long-term work) whereas second-line providers are more likely to work with long-term issues (e.g., mental health issues related to COVID-19).

Healthcare providers’ work may be different depending on the proximity to COVID-19 patients, and there are likely important similarities and differences in their experiences with distinct public health and clinical implications. Although research on how COVID-19 has impacted frontline healthcare workers’ mental health is burgeoning, significantly less attention has been devoted to understanding the experiences of second-line workers. Some research on this topic has begun to emerge in other countries (e.g., Israel; Itzhaki-Braun, 2021; Feldman et al., 2022). Further, large-scale quantitative studies have begun to describe the experiences of trauma, grief, and burnout of second-line workers in the U.S. during COVID-19 (Holmes et al., 2021; McFadden et al., 2021). However, the literature has only begun to give voice to mental health providers directly impacted by COVID-19 in the United States (U.S).

In this paper, we advance this new area of research by presenting qualitative findings examining how COVID-19 shaped both the wellbeing of second-line workers, namely mental health providers, as well as their clinical work in the early months of the COVID-19 pandemic in the U.S. Our findings are among the first to specifically examine how COVID-19 impacted the mental health of second-line workers in their own words, advancing emerging findings and offering important implications for both the wellbeing

of mental health providers and the clinical work they impart as part of the public health response to the COVID-19 pandemic.

Literature Review

The COVID-19 pandemic has created an unprecedented amount of stress for people in the United States (U.S.). The fear of and rumination over contamination risks, experiences of severe and debilitating illness, the potential or actual loss of life and family members, widespread job loss, and economic crisis, as well as the extensive social distancing and quarantine measures, have not only posed a serious threat to people's physical health, but also had a grave impact on their mental well-being (Feijt et al., 2020; Holingue et al., 2020). Recent evidence from China has suggested that the mental health impacts of COVID-19 are severe: COVID-19 patients displayed a high level of post-traumatic stress symptoms and significantly higher levels of depressive symptoms.

The general public showed a decrease in psychological well-being and higher scores of anxiety and depression compared to before COVID-19 (Vindegaard & Benros, 2020). Past research on public health crises, such as SARS or natural disasters has established robust evidence that these large-scale public health crises can lead to significant mental health consequences such as trauma, depression, and anxiety (Huremovíc, 2019). These mental health challenges are very likely to be worse for people with pre-existing mental health conditions or (and are in disadvantaged social-economic groups, as they struggle to gain access to health care services they need and fight against the pandemic-related stressors (Fish & Mittal, 2021). At the same time, the recommended physical distancing measures may further exacerbate these mental health difficulties due to the negative consequences of social isolation (Leigh-Hunt et al., 2017).

As the COVID-19 pandemic continues to engender and exacerbate mental health conditions of the general population and increase demand for mental health services, second-line workers are being called to action to provide clinical care for their clients and communities in need (Gruber et al., 2021). Yet, we know very little about how second-line workers, particularly mental health providers, are faring as they navigate multiple stressors ranging from the transition to teletherapy to the pandemic itself.

The Impact of COVID-19 on Mental Health Care

As strict social distancing and lockdown measures were abruptly imposed at the onset of the pandemic, mental health providers were forced to transition their traditional in-person care practice to online platforms (Eppler, 2021; Madigan et al., 2021; Morgan et al., 2021; Shklarski et al., 2021). The primary adaptation was transitioning from in-person services to teletherapy, which we define as the use of technology (e.g., video conferencing), to deliver remote mental health assessment and treatment (Whaibeh et al., 2020). With little prior training and experience in delivering mental health services on a new platform, the unanticipated and radical shift suddenly disrupted the way mental health providers deliver their services, which required immediate adaptations and a steep learning curve for many (Feijt et al., 2020; Fish & Mittal, 2021; Morgan et al., 2021). Indeed, findings by Phillips et

al. (2021) indicate that of 207 surveyed mental health providers, the vast majority had never used teletherapy before (i.e., 46.80%) or used it less than a quarter of the time (i.e., 42.36%).

Broadly, research suggests that teletherapy is generally effective across different settings, clinical presentations, and populations (Shore, 2013; Whaibeh et al., 2020) and may even be as effective as in-person psychotherapy (Gloff et al., 2015; Madigan et al., 2021). Further, teletherapy may reduce or eliminate barriers to treatment access, such as transportation and areas with provider shortages (Madigan et al., 2021; Nelson et al., 2017). Yet prior to the COVID-19 pandemic, teletherapy appeared to be employed varyingly. For example, Hertlein and colleagues (2015) found that the majority of the surveyed couple and family therapists (CFTs) were both reluctant to deliver psychotherapy via a virtual platform and endorsed the need for significant training in teletherapy.

The rapidly evolving circumstances of COVID-19 required mental health providers to shift from “Should we do teletherapy?” to “How do we conduct teletherapy?” In the early months of 2020, some literature began to emerge on recommendations for teletherapy. For example, Rosen and colleagues (2020) recommended teletherapy for two levels of intervention: (1) strengths-based interventions aimed at helping people cope with disruption and distress related to the pandemic, and (2) treatment delivery to assist those with chronic mental health conditions, especially related to traumatic stress. Although the emergence of these important resources offered some critical guidance, it is likely that the sudden widespread implementation of teletherapy likely added to existing stress, uncertainty, and confusion inherent to the experiences of COVID-19.

Indeed, in early 2020, mental health providers and agencies were suddenly faced with navigating the logistics, ethical and legal considerations, and best practices of teletherapy to prioritize continuity of care (Morgan et al., 2021). The rapid shift from healthcare-as-usual to a virtual teletherapy context likely has consequences for providers and client care alike. For example, emerging research illustrates the concerns providers experienced in the transition to teletherapy, such as learning how to do teletherapy “on the fly”, working virtually from home, and having a general sense of unpreparedness (Morgan et al., 2021). As we surpass the two-year mark of COVID-19’s existence, many important questions regarding teletherapy have begun to be addressed, such as technological logistics, legal considerations, and best practices. However, significantly less is known outside of the “doing” of teletherapy. Questions such as, “How has COVID-19 impacted the mental health of mental health providers?” and “How has COVID-19 influenced the clinical work of mental health providers?” remain to be answered.

The Impact of COVID-19 on Mental Health Providers

As the demand for mental health services continues to grow in the U.S., mental health providers are faced with a shadow mental health pandemic while simultaneously navigating service delivery transitions inherent to COVID-19. Concurrently, mental health providers also live in the same international emergency and are likely experiencing similar pandemic-related stressors of their clients such as grief and loss, anxiety about health and safety, economic concerns, and balancing work and home demands (Fish & Mittal, 2021). In this

way, helping professionals working in the wake of the pandemic are likely experiencing a "shared trauma", which appears to be causing significant emotional distress (e.g., anxiety, trauma, insomnia) (Baum, 2010; Bansal et al., 2020; Shklarski et al., 2021; Werner et al., 2020).

The COVID-19 pandemic may also be accelerating burnout, which is understood as, "a state of mental and physical exhaustion caused by one's professional life" (Freudenberger, 1974). Features of burnout may include fatigue, depersonalization, cynicism, imposter syndrome, reduced sense of meaning or accomplishment, and a general sense of feeling overwhelmed, exhausted, and depleted (O'Connor et al., 2018). Recent findings by Aafjes-van Doorn and colleagues (2020) found moderate levels of vicarious trauma, with higher rates associated with younger age, less clinical experience, and online psychotherapy experiences. Further research has identified the impact of "zoom fatigue", a phenomenon in which providers experience burnout and fatigue related to both being in front of a screen for long periods of time, and due to factors inherent to the pandemic itself (Lin et al., 2021; Shklarski et al., 2021; Wiederhold, 2020).

Scholars have proposed that the antidote to burnout, in addition to caring emotionally and physically for one's self, is positive work engagement in which one feels connected, dedicated, and fulfilled by their work (O'Connor et al., 2018). A recent (pre-COVID-19) meta-analysis found a burnout (i.e., emotional exhaustion) prevalence rate of about 40% across all mental health professionals (O'Connor et al., 2018). Burnout has been found to be associated with low commitment to work (Maslach & Leiter, 2016), as well as depression, anxiety, substance use, musculoskeletal disorders and cardiovascular diseases (Ahola et al., 2010). In particular, mental health providers experiencing burnout may develop issues with sleep, back pain, headaches, gastrointestinal problems, depression, anxiety, and post-traumatic stress disorder (Simionato et al., 2019). In the era of COVID-19, emerging research has identified staggering rates of trauma, grief, and burnout among mental health providers. For example, Holmes and colleagues (2021) found that 99.1% of sampled social workers were experiencing average to high compassion fatigue, nearly half (i.e., 49.6%) reported symptoms of secondary trauma, and over a quarter (i.e., 26.2%) met diagnostic criteria for post-traumatic stress disorder.

Research examining strategies to combat burnout suggests that, in addition to positive work engagement, it is imperative that mental health providers also disengage from work when not working (O'Conner et al., 2018). Yet, one of the greatest challenges and concerns about working from home is work-home life balance, which was significantly disrupted during the height of COVID-19 as many households had multiple people working from home simultaneously, as well as children needing supervision and assistance with homeschooling (Dockery & Bawa, 2020). As many worked from home due to the circumstances of the COVID-19 pandemic, the physical separation between office and work spheres was almost entirely eliminated. In this way, disengaging from work became much more complex and difficult while demands at home increased for many (Dockery & Bawa, 2020). These intersecting forces likely contribute to faster burnout and negative spillover into home and family life, though research on this topic is limited. In examining coping strategies of mental health providers during COVID-19, McFadden et al. (2021) found that positive coping

strategies (e.g., engaging with coping skills and help-seeking) were associated with overall better wellbeing and work-life experiences.

Research indicates that unmanaged burnout among mental health professionals may contribute to reduced capacity for empathy and clinical effectiveness and, in some cases, ethical misconduct (Simionato et al., 2019). Considering the degree of emotional labor, sensitivity, and attunement needed to effectively conduct psychotherapy, mental health providers are particularly vulnerable to burnout, and by extension their clients. Indeed, research on the therapeutic impact of burnout indicates a potential reciprocal relationship between burnout and clinical work. Simionato and colleagues (2019) describe an example of this mutually perpetuating process as, “Emotionally exhausted therapists find it increasingly difficult to derive satisfaction from clinical work, resulting in a tendency to put less effort into their job, and thereby reinforcing poorer client outcomes and further reducing personal satisfaction from therapeutic work.” Given our understanding of how burnout negatively affects clinical work and outcomes, and the many COVID-19 related circumstances contributing to overall stress and burnout, it is likely that clinical work has been impacted by COVID-19 vis-a-vis the mental health and wellbeing of mental health providers working as second-line workers.

Current Study

At present, the majority of the literature on this topic focuses on the mental health of the general population (e.g., Gruber et al., 2020), as well as frontline healthcare workers (e.g., Spoorthy et al., 2020). Research suggests frontline healthcare workers have struggled with increased depression, anxiety, psychological distress and poor-quality sleep (AlAteeq et al., 2020; Spoorthy et al., 2020; Zhang et al., 2020). Emerging research on the unique experiences of second-line mental health providers suggests higher rates of trauma and compassion fatigue (Holmes et al., 2021, McFadden et al., 2021). Although these studies provide important quantitative findings, we have yet to hear the voices of the providers themselves. For mental health care to be sustainable for providers, it is imperative we understand the breadth and depth of their distinct needs as second-line providers. Toward this end, the present study investigated how the COVID-19 pandemic impacted the wellbeing and clinical practice of mental health providers across the U.S by giving voice to providers’ experiences. We aim to provide an experiential understanding of the emerging quantitative findings describing how mental health providers were living and working within a global pandemic. Our research questions were: How has COVID-19 impacted mental health providers’ wellbeing? And, how has COVID-19 shaped mental health providers’ clinical work?

Method

Procedures

To explore our line of inquiry, we asked mental health providers to describe their experiences of living and working as clinicians in June and July 2020. Given the levels of heightened stress at the time of our data collection, we sought meaningful data in the least burdensome manner possible. In this way, collecting open-text responses allowed us to

conduct this research at a critical moment (i.e., first six months of the pandemic) with the most accessible means possible (i.e., a brief survey). Participants were presented with open-ended questions inquiring how the pandemic had impacted their mental health, ability to serve clients, and clinical practice. Participants answered the following questions: (1) How are your experiences as a mental health provider during COVID-19 pandemic affecting your mental health? and (2) How has the stress that you are experiencing in your life (outside of clinical practice, but related to COVID-19) affected your clinical practice? Participants were offered the opportunity to win one of four, $50 Amazon.com gift cards.

Sample

We recruited a sample of U.S.-based licensed mental health providers. The survey was distributed to these providers nationwide utilizing personal connections, various mental health providers and professional listservs, snowball sampling, and word of mouth. In total, 143 people completed the informed consent and agreed to participate in the study. However, 136 people completed the open-ended responses. Seven participants did not provide any responses and were dropped from this study.

Sample demographic information is presented in Table 1. Approximately 81% of the participants were White, 5% were Asian American, 3% Black or African American, 2% Hispanic (Latino, 8% were bi- or multi-racial and 2% reported another race not listed. Roughly 84% percent of the sample were women, 14% were men, and 2% were non-binary or genderqueer. The age range of respondents was 27–58, with a mean age of 45.5 years. Most participants were licensed psychologists (28%), licensed marriage and family therapist (24%), and licensed clinical social worker (32%). More than half (63%) worked exclusively in private practice; around 21% of participants worked in two or more settings (e.g., private practice, and community mental health). Roughly 41% had offered the option for teletherapy prior to the COVID-19 pandemic. Approximately 44% of the sample were from the Northeast, 23% from the Southeast, 13% from the Midwest, and 19% from the West.

Data Analysis

Data were analyzed in Dedoose (Dedoose *9.0.17,* 2021) using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes). A group of five individuals trained in qualitative data analysis analyzed the study data. Our coding team consisted of one faculty member who has a PhD in couple of family therapy, one PhD student with a masters in couple and family therapy, two couple and family therapy students in a master's program, and one undergraduate student who was a neurobiology & physiology and a public policy major. Data analysis involved six steps: (1) Becoming familiar with data. This involved re-reading data and noting ideas using Google's Jamboard; (2) Generating initial codes. During this step, we coded interesting features of the data in a systematic fashion across data from the first 15 respondents. We then collated data for each relevant code; (3) Searching for themes. Using the codes developed in step 2, we coded the entire data set and collated codes into potential themes; (4) Reviewing themes. As we reviewed themes, we generated a thematic map by re-organizing themes and bringing them together; (5) Defining and renaming themes. In this step, we continued to refine themes and the overall story, and (6) Producing the report. In this step, we

selected compelling examples that relate to the research questions and detailed them in this manuscript.

Rigor and Trustworthiness

Since many of the coding team members were mental clinicians or clinicians in training, we met to discuss our experiences before starting the coding process. Further, during the data analysis phase, the coding team met weekly to discuss the emerging themes, questions on how to code specific parts of transcripts, if we needed to create a new code, or edit the existing codes and themes. Data analysis was an iterative process in which codes and themes were continually evaluated, edited, and adjusted to fit the data. To enhance rigor and trustworthiness, we continued to have conversations about our experiences and how similar or different they were from that of the study participants. These reflexive conversations helped us to maintain prolonged engagement with the data and generate thick descriptions of participants' experiences. We also double coded 25% of the transcripts. Whenever differences arose, we discussed them until we came to a new understanding of the data.

Results

Broadly, participants identified emotional and physical tolls incurred from the COVID-19 pandemic, which indirectly shaped their clinical work. However, some participants also derived meaning from their roles as second-line workers. Below, we explore the nuances of these themes with exemplar quotes from participants.

Mental Health of Providers During the Pandemic: "Each week feels like a mountain"

Our findings highlight how the pandemic affected clinicians' physical and mental health and had a significant influence on their clinical work. Many providers indicated that being a mental health provider in the early months of the COVID-19 pandemic took a severe toll on their mental and physical health. They reported feeling lost, vulnerable, stressed, overwhelmed, and emotionally burned out. Participants also stated that they felt isolated, lonely, worried, anxious, and depressed. They shared, "it highlighted my own loneliness, isolation and need for meaningful connections" and "There are some days when I feel particularly drained from multiple telehealth sessions and lack of social contact with my colleagues." Participants worried about their clients as well as themselves. One participant shared their fear that depression and suicide rates would increase among their clients because of the pandemic. Additional comments that reflect this worry and poor mental health include, "I have an increased anxiety, the amount of self-care I used to do is not enough for Covid. Each week feels like a mountain, and it seems like the work is taking more from me. I can't get filled up before the next week begins," "I have likely entered a depression episode, have little motivation to complete work tasks and engage in self-care, and feel overwhelmingly anxious much of the time" and "I have had a HUGE range of emotions. I have PTSD and it has been well treated and controlled, but I was very easily triggered, tearful, anxious, and even irritable a lot of the time".

Mirrored Experiences

An overwhelming number of participants commented on their stress levels being compounded because of "mirrored experiences" related to COVID-19 between themselves and their clients. They stated, "I am finding myself a bit burned out holding the collective trauma of my clients….it is taking a toll on my emotional/mental/relational health," "I find it very exhausting to both help others while also going through the same experiences myself," and "It has been difficult helping clients to reframe their negative thoughts about the pandemic when I largely share those thoughts."

Zoom Fatigue

Teletherapy fatigue was another common experience that was shared by many participants. Overall, they reported that seeing clients online was more tiring than face-to-face. They shared, "I find it much more exhausting to provide care via telehealth, going from video chat to video chat with both patients and meetings," and "I find doing telehealth more draining and tiring and not as enjoyable as in person work….feel more isolated and anxious."

Decline in Health

Coupled with compromised mental health, isolation, and burnout, many clinicians also reported negative general health outcomes, such as headaches, trouble sleeping, poor appetite, back pain, eye strain and so on. One participant shared that "The adjustment to looking at a screen all day was particularly rough on me. I had headaches and felt more fatigued, until I figured out how to set blue blocking on my computer." Other participants reported similar experiences. "Telehealth is exhausting and my eyes get tired," "I am more tired than usual. Some pain in my back and hips from sitting in a different chair," "I am sleeping poorly, have reduced appetite", and "This is exacerbating several gastrointestinal health concerns I have."

Sense of Meaning

Not all the participants reported that being a mental health provider during the pandemic had bad implications for their mental and physical health. A few participants shared that being a mental health clinician during the pandemic was both a difficult and rewarding experience. One provider stated, "It sucks. It is hard. It's rewarding. It's surreal." Another participant said, "At times it's been challenging…but it's also been rewarding to provide a much needed space for my clients during a challenging time."

Some clinicians reported that being a mental health provider during the pandemic was gratifying and it gave them a sense of pride and meaning as they were able to help people under this stressful time. "I feel proud that I have been able to help people when they need it most," and "Helping people has helped my mental health. It has helped me to keep working" are examples of the positive impact of being a clinician during the pandemic. Several participants expressed gratitude towards their profession and its sustainability.

> I am grateful to my clients for their patience and understanding with technical difficulties and their care and concern for my well-being. I am grateful to do this important work and to support others during some of the worst days of their lives.

Some of the participants also shared that they experienced a reduction in their stress levels. They attributed this relief to having an appreciation of being able to work from home, having more time with their families, and benefiting from flexible schedules. This experience can be summarized by the following participant's response,

> For me, it's actually helpful to be able to sit with and validate the difficulty of the situation [and] to give voice to clients' experiences in a way they haven't had permission to acknowledge or feel before. I center myself on that purpose during this pandemic and it helps me channel my own feelings of helplessness. I am appreciating the additional time at home with family and hobbies now that I don't have a commute. I focus on that rather than the ambiguity of the situation and the lack of control.

Impact of COVID-19-Related Stressors on Clinical Practice: "Distracted and less engaged"

While describing the effects of COVID-19-related stressors on their clinical practice, participants highlighted a number of sources of stress during the pandemic. They shared feeling stressed out about the safety of their loved ones, loss of loved ones due to COVID-19, financial stress because of income uncertainty, and stress related to racism and the political climate. They stated, "I am worried about particular loved ones, and that stress is often on my mind, though I would not say it has gotten in the way of being present for clients. If anything, since clients need more now I have been less engaged with others in my life so I can save my energy for clients," "The economic impact has been even worse- I had a job offer rescinded and still do not have a plan for where I will work or live one month from now," "I'm paying monthly rent for a private practice office that I can't use right now. That's about it." and "Initially my caseload went down by half and the money stress was very dysregulating." Several mental health providers shared their experiences of working during a pandemic and concurrently experiencing the racial justice movement in the U.S. One participant stated, "It's been additionally trying to manage my caseload and personal mental health with the social unrest and news cycle that amplifies polarizing views and uncertainty in our world." This unique and challenging experience is further exemplified in the quotes below.

> The uncertainty of early lock-downs, transitioning to tele-appointments only, reduction in hours, increase in client distress and symptom management concerns, difficulty in finding professional resources (e.g., consultation groups) as well as unpacking personally and professionally the concept of systemic racism have created a very challenging environment to provide useful and helpful psychotherapy.

> The racism in my personal life is replicated in the workplace and this has been stressful. Racism has increased since COVID-19 toward Black, Brown communities. I manage racial battle fatigue and race-related stress sufficiently such that it doesn't negatively affect my clinical practice, but I do not anticipate staying in my organization long-term.

Practicing and Living in the Same Space

A few clinicians highlighted additional stressors that they were facing as a result of practicing from home and being responsible for other members in the household. The following quotes demonstrate their thoughts and feelings, “Working from home has had its challenges and made practicing optimally more difficult. I find myself more distracted in my home environment.”

> The stress has been high as my 2 children were home from school for the past 3 months. Trying to do telehealth while home-schooling 2 kids was a mess and at times impossible. The stress has made me distracted, while I try to still give all my clients the best care, the quality of my notes and assessments have declined.

Decreased Work Satisfaction

Mental health providers reported that the pandemic-related stressors had significantly impacted their satisfaction with work. Study participants shared, “Extremely unsatisfying for me as a clinician as I am limited in providing services and doing what I love” “[I] have not enjoyed my job as much as I used to” and “Increased isolation (mine) has decreased “informal” times to reach out to colleagues during the day, therefore increasing stress and decreasing satisfaction found in the work environment.” Several other participants talked about losing motivation and questioning the meaningfulness of their work. They stated, “Many days I am distracted and unmotivated to complete my work,” “I’m less motivated to see clients and feel like quitting my practice. I feel overwhelmed with my practice and necessary paperwork,” and “I have been feeling more lost, questioning if my work is as meaningful as I thought it was.” Some participants elaborated on their dissatisfaction with their clinical work and expressed feeling less engaged, more distracted, and as a result less effective with their clients. They shared, “I don’t feel connected to my clients, I have an increased sense of imposter syndrome, and a decreased sense of efficacy as a clinician,” “It’s (the pandemic) made it harder to concentrate and focus. It’s left me distracted and less engaged. It’s made it harder to access empathy at times,” and “I’m more anxious. I’m less present with clients or I have to force it, draining more energy.”

Ethical Concerns

A few participants talked about being concerned about boundary violations between themselves and their clients. They shared that being lonely, vulnerable, and in the same situation as the clients were factors that influenced their concerns about potential boundary violations that they were mindful of. Some statements shared by participants include, “Because I’m less motivated and somewhat lonely, I’m worried that I may be inappropriately disclosing with clients. I haven’t, but [I am] concerned about possibility,” “I feel less able to hold boundaries and less focused in session,” “[I have to be mindful of] feelings of vulnerability at times around my own sadness or anxiety. Also, an urge to self-disclose that I keep an eye on, just related to us all being in the same boat,” and

> There is more parallel process happening than usual because we are all going through this at the same time, so I’m having to stay mindful of that in sessions so there is space for the client (which is the purpose of therapy, obviously)...this takes more effort.

Positive Effects

Although the majority of the mental health clinicians discussed the negative impact of COVID-19 related stressors on their clinical practice, there were a small group of participants who shared that they were not experiencing significant stressors and therefore, did not feel that their practice had changed significantly. They attributed their experience of not feeling additional stress to having work-life balance or being in a different life and relationship stage.

> COVID-19 has caused some stress in my personal life, which has made me feel less effective some days as a provider. However, managing work-life balance is an important [part] of this work and I have been able to not have [it] impact my work too much.

> I am fortunate - I am not alone, nor am I having to work while taking care of and homeschooling children. I am older and my husband and I find that our lives have not changed terribly significantly other than not being able to see friends and family in person - but we're finding lots of ways to keep in touch.

Some others shared that the stressors that they were experiencing during the pandemic had some positive effects on their clinical practice. They shared that they felt more connected with their clients and greater empathy towards them. "In some unexpected ways it has deepened the work with many of my clients," "I am more stressed but I think it has helped create more bonding between therapist and client," and "It has definitely made me more attuned to some of the potential varying experiences my clients are going through. My empathy has increased as well as my physical exhaustion," Several of them attributed these positive changes to limiting their client load and being able to compartmentalize and take a break from the personal stressors that they were experiencing. One participant shared, "I have had to set limits on taking on new clients, and I've rearranged my schedule to limit the number of clients daily. In some unexpected ways it has deepened the work with many of my clients." Another stated,

> I believe that I have been able to compartmentalize in my work and use appropriate self-disclosure where I can in order to join with my clients in this shared pandemic experience. The work has also continued to be rich and grounding, a welcome reprieve from the stressors of my life.

Discussion

In this paper, we present qualitative findings from an open-ended survey examining how COVID-19 impacted mental health providers, and by extension their clinical work. Participants indeed described the effects of COVID-19 as having a direct impact on their own wellbeing (i.e., "Each week feels like a mountain"), as well as the self-perceived quality of their clinical work (i.e., "Distracted and less engaged"). Interestingly, across both wellbeing and clinical work domains, many participants described a "two-sides of the same coin" effect in that they identified both positive and negative characteristics of being a second-line worker during the COVID-19 pandemic. These findings advance the literature

on COVID-19 and mental health in three meaningful ways. We discuss these contributions below in conjunction with possible implications for second-line workers.

First, our study advances preliminary research (i.e., Feldman et al., 2022; Holmes et al., 2021; McFadden et al., 2021) describing how COVID-19 impacted the wellbeing of mental health professionals, which provides important insights into how second-line workers are faring during a global pandemic. Although recent research has examined the shift to teletherapy (Phillips et al., 2021; Rosen et al., 2020), rates of vicarious trauma (Aafjes-van Doorn et al., 2020), and experiences of shared trauma, anxiety, and zoom fatigue (Lin et al., 2021; Shklarski et al., 2021; Webster, 2021; Wiederhold, 2020), this study is among the first to qualitatively explore and present providers' experiences in their own voices. Participants described isolation, emotional exhaustion, and a diminished sense of purpose and meaning. Experiences of isolation, fatigue, and "shared trauma" greatly impacted the degree to which mental health providers were able to function personally and professionally, suggesting that these findings are inexplicably tied to circumstances of the pandemic. This shared trauma has been described as a "double exposure" (Werner et al., 2020), in which mental health providers first experience the COVID-19 pandemic as citizens, and second through the experiences, stress, and trauma of their clients. It is likely that double exposure scenarios inherent to second-line work in COVID-19 foster experiences of burnout more rapidly than psychotherapy-as-usual contexts. As such, second-line workers taking care of themselves is more important than ever.

Mindfulness exercises are a promising type of intervention shown to be effective in reducing stress and increasing compassion (Suyi et al., 2017). Second-line workers may also benefit from personal psychotherapy in order to process their double exposure and develop general stress-reduction coping skills (Treter et al., 2021). In particular, "third generation cognitive behavioral therapy (CBT)" interventions, which incorporate both traditional CBT as well as meditation and mindfulness are demonstrating promising results (Hayes et al., 2004; Morse et al., 2012). Acceptance and commitment therapy workshops have also been shown to reduce symptoms of burnout for mental health providers (Hayes et al., 2004; Morse et al., 2012).

More recently, Krasner and colleagues (2009) developed and tested a burnout prevention and reduction intensive educational program that included mindfulness, communication, and self awareness; results indicated significant improvements that were sustained over time (Krasner et al., 2009). Of note, in addition to burnout reduction strategies, a critical element in Krasner and colleagues' (2009) study was that it incorporated techniques to strengthen positive personal attributes such as connecting with one's sense of meaning and purpose (Morse et al., 2012). Self-help books that provide strategies for helping professionals while they care for others (e.g., Trauma Stewardship; van Dernoot Lipsky & Burk, 2017) may also be both useful and accessible. Lastly, Crittenden and colleagues (2021) offer caring approaches for healthcare providers in COVID-19 that emphasize celebrating successes, reducing isolation and impersonality, accepting distress, and improving the context. Extraordinary times and circumstances must be met with extraordinary responses. For second-line workers, providing mental health care during COVID-19 means going

beyond traditional self-care approaches and thoughtfully incorporating advanced burnout prevention and reduction strategies.

Second, our findings lend credence to the mutually perpetuating relationship between isolation, burnout, diminished clinical work, and possible ethical misconduct scenarios. Existing research on therapist burnout suggests that mental health providers who endorse burnout symptoms are more likely to violate ethical codes and enact misconduct (Simionato et al., 2019). Research indicates that the pathway between burnout experiences and ethical misconduct is the product of a diminished ability to perceive cues of client affect and risk, blurred therapist-client boundaries (e.g., overly self-disclosing), and overall "blind spots" created by burnout symptoms (e.g., reduced memory, attention, and empathy) (Simionato et al., 2019). Participants overwhelmingly described burnout symptoms, and some wondered if their burnout was reducing their capacity to uphold strong ethical care. Second-line workers are a critical facet of the public health response to COVID-19 and will continue to be likely for years ahead. Prior research shows that in the immediate aftermath of a disaster, 311 calls primarily focus on requests to help basic needs (i.e., frontline needs such as economic assistance, food, shelter, etc.) and requests for second-line services (i.e., mental health treatment) did not begin until two years post-disaster, with the highest frequency of mental health service requests peaking at five years post-disaster (Eugene et al., 2021).

Research on the long-term need for mental health services following mass trauma indicates that second-line workers must find ways to make their work sustainable to prevent burnout, reduce the possibility of ethical misconduct, and provide the highest quality clinical care. In this way, we recommend that mental health providers at risk of burnout, and therefore possibly ethical misconduct scenarios, engage in both peer consultation and supervision that focuses more on self-of-the-therapist self-reflection than on case management or clinical consultation (Simionato et al., 2019). In conjunction with burnout prevention strategies, these recommendations may indeed promote realistic sustainability for second-line workers providing mental health treatment during COVID-19 and beyond.

Third, teletherapy burnout may happen more quickly and substantially than burnout from in-person psychotherapy. Due to the qualitative nature of the study we cannot examine causal links. However, many participants specifically mentioned finding teletherapy more draining and isolating, and less fulfilling, than in-person clinical work. This finding is in line with previous telework research in the context of COVID-19 identifying "zoom fatigue" as a significant drain on their wellbeing (Lin et al., 2021; Shklarski et al., 2020; Wiederhold, 2020). Further, blurred work-home boundaries are more common with telework than in-person work, and result in reduced motivation and work-life satisfaction (Hallin, 2020). Interestingly, research indicates that reduced motivation and work-life satisfaction are significant indicators of burnout (O'Connor et al., 2018). Therefore, it may be that forced telework (i.e., due to a pandemic rather than choosing from multiple work setting options) and increased screen time begets burnout more rapidly than either in-person work or telework by choice. Having choices in one's work environment may foster a sense of empowerment and buy-in to the work itself.

In the absence of choices, and in the context of forced telework, it may be critical for second-line workers to have opportunities for choice and screen time breaks throughout the day. We echo the recommendations of Treter and colleagues (2021) on how to reduce the negative impact of screen time on mental health providers during COVID-19: (1) take breaks whenever possible (e.g., taking meetings via phone and psychotherapy sessions via videoconferencing, 5–10 minute post-session screen breaks, etc.); (2) reallocating previous "commute time" toward a self-care activity (e.g., physical exercise or social connection); (3) increasing social support with personal and professional connections where possible to reduce experiences of isolation; and (4) prioritizing self-care activities even more than before COVID-19, including mindfulness, physical exercise, and personal psychotherapy (Treter et al., 2021).

Although not a unique literature contribution, the apparent resilience of our participants was noteworthy. Even during a global pandemic where second-line workers were isolated, and asked to do more with less, many found reasons for hope, meaning in their work, and capacity to compartmentalize. One participant aptly stated, "It sucks, it's hard, it's rewarding." Our findings here are consistent with recent research from Israel, in which social workers were able to see the "upsides" of their roles and opportunities to conduct meaningful work during the pandemic (Itzhaki-Braun, 2021). Many mental health providers are drawn to their line of work through a sense of helping others and despite the difficult circumstances during COVID-19, many participants were able to connect with the significant meaning and purpose of clinical work as second-line workers. Further, based on available data we know that women and people of color have been disproportionately impacted by COVID-19 for a variety of reasons including gendered care-work expectations, institutional and systemic oppression, and heightened racial stress and injustice over the past few years (Kantamneni, 2020). Considering how COVID-19 intersected with racial injustice and disproportionate employment impacts on gender minorities, it is especially remarkable that so many of our participants were able to name the duality of their experiences – the difficult and the meaningful.

Limitations and Future Directions

The present study meaningfully advances our understanding of how second-line workers are faring personally and professionally during COVID-19. However, this research has limitations. Although the qualitative nature of this inquiry allowed us to give voice to second-line workers, it is preliminary. Future quantitative research may deepen our understanding of the pathways between environmental stress, burnout, and clinical practice during COVID-19. Although we were limited to open-text responses, precluding the possibility of follow-up questions, the use of a survey allowed us to: (1) collect meaningful data at a critical time (i.e., early months of the pandemic), and (2) reduce the burden (i.e., time and energy) placed on participants, many of which were already experiencing burnout.

Further, the present findings are inextricably tied to circumstances of the pandemic and cannot be generalized to telework in general. The primary difference between these conditions is that telework during COVID-19 was forced, whereas telework prior to COVID-19 was more likely to be a choice. Although our findings are highly relevant to

the present pandemic-based context, we cannot reliably apply these findings to outside the COVID–19 pandemic. Similarly, this study was conducted in the early months of the pandemic (i.e., mid-2020), which may have captured the acuity of participant experiences. However, our findings may not be representative of second-line workers' experiences after settling into the long-haul of COVID-19 telework. It is likely that the long-term nature of COVID-19 continued to exacerbate burnout, however it is just as likely that second-line workers settled into a "new normal" and found ways to combat burnout. Future research should examine the contextual influences of second line worker experiences throughout the pandemic. When was burnout at its highest? What were the important turning points? What resources and strategies helped providers make their work sustainable? Should we identify "best practices" for clinicians that outline ideal working limits? How do we identify burned-out clinicians? How can we better prevent burnout? How do we support clinicians in managing the stress of their caseloads and the limits of our mental health care system? Further, the COVID-19 pandemic overlapped with national conversations about institutional and systemic racism. Future research may benefit from examining the effects of systemic racism on mental health providers during COVID-19, especially therapists of color. Finally, research on the relationship between mental health provider burnout and clinical work, especially ethical misconduct, is preliminary and still emerging. It is imperative that we more closely and rigorously examine these pathways to support second line workers, prevent and reduce burnout, and maintain excellent standards of clinical care for clients and communities in need.

Conclusion

In the wake of COVID-19, mental health providers are being called to action. Despite double exposure experiences, provider shortages, and professional isolation, these second-line workers are providing critical mental health services in the public health response to COVID-19. It is imperative that our helpers also receive the help they need in order for their work to be sustainable, ethical, and maintain excellent standards of care. At present, many mental health providers are describing profound COVID-19 related burnout, which is likely impacting their clinical work. Traditional self-care methods may need to be bolstered with targeted interventions such as mindfulness, self-awareness, and reflection-based supervision and consultation. We can support mental health providers by making burnout prevention and reduction interventions accessible, while simultaneously advancing our empirical understanding of what second-line workers need in order to maintain wellness of themselves and the communities they serve.

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Public Significance Statement

Given the long-term nature of the COVID-19 pandemic, it is imperative we identify and address the needs of mental health care providers as they serve their communities during the pandemic. This paper describes the psychological burnout, trauma, and exhaustion experienced by mental health providers in the United States, as well as the meaning derived from being part of the COVID-19 public health response. Based on these findings, we offer recommendations to support mental health care providers to prevent and address burnout, promote personal wellness, and foster sustainable work practices.

Table 1

Descriptive Characteristics of Study Participants

Characteristics	N (%)
Gender (*n* = 134)	
Male	19 (14.2)
Female	113 (84.3)
Other	2 (1.5)
Race (*n* = 133)	
White	108 (81.2)
Black	4 (3.0)
Asian	7 (5.1)
Hispanic	3 (2.3)
Bi-or multi-racial	8 (6.0)
Other	3 (2.3)
License type (*n* = 136)	
Licensed psychologist	38 (27.9)
Licensed marriage and family therapist	32 (23.5)
Licensed clinical social worker	44 (32.4)
Licensed professional counselor	18 (13.2)
Other (e.g. Psychiatrist)	4 (2.9)
Work setting (*n* = 136)	
Private Practice	86 (63.2)
Non-profit	1 (0.7)
Hospital	6 (4.4)
Community mental (behavioral organization	4 (2.9)
Private mental (behavioral organization	3 (2.2)
Other (e.g. University)	8 (5.9)
Multiple settings	28 (20.6)
Region (*n* = 135)	
Northeast	60 (44.4)
Southeast	31 (23.0)
Midwest	18 (13.3)
West	24 (18.6)
Outside of US	1 (0.7)