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Research Article

Psychological Suffering during COVID-19 Pandemic-A Sample from a Brazilian University

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ABSTRACT

The Coronavirus Disease 2019 (COVID-19) pandemic has imposed changes with important repercussions on the mental health of the world population. The objective of the study was to characterize the profile and complaints of patients who sought psychological help from three services provided by a university in São Paulo, Brazil, during the pandemic. The study analyzed and compared data obtained in the survey from the three psychological services and verified the characteristics of telemental health. This is a retrospective and comparative research, carried out by surveying the profile and complaints of people who sought psychological help during the defined period, through the analysis of registration forms and screening notes of the participants who expressed consent. The final sample comprised 628 participants, of which 76.2% were women, with average age of 36.6 years. The main complaint reported in the three services was anxiety, followed by depression. Telehealth for mental care showed positive aspects, such as enabling the reception of patients during the period of social distancing. The following difficulties stand out: Confidentiality, lack of a protected environment for the sessions, and issues imposed by internet connection and use of technology.

Keywords: Mental health; Pandemic; Online psychological care; Social isolation; School-clinic

INTRODUCTION

The COVID-19 pandemic has changed, and is still changing, the way individuals and the society as a whole look at the world. Given the priority of the physiological impact on health, the psychological consequences of pandemic effects have not been a priority until the present time [1]. According to, "the COVID-19 pandemic caused by the new coronavirus (SARS-CoV-2) has presented itself as one of the greatest health challenges on a global scale of this century" [2].

Social distancing, isolation and the pandemic generated psychological crises, but there were other issues as well: Difficulties in dealing with remote work (home office) or distance learning; the risk of being contaminated; and the increasing number of deaths. Additionally, there were factors that contributed to mental health issues during the pandemic period, such as: Reduced family income; unemployment caused after isolation; intensified family life; the uncertainty of a future in relation to social distancing; the duration of the pandemic state; overexposure to worrisome information; increased time spent on social networks; and disinformation [3-13].

Such conditions have multiple effects on a person's mental health, which is defined by biopsychosocial factors, in their respective complexities that together contribute to their emotional well-being [14]. Brooks, et al. [15] report an increase in multiple symptoms related to mental health, including stress, depression, insomnia, post-traumatic stress disorder, irritability and generalized distress. It is suggested that problems initiated in the pandemic period can have long-lasting effects, and stressors such as lack of reliable sources about COVID-19 and healthy behaviors in relation to the disease, little or no accessibility to mental health, economic problems, self-judgment etc., appear as

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the main cause for stress, anxiety and depression [8].The COVID-19 pandemic produced psychological sequelae in the society at large, with ubiquitous effects across global regions and population ages. But there were specific manifestations for particular social groups, such as frontline workers and COVID-19 patients. For the general population, the pandemic added an additional psychological burden on top of preexisting mental healthcare needs [16]. The interpersonal challenges that arose from this global crisis are unprecedented in this generation [17].

Based on this scenario, there has been a significant growth in the demand for mental health care treatments, most of which were characterized as urgent, while there has been a decrease in the availability of public and private services, which are mostly provided face-to-face. Mental health professionals, therefore, developed new forms of providing care, usually at a distance (*via* the internet). COVID-19 highlighted the impact of physical ill-health and social disruption on mental health and well-being and, at the same time, removed our usual first line response to mental health challenges: In-person face-to-face therapy. By the end of May 2020, almost every country had restricted movement and experienced the closure of nonessential businesses [18].

There was moderate skepticism regarding alternatives to in-person treatment, from persons inside and outside the clinical profession, and tele psychotherapy was viewed as a less authentic and less effective form of psychotherapy. Among the general public, there was limited knowledge regarding this treatment option and concerns about treatment quality [19]. According to Burgoyne, et al. [20], many issues were presented in transition to tele therapy, concerning preparation of the environment for the sessions, in both sides, including privacy, reading feedback was also more difficult to therapists deprived from elements of the face-to-face interaction, among others.

But during the pandemic, responding to the need for flexible and prompt clinical care, online interventions have become widely used and research has shown that these interventions registered good success for a variety of social groups and clinical conditions, allowing us to conclude that "Remote psychotherapy can be a credible and trustworthy alternative to in-person treatment to be adopted and implemented on principle by a majority of psychotherapists regardless of their orientation" [19]. Although the use of video conferencing psychotherapy the most common way of teletherapy-does not change the needs of patients and thus the general therapeutic goals, the massive dissemination in COVID-19 has been positive since millions of people could benefit from these treatments [21].

Even though there wasn't a tradition of online psychological treatment or training for psychologists in this field, Brazilian psychologists changed their practice, turning to online services [22]. In Brazil, some of the services were created or changed to meet this demand, in the university omitted for blind review. An example is the clinic "omitted for blind review", a school-clinic of psychology that has been providing psychological care to the general population and the university community. Both the clinic and its methodology have been restructured to an online format. In this clinic, service 1 (omitted for blind review) offers online psychotherapy service *via* video conference since 2017, offering individual care for people over 18 years of age. The main change was the increase in the number of service requests. There was also an increase in the severity of cases and the service was sought by patients that were not previously served.

There is also another service, created specifically for the pandemic situation, the service 2 (omitted for blind review). The main objectives of this service were to provide an online mental health care group service for "omitted for blind review" community in relation to mental health problems derived from social distancing, as well as to inform about support services in mental and psychosocial health, bringing together professionals or psychology students who volunteered for such activities. The three services aforementioned were provided by the same university "omitted for blind review".

Considering the observations regarding the forms of care developed in these three psychology services and the previously published studies, it was considered important to develop a research in order to compare and understand the impacts of the COVID-19 pandemic on these services and the dialectic effect of these services on the population served, characterizing the profile and complaints of these people, and also delving into the emotional impacts suffered, thus contributing with relevant data to the scientific community and to teaching clinics to improve their services.

MATERIALS AND METHODS

This study sought to characterize the profile and complaints of patients who sought psychological help at the clinic "omitted for blind review", at service 1 and service 2, during the pandemic period from April to December 2020. From a methodological point of view, this is a retrospective and comparative research, carried out by surveying the profile and complaints of people who sought psychological help in these three services during the defined period, through the analysis of registration forms and screening notes of the participants who expressed consent.

A total of 628 individuals took part on the research, of which 363 were patients from the clinic "omitted for blind review", 126 were enrolled in the service 1 and 139 were receiving care in the service 2. Participants were individuals over 18 years old who sought these services between the months of April and December 2020. The university services were provided remotely during this period. Informed consent was obtained from all individual participants included in the study. Individuals who did not express consent to participate in the research were excluded from the sample.

The instruments used for data collection were the registration forms (sociodemographic data) and screening reports (characterization of demands and initial interventions) from the clinic "omitted for blind review" , the service 1 screening questionnaire (sociodemographic questions and inquiries about medical care and about the service), and the service 2 reception screening questionnaire (sociodemographic data). Patients contacted the service *via* phone (clinic omitted for blind review) or website (clinic omitted for blind review, service 1, service 2), and the dissemination was carried out through official university newsletters. The questionnaires were hosted on the Google

forms. Data on screening reports were collected from electronic psychological records retrieved from an electronic system.

In order to perform the analysis, the following statistical tests were used: For "yes" or "no" categorical variables, confidence intervals were calculated using the Agresti-Couli method, as described by Brown, et al. [23]; to assess potential relationships between categorical variables, chi-square tests were used (in cases of description of the test statistics) or, when breaking assumptions, Fisher's exact tests were employed (cases without statistical description of the test); for age assessment, a Kruskal-Wallis test was used; and for age as an ordinal variable (age range only), nonparametric tests and Spearman's correlation test were used.

In addition to the socio-demographic data, the study also analyzed the complaints of all patients, evidenced in the psychological records of suffering related to COVID-19. The results among the services were also compared when such comparisons were feasible. This research project was approved by the Research Ethics Committee at the university omitted for blind review CAAE: 45558921.1.0000.5482. The procedures conducted in this research complied with the Criteria of Ethics in Research with Human Beings, according to Resolution No. 466 of December 12, 2012, of the Brazilian National Health Council. It is also important to clarify that the forms used in the research were filled in by the patients in their first contact, according to the service used. In the last topic of the registration forms there was an item called "Statement of acknowledgment/consent", which was signed by the patient in agreement with the use of their information for educational and research purposes, including scientific publications.

The sample consisted of 628 participants among which 57.8% were from the Clinic "omitted for blind review"; 22.1% from service 1; and 20.1% from service 2. There was a difference in relation to the sex/gender of the participants, with women predominating in the sample, as a whole, and with slight variations in such difference among the analyzed services. It is worth mentioning that, individually, the percentage of women in the services has always been higher than the percentage of men, with women accounting for 72.7% in the Clinic "omitted for blind review", 83.2% in service 1, and 78.6% in service 2.

Concerning psychiatric treatment, in service 234.9% of users had already undergone psychiatric treatment, whereas in service 111.68% were in psychiatric care. According to service 2, in relation to participants who have already sought previous psychiatric treatment, it can be interpreted as the search for an already recognized way of dealing with the imposed stresses. It is indicated that patients who already had a psychiatric diagnosis prior to the pandemic were more likely to have their condition worsened [24]. For those who sought this service, it could mean the search for new strategies to cope with the situation.

Regarding medication, a significant use of antidepressants was reported. In the service 2 sample, the use of such treatment was reported by 40.9% of those who had already used medication, as well as in service 1' sample, along with antipsychotics, anxiolytics, anticonvulsants, mood stabilizers, addiction medication etc. It was observed that antidepressants were used in cases of depression and anxiety, the most frequent complaints, and corresponded to most of the statements about drugs.

RESULTS AND DISCUSSION

There was a difference in relation to the gender and sexual orientation of the participants, and it was evident that, for the three services, most users were women. It is worth mentioning that, individually, the percentage of women's presence in the services has always been much higher than that the percentage of men. The age range between 18-25 years of age appeared with the highest percentage in the sample, but there was a significant variation in the age range, with participants from all ranges (5-year intervals) up to people over 70 years of age.

According to Bianconi, et al. Gonçalves, et al. and Nunes, et al. women's workload increased during the pandemic period, whether due to the need of taking care of other people or to having a greater workload despite the salary being kept the same [25-27]. We can infer, for example, that women sought emergency psychotherapeutic services more often because of the overload imposed by family settings and increased work (formal and informal paid work or longer hours of housework), a hypothesis that was also found in the statements of the female users, who were the majority in the sample. Differences were also observed in relation to marital status, with a higher occurrence of single individuals in service 1 and prevalence of married subjects in Clinic "omitted for blind review", denoting a greater number of single subjects in this research than in previous surveys carried out in the services.

Regarding the work/academic situation, it is worth mentioning that most of the individuals in the sample were employed (50.6%) or students (32.9%), with 12.3% of the sample being unemployed, 3.7% retired, 0.4% on leave and there was one participant who was a volunteer worker, accounting for 0.2% of the sample. There was an increase in the amount of the employed population seeking psychological help, even though employment is a protective factor for mental health [28]. We can highlight that service 2 was limited to the university community and its sample was composed mostly of students (89.7% of the users served), who come from a wealthy socioeconomic status, except for scholarship holders.

It was observed that the presence of older people was more common in the clinic and that younger people were more prevalent in the service 2. Regarding age, it is clear that young people were more affected by issues involving anxiety (especially in relation to loss of opportunities, distance learning and contamination of family members). Such anxieties, in addition to already being common in relation to age [4], may reflect the high number of university students present in the sample and may also indicate that such an environment is known to enhance anxiety and other psychological forms of suffering [29-32].

On the other hand, the elderly experienced worsened depression-related conditions (loss of interpersonal bonds and physical distancing) [33,34], although there was also an increase in anxiety due to excessive information about mortality of the

elderly population previously to the vaccination [35]. Regarding the location of the participants, 94.3% of the users were from the State of São Paulo, which is due to the physical location where the services are provided.

Analysis of complaints

Regarding the complaints presented by patients, it was noticed that cases of anxiety were the most common in all services, especially in the service 2 (42.8%), and in service 1 (27%), followed by the Clinic "omitted for blind review" (19.5%). Depression was the second most common complaint from users in general (16.7%), with service 1 accounting for 22.6% of complaints, clinic "omitted for blind review" for 18.5% and service 2 for 5.8% of complaints. Other complaints observed were difficulties in interpersonal and family relationships, insomnia, sadness, unwillingness to perform tasks, anguish etc. (Table 1).

Anxiety-related complaints were considered amongst the most significant ones, and this is related to the fact that the pandemic is a disaster situation, with different degrees of coping related to hardships, with little to no prediction of what can happen in the present time or in the medium/long term [6,36]. Multiple stress factors that contribute to increasing depressive symptoms (e.g. unemployment, loss of income, difficult family life, etc.) arose during the pandemic or social distancing period [37]. The feeling of fear and isolation in general often worsened the feelings of anxiety and depression. General data do not show significant differences between the three services, which is generally compatible with studies and research on the worsening of depression and anxiety during the COVID-19 pandemic period, indicating a decline in mental health levels in the pandemic scenario [7,9,38] .

Regarding COVID-19 and complaints by age group, the effects caused by social distancing, or by severe health condition of close people or family members, were noticeable when observing the most frequent mentions of these events by people of younger age groups. The opportunity to receive free assistance in services such as service 2 allowed students who had never sought psychological services to benefit from this type of care. Considering the level of education, some relations can be noticed

Proportion of the main complaints			
Main complaint	**%**	**Lower limit (95% CI)**	**Upper limit (95% CI)**
Anxiety and Generalized Anxiety Disorder (GAD)	24.8	21.3	28.5
Personal relationships	4.1	2.4	5.9
Romantic relationships	4.3	2.6	5.9
Identity conflicts	1.1	0.4	2
Behavioral dependence	0.4	0	0.9
Professional difficulties	7.4	5.4	9.8
Depression	16.7	13.7	20
Disorders*	3.9	2.2	5.6
Violence	0.7	0.2	1.5
Family relationships	10.6	8.1	13.1
Drug addiction	0.6	0	1.3
Suicidal ideation	1.5	0.6	2.8
Psychotic symptoms	0.7	0.2	1.5
School/university-related complaints	2.6	1.3	4.1
Other	20.7	1.3	4.1

Note: *OCD, oppositional, bipolar, eating, mood disorder.

Table 1: Proportion of the main complaints.

in the survey of complaints by the clinic "omitted for blind review" and service 2 concerning anxiety, depression and other demands that are common to the university context, as well as stress factors caused by the new forms of remote work [11,31,39-41].

There were also reports of suicidal ideation, although they were low in relation to the total number of patients. Clinic "omitted for blind review" reported 11 people (3.03%), service 2 reported two students (already undergoing treatment before the service) and service 1,2 people (approximately 1.5% of the cases) with suicidal ideation. There was stability or even a decrease in data compared to previous years. However, Pirkis, et al. [42] report that family proximity and the protection of individuals by communities contributed to the maintenance of these rates, but there may be a significant increase of this complaint after the pandemic period, especially in case of economic recession [43].

Regarding the support network of the participants, there was a need to strengthen them while the individuals were isolated. While 80.64% of service 2 users reported having a support network, data from service 1 indicate that 6.8% of users were alone during the social distancing periods. Hwang, et al. suggest that while not necessarily equivalent, feelings of social isolation and loneliness are associated with a range of mental health problems [44]. Good relationships with friends, colleagues and family members maintain lower levels of depressive, anxious and loneliness symptoms [33,39, 45]. To compensate for difficulties in socializing, a frequent use of social networks was noticed, however, this could cause other conflicting feelings (e.g. information overload, fear of missing out, tiredness, socializing, social comparison etc.) [44,46].

Complaints about the pandemic and social isolation

Data from clinic "omitted for blind review" and service 1 indicated a relationship between greater psychological distress and social isolation. Among the participants in general, 19.5% mentioned social isolation as an impact of COVID-19, with social isolation being mentioned more frequently by people of younger age groups. Among some characteristics that can be reported from social isolation, there were difficulties in adapting to remote work and distance learning, decrease in family income, unemployment generated by the crisis, accentuated family life, loss of freedom, separation from loved ones, loneliness, changes in daily activities etc. [6,11,13,15,47] .

Another observed demand was the fear of the virus, which stands out due to the increase in anxiety levels and due to being the specific direct impact of COVID-19 with greater quantitative relevance compared to other causes of psychic suffering (considering that social isolation, the aggravation of situations and other conditions are not caused by the virus itself) [48]. In the sample, 5.3% of the participants mentioned fear of the virus.

Data regarding a decline in their mental health condition due to the death of family members, acquaintances or friends were similar. In the clinic "omitted for blind review", 3.4% reported death of a family member or a loved one, 1.7% mentioned severe health condition of a family member or close friend and 0.9% mentioned mourning. In service 2, 3.6% reported death of family members or acquaintances and 2.4% mentioned mourning. In the general sample, 2.4% of the participants mentioned grief, often people from older age groups. At first, cases of bereavement that sought service 1 were referred to the clinic "omitted for blind review"; however, with the growth of the waiting list, service 1 began to provide services to these cases. Regarding the grieving process, what stands out is the interference caused in such process by the pandemic and its restrictions, which can result in pathological mourning, such as the impossibility of farewell rituals (without being able to visualize the body or saying goodbye to the loved ones), potentially leading to feelings of anger, sadness, frustration and resentment [49-51].

Given the specific amount of demands, the greater number of stressors and the calamity situation, as previously explained, there was a large increase in the demand for psychological care. A comparison made between the 2016 and 2020 complaints of the clinic "omitted for blind review" showed that complaints of anxiety and depression in these years remained at similar percentage levels. Service 2 highlights that 75% of the 126 registrations made in 2020 were carried out in the first semester (April to July 2020), with 47% (60) of the registrations in April. Service 1 also demonstrated a similar increase in requests for care from April 2020 (from 4 to 8 messages per day, when previously it used to receive 4 to 5 messages per week), closing the application process in September 2020 in as much as there was no longer any possibility of providing services for those in queue. Of the 139 users who filled out the registration form, 38.2% received care provided by the service.

The three services highlighted that the aggravation of complaints regarding anxiety, depression and family relationships was far more common. This exacerbation may be related to several of the factors already described above, with 39.1% of the sample mentioning worsening of their situations. Research indicates that the pandemic aggravated pre-existing problems. The frequency of negative feelings was higher in people with a previous diagnosis of depression [3]. Regarding other consequences of the pandemic, clinic "omitted for blind review" reported complaints such as difficulty in family relationships (12.8%), professional difficulties (12.1%), and problems in romantic relationships (5.7%) and in interpersonal relationships (4.3%).

In the reception of service 2, 21.3% mentioned other issues, such as financial difficulties, issues related to sexuality, divorce and caring for children during quarantine, in addition to low academic performance. Regarding school difficulties in the general sample, what stands out is the struggle with school performance found in the service 2 complaints (from a sample largely composed of students) and the efforts of adapting to online education mentioned in service 1, in addition to concentration difficulties, indicating that part of the students did not adapt to distance learning.

Regarding service 1, participants mentioned issues such as initial confusion brought about by the demands of the pandemic, search for personal improvement and self-knowledge, addiction

to masturbation, illness due to factors other than COVID-19, search for psycho-pathological diagnosis and addiction to technology. It is observed that complaints related to difficulties in family relationships appear with significant frequency, both in the clinic "omitted for blind review" and in the service 2. Relations with Janus go in the direction of other pandemic consequences. Social isolation forced part of the population to live together during extensive periods of time, with families struggling to adapt to new situations, with parents and children working and studying remotely. In service 1, there were cases of women overloaded with the care of the house, of children and older people due to the absence of caregivers.

In the three services there were complaints related to professional life, as well as to financial difficulties due to either reduced workload or job loss. Work-related issues were a powerful stressor and unemployment, in particular, impacted those entering the workforce. Of all the users who were contacted, 62.4% received some level of attention from the services (at least screening): 38.23% at service 1, 46.82% at service 2 and 76.86% at clinic "omitted for blind review". There were dropouts in all consultations, however the service 1 laboratory did not collect data regarding these subjects. An average dropout rate of 13.1% was obtained (service 2 and clinic "omitted for blind review" only, with no significant difference between the two). Among the reasons for dropping out, in a comparison between service 2 and service 1, a few similarities stand out, such as: Improvement of mental health, return to face-to-face care, adaptation and improvement sufficient for interruption, and some without justification.

Men had a higher chance of quitting the treatment. In a logistic regression model controlling for age, it was found that the chance of dropping out in either of these two services is 96.7% greater for men than for women. The model was adherent but poorly predictive (p=0.837; Nagelkerke's Pseudo R=2%). Service 1 did not provide group therapy sessions and the dropouts from the service 2 did not appear linked to difficulties with this modality, given that, according to explicit requests, users could receive care through individual consultations.

The three services showed high adherence and relevant permanence. All had a queue, and the clinic "omitted for blind review" had a more sophisticated queue due to the large number of service modalities, which were redirected from the screening process (that functioned as a reception). The waiting time for screening varied from one week to two months, depending on the time of enrollment, and the clinic closed new enrollments when the queue was extended, to ensure that those already enrolled would receive care. In relation to care, users had an average waiting time of 16.81 days, ranging from 1 week to two months depending on the urgency of the case, the time of year and the available places. Often, enrolled users requested prediction or agility in their care, and such situations were examined by the coordination of the clinic to discriminate the emergencies.

In all of the services, themes related to the pandemic were more evident at the beginning, but, even though they did not disappear, they became secondary and were replaced by other issues throughout treatment, and the reasons for permanence were not issues exclusively related to the pandemic. The time period of the provided service, from the beginning until the end, was specific for each service. The clinic "omitted for blind review" had two to five screening sessions, and from there each internal service specified the duration of the service. Service 1 delimits the scope of work and forwards the patient to other services according to the clinical evaluation. In service 2, the volunteer professional determined the duration of the service, for various reasons, such as: Observation of clinical improvement of the initial complaint; the need for individual psychotherapy; the completion of the university program in which the student was enrolled; or the user's desire to end treatment.

Some of the experiences and qualitative characteristics lived during the online consultations can be mentioned, such as the difficulty in maintaining confidentiality, changes in the patient's environment during the session, the care of severe cases, cases of domestic violence and the breadth of regions allowed by the online services, among other features. Difficulties in maintaining confidentiality were common to all services, as described in the literature [52,53]. Not all patients had access to privacy, acoustic protection and places free of interruptions, not to mention limited Internet access (instabilities or lack of devices connected to the Internet). The main difficulty reported was the fear of having other people in the environment listening to the users, or even invasions of the therapeutic space during the sessions.

However, clinic "omitted for blind review" and service 2 identified a positive point in this context, which was the inclusion of external factors to the session (e.g. patients sharing their home environment, objects and artistic manifestations created during the pandemic period), increasing the proximity and intimacy of the participants in the consultations. An alternative found by users to tackle the confidentiality issue was to hold sessions in unusual places such as cars, squares, work environments or public transportation. In some cases, patients struggled to understand the need to carry out the sessions in a place where they could be alone, without the presence of other people.

In addition to the difficulty of finding an environment to carry out the session, there were also changes that occurred in environments (such as displacements) during care or characteristics such as the lack of focus of patients who were involved in other tasks (driving, performing tasks domestic work, answering emails, etc.). Such changes have also been reported in the literature [54]. The study observed that online assistance services faced similar challenges and it was noted, sometimes, a low level of involvement with the process, with patients not looking for safer places to carry out the sessions. Patients showed involvement in several tasks at the same time, with little focus on the therapeutic process, compromising the potential progress and outcome of the treatment. Thus, the contracts and pacts for carrying out the services had to be periodically revisited, in order to be remembered or readjusted during the online consultations.

The most cited and common risk situation in the services was the risk of suicide. Both service 2 and service 1 services

identified cases of domestic violence, and the clinic "omitted for blind review" saw cases of psychotic outbreaks and panic attacks, while service 1 identified cases of chemical dependency. Severe cases received prompt care, but often had to be referred to an emergency department. The search for a 24-hour care service was frequent, and patients were redirected to the services present in the public healthcare network after seeking the online service. Regarding cases of domestic violence, a potential for an increase was observed in situations of domestic violence despite a decrease in complaints [28,41,55]. The increased struggles in family relationships noted in the complaints from clinic "omitted for blind review" stands out, while in the service 1 and in the reception of service 2 there were descriptions of situations of violence against women and violence against the LGBTQIA +population, respectively in each service.

Faced with the social distancing imposed by the pandemic, service 2's online reception service provided care to patients who were experiencing verbal violence and situations of prejudice against their sexual orientation at home. Often, these individuals suffer when they are confined with intolerant family members who are distant from their community, represented by social bonds that protect their mental health. In this case or in relation to violence against women, social isolation can often mean remaining confined with potential aggressors, often their own families or intimate partners [28,55]

During the consultations, patients assisted by service 2 reported experiences of verbal violence and situations of prejudice against their sexual orientation at home, and in service 1, while providing care for a woman, a therapist experienced several interruptions made by her aggressor during the sessions and was able to develop non-verbal communication signals to protect the victim, who did not have a safe environment where she could attend her therapy sessions. It is evident that family conflicts were intensified during the period of social distancing, with an increase in feelings of loneliness and cases of physical and psychological violence. Data on sexual orientation and marital status were not collected in all services, thus jeopardizing any potential comparative interpretations.

The three services, according to the literature, indicated a greater possibility of serving people through online service, managing to assist people with mobility difficulties, with physical barriers or with financial restrictions in relation to means of transportation [54]. The Clinic "omitted for blind review" saw an increase in patients from more distant/ peripheral neighborhoods, indicating 23.5% of patients only from the South Region of the city. In the case of Service 2, there was no comparison because it was a service created during the social distancing period, but even though all cases were from the state of São Paulo, not all of them resided in the capital. Service 1 already treated patients from other states and countries before the pandemic, however, after the pandemic started, there was an increase in demand for care outside the state of São Paulo. In some cases of patients living outside the country (4.3%), there was a need to learn about the healthcare services available in that country to carry out the necessary referrals, especially in more severe cases.

In relation to other characteristics, it can be described that online services have shown surprising results, making mental health care widely feasible, allowing patients to feel relief for being contacted, allowing bonds of trust, the creation of new support networks, and the encouragement to seek help online. There was also the opportunity to observe the importance of assistance in groups, especially in service 2. The groups allowed the perception of suffering occurring for similar reasons, creating notions of universality of feelings and decreasing feelings of loneliness. The Service 1, however, could observe instability in the permanence of online services. Of the 139 users receiving care, 33 ended treatment as proposed by the therapeutic planning, which may indicate low commitment to online treatments [56].

CONCLUSION

Psychotherapeutic work during the pandemic and the research that it entails are fundamental to public health. The pandemic demanded quick responses in relation to the conditions it imposed on mental health. A quick refinement in relation to new technologies, such as online services, was necessary for an efficient psychological care. This research sought to analyze a specific scenario, based on the comparison among three online psychological care services, the clinic "omitted for blind review" (through its general service and through service 1) and in the service 2 mental health support and reception network, a service available for the community omitted for blind review. This enabled a comparison of the effects caused by the pandemic on psychological care in relation to the services themselves and their main differences (such as the historical strength of the Clinic "omitted for blind review", service 1 previous experience and the new reception service of service 2) and also pre-pandemic differences and online psychological care currently provided. It was possible to analyze and understand the expansion of the possibilities of the services from an unprecedented situation such as the COVID-19 pandemic.

There was a significant increase in the demand for psychological services, and the need for remote care in cases of high severity and urgency, sometimes the only form of care, since, in previous periods, these cases could not be provided with remote care. Another constant need was the frequent external referral in relation to these cases, whether initial, subsequent or parallel to the online service. The most common symptoms were depression, anguish, anxiety, family conflicts, most of which were aggravated by social distancing, dialectically hindering the development of therapeutic processes. Social distancing, although essential for mitigating and managing pandemic issues, was one of the main factors responsible for these aggravations and triggering many of these symptoms.

Even with a sudden need to adapt to online service, and despite the diversities presented by the social distancing, by the pandemic and the service itself (the difficulties in relation to secrecy, safe environment, internet connection etc.), there were positive outcomes with regards to care and the possibilities of caring for patients and forming bonds with them. The online service was understood, therefore, as ambivalent. While it provided care and reception for positive patients, it also posed

challenges that would not have been encountered before during face-to-face care. It allowed assistance in situations that would not be contemplated. The study also identified a need to provide better preparatory training to psychologists who decide to continue with remote consultations.

It was also possible to create a map of the most impacting psychological issues in the pandemic, especially when compared with more traditional data. While social distancing allowed some demands to become rarer, others became more common, and it was also possible to understand what the aggravations were caused by the pandemic and social distancing. Therefore, relevant data contributed to the academic and student community in general, allowing the researched services to understand professional gaps and their availability for the improvement of professionals and their services. Alerting healthcare professionals to new directions was also essential, such as possible increases in post-pandemic suicide rates. There is also a need for further studies to better identify the longitudinal pandemic impacts and following large-scale vaccinations. This research also enabled planning for new therapeutic works (preventive and immediate) in the future, pointing out important expansions in general psychology services, whether remote or face-to-face, within unprecedented and calamitous situations.

DECLARATIONS

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Competing interests

All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.

Ethics approval

Ethical approval was waived by the local Ethics Committee of Pontifical Catholic University, view of the retrospective nature of the study and all the procedures being performed were part of the routine care. This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of Pontifical Catholic University, CAAE: 45558921.1.0000.5482.

Consent

Informed consent was obtained from all individual participants included in the study. The authors affirm that human research participants provided informed consent for publication.

Data availability

The dataset generated during the current study is not publicly available as it contains patients' information that the authors acquired through the clinic archives. Information on how to obtain it and reproduce the analysis is available from the corresponding author on request.

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