"It's real. It's a thing:" Mental health counselors' listening exhaustion during COVID-19

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ABSTRACT

Mental health counselors regularly use active listening skills to be present with each client; however, active listening may cause burnout due to high emotional labor, inadequate staffing, excessive workload, and many other issues, each of which contributes to career exits. COVID-19 exacerbated all of these factors, and—adding to already stressful conditions—most mental health professionals were forced to conduct therapy sessions via telehealth. For this study, twenty licensed mental health counselors at various stages of their careers were interviewed during the height of the pandemic to understand their experiences with the technology and other factors related to their workload during that time. Thematic qualitative analysis was used to explore effects of active listening—including requisite adjustments made for virtual therapy sessions—on counselors' emotional exhaustion and burnout levels. Results show how back-to-back, daily therapy sessions increased listening exhaustion levels and that counselors experienced both long-term and short-term listening exhaustion when utilizing telehealth due to lack of nonverbal cues and other related factors pertaining to online delivery. Implications for counselors, social workers, and other mental health professionals are discussed.

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Key words: Interpersonal communication, burnout, emotional exhaustion, listening, thematic qualitative analysis, COVID-19

Conflict of interest: The authors declare no potential conflict of interest, and all authors confirm accuracy.

Ethics approval and consent to participate: The Ethics Committee of the University of Texas at Arlington approved this study (2020-0496). The study is conformed with the Helsinki Declaration of 1964, as revised in 2013, concerning human and animal rights.

Informed consent: All participants to this study signed a written informed consent form for participating in this study.

Participants' consent for publication: Written informed consent was obtained from a legally authorized representative(s) for anonymized patient information to be published in this article.

Availability of data and materials: All data generated or analyzed during this study are included in this published article.

Received: 16 February 2023.
Accepted: 24 May 2023.

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Licensee PAGEPress, Italy
Qualitative Research in Medicine & Healthcare 2023; 7:11261
doi:10.4081/qrmh.2023.11261

Introduction

Mental health professionals (MHPs) provide important services for their clients, including preventive, remedial, and crisis counseling. MHPs provide more than a listening ear as they help clients navigate a variety of issues. Active listening is a fundamental skill that helps the MHP build rapport and be in the present with the client by being engaged and consciously hearing, effectively attending to the speaker's message by using paraphrasing and reflection (Rogers, 1951). Active listening is therefore particularly vital for person-centered therapy approaches within the context of clinical mental health counseling. As Bletscher & Lee (2021, p. 151) write, active listening is "acknowledging others' needs or showing care" in such a way that increases the understanding of another individual's concerns.

Unfortunately, many MHPs face challenges which may lead to burnout, and these challenges can be related to demands required by active listening (Campbell et al., 2020). In turn, burnout leads to poorer client and provider outcomes, facilitating conditions for MHPs to exit the profession (Delgadillo et al., 2018). The COVID-19 pandemic further exacerbated the strain on healthcare workers, including MHPs (Fischer et al., 2022).

COVID-19 caused massive layoffs, loss of healthcare insurance—often including mental healthcare coverage—

contributing to increased depression levels among those diagnosed with COVID-19 (Crayne, 2020; Vindegaard & Eriksen Benros, 2020). The resulting increase in demand for mental health services during the pandemic merits further study regarding how MHPs managed their increased caseloads, particularly via telehealth—a new channel for many healthcare providers. Specifically, it is important to understand how increased caseloads affected MHPs' ability to be present and to engage in active listening during a tumultuous time.

The term "mental health professional" covers a wide range of professional responsibilities and certification requirements. As with most qualitative research, the sample for this study was relatively small, allowing for exploratory data collection and analysis. As such, this study focuses solely on Licensed Professional Counselors (LPCs) and LPC Associates, concluding with implications that may apply to other forms of MHPs. More specifically, this study investigates MHPs' perceptions of i) active listening demands and expectations, ii) emotional exhaustion, and iii) telehealth usage during the height of the pandemic in the hope of better preparing for future public health crises.

Active listening implications, burnout, and COVID-19

Active listening

Active listening is a fundamental expectation in a variety of disciplines such as counseling, psychiatry, psychology, and other forms of health care. Weger and colleagues (2014) highlighted the importance of utilizing active listening during initial communication with others, concluding that participants felt more understood when active listening skills such as paraphrasing and effective nonverbal communication were utilized, rather than providing suggestions or feedback. A MHP's focus on staying in the present is one of the most fundamental aspects of communication, requiring the practitioner to provide undivided attention to the client during the session to actively listen, paraphrase, and empathize with the client effectively. Clients' perception of active listening can result in positive emotional appraisal (Kawamichi et al., 2015), which could, in turn, build trust. Effective active listening skills can promote growth and empathy during therapy sessions (Bodie et al., 2015) and can help MHPs moderate their own negative thoughts while working with distressed clients (Altabef et al., 2017).

Some differences in performing active listening have been found between male and female MHPs, with female MHPs—who often feel less need for control of the sessions—being more likely to utilize active listening skills with their clients. Conversely, other differences can occur based on professional experience, with newer MHP being more likely to have the need to control the session and view their roles in a more rigid way (Altabef et al., 2017).

Among MHPs, in particular, the value of active listening accompanied with empathy is especially evident when working with clients who have narratives related to past trauma (Jeftić, 2020). On the other hand, MHPs face burnout due to continuous, intensive exposure to negative topics and the pressure to perform as an effective listener. Feeling like one is "on" for actively listening all the time may create psychological strain for MHPs. In other words, MHPs know that they should actively listen to their clients, but the active listening expectations that are a part of increasing caseloads and an increased number of people seeking therapy (Vindegaard & Eriksen Benros, 2020) may be unrealistic and contribute to MHP burnout.

While there are many resources to help reduce burnout levels such as utilizing mindfulness techniques, going to therapy, and facilitated burnout discussions in graduate school, many MHPs do not fully comprehend the symptoms of burnout until they start experiencing them firsthand. It is not surprising, therefore, that MHPs are subject to high levels of burnout (Warlick et al., 2021). One study reported that nearly half of clinical or counselling trainees report experiencing burnout (Kaeding et al., 2017) which is similar to recent reports indicating 45% of fully licensed psychologists feeling burned out (American Psychological Association, 2022) and that as late as 2022, 78% of psychiatrists feel burned out (Summers, 2022; see also Morse et al., 2012.) It is possible that current training may not be sufficient for managing burnout levels of MHPs, especially considering that the pandemic increased active listening demands (Gold, 2021).

Emotional exhaustion and burnout

A major factor in MHP burnout is emotional exhaustion. Psychological stressors can lead to emotional exhaustion, leading to decreased motivation, work performance, and mental health issues, each of which can result in lower work engagement, absenteeism, and burnout (Charoensukmongkol & Phungsoonthorn, 2021). Not surprisingly, emotional exhaustion is a frequently cited reason for burnout among MHPs (McCormack et al., 2018). Ultimately, burnout can lead to leaving one's job, particularly for MHPs who deal with high emotional labor, involuntary detention of their clients, underfunding, excessive working hours, and related factors (Johnson et al., 2018). Common factors of emotional exhaustion specific to MHPs are directly linked to working in a community setting, limited personal resources, lack of experience or less time practicing, and/or being younger (Craig & Sprang, 2010; Emery et al., 2009). Gender is another factor contributing to emotional exhaustion, with female MHPs facing greater exhaustion levels (Craig & Sprang, 2010; Johnson et al., 2018).

Further, in community settings, MHPs experience

burnout and emotional exhaustion due to the higher number of weekly hour requirements, larger caseloads, and pressure to implement multiple evidence-based practices (Kim et al., 2018). Burnout levels of MHPs are directly linked to in-session feelings of anxiety due to continuous emotional involvement (Steel et al., 2015), and MHPs are more likely to experience burnout when the progress of their clients is minimal and therapy outcomes are poor (Delgadillo et al., 2017). Lack of knowledge, inexperience, and limited training also negatively impact burnout levels (Craig & Spring, 2010), and MHPs are also more likely to experience burnout when they must continuously manage conversations with challenging clients who may be hostile, negative, or dangerous (Lee et al., 2019).

Recent research further shows that MHP burnout has a negative effect on client treatment outcomes and is correlated with lower job satisfaction ratings (Delgadillo et al., 2018). MHPs who are working long hours and experiencing listening exhaustion may decide to leave the profession or at a minimum, struggle with providing quality care to their clients. Clients, of course, are also impacted by MHPs' mental and emotional states. The purpose of conducting therapy becomes meaningless if MHPs are experiencing listening exhaustion and missing essential verbal and nonverbal information that could be vital to both parties. While MHP burnout is not new, conditions pertaining burnout were exacerbated by the pandemic's far-reaching effects including heavier workloads and requisite shifts in modes of delivery (Joshi & Sharma, 2020).

Telehealth *vs.* in-person therapy

Along with active listening, the choice of communication channel must also be considered to evaluate burnout level and emotional exhaustion. Selection of communication channel is an important part of conducting effective therapy, and therapy can be conducted through variety of channels such as face-to-face, telephone, or videoconferencing. The COVID-19 pandemic limited professionals' contact with clients; therefore, MHPs began using telehealth to ensure safety for themselves and their clients. The eventual shift to near-universal use of telehealth during the pandemic limited MPHs' contact with clients and may have had an impact on the efficacy of active listening, further contributing to burnout and emotional exhaustion.

Telehealth provides many benefits to healthcare providers and clients alike, specifically by reducing barriers clients face when seeking therapy, including alleviating travel concerns and costs, and increasing the availability of potential MHPs, as one is not limited to geographically local availability (Brown et al., 2017; Moring et al., 2020; U.S. Department of Health and Human Services, 2020). Despite benefits of telehealth under optimal circumstances (Hawley et al., 2020), many professionals remain skeptical (Poletti et al., 2021), often choosing not to utilize telehealth due to privacy concerns, interruptions in the household, safety of clients who may be high-risk for suicide and/or self-harm, and general technical complications based on internet connection and equipment.

Many professionals among healthcare organizations were forced to reconsider the virtual therapy option when COVID-19 pandemic shook the public (Zhou et al., 2020). In 2020, the American Psychiatric Association (APA) extended guidelines so that clients on Medicare could be treated by telehealth regardless of geographical location, enabling clients to receive mental health services online throughout the pandemic. America's Health Insurance Plans (2021) listed a variety of health insurance companies' alterations to their policies, allowing therapy sessions through telehealth and ensuring that clients and MHPs stayed safe by continuing to practice social distancing. An unintended outcome, however, was added stress for MHPs. Sklar and colleagues (2021), for example, found that during COVID-19, higher levels of work changes (e.g., modality shifts) were associated with higher levels of burnout (Sklar et al., 2021). On the other hand, research on COVID-19 and telehealth also showed promise—for women in particular—by improving control and increasing flexibility which, in turn, could increase participation in academic advancement opportunities (Nadkarni & Mittal, 2021).

As recently as 2022, more than half (58%) of one study's sample of psychologists reported treating some clients remotely, suggesting that telehealth as a modality for mental health treatment is here to stay. Even so, psychologists still report approximately 48% of all clients facing Internet access or connectivity challenges and 44% facing difficulties in finding a private place to connect for their sessions (American Psychological Association, 2022).

Research questions

Thus far, we have seen interrelationships among active listening, burnout, emotional exhaustion, and channel of delivery—all of which were further complicated by the COVID-19 pandemic. In consideration of these complications and in the hope of preparing better for future national and international health crises, we address three research questions regarding counselors' experiences during the COVID-19 pandemic: How did counselors perceive burnout based on listening exhaustion in their professional and personal lives? How did counselors perceive their emotional exhaustion? And how did they feel about the costs and benefits of using telehealth?

Materials and Methods

Author positionality

Before we present findings of the present study, we want to be self-reflexive and acknowledge our own standpoints based on our geographical location, race, nationality,

and level of training related to counseling (Levitt et al., 2018). At the time of the manuscript being drafted, one author self-identified as a U.S.-based, mixed-race woman from the Middle East with formal LPC training, and one author self-identified as a U.S., White-presenting, American woman without any formal LPC training. We were colleagues before undertaking this project, but had not yet worked together. After an informal conversation about burnout avoidance strategies, we realized that there was existing literature regarding higher education professionals, yet at the time, little to nothing for LPCs. Simultaneously, the LPC coauthor had several therapist colleagues who were making major career transitions due to increased demands on their time with little support. This series of conversations sparked our idea to conduct this research.

Participants

Participants in this study ranged in age from 27 to 56 years of age. Of the 20 participants, 10 were LPCs, and 10 were LPC Interns (LPC-Is).[1] Seventeen participants identified themselves as Caucasian, two as Asian, and one as Native American. Twelve identified themselves as women and five as men. Fifteen were working full time; five were working part time, with two of those stating they were working fewer hours due to the pandemic.

Procedures

After receiving approval (2020-0496) from University of Texas at Arlington's institutional review board, participants were recruited through purposive and snowball sampling (Creswell, 2007) via social media groups created for counseling and graduate schools. The posts asked for LPC and LPC Associates to participate in a telephone interview with compensation of a $5 virtual Starbucks gift card. Each willing participant contacted the first author who sent an online, informed consent form to the participants. Informed consent was also read aloud at the beginning of the interviews, and participants then agreed to audio recording. Interviews were held between July 7th and September 7th, 2020, i.e., during the COVID-19 lockdown period. Participant enrollment ceased after 20 interviews were completed based on similarly occurring themes. Interviews took place during a time of the participants' choosing. The primary goal of the study, and thus the interviews, was to investigate how LPCs and LPC Associates experience burnout and listening exhaustion during the early days of the COVID-19 pandemic. We also sought to understand their perceptions of active listening related to telehealth versus face-to-face therapy sessions. Interviews were conducted using a semi-structured interview guide (Spradley, 1979) so that both interviewers asked several similar key questions of the participants. Telephone interviews were used instead of face-to-face interviews to respect participants' privacy and to adhere to public health guidelines for social distancing.

Interviews ranged from nine minutes to 35 minutes, for an average of 21 minutes per interview. Because many participants were busy doing important work, we did not feel that asking for more of their time was appropriate, however participants were allowed as much time as they wanted to ask questions about the study design and the purpose of the study.

A demographics questionnaire was provided for participants to verbally answer at the beginning of the interview. Participants were asked to identify their age, gender, race, ethnicity, current average amount of hours worked as a clinician, years of experience, and current licensure. Participants were asked for background information on active listening and experiences related to exhaustion. Interview questions included "How would you describe 'active listening' skills [as a therapist]?" and "What are your thoughts about listening exhaustion?" As the interviews were conducted, both authors checked for understanding with participants to clarify that the preliminary findings were accurate, allowing participants the chance to challenge authors' potential misunderstandings in the process. At about the 18th interview (of 20), responses become similar with no new or emergent data, indicating saturation (Hennink & Kaiser, 2022).

Data analysis

Both authors took notes identifying preliminary themes and marking comments during interviews. Interview recordings, transcribed by a professional transcription company, yielded 110 single-spaced, typewritten pages covering almost seven hours of interview time. Pseudonyms selected by participants are reported throughout to ensure confidentiality. Data analysis, which both authors participated in, was a two-stage procedure, using reflexive thematic analysis (Braun & Clarke, 2006, 2013).

The authors met in-person and virtually throughout the analytic process to discuss the themes and codes. First, interview transcripts were read in their entirety by each investigator. After reading the transcripts multiple times, the authors identified initial themes and began an open coding process to categorize the primary information by content area. The authors then used axial coding to identify the initial coding categories and subcategories, followed by selective coding to identify specific exemplars from the transcripts illustrating the themes of the research (Creswell et al., 2007). The two authors reread the transcripts after creating the codebook to ensure that informa-

[1] LPC-Interns are now referred to as "LPC-Associates (LPC-As). Both LPCs and LPCAs in Texas have the same educational requirements (graduate degrees, completed practicum [at 300 hours, 100 hours of which are direct client contact]), have passed the NCE or NCMHCE, and have passed the Texas Jurisprudence Exam. The difference is that LPCs have completed the additional 3,000 hours of supervised post-graduate-degree experience over at least 18 months, including 1,500 hours of direct client counseling contact (over the LPC-I/As).

tion was reported correctly. Differences were resolved through discussion.

Participant experiences and explanations

Understanding active listening expectations

As a starting point for the first and second research questions, participants were asked questions related to the meaning of active listening and the importance of listening skills in therapy sessions. Participants defined "active listening" in a variety of ways: i) actively engaged listening and being present with the client, ii) utilizing empathy, paraphrasing content and meaning to fully comprehend the message, iii) going beyond the words to understand what the client is conveying, even if they are not able to express their feelings appropriately, and iv) maintaining eye contact with the client and paying attention to nonverbal cues such as body language, affliction, and facial expression. To understand the role of listening in therapy, participants also answered a question related to their thoughts about how listening skills affect therapy sessions.

All twenty participants agreed that active listening is one of the most essential skills in therapy. Kyle, for example, described what active listening means to him as a mental health professional:

> Active listening as a therapist is when somebody is presenting a problem to you or presenting an issue to you. It's not just hearing what they are saying or even necessarily reflecting back. It's not just necessarily communicating that you are listening. It's really practicing your empathic skills and placing yourself in the client's situation, so you are adopting their feelings, their values, their perspectives about the world, and you are putting yourself in that place almost in a sense that you feel their emotions and the conflict yourself.

Kyle's quote indicates that listening actively goes beyond simply hearing the client and includes significant mental and emotional investment with the client's narratives.

In another example, Elaine identified the difference between paying attention and active listening: "Active listening means more than just paying attention. It means attending to everything that's happening with the person and around the person, between you and the person, between the person and their environment, and between you and your environment." Like Kyle, Elaine acknowledged her responsibility to go beyond simply hearing what a client is sharing. It takes time, effort, and attention to focus on what is being said in what context, along with what is not said.

Participants described active listening as reading between the lines, interpreting relationships among verbal content, emotions, and body language. Daya explained: "Active listening is going beyond the words and maybe some type of meaning.... Or, I guess, when I think about it, it's understanding what they are trying to convey, even if they can't necessarily express their feelings properly." This level of attention to detail and interpreting what is explained and not explained, while often expected of mental health professionals by clients, creates a significant mental and emotional load that can be difficult to disengage from.

Burnout amidst counselors' multi-contextual listening experiences

While some participants stressed that they could utilize some of their listening skills in their personal relationships—since they have improved their listening abilities through practice within the profession—others mentioned the challenges of leaving their counselor persona "on" in their own personal relationships. For example, Misty explained that "I would definitely say I'm a much better listener now. Even if I'm not counseling them or anything like that, I am trying to be more mindful of other people and give them space and create empathy for them." And Chris mentioned, "In my personal life, my listening skills have increased by a lot. I listen too much now, I guess I should say. I do have to bring myself back and not fall into a therapist role." Both Misty and Chris acknowledged how their profession has improved their attention, and therefore, their interactions with others. Yet, in doing so, they had to navigate the unclear boundaries of friend or family member in contrast to therapist. If a friend or family member does not want to have the "therapist role" focused on them, there could be negative relationship ramifications.

Indeed, while counselors reported improved listening abilities in their personal lives, they also explained the challenges of role-switching from being a counselor to a friend. Like Chris' experience, Elaine mentioned,

> [Before being a counselor,] I would engage with people on a social level or want to go and hang out with people or invite them over. I don't want that. It's not like I'm trying to isolate, but I also don't just invite more social circumstances into my home and my life which is hard because I am still pretty young and still like to have friendships. I hadn't really thought about it really until now. Now I'm talking about it, but that's really the big thing.

Elaine's experiences in feeling the need to role-switch subconsciously affected her ability to form and maintain friendships, which as she noted, she had yet to ruminate on or explore. During the time of COVID-19, this was a particularly poignant observation as most people lost

much of their ability to socialize with others, which could have contributed to feelings of isolation and decreased social support.

Based on these examples, listening exhaustion could be linked to how counselors might feel distant towards friendships, leading to limited interaction with others. Importantly, the effects of listening exhaustion could result in reducing communication and, thereby, reduced connection, with others, including the most intimate of relationships. Sarah, for example, described the way her listening skills have impacted her marriage: "When we first got married, my husband would occasionally say to me, 'Okay, you're therapizing me. You need to stop that.' So, I had to learn over time how to turn that off." Glen shared a similar perspective:

> I think about when I go to the grocery store, and I get a chatty checker. I am like UGGHHH. You know, it's like I haven't turned that switch on, and I'm not settled and prepared to do that. No! I don't want to hear about your dental work!

In these examples, counselors described that their patience with others tended to decrease over time. This decrease in patience was also demonstrated by counselors' recollections of creating distance in conversations or avoiding topics. By creating distance or avoiding topics, interpersonal relationships with one's closest friends, family members, or even spouses, therapists could thus unwittingly contribute negatively towards their relationships, possibly setting groundwork for relational turbulence or even relationship dissolution.

Emotional exhaustion

To answer the second research question, participants identified how they have experienced listening exhaustion. Three themes were identified: i) topic related listening-exhaustion, ii) number of daily client sessions and lack of breaks in between sessions, and iii) short- and long-term listening challenges.

Difficult topics

The frequency of exposure to difficult topics can cause counselors to experience listening burnout, with over half of the participants (55%) specifically mentioning topics that created tensions. These topics included, but were not limited to trauma, discussions related to uncomfortable topics such as sexual offense, difficult clients with disrespectful behaviors, and clients who were not showing progress. As Kyle explained:

> When you're actively listening, you're listening, like I said, and you're adopting a sex offender's values and a sex offender's emotions, and you're really not congruent with those feelings, that's a very distressing place for anyone to put themselves into.

For counselors, particularly less-experienced counselors, who interface with more challenging issues, connecting with the client may thus be difficult mentally and emotionally, particularly during times of crisis when numbers of clients increase.

The emotional load in gathering information may also be heavy during these times, particularly as emotional or mental distance needs to be kept while creating the safe space for clients to grow:

> I'd say the only time I do [experience listening-exhaustion] is if I've had a client, 'cause I work with teenagers too, so if they've been disrespectful, I definitely find those days more draining, when I'm having to challenge them or redirect them as opposed to when they're motivated and cooperative. (Mike)

> I think... I work with trauma, and so I know that on days where I have had a heavier day is what I would think of it as, where I've had maybe a lot of clients that day share details about their trauma, and then I go home, and I'm tired because I took all of that in. (Paulette)

These examples indicate the depth of burnout that counselors experienced on a daily basis during the pandemic, potentially negatively affecting their listening, which could, in turn, adversely affect their interactions with clients.

We know that counselors working with clients experiencing extensive trauma are more likely to experience secondary trauma based on the information shared in sessions (Sodeke-Gregson et al., 2013), yet we see how COVID-19 made this situation worse. Counselor burnout levels were high pre-pandemic and often experienced mostly by newer counselors in the field lacking experience and knowledge, but COVID-19 further exacerbated clients' emotional levels broaching specific topics (e.g., trauma) during sessions (Craig & Sprang, 2010). While more experienced counselors have identified ways to counter their exhaustion levels through self-care, newer counselors may need more encouragement and conscious effort towards self-care. This finding supports the need for counselors to utilize self-care activities during times of crisis and is supported by previous research highlighting the importance of personalized self-care in helping with burnout levels (Colman et al., 2016; Rokach & Boulazreg, 2020).

Number of daily therapy sessions

The amount of time spent in sessions with clients caused listening exhaustion in counselors, with fourteen

of the participants mentioning that the number of daily client sessions as well as the lack of breaks between sessions increased their listening exhaustion. Specifically, having too many clients in one day or in a row without a break was mentioned as reason for possible listening exhaustion. The number of sessions related to listening exhaustion varied from "four to five sessions in a row" to 40 hours of listening in a week. Given that the need for counselors had increased, yet the numbers of available counselors had not, coupled with the pandemic's other demands, many counselors experienced increased client load. Steve described his experience:

> Listening exhaustion is definitely present, you know. It can be tough, especially when you have like four or five sessions in a row. It's hard to…. You got to really make sure that you know, you're taking care of yourself in your little ten-minute breaks between sessions.

Elaine similarly reported that she felt overwhelmed as a student, leading toward burnout:

> So, when I was an intern, I can think of a couple of times that I saw like eight or nine clients in a day, which was a lot for being so new, and I just remember like this full body tiredness. And I can't listen to anything else driving home from work with no music on or anything because I just can't absorb it.

Short- and long-term listening exhaustion levels

These findings are further complicated by variation in short- and long-term listening exhaustion levels. Previous research has found that feeling moderate/high levels of exhaustion over long periods of time after listening to complex and intense information may lead to burnout, especially when multiple back-to-back counseling sessions day after day occur (Rosenberg & Pace, 2007). Since many mental health counselors leave their profession due to burnout or because they no longer find their counseling career fulfilling (Farber, 2008), identifying methods of decreasing the burden on our already overstrained and under-supported mental healthcare system should be a priority for health interventionists. As such, it is particularly vital to recognize the effects of listening exhaustion on counselors' personal lives and mental health.

Among responses of participants, listening exhaustion was further described in terms of short-term or long-term implications of mental, emotional, and physical fatigue created by extensive and continuous active listening. Symptoms of listening exhaustion included physical fatigue, tiredness, irritability, isolation, lack of motivation, depersonalization, headaches, a sense of being overwhelmed, and information overload. While listening exhaustion is not necessarily the direct result of active listening, it may be one of the leading factors to compassion fatigue, emotional exhaustion, and burnout in counselors. Elaine, for example, used a metaphor to describe listening exhaustion by stating that listening exhaustion "is like a pitcher of water that is totally full, and it cannot take any more water, or it will spill over."

Nearly two-thirds (13) of participants' answers included daily or short-term listening exhaustion due to the rate of the client's speech, the type of content shared during the session, and/or the redundancy of some content. As Misty explained, "Listening exhaustion happens more to me when I am sitting with a client who is just kind of rambling about something." Arlene mentioned a similar experience:

> I guess there are some clients that want to answer a bunch of questions that you don't ask when you're trying to get them to a point or work through an exercise like that. I find clients where I'm asking one question, they briefly answered it and then gone on to this huge story that isn't even relevant.

Counselors thus associated irrelevant topics that deviated from the session's focus as a cause of listening exhaustion. One major challenge of therapy, therefore, is redirecting the conversation to focus on the goal of therapy. Of course, what may be irrelevant for the counselor may not necessarily be irrelevant for the client, increasing the complexity of managing conversations.

Counselors reported that client redirection to focus on the goal of treatment could be tiring. Elsa explained:

> [C]lients that are really redundant and kind of speak in more circular conversations where they just tend to stay in that circle and repeat the same things and never getting to the point of what they're there for and what they need to work on.

Like lack of focus in content shared by the clients, here, Elsa correlated repetition of information with an increase in listening exhaustion levels. Further, Elsa emphasized that the rate of language can cause listening exhaustion: "It can happen when the person is communicating at a very fast pace…, but also at the same time, maybe a very slow place, and there's not much opportunity for being able to interject and say something."

Four other participants focused on listening exhaustion over the long term, noting that listening exhaustion can impact how much someone wanted to be around others, possibly affecting interpersonal relationship development. As Patrick stated: "I definitely remember there were times where I was like, I just don't want to talk to people, I don't want to listen to people. [laughs] I am just kind of spent, like I'd actually like to be listened to if anything." Like Patrick, Victoria stated,

> In session I'm fine, but after that, I snap. I get easily irritated. I just need some quiet time…. You don't want to come home in a snappy mood, right? So, I've noticed that on harder days, I'm just exhausted to the point that I don't want to say anything. Sometimes I just sort of check out, I guess. Watch TV. Just sit down. Just dissociate for a little bit. Give myself some rest, and after a good two, three hours I should be in a better mood.

As these quotes suggest, long-term effects of listening exhaustion levels were associated with withdraw from daily social interaction. Counselors' experiences of being drained over long periods of active listening could thus affect interactions outside of the workplace, including counselors' personal lives.

Telehealth and exhaustion

Mixed responses to telehealth

The third research question investigated how counselors in the early months of the pandemic perceived the use of telehealth therapy sessions related to their emotional exhaustion levels. Eighteen participants had experience using telehealth for therapy sessions, with most gaining that experience due to the pandemic. The same number of participants stated that they prefer in person, face-to-face sessions rather than telehealth. Some participants explained that during COVID-19, telehealth was necessary for a variety of reasons, but that if there was not a pandemic, they would much rather conduct face to face sessions. Sarah, for instance, stated:

> I have to say I am in the high-risk group for the pandemic, and so I don't have a choice to go face-to-face. I have to do telehealth right now…. I am trying to figure out new ways to connect with my clients and be able to listen to them.

As demonstrated by Sarah, even if some of the counselors preferred face-to-face sessions, fear of contacting COVID-19 caused them to consider telehealth to conduct sessions—but at a potential cost.

On the other hand, a minority (four) of participants preferred telehealth as their choice of channel to conduct therapy. Convenience for both the counselor and the client were highlighted:

> I literally woke up 15 minutes before this call. If I had to drive to your office, then I would have to wake up and shower and change and make sure clothes were ready. There is much less time involved that is not necessarily have anything to do with our interaction together, but its time out of my day that I have to get ready for! (Kyle)

Kyle's experience highlighted the benefits of working from home, saving time and energy to expend elsewhere. In comparison, Daya contextualized her preference for telehealth around public safety measures due to COVID-19:

> I love working from home, and I have done this in the past. Obviously, the safety aspect of not feeling like I'm being exposed…. Not having to sit face-to-face with someone, and them sneezing or coughing or spitting. I just love having my own clean space.

Other participants said that clients were less likely to cancel because of the telehealth convenience and explained that increased access due to geographical limitations was much less of an inhibiting factor for help-seeking behaviors. And as noted above, counselors also appreciated using telehealth to adhere to social distancing recommendations and reduce risk of COVID-19 transmission during the height of the pandemic, particularly as the physical distance created increased safety perceptions.

Although a minority of participants preferred conducting therapy sessions through telehealth, all participants nevertheless indicated some concerns and hesitations related to utilizing telehealth. Victoria, for instance, explained the difficulties of working with telehealth:

> I find telehealth to be a little more tedious than face to face, especially when it comes to listening. I have to pay more attention, or maybe it's harder to be fully present because there's other people in the background both in my end or their end.

Like Victoria, Julia mentioned her concerns with utilizing telehealth, emphasizing the conscious effort required to concentrate and its effects on both her and her client, along with the session's quality:

> I think I am always in this I-am-missing-something kind of mode with telehealth, so just in this heightened concentration, trying to make sure that I am not and that I am picking up on as much as I can. I think it makes both the client and me kind of ready to be done earlier than a normal session, and I feel like there are more awkward pauses.

Concerns about nonverbal communication

Our findings show that while telehealth was recognized as the safest option during the pandemic to conduct therapy sessions for both the client and the counselor, one particular weakness was a factor that majority of the counselors felt contributed directly to their listening exhaustion levels due to the inherent limitation of online communication, i.e., the absence (or at least, obfuscation) of nonverbal cues.

Because a large part of therapy sessions concentrates on clients' nonverbal communication such as facial expressions, gestures, and body movements, a concern associated with telehealth usage is the limited feedback provided through the channel. As with Victoria's concerns with missing a gesture noted above, Elaine further expanded on the nonverbal limitations:

> Therapy is not just a speech. I think the therapeutic relationship hinges on where you are in the room, what position you are in the room based on the person, even which seat the person chooses. Body language, facial—even how they sit in their chair. But also, not being able to see what they are doing with their hands. Are they jiggling their leg? I personally would call out and ask about the gestures. I can't do that [in telehealth].

Here, Elaine described the important qualities of in-person sessions by highlighting the importance of observing the gestures of the client to fully comprehend the client's feelings and emotions. This information is supported by past research demonstrating that individuals prefer richer channels (e.g., receiving a greater variety of cues) when they have a choice between different media (Thompson-de Benoit & Kramer, 2021). Foley and Gentile (2010) similarly highlighted the importance of nonverbal communication to attain appropriate information when identifying clients' feelings emotions and personal needs.

Some counselors were also concerned about the accuracy of the limited information they received through telehealth because nuances in meaning can be missed when a visual channel partially obscured clients or was completely absent. Patrick, for example, described a moment in therapy when he misunderstood the client's tone due to an absence of visual cues, thereby affecting his ability to assist the client to the fullest capacity:

> I was like "So how's it been since we last talked?" And he's like, "Just fantastic." I started to say, "Oh, that's great," that "I don't get to hear that often." He was clearly being sarcastic, because he launched into something afterwards. So you do miss stuff like that.

Though telehealth has made connecting with clients easier, increased accessibility (particularly in remote areas), and more cost efficient, technical issues and limitations of nonverbal cues have made some counselors experience listening exhaustion. Specifically, losing out on nonverbals like bouncing a leg, hand clenching, or fidgeting may not be visible on a telehealth visit, particularly if the client is holding their own phone for the session's videoconferencing, limiting the visibility of both the client and the external environment. Further, some telehealth visits are audio only, limiting any visible cues, which is possibly why Patrick missed his client's sarcastic response. And Chris shared his concerns with misreading client's statements due to limited availability nonverbal cues, noting how tiring the process can be, thus severely limiting his ability to make clinical decisions, echoing previous research (Foley & Gentile, 2010):

> It [telehealth] can get exhausting at times, because not only are you missing some of the nonverbal, what they're saying…. And on top of that, I have to also check myself to make sure I'm not filling in the blanks on things I can't physically see.

Indeed, fourteen participants mentioned experiencing some form of exhaustion in conjunction with telehealth. As Victoria explained:

> I feel like I have to strain a little bit to listen, whereas in-person I never have to strain. [In person,] I was listening, and it was fine. It seemed to come more natural then, whereas in telehealth it seems a little bit forced. I'm not really sure why.

Sarah said, "It was so much harder to connect…. I felt like my mirror neurons were scanning so hard to connect with that other person, and you just can't do it in the same way over a computer." While Sarah's experience was focused on the emotional and mental aspects of being drained, Paulette's was more physical: "I feel physically drained. It makes me feel a little more burnt out than normal."

Jessica mentioned her own experience of being in therapy on the other side of the counselor/client relationship to provide further context: "I was actually talking to a psychiatrist about this two days ago. We're both talking about how much longer [laughing] the hour in person just flies by, but really like an hour online can just drag on sometimes."

Concern about visual communication was also described with regard to clients' ability to be present in their sessions. As Steve described it: "The client's a little distracted when you see them messing with their phone…. They're not fully present it's frustrating…. In all honesty, I hate to say that, but it does [add to listening exhaustion]." For Steve, the client's distraction made it harder on both the client and the counselor to engage appropriately during the session.

Each of these responses indicates that while counselors were meeting their clients' immediate needs by offering telehealth services, they did not yet feel that they were i) trained or comfortable enough in managing client interactions via telehealth, and/or ii) that they were not meeting their clients' long-term needs because of unexpected issues like client distractions and technological limitations—both factors augmenting therapists' feelings of exhaustion.

Implications

Our findings highlight the experiences of mental health counselors during the early days in the pandemic. Specifically, they show the presence of burnout based on listening exhaustion in counselors' professional and personal lives, that counselors felt exhaustion, and that while there are benefits to using telehealth (and that it was necessitated at the time) there are clear drawbacks for both the client and the counselor in using telehealth.

This study's findings provide implications affecting mental health counselors' health, well-being, and ability to offer quality services to those who need therapy, focusing on experiences of mental health counselors during the COVID-19 pandemic. First, it is imperative to remember that listening exhaustion levels can affect quality of services provided to others. Listening exhaustion should be recognized as one of the many reasons leading to burnout, and more research is needed to fully comprehend the challenges of active listening in both the short term and long-term. Agencies, private practices, and other mental health-centered organizations should consider the number of daily sessions provided by counselors and the complex nature of content discussed during these sessions. Modalities used to conduct therapy should also be considered for quality of therapy sessions to help set realistic expectations of counselors' efforts to decrease listening exhaustion levels that may later lead to burnout. Future research should continue to examine the effects of telehealth communication in mental health contexts, particularly focusing on the channel of communication chosen by the practitioner and the client. A recent scoping review emphasized the need for further investigations evaluating discourse related to mental health challenges after COVID-19, so research should continue this trajectory. Further, counselors in training (LPC Interns/Associates and earlier) should be offered training that addresses listening exhaustion, how it may manifest, and strategies for dealing with listening exhaustion both inside and outside of their work as a counselor. In light of COVID-19, and to prepare for other such public health crises, it is of the utmost importance to have stability and consistency for mental health counselors regarding caseloads and established norms for how to manage both virtual and face-to-face client interactions. And, while the exact future of online therapy is unclear and is being used less often than at the height of the pandemic, it is still a go-to modality, meaning that telehealth is here to stay.

Conclusions

Our study provides relevant and timely information based upon twenty counselors' experiences providing therapy using telehealth during the COVID-19 pandemic. Active listening provides many benefits, yet is a complicated phenomenon, particularly within the context of health care—even more so amidst major catastrophes such as the COVID-19 pandemic. While mental health professionals have training and resources to help with burnout levels, many still report concerns. Telehealth is a useful option for delivering mental health services, especially during health crises, yet its use in the therapy setting should be tailored to the specific client (e.g., some participants may not be comfortable in using a videoconferencing tool due to privacy concerns).

As with any exploratory, qualitative study, several limitations exist; however, these limitations provide the context for future research. One specific limitation includes that all interviews were via the telephone. While this did allow us to conduct research safely during the COVID-19 pandemic by adhering to public health recommendations and safety protocols, we missed some nonverbal communication that may have been clearer in face-to-face interviews.

Another limitation includes credentials of those who volunteered to be interviewed related to their active listening and telehealth experiences. This research focused on LPC and LPC Associates. Future research should include a wider range of healthcare providers. In this way, possible distinctions can be made when considering counselor experiences associated with listening exhaustion and telehealth.

Aside from licensure, other participant-related factors should be considered in future research. While our participants varied in age (27-56), the majority were females (65%) as well as Caucasian (85%). Variation based on demographic characteristics must be taken into consideration to get a more accurate understanding of therapy experiences of counselors.

Future research should also focus on the efficacy of training and discussions related to burnout during times of crisis and possibly other successful interventions, particularly as burnout-centered interventions are promising (Awa et al., 2010). Clinicians experiencing listening exhaustion may be more likely to burn out and leave the profession, which is especially relevant given the increasing workloads and demands for treatment since the beginning of the pandemic. Ultimately, healthcare organizations may need to support their counselors better, particularly as one method of self-care for counselors is counseling for themselves.

Finally, further research could also address in what ways listening exhaustion affects professionals in other fields aside from counseling. Such fields would include healthcare administration and education at all levels.

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