Remote video interface psychological assessment during the COVID-19 pandemic: Experiences of consultants and clients

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Abstract
The need for remote psychological assessment came to the fore during the Covid-19 pandemic lockdown. This paper examines the qualitative experiences of psychologists and patients using remote video interfaces for psychological assessment during that period. The aim was to gain qualitative data on the personal experiences of both parties and explore whether remote assessment via video interface is a satisfactory method for psychological evaluations. Patients were seen for psychological assessments by consultant Clinical and Counselling Psychologists via through videoconference. Consultants and patients were asked about their experience of the video assessment and the consultant recorded their responses. Content Analysis was used to analyse the responses. The remote mode of assessment was found to be satisfactory to both patient and psychologist, although technical issues were highlighted to be the most disruptive to assessments. Consultants reported a certain level of fatigue,
1 | INTRODUCTION

The Covid-19 pandemic has had a significant effect on every facet of society and has meant that the world has had to adapt to a new, "social-distance" based situation (Liu et al., 2020; Sun et al., 2020). Like many other aspects of life (Badawy & Radovic, 2020; Helou et al., 2020; Newman & Lattouf, 2020), psychological evaluation services have had to be adapted immediately so as not to stop such essential activity (Roncero et al., 2020). It has been necessary to act quickly to set out priorities and ensure assessments were undertaken safely and effectively in psychological services during the Covid-19 lockdown and from the first moment the British Psychological Society (BPS) collected in a guide the recommendations in this regard to structure the work during this time (Psychological Assessment Undertaken Remotely | BPS, n.d.). Adapting assessments for remote conditions was not only an important priority in order for the clinician to continue caring for patients but also provided a unique opportunity to collect important data and conduct research on the effects of the Covid-19 pandemic in psychology and psychiatry as a priority.

There is recent promising evidence that supports feasibility, acceptability and efficacy of digital health interventions in different chronic medical conditions, mainly in children and adolescents who are avid users of technology (Badawy & Radovic, 2020; Radovic & Badawy, 2020; Thakkar et al., 2016). The use of online platforms had previously been shown to be useful for remote psychological assessments (Fox-Fuller et al., 2021), even in forensic contexts (Goldenson & Josefowitz, 2021). More specifically and in relation to psychiatric disorders, the use of online platforms has demonstrated its effectiveness for the application of psychological treatments of cognitive-behavioural therapy both in adults (Bantjes et al., 2021; Matsumoto et al., 2021), as well as in children and adolescents (Hollmann et al., 2021), thereby solving accessibility problems to therapy. But the use of the internet has not only demonstrated its viability for treating patients but also for conducting online psychological evaluations, for example, in patients with suicidal risk (Exner-Cortens et al., 2021), neurodevelopmental disorders (Valentine et al., 2021) or obsessive-compulsive disorder among others (Ferreri et al., 2019). Forensic Psychological Evaluations (FPA) are mainly based on the results of a clinical evaluation supported by the use of psychometric techniques (Nicholson & Norwood, 2000). The success of the clinical interview lies largely in obtaining good engagement with the patients, since they have to share information on topics which are sensitive for them with someone unknown and involved in their judicial process (Marshall et al., 2005). According to Chawke et al., the therapeutic relationship that the patient achieves with the clinician can significantly influence the information shared with him (Chawke et al., 2021). Thus, from the point of view of the clinician who performs the FPA, obtaining a good

**KEYWORDS**

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rapport with the patient is essential to achieve a good clinical interview (Chawke et al., 2020). It is also of relevance to collect the information from the perspective of those evaluated in order to learn from their experience and thereby maximise the success of FPAs performed in this way. Thus, given the importance of the development of rapport to enable successful assessments, this study will consider the perspectives of both the clinicians and the clients in terms of their experience and view of the level of rapport built through the videoconferencing method of engagement with a view to using that analysis to shape improvements to the method.

Qualitative research has proven to be an appropriate method for studying this type of situational context, mainly as a first step of research (Clarke et al., 2019; Greenhalgh et al., 2016), due to its exploratory and descriptive nature. This type of research provides us with a naturalistic observation of a context centred on phenomenology and on the understanding of the subject/situation investigated. However, there has been little qualitative research on the experience of using video interfaces for remote psychological assessments. The few references to the topic found by the authors of this study explored the effectiveness of telemedicine including psychology, psychiatry, intervention, and assessment but did not focus on qualitative experience. One paper, which reported an online survey of mental health workers in Canada who used remote assessment working with rural and First Nation communities, specifically referred to the experience of professionals’ use of remote sessions (Gibson et al., 2011).

The main objective of our study was to explore the consultants’ and patients’ experience of using an online platform to conduct the remote psychological and cognitive assessments.

2 | METHODS

Our research has been conducted in a clinical psychology setting in the UK. From the beginning of the Covid-19 lockdown, and following BPS and government recommendations, we were able to adapt the majority of the schedule of upcoming assessments to be conducted remotely using a video interface platform. All research so far was conducted under the Covid-19 2020 lockdown between March and November 2020.

2.1 | Participants

As part of the process of establishing new remote assessment protocols, all consultant psychologists were provided with a guide on remote assessment and also with a short training session with the Assistant Psychologist to cover the technical aspects of using the software. Clients were provided with a simplified guide explaining what to expect from their remote assessment using videoconferencing and how to use the software. The use of a videoconference platform allows the ‘host’ of the call to record the call, which is helpful in thereafter reviewing and analysing data.

This study presents qualitative analysis of the results of an ad-hoc questionnaire designed to elicit the views and experiences of using a videoconferencing platform to conduct assessments from the point of view of both the psychologist who conducted the assessment and the patient who was assessed.

Patients were seen for psychological and cognitive assessment via videoconference by qualified Clinical and Counselling Psychologists as part of routine work conducted by the clinic. The mean level of experience in clinical evaluation of these psychologists was 10.2 years. All of the patients were referred from Social Services for evaluation in cases of child protection. The inclusion criteria were: minimum age of 12, referred for psychological assessment, fluent level of both spoken and receptive English, having access to appropriate technology supporting the online platform and adequate internet connection, having consented to participate in the study.

Ethics Statement: All participants gave written informed consent to participate in the study and in the case of participants under 18, their parents/legal guardian also signed the informed consent form. The study protocol was approved by the corresponding Ethics Committee and all the research conducted in this study meets the “Ethical principles of psychologists and code of conduct” (American Psychological Association, 2016).
Due to the Covid-19 lockdown, clients who were normally seen face-to-face in a clinical setting, solicitor's office or contact centre were seen remotely using videoconference. This was the first time that the participating patients had been evaluated online. The assessments were set up using the standard administrative protocol used by our clinic, with the only difference being the delivery platform. The approximate average duration of the sessions was 3 h. The research conducted aimed to identify areas of strength and weakness in this form of remote assessment. A short list of questions was drawn up relating to the experience of the patients and psychologists. Questions were completed by patients and psychologists immediately after the assessment by completion of a standardised set of open questions designed to explore their experience of the remote assessment (see Table 1 for further details regarding the content of the questionnaire). Due to the assessment taking place over an internet platform, the psychologist conducting the assessment asked the questions to the client and recorded their responses verbatim. Consultant and patient questions are detailed in Table 1.

Due to the heterogeneity of the data, qualitative content analysis was chosen to analyse the data. That allows us to objectify human communication through the generation of categories from the data. The units used for content analysis were grammatically based and were the phrases given by the participants in their responses. Regarding the coding rules, we grouped into categories those sentences whose content was similar or referred to the same aspect of the clinical evaluation. Once the sentences were segmented into categories, we proceeded to assign a code to each of the categories obtained. The content analysis was performed by two independent researchers through an iterative process in which, faced with a disagreement, there was a discussion and subsequent modification, repeatedly. All deviations in interpretation were discussed until a consensus was reached. After the description of the categories, we proceeded to interpret the findings.

All interviews were done by native English consultants and all the patients were native English speakers so there was no bias related to the interpretation of the language.

### 2.2 Procedure

In total, 6 consultants (3 women and 3 men) and 19 patients (13 women and 6 men) completed the questionnaire. The patient age ranged from 12 to 48 years; 25.1 being the mean age; all of them were Caucasian with their geographical origin being the UK.
The consensus was that the assessments through videoconference worked well and have been a success, although there have been some technical issues which have affected assessments; these have been frustrating for clients and consultants and have interfered with the completion of some assessments. Despite this, there have been no major concerns raised over the utility of the assessments completed over the platform.

The following summarises the current findings based on client and consultant responses. As explained above, to organise all aspects raised by participants in the context of the questionnaire-based survey, a structured classification based on categories was performed, with there being three main categories: technological issues, psychologists’ experience and patients’ experience. For each category, several sub-categories were delineated according to the content analysis. Sample quotes from the experimental material are presented in Table 2.

| TABLE 2 | Results of the questionnaire: sample quotes |
|---------|------------------------------------------|
| **TECHNOLOGICAL ISSUES** | |
| “Although the patient did not manage quite well with technology in daily life, he has found the assessment easy to engage” | “He has managed really well with the technology” |
| “Most phones, tablets, laptops and internet connections are good enough to conduct the assessments” | |
| “More control over quality is needed. If there is a bad signal this can be very disruptive to the assessment” | |
| **PSYCHOLOGISTS’ EXPERIENCE** | |
| Psychologist’s comfort | “I have found that using videoconference is impressively like a face-to-face assessment” |
| “I have found myself giving slightly more of myself” | |
| “I have noticed feeling more tired after an internet-based assessment than face-to-face” | |
| Intelligence quotient (IQ) issues | “The patient has a learning disability with a low IQ but he manages really well with the interface” |
| Assessment of children | “I have not been able to use any activity based method” |
| “Some children know how to video call already and this familiarity is helpful” | |
| Psychologists’ settings | “It can be distracting seeing yourself on the screen” |
| Contact observations: | “It is more naturalistic to see a family in their home but at the same time there could be more distractions than in a centre-based contact observation” |
| Psychometrics | “Screen sharing has been successful to perform psychometrics” |
| **PATIENTS’ EXPERIENCE** | |
| Patients’ comfort | “the assessment was very good, it was fine”, |
| “It has been a bit overwhelming but it was okay” | |
| “I feel better in a remote assessment as I can turn the camera round when I am crying” | |
| Patients’ settings | “I feel more comfortable since I do not feel as directly observed as in a face-to-face consultation” |
3.1 | Results of content analysis

3.1.1 | Technological issues

Individuals who struggle with technology in daily life have found the assessments easy to engage with (“Although the patient did not manage quite well with technology in daily life, he has found the assessment easy to engage”). Most phones and tablets that people use appear to be of good enough standard and most people seem to have good internet connection. One Psychologist noticed that quality was impacted when a client used an old laptop and, because of this, the session in question had to end slightly early. “More control over quality is needed; if there is a bad signal this can be very disruptive to the assessment”, creating stopping and starting which would not be present in a face-to-face assessment.

When signal cuts out and the call disconnects, this can be disruptive for the assessment and creates a “fragmented” effect. This has been alleviated somewhat by the use of the chat function on the platform, which allows the participants to communicate via typing. Consultants were also instructed to set up a contingency plan at the beginning of the assessment and to inform the client that they would call them back immediately if the connection dropped. This information was also communicated in the remote assessment guide for clients so they knew what to expect.

3.1.2 | Psychologists’ experience

Psychologists’ Comfort. One consultant said that using videoconference is “impressively like face-to-face assessment” and that they had often forgotten that they were not in the same room as the client. One consultant also commented, “I have found myself giving slightly more of myself as well; perhaps I’m compensating for my concerns about the difficulty of establishing a relationship online”.

Psychologists have reported that they have struggled having the assessment effectively take place in their home environment due to using remote assessment. This meant that when assessments involved the recounting of trauma or unpleasant emotions or topics then their space felt “contaminated” after the assessment had finished. Psychologists also noted that this had been a problem for some clients when they had to discuss difficult topics and recount trauma because they were also in their home environment, rather than in a neutral or professional setting.

Some clients were seen for reassessment, meaning that they had already had a face-to-face assessment with the consultants. Consultants in this situation mentioned that they felt this was beneficial as they already had rapport with the client and had already covered some of the same content with them.

Intelligence Quotient (IQ) Issues. Individuals with borderline IQ and intellectual/learning disabilities seem to be able to manage the technology and engage normally. There were no special problems in the management of technology or in the development of the sessions in the case of evaluations of people with low IQ (“The patient has a learning disability with a low IQ but he manages really well with the interface”)

Assessment of Children. Assessments of children have been found to be less straightforward. Consultants have struggled to use activity-based methods like Story Stems or the Family Relations Test, which would regularly make up a key part of the children’s assessments at the Clinic; this has been partly attributed to the technology as, if the device is not pointed directly at you, then the sound is not picked up (“I have not been able to use any activity based method”). This is a basic issue but consultants have commented that it is frustrating and detrimental to the assessments. Some children have prior knowledge of using video calls and this familiarity is helpful. In one assessment, the psychologist observed the child looking over the top of the screen before answering questions. The psychologist deduced over time that they were just looking away from the camera, but it can be difficult to know whether or not the child is being coached or if someone else is in the room.
Psychologists’ Settings. Seeing oneself on the screen during an assessment has been observed by respondents to be somewhat disconcerting; evidently, this is not something that happens in a conventional face-to-face assessment and requires attention. Some psychologists report that it was strange to see their own face on the screen, which can be, distracting (“It can be distracting seeing yourself on the screen”).

Contact Observations. Seeing the family in their own home was, in a sense, more naturalistic than in an office or contact centre, which meant that the level of interaction between them was different from what might be expected in a face-to-face evaluation, since they could be distracted with other things that they would not be in a typical contact observation session. The initial impression of observing contact remotely is that it can be useful in informing an assessment and is better than no contact observation.

Patients’ Settings. There can be some distractions on the client end – people coming in and out of the room and so on. Some assessments have taken place with the client sitting in their bedroom and this was observed to be appropriate. One consultant had an assessment in which the client trapped their hand in a door, which was disruptive to the continuity of the assessment. It was observed that clients sometimes got up and left the room, under the pretext of getting a drink or using the toilet, when difficult issues were bought up by the psychologist, and it was noted that clients can avoid these situations much more easily during the videoconference than in a face-to-face setting.

Psychometrics. Using screen sharing for the completion of psychometrics led by the practitioner has been successful. It has been reported to be a method of conducting psychometric testing as comfortable as in a face-to-face session (“Screen sharing has been successful to perform psychometrics”). The platform allows you to share the necessary documents with the patient in real time.

Formulation Outcomes. Consultants reported that they did not feel the use of videoconference affected the outcome of their formulation. They feel that they have been able to collect all the information they needed through the virtual evaluation.

3.1.3 | Patient experience

Patient Comfort. Patients are more comfortable communicating through technology than perhaps had been previously credited (“the assessment was very good, it was fine”). Most of the patients answered that the video-experience was very good. In a few cases, the patient claimed that the session was a bit overwhelming or intense. It was unclear whether this intensity related to the content of the assessment or having to complete it remotely. It was also a little frustrating for them if the internet connection did not work well, which was also the case for the psychologist.

There were mixed responses from clients as to whether they felt that the assessment via videoconference was better or worse than a face-to-face assessment would have been. Some of the patients responded that it would be different to a face-to-face session as communication seems easier in person. On the other hand, one patient commented that she preferred the video interface because “I can turn the camera away when I do not want the psychologist to see me crying”.

Patient Settings. The client’s space is not seen to be invaded in the same way as with a conventional face-to-face assessment (“I do not feel as directly observed as in a face-to-face consultation”); there is more physical distance and consequently people seem to report being more at ease. In contrast to prevalent assumptions prior to the frequent use of virtual assessment, clients have been observed to be more relaxed when being assessed in this manner, rather than more awkward.

4 | DISCUSSION

This is, to our knowledge, the first study assessing both consultant and patient experience when performing an online psychological assessment and it reflects the urgent need to continue with these evaluations in the context of the Covid-19 pandemic. Indeed, given that use of online methods of assessment can increase ease of access to
assessment resources, avoiding travel costs and time, for example, it is of interest to establish the utility of remote assessment methodologies for use even in non-pandemic times. This study constitutes an initial stage of a participatory design method in telemedicine since it promotes the participation of users in the process of designing potential telemedicine applications. To achieve this participatory design, it is necessary to start by identifying the needs of the users, including strengths and weaknesses of the model, which is what has been carried out in this study (Clemensen et al., 2017).

In general, both patients and psychologists have reported that the videoconference approach is a useful tool for evaluation and assessment and that they have felt comfortable during the sessions. Some Psychologists have even acknowledged being more focused and trying harder to maintain communication dynamics to bridge the technological gap and better engage with the patient.

A recent paper of Serlachius et al. highlights that during the COVID-19 pandemic, reduced access to physical and psychological support has been reported in many countries. In some cases, delay in healthcare provision has had devastating effects on children with serious psychological conditions. In one such paper, authors recommend rapidly expanding healthcare via videoconference in order to minimise this lack of the required provision (Serlachius et al., 2020).

A previous study by Gibson et al., conducted in Canada measured for ‘perceived usefulness’ of tele-mental health, recovering information only from mental health workers (Gibson et al., 2011). Approximately 50% of participants said they found it useful, with 9% finding it not useful at all. Some participants in the study noted physical distance as a benefit and felt that it was less disruptive for the clients; consequently, virtual assessment was perceived as a tool that could improve the consistency of therapeutic relationships and that clients were more likely to disclose sensitive information this way rather than face to face, as we found in our study since patients did not feel as directly inspected or observed as in a face-to-face evaluation. Gibson et al. stressed the need for an initial face-to-face meeting in order for the remote relationship to be successful and effective. Some of the participants in this study were being seen for reassessment, which meant that some consultants had met with them in person already and this was generally found to be beneficial for both parties. The impact on the therapeutic relationship between the practitioner and the client must also be considered in this context.

As in other studies assessing telemedicine interventions (Bucci et al., 2019; Taylor & Coates, 2015), our participants also reported that the main concern has been technical issues. We believe that to avoid these technological problems, it is necessary to take several measures: (a) do a previous session to check the connection; (b) make sure that the patient knows how to connect and understands the procedure (Smith et al., 2005); and (c) explain to the patient the contingency plan in case the session fails (communicate by chat, telephone, retry the connection, etc.). However, even with all of these checks in place, using remote technology means that there will always be a chance of technological difficulties affecting the assessment. The use of technology also means that the practitioner has limited control in comparison to face-to-face assessments in terms of interference, both from the technology itself and potential distraction in both locations. It was noted by one consultant that it was much easier for the client to get up and leave the room when difficult issues were brought up than it would be in a face-to-face setting. In a clinic room or venue, the practitioner has an elevated level of control in that other staff members are aware a session is taking place within the room and know to avoid interruptions, thus ensuring good continuity of the face-to-face assessment.

According to the experience of the professionals, the online method used for the evaluation has been useful for the use of psychometric techniques, which is consistent with recent research carried out in this regard (De Luca et al., 2021; Lee et al., 2021). Both professionals and patients have reported a higher probability of distraction in this study. To avoid this, we believe that participants should be reminded in the initial face-to-face session if there is one, and at the start of the remote session, that distractions should be avoided during the remote session. In addition, care should be taken that other people who may be in the house are warned not to interrupt the session. With these checks in place, it should be easier to replicate an environment more akin to a face-to-face assessment in a clinic or professional venue.
The impact of videoconference fatigue has also been noted as an important issue for professionals using remote technology during the Covid-19 Pandemic and lockdown. Some consultants reported feeling more fatigued after a remote session than they would after a normal face-to-face assessment. This is a phenomenon that has been studied with the rise of remote working during the pandemic; it is theorised that individuals feel they have to make more effort emotionally to appear engaged and, in the absence of nonverbal cues, the intensity of sustained eye contact can lead to more exhaustion. Some consultants reported that they felt that they made this "extra" effort and "gave more" of themselves in remote assessments, consequently reporting a higher level of fatigue after these assessments. This has implications for the longer-term use of internet platforms for psychological assessments and in the wider professional world. Videoconference fatigue also has implications during the sessions themselves, as the practitioner is using more focus and energy to keep the session engaged for both themselves and the client. With more emphasis on facial expressions where other cues are absent, seeing themselves reflected can also be an added stressor. Consultants indicated that they found seeing their own face distracting. There has been some research (Vergallito et al., 2020) into the effect of seeing one's own facial expressions which suggests that having our own expression reflected back to us leads to more intense emotional reactions than when others' expressions are observed; this could potentially contribute further to videoconference fatigue.

An important finding of our research is that sometimes, after a strongly emotional session, the personal environment is felt to be ‘contaminated’ to some extent by those emotions. This feeling has been found to be affecting both the practitioner and the client significantly and suggests that some form of therapeutic ‘cool down’ and regulation might be helpful to include at the end of these remote assessments to allow both the client and practitioner to reset themselves and make their space safe again. This could perhaps be done through an internet-based relaxation exercise at the end of the session, which has proven effective when using online methodology (Alfonsson et al., 2016; Pizzoli et al., 2020).

The inability to use activity-based methods was noted as a particular drawback of using remote assessment and raises doubts over whether remote assessment will be able to be used as a complete replacement for face-to-face assessment. Since the use of activity-based methods with children is not always possible, perhaps in these cases the combination of online assessment with face-to-face sessions would be an appropriate approach to consider. This combination has been shown to be useful in the treatment pathologies that require motor interventions (Demartini et al., 2019).

In general, we have found that the observation the patient and even family dynamics in their own environment offers the advantage of being a more naturalistic way of collecting information. We consider that these semi-naturalistic observations can provide professionals with more realistic information on family relationships than observation in a more clinical context. There are several authors who also find that the collection of information in the patient’s own environment offers more ecological information and is therefore closer to the patient’s daily functioning (Bai et al., 2016; Diniz & Koller, 2018; Sears et al., 2014). There is, however, also a limitation in that the consultant will not be able to observe certain factors about clients, such as their personal hygiene and whether they have been drinking or using drugs. There are physical limitations in that the consultant can only view the client’s head and or upper body and this may mean that other physical signs of stress or anxiety may be obscured, such a foot tapping or hand wringing.

Despite the fact that our method has been useful in patients with learning disabilities, the limited sample size means that more studies are necessary in this regard, perhaps considering a stratification by IQ.

Some other limitations of this study must be acknowledged. This study contained both strengths and weaknesses considering it was operationalised during the Covid-19 pandemic lockdown; this situation both necessitated the use of remote assessment via videoconference and created a highly emotive and stressful environment for many people, adding extra stressors which would not usually be present. Therefore, it should be considered that, while the Covid-19 pandemic made it an opportune moment to collect data from multiple remote assessments, the data may also have been influenced by this and that if the study was replicated at a time in which there was no pandemic, the results may be different. The lockdown caused by Covid-19 means that it should be considered that clients and
consultants may have been influenced by their anxiety about being around other individuals, rather than simply addressing whether the remote method was convenient and accurate in the context of normal, everyday life, that is, not during a global health crisis. The study also used a relatively small sample, all with clients facing similar issues related to trauma, which will limit the study’s scope. Furthermore, it is important to consider that in this type of research there is an acquiescence bias that the subjects tend to give socially acceptable answers when answering the questionnaire. Even with the above limitations, the study identified a range of data that informs the use of videoconference for remote psychological assessment and provides valuable information about future directions for research and unanswered questions.

This study has reported relevant information on the perceptions of both professionals and patients during the development of online psychological assessment protocols and should serve as a basis for the development and improvement of future internet-based assessment programmes.

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CONFLICTS OF INTEREST
All the authors declare not conflicts of interest.

AUTHOR CONTRIBUTIONS
Maria-Teresa Martínez-Cengotitabengoa, Mónica Martínez-Cengotitabengoa and Araminta Peters-Corbett have equal contributed to the conceptualisation and design of the project, by carefully specifying the methodology to follow. Daniel Long-Martinez, Andoni Sanchez-Martinez, Monike Sanchez-Martinez, Eleanor J. Pugh, Fraser W. F. Field worked and supervised the data acquisition process during the investigation phase. Araminta Peters-Corbett and Mónica Martínez-Cengotitabengoa wrote the original draft of the paper which was reviewed and edited for all the authors of the paper who finally approved the final version.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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