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THE EXPERIENCES OF MARRIAGE AND FAMILY THERAPISTS BALANCING RELATIONAL TELETHERAPY AND SELF-CARE DURING THE COVID-19 PANDEMIC: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

A Dissertation

Presented to the Faculty of

Antioch University New England

In partial fulfillment for the degree of

DOCTOR OF PHILOSOPHY

By

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August 2022

THE EXPERIENCES OF MARRIAGE AND FAMILY THERAPISTS BALANCING RELATIONAL TELETHERAPY AND SELF-CARE DURING THE COVID-19 PANDEMIC: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

This dissertation, by Elizabeth Dumayne, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University New England in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY

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ABSTRACT

THE EXPERIENCES OF MARRIAGE AND FAMILY THERAPISTS BALANCING RELATIONAL TELETHERAPY AND SELF-CARE DURING THE COVID-19 PANDEMIC: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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The COVID-19 pandemic has brought many changes to the world of mental health, especially in the delivery that marriage and family therapists provide services to their clients and while balancing their own self-care. In order to provide therapists with a base from which to work through these changes, a thorough review of the literature is provided as well as an interpretative phenomenological analysis. Chapter one provides an introduction to the topic of relational teletherapy during the COVID-19 pandemic and self-care for therapists, defines the terms teletherapy and self-care, and clarifies the conceptual frameworks at use in the dissertation: ecological systems theory. Chapter two is a review of peer-reviewed literature on relational teletherapy and self-care practices for marriage and family therapists. There is a focus on teletherapy provided during the COVID-19 pandemic, especially during the initial shift from face to face services. Chapter three is an interpretative phenomenological analysis that answers the question: how has the shift and practice of teletherapy impacted marriage and family therapists professional therapeutic work and personal self-care practices through the ongoing COVID-19 pandemic? Chapter four provides the four themes and twelve sub themes that

emerged from the eleven participants' experiences in this study. Chapter five is a discussion of the research findings among the themes, implications, limitations within this study, a call for future research, and conclusion of findings from this study. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: marriage and family therapists, teletherapy, self-care, COVID-19, pandemic, experiences, interpretative phenomenological analysis

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DEDICATION

Throughout my education and career, my children have always been my motivation to continue to better myself as a student, therapist, and mother. I dedicate this dissertation to my children, Eva, Mollie, Aria, Damian, and Rosalie. This piece of work would not have been possible without the love and support from my husband, Jason Dumayne. Thank you Jason, for all you have sacrificed during these last several years.

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CHAPTER I: INTRODUCTION

In mid March of 2020, the world that we had known changed. Across the United States, schools shut down, businesses closed, travel was restricted, and many people lost their jobs or were forced to make the shift of working from home because the World Health Organization (WHO) officially declared a global pandemic due to the spread of Coronavirus (COVID-19). According to the Centers for Disease Control and Prevention (CDC, 2020), COVID-19 is an infectious disease caused by the coronavirus that can spread from person to person; people can become infected when in contact with the respiratory droplets of an infected person. In accordance with World Health Organization (WHO, 2020) recommendations for interpersonal distancing to try to stem the spread of COVID-19, U.S. institutions and companies transitioned nonessential personnel to working from home (McKee et al., 2021). Since March of 2020, COVID-19 has spread like wildfire across the globe, and though mandates of social distancing, quarantining, and wearing a mask in public settings have been enforced, this illness has infected more than 88.78 million and taken the lives of over 1.01 million United States citizens as of July 2022 (CDC, 2022).

The COVID-19 pandemic has reverberated throughout the entire ecological system (Bronfenbrenner, 1979) including the field of Marriage and Family Therapy (MFT). Individuals, including marriage and family therapists, have been impacted within their homes, schools, and workplaces; challenges to mental health access are causing isolation. These impacts have created a ripple of larger changes in the meso system as it has blurred the boundaries between home, school, and work because they are all now happening in the same physical location due to social distancing restrictions. This change continues to ripple to the larger exo system that may include not having access to extended support systems and extended family, navigating new job

requirements and policies, changes within state laws and insurance companies, no access to libraries, playgrounds, regular medical visits such as dental and primary care, etc. Lastly, the macro systems have experienced increased confusion and tension about COVID-19 regulations, changing protocols, vaccination safety, etc. In order to stay connected and provide services to their clients', marriage and family therapists, (i.e. microsystem) have had to quickly adapt to a form of remote relational therapy. Individuals, couples, and families who were once seeking mental health services in an agency or non-profit setting, were required to have teletherapy sessions (Wrape & McGinn, 2019). Teletherapy is defined as mental health counseling over the phone or online using virtual video platforms (Villines, 2020). A study of private health care claims conducted by the American Medical Association (AMA), found that telemedicine/teletherapy claims were 4000% higher in March 2020 than in March 2019 (Fisher et al., 2020). Over the years, tele-therapeutic services or 'remote psychotherapy' have taken on many names, though most recently and for this study, the term ' relational teletherapy' will be used throughout to define psychotherapy at a distance via telecommunication technology and online platforms with couples and families (Maier et al., 2021; Markowitz et al., 2020).

Background and Statement of the Problem

Recent studies (Goldin et al., 2021; Disney et al., 202l; Lewis et al., 2021; Markowitz et al., 2020; Morgan et al., 2021) have shown that teletherapy has provided access to mental health services for couples and families during the ongoing pandemic which has shown challenges and benefits to this mode of service delivery throughout the ecological systems. One benefit is that relational teletherapy grants the therapist revealing glimpses of couples and families personal lives, such as their home, pets, etc., through the screen of a computer or electronic device (Disney et al., 202l; Morgan et al., 2021). On the other hand, teletherapy has created barriers and

challenges for many clients as they may not have the resources or accessibility to virtual therapeutic services. Although teletherapy is not a new method of providing services and has been shown to be an effective treatment, many marriage and family therapists had to adapt to the contextual factors they were faced with during the rapid shift to providing telehealth services within a few weeks, without prior knowledge or training on these essential services from their larger support systems. For example, teletherapy services made up 2% of practice prior to the COVID-19 pandemic at agencies; beginning the week of March 15–21 2020, however, agencies were forced to vacate and practice 100% teletherapy after that time (Burgoyne & Cohn, 2020). Many agencies have continued offering teletherapy, primarily and part time, as the pandemic continues. From an ecological perspective, marriage and family therapists and their larger systemic levels, (i.e. their clients, agencies, teletherapy practice, and larger organizations) have had to learn and adapt to this shift to teletherapy from the previous traditional face to face therapy to teletherapy, creating multisystemic influences of change.

As the pandemic continues into its second year, research has begun to highlight its impact on the field of mental health and assess the effectiveness of teletherapy practices. However, there appears to be a lack of information about the impact of providing relational teletherapy on marriage and family therapists' mental health and self-care practices during the initial and ongoing COVID-19 pandemic. Utilizing the ecological systems theory perspective, this research will shed light on the impacts of the ongoing COVID-19 pandemic on marriage and family therapists, exploring how they balance their relational teletherapy practices and self-care.

CHAPTER II: LITERATURE REVIEW

Introduction

Since the beginning of the pandemic, research on COVID-19 the progress and challenges of individuals seeking mental health services via teletherapy has significantly increased (Fegert, et al., 2020). Research has shown a significant rise in individuals' mental health concerns due to the detrimental impacts of COVID-19 (Reilly et al., 2021). Amidst these increased mental health concerns, mental health clinicians, including marriage and family therapists, are also struggling with emotional and behavioral health concerns as the global pandemic continues (Vanhaecht et al., 2021). Recent reports from the CDC suggest that the need for mental health services has increased three-fold from 2019 to 2020; this surge has undoubtedly put strain on the mental health workforce (Miller et al., 2021). Not only are marriage and family therapists navigating changes to new systems of mental health delivery (i.e., teletherapy) but they are also broadening their external systemic influences by providing support to additional clients. There appears to be a gap in the current field of mental health examining marriage and family therapists' perspectives on the swift change to remote therapeutic practices (i.e., teletherapy) with their clients while managing their own stress through self-care and burnout prevention.

Theoretical Framework

Ecological systems theory provides an understanding on how human development is influenced by different types of environmental systems (Bronfenbrenner, 1979). Bronfenbrenner's traditional rendition of the ecological system theory (1979), includes four levels, the (1) micro-, (2) meso-, (3) exo-, and (4) macrosystems. These levels range from small, proximal settings in which individuals directly interact, to larger systems which are further away from an individual's intimate environment, but indirectly influences development (Ettekal &

Mahoney, 2017). According to Bronfenbrenner (1994) and Ettekal & Mahoney (2017), the most proximal ecological level is the microsystem, which comprises the individual's immediate environment, including pattern of activities, social roles and interpersonal relationships such as family members, peers, etc. Moving outward in Bronfenbrenner's ecological levels is the mesosystem, which involves processes that occur between the multiple microsystems in which individuals are linked and the processes taking place between two or more settings, (i.e. physical setting). The exosystem is the next outermost level and includes the systems in which individuals are involved but not directly linked, but events occur that indirectly influence processes within the immediate setting of the individual (i.e. teletherapy practice). The outermost system of Bronfenbrenner's traditional system, is the macrosystem, which is defined as the set of overarching patterns of beliefs, values, and norms, as reflected in the cultural, religious, and socioeconomic organization of society, (i.e. AAMT code of ethics, state guidelines and regulations). Bronfenbrenner added a final system that extends the environment into a third dimension, the chronosystem, that encompasses change or consistency over time for both the characteristics of the individual and the environment in which they live, i.e. the ongoing pandemic (Bronfenbrenner, 1994). Utilizing the ecological systems theory provides insight into each system of the individual from micro to macro and will assist in discovering the impacts each system directly has on the individual, marriage and family therapist.

This literature review will summarize the current research available on marriage and family therapists delivery of relational teletherapy and how the ongoing COVID-19 pandemic has impacted therapists' self-care practices strategies and clinical work with couples and families. The ever-changing nature of the ecosystem makes it difficult to capture the essence of multisystemic influences (Robbins et al., 2012; Rolland, 2020). However, with regard to

ecological systems theory, the global pandemic has impacted everything in the entire system which has created a cascading effect on the other systems, such as the mental health agencies, clients, and marriage and family therapists; including their clinical work and self-care.

The COVID-19 Pandemic & Relational Teletherapy Practices

In March of 2020, teletherapy services became integrated into U.S. health care delivery systems as a strategy to improve mental health treatment and deliver care to clients while limiting the transmission of the COVID-19 virus (Goldin et al., 2021). Teletherapy refers to the use of technologies, particularly video conferencing, to remotely provide mental health care, including evaluations, medication management services, and psychotherapy treatment (Morgan et al., 2021). According to Goldin et al. (2021) teletherapy services provide marriage and family therapists the ability to deliver timely assessments, facilitate and leverage scarce resources, and maintain client connections in a time when social distancing is endorsed and in some cases mandated. The practice of teletherapy (also referred to as telemental health, telepsychology, tele-medicine, telehealth, or telepsychiatry) is neither new nor uncommon and the industry has grown and adapted over time. Companies such as BetterHelp, Talk-space, Regain, Pride Counseling, Teen Counseling, Faithful Counseling, and Online Therapy offer services that include live chat, text, phone, and video chat for various target populations, though these services were typically not covered by insurance prior to the pandemic, though some insurance barriers remain (Burgoyne & Cohn, 2020). Mental health agencies have had some preservation to their work with clients throughout the COVID-19 pandemic through platforms such as Zoom, Skype (Pruitt & Glennon, 2019). Teletherapy helps therapists maintain the structure of therapy through regular sessions and treatment approaches, encouraging clients to not let the physical distance of "social distancing" impede their existing relationships and cost them protective social support

(Markowitz et al., 2020). Therapists maintaining structure of the teletherapy system is a prime example of how their microsystem is strengthening the larger subsystems (Robbins et al., 2012). Although teletherapy was an overnight change for many MFTs, there appears to be many benefits and positive steps towards growth in the delivery and accessibility of therapeutic services.

Benefits of Relational Teletherapy

According to Asad et al. (2021) teletherapy has emerged as a frontline strategy for safe healthcare delivery during the COVID-19 pandemic and is being promoted across the world for cost-effective, safe, and strategic medical care with clear guidelines. Teletherapy demonstrates success in access and convenience during a time of unprecedented crisis, across various clinical settings, presentations, and populations (Markowitz et al., 2020; Morgan et al., 2021). The effectiveness of teletherapy services has long been debated though many research studies indicate positive outcomes (Disney et al., 2021; Goldin et al., 2021; Markowitz et al., 2020; Morgan et al., 2021; Turgoose et al., 2017). Teletherapy has been effective in addressing anxiety, autism spectrum disorders, chronic pain, depression, eating disorders, post-traumatic stress disorder, substance use disorders, and pediatric traumatic brain injury (Morgan et al., 2021). Turgoose et al. 's (2017) research of trauma focused teletherapy for veterans revealed that the majority of cases were found to be as effective in reducing PTSD symptoms as in-person interventions. These findings suggest that teletherapy is an effective method of treatment for marriage and family therapists working with diverse populations of clients systems and needs.

An important variable within the systems of marriage and family therapist are the benefits of teletherapy for clients, which include feasibility, increased satisfaction, and lowered anxiety related to initiating treatment; while also providing an alternative to in-person services

(Morgan et al., 2021). Additional benefits associated with teletherapy include time and cost efficiency, accessibility, particularly for rural and vulnerable populations, flexibility, increased ease in case management, and sustainability. For example, Markowitz et al. (2020) reported the greatest strength of teletherapy is that it expands access: the great majority of Americans have access to a telephone or computer, a claim teletherapy advocates have touted. Teletherapy services have increased psychiatric care access for individuals living in rural areas and those with lack of reliable transportation, a service that may have been limited previously (Goldin et al., 2021). This timely access to mental health services has led to decreased hospitalizations and improved client compliance and satisfaction (Goldin et al., 2021). Teletherapy services improve individual level variables such as continuity of care, promote client/ caregiver engagement and are cost-effective due to increased productivity, time management, and reduced transportation costs (Goldin et al., 2021). Heckman et al., (2017) suggested that the delivery of teletherapy via telephone has been an innovative way to deliver mental health services to clients in the privacy and convenience of wherever they can access, such as their home, work, etc. Teletherapy may also address barriers to therapy such as stigma, distance, scheduling, and childcare (Morgan et al., 2021).

The mental health field is increasingly integrating and growing a teletherapy presence, and marriage and family therapists are uniquely situated to offer services based on a history of innovative approaches (Cravens Pickens et al., 2019). Relational teletherapy has a plethora of benefits that have brought unimaginable changes and advancements to the mental health field. Teletherapy facilitates attendance of therapy sessions for couples and families as it is from the convenience of their own home without concern about being observed or stigmatized (Simpson et al., 2021). Providing sessions in the clients' home may enable the clients to be more

comfortable to experiment with some of the tasks and skills that have been more difficult in the context of the psychotherapy office, such as exposure-based tasks, relaxation or meditation. Family pets can also provide an additional element of comfort and familiarity that would not generally be available in the therapist's office (Simpson et al., 2021). Recent research reveals that most therapists appreciate the accessibility and flexibility of online therapy and these positive attitudes were associated with therapists' previous experience with online therapy (Connolly et al., 2020).

Teletherapy offers several unique advantages in family work. Most notably, relational teletherapy allows for fewer constraints on time and distance, enabling more members of the family system to participate (Burgoyne & Cohn, 2020). Teletherapy also allows the therapist to see the family in their living space. During family therapy, teletherapy appears to constrain the ability to quickly establish an alliance with a new couple. Some families may be more open to sharing their personal space than others, though it does allow opportunities to strengthen the therapeutic alliance. Teletherapy also appears to help conflicted couples and families in reducing intensity and hostility as video conferencing inserts a formality of taking turns while speaking and looking at the screen (Burgoyne & Cohn, 2020). These specific benefits assist in meeting goals and producing positive change and outcomes.

While much is still unknown about the trajectory of COVID-19, teletherapy will likely remain a primary method of treatment delivery for some time. Future research on the continued beneficial variables and influences will assist in continuing to normalize teletherapy. Although teletherapy continues to evolve and the positive aspects are prevalent, it would be remiss to ignore the boundaries and barriers associated with this service delivery for marriage and family therapists and their clients. Teletherapy is a new method of treatment delivery for the majority of

therapists in current practice. Reviewing evidence about the challenges and barriers experienced by therapists and clients helps to provide insight on how to continue to modify teletherapy.

Challenges in Relational Teletherapy

As of July 1, 2020, COVID-19 had impacted nearly every country or region with over 10 million confirmed cases and nearly half a million deaths worldwide, and these numbers continue to increase (Brock & Laifer, 2020). The swift transition to relational teletherapy for marriage and family therapists brought forward many boundaries and challenging variables to their ecological subsystems. Many therapists felt ill-equipped for the quick transition and complying with new financial and regulatory policies (Miller et al., 2021). This transition also forced marriage and family therapists to find a balance with their own micro-system of stressors, fears and personal needs, including the struggle with being ill-equipped during this transition. Therapists were also faced with the responsibility of working with clients stressors and losses related to the pandemic while also managing their own personal needs impacted by the pandemic (Connolly et al., 2020; Goldin et al., 2021; Miller et al., 2021).

Many of relational teletherapy skills are similar to techniques used in face to face sessions; though multiple obstacles have been reported while providing teletherapy, including resistance from clients and therapists, lack of training, clinical workflow and technology barriers, licensure or credentialing requirements, reimbursement barriers, and increased administrative overhead (e.g. Eppler, 2021; Markowitz, 2020; Disney et al., 2021). For example, Markowitz et al. (2020) reports formerly homeless clients may decline to continue therapy even by telephone because sessions would have cost precious billed minutes on their prepaid cell phone, while several others' lacked any private space to speak away from family members. An additional barrier is that clients may not have strong enough Wi-Fi signal/data on their phone to have a

video session, indicating that even if the clients have access, they may not have enough bandwidth to engage in video sessions (Disney et al., 2021). This may also be true for therapists providing teletherapy services that do not have strong internet connections and disconnection issues, though literature did not provide any evidence at the time of this review.

Simpson et al. (2021), reviewed typical challenges raised by therapists using teletherapy. The majority of concerns included obtaining informed consent and capacity to guarantee client confidentiality. Concerns about privacy and confidentiality with teletherapy delivery to the home setting are not unique to couple and family therapists, though many rely on clients to protect their own privacy by finding an adequate space to help ensure confidentiality (Simpson et al., 202; Barker & Barker, 2021). From an ecological systems perspective, there was significant change within and across the system as many states dropped their requirements that therapists had to be in the state that their client resides, creating both risks and protective factors among the subsystems. Though according to Caldwell et al. (2017) the AAMFT Best Practices for Online Therapy Report states, therapists should be careful to ensure end-to-end encryption, as well as appropriately protected hardware and software in order to secure confidentiality of electronic communications, and documentation of informed consent around privacy and confidentiality. When working with clients with family members that are located out of state in a therapy session, as noted in the AAMFT guidelines (2017), it is imperative that therapists are aware of state licensing and applicable mental health laws for the location of everyone who would be present on the teletherapy session. The clinician would be wise to also consult their own licensing board (i.e., macrosystems) to determine the legality of practicing with an out-of-state individual (Caldwell et al., 2017).

Marriage and family therapists face unique challenges in doing relational work via teletherapy (Lebow, 2020a). Some of these challenges are logistical, such as all the family members fitting onto the screen and finding an acceptable space for all family members involved (Wrape & McGinn, 2019). For example, Burgoyne & Cohn (2020) stated that therapists report having difficulty with all family members on the screen at the same time and have had to choose between asking family members to use different screens or asking the family to focus the camera on the person speaking, resulting in concerns of missing nonverbal interaction patterns. When working with families with younger children, researchers found it difficult to engage the younger children throughout the session (Burgoyne & Cohn, 2020; Lebow, 2020b; Wrape & McGinn, 2019). When working with high conflict relationships, marriage and family therapists should pay special attention to safety planning. Marriage and family therapists may feel reluctant to address family conflict via teletherapy because of safety issues, such as the duty to assess and report child abuse or suicidality in minor patients (McKee et al., 2021). Muchluf et al. (2021), reported that achieving a balanced alliance among the couple may be more complicated via teletherapy, as the experience can be less personal. In addition, during a traditional couples therapy session, partners are often in close physical proximity; among those couples with reactive and volatile relationships, negative interactions can escalate quickly (Muchluf et al., 2021). When the therapist is conducting relational teletherapy, it is more difficult to help the couple down-regulate during these escalations (Muchluf et al., 2021).

Recently, literature has revealed clinicians have noted the unique drain of teletherapy as opposed to in-person sessions (Captari, 2020). Captari (2020), reports that “Zoom fatigue” has been discussed across many professions as people report needing to exert unique emotional effort to stay present. Petriglieri (2020) pointed out that “our minds are tricked into the idea of

being together when our bodies feel we're not. Dissonance is exhausting… our bodies process so much in context, so much information, that meeting on video is a weird kind of blindfolded." Teletherapy has created a considerable amount of screen time for therapists as they work with clients back to back from their computer, phone, or tablet. This amount of screen time can lead to distraction that is caused by the therapists' digital environment and the ability to have multiple screens open (Captari, 2020; Petriglieri, 2020; Pruitt & Glennon, 2019). It is important for therapists to ensure that their attention is fully on the client during teletherapy sessions and avoid technology distractions, such as a new email alert popping up on their desktop or seeing a text message come through on their laptop or phone (Pruitt & Glennon, 2019). Clients may fall into these same distractions and it is essential that therapists discuss boundaries and provide psychoeducation with their clients about creating a distraction free environment (Pruitt & Glennon, 2019).

Literature (Burgoyne & Cohn, 2020; Scharff et al., 2020) appears to be limited about marriage and family therapists providing services to clients in the context of their own homes and the consequences of such an unprecedented transition, especially for trainees. This may be due to the softening of boundaries between clients and therapists, limited private space, decreased sense of control of the therapeutic space, stressors related to technological difficulties and limitations, and difficulty interpreting limited nonverbal cue, and an altered therapeutic relationship (Burgoyne & Cohn, 2020; Scharff et al., 2020). Special considerations must be taken with relational teletherapy, including determining which subsystems in the home should participate in therapy, managing partner or family member escalation, and additional creativity and coordination with caregivers when working with young children (Burgoyne & Cohn, 2020). According to Captari (2020) even seasoned therapists may experience a rattled sense of

professional efficacy in navigating this new territory. In addition, workplace expectations may further contribute to stress and self-doubt among therapists, which could include unclear communication from supervisors, higher workloads, lack of flexibility to conduct clinical services remotely, isolation from peer support networks, or failure of employers to consider well-being and work-life balance. For example, some therapists have been told they will be terminated if they do not come into the office to conduct telehealth sessions, despite pre-existing health conditions and significant risk of exposure while commuting via public transportation (Captari, 2020).

In response to the many challenges that marriage and family therapists have been working through during the global pandemic, various professional associations have established guidelines to help increased successful use of teletherapy, including those of the American Association for Marriage and Family Therapy (AAMFT, 2017) and the American Psychological Association (APA, 2022). The American Association for Marriage and Family Therapy (AAMFT) has published a best practices guide to online therapy that speaks to many of the ethical and clinical considerations inherent to telehealth in general, such as Internet security, practicing across state lines, and responding to technical difficulties (Caldwell et al., 2017). Organizations have also emerged to provide training and certification to assist therapists in the transition to teletherapy, including The Board Certified teleMental Health Provider (BC-TMH) and Zur Institute Certificate Program in teleMental Health & Digital Ethics (Burgoyne & Cohn, 2020). This suggests that the larger macrosystems are making strides to help support each marriage and therapists as they continue to make their way through the unwavering challenges that the COVID-19 pandemic has brought to the world.

The pandemic has highlighted that there is a greater need for digital mental health interventions, but it would be remiss to ignore the barriers to teletherapy implementation. There are many documented boundaries and barriers associated with the practice of teletherapy from the experiences of clients and MFTs. These negative aspects and challenges provide insight for future research to consider when making modifications in regards to best practices for therapists working with individuals, couples and families. As the pandemic continues, best practices for marriage and family therapists will also continue to evolve and change with regards to state laws and policies, code of ethics, insurance reimbursements, and CDC guidelines.

Current Practices for Relational Teletherapy

There are many external variables that marriage and family therapists may consider while preparing and practicing teletherapy visits. In order for relational teletherapy services to be effective, services must include safe, effective, client-centered, timely, efficient, and equitable care (Goldin et al., 2021). Researchers provide many insightful suggestions to consider such as proper training to providers and staff is essential in understanding how to implement and conduct teletherapy visits (Asad et al., 2021; Goldin et al., 2021; Simpson et al., 2021; Sucala et al., 2013). Marriage and family therapists must consider their macrosystem; protocols on roles and responsibilities, process for obtaining client consent, privacy and confidentiality compliance, therapeutic alliance, and protocols for emergency situations while conducting teletherapy (Asad et al., 2021). These current best practices are vital for maintaining the individual microsystem and providing effective treatment to clients and findings suggest a better balance among clinical work and stressors.

Goldin et al. (2021) reports that while providing relational teletherapy, a clear process for documentation, storage, and retrieval of information is required and therapists must also be

familiar with legislation laws regarding client consent, confidentiality, and privacy. Attention to the regulations around licensure, billing, reimbursement, and insurance coverage is also necessary as it varies nationwide; document thoughtful written plans that reflect careful consultation with colleagues; provide clients with a clear statement on limitations of confidentiality at the beginning of services; providers must also balance proper teletherapy etiquette, including their appearance, maintaining eye contact, speaking clearly, proper room lighting and being mindful of the environmental noises and distractions. Many marriage and family therapists are obligated to provide clients with the opportunity to familiarize themselves with teletherapy technology prior to their initial session, including thoroughly informing clients of what they can expect in terms of services offered, unavailable services (emergency services and psychopharmacology), access to the practitioner, emergency coverage, and similar issues; and must be diligent about offering additional support and answering any questions clients may have about teletherapy software (Asad et al., 2021; Goldin et al., 2021; Koocher & Morray, 2000).

According to Asad et al., (2021), one of the most notable changes in the teletherapy process was that clients were only allowed to have one family member with them during the initial consultation; before was more of an individual process and now there is the ability to have more relational dynamics, providing more insight into the clients' and families needs. Previous reviews on best practices for teletherapy confirms much of this anecdotal information and professional documents with a focus on identifying and mitigating the inherent limitations of video technology, such as audio delays; lack of eye contact; frozen images; and limited view of gestures, postures, and body movements, resulting in greater incidences of confusion and therapist-client conflict (Barker & Barker, 2021). At this point of the pandemic, the knowledge

of which video conferencing platforms are approved by insurance companies and how to use them have likely plateaued among a basic competence for therapists'; however there may continue to be some discomfort and knowledge of the ever-growing list of mental health apps that can supplement or replace interventions lost during the pandemic (Pruitt & Glennon, 2019). Overall, a clear process for relational teletherapy is important, including the platform being used and specific protocols should be developed by marriage and family therapists and their larger ecological macro- systems to promote current best practices and resources to promote balance and organization in their clinical work.

Therapeutic Alliance

One of the most pivotal factors of an effective teletherapy experience is the therapeutic alliance, defined as the nature of the working relationship between patient and therapist (Norcross & Lambert, 2011). According to Barker & Barker (2021), to help promote a healthy therapeutic alliance, the therapists needs to normalize the nature of teletherapy and online communication, explaining that when the therapists is looking at the client on the screen, it may seem as if they are looking down, depending on the location of the camera. A review from Sucala et al. (2013) suggested there is considerable evidence indicating that therapeutic alliance correlates positively with therapeutic change across a variety of treatment modalities and presenting problems. A strong therapeutic alliance has been repeatedly associated with positive outcomes in psychotherapy and is a combination of tasks, bonds, and goals (Sucala et al., 2013).

Potential perceived barriers would impede the ability to develop a strong therapeutic alliance with their teletherapy clients may include barriers such as having difficulty reading patient cues and understanding patients, conveying warmth and empathy, monitoring patients' involvement in therapy, and dealing with technical barriers (Sucala et al., 2013). Overcoming

these potential barriers may include the therapists practicing strong communication skills, the ability to accurately understand the client, the ability to convey warmth and empathy via online channels, and increased computer/Internet skills.

While many professions have learned to adjust to virtual environments, marriage and family therapists' had additional challenges as they navigated management of boundaries that are part of teletherapy and worked to assure that the therapeutic relationship remained intact (McCoyd et al., 2022). Mishna et al. (2021) noted therapists' sense that clients felt freer to attempt communications outside the typical therapeutic work hours. McCoyd et al. (2022) reported the same dynamic among their study with reports of therapists' difficulty to maintain boundaries between professional and personal time. When therapy takes place in cyberspace, boundaries need to be flexible enough to embrace the benefits that teletherapy offer whilst providing a stable base for containment, affective attachment, attunement and safety (Sabin & Harland, 2017). In fact, it has been suggested that a 'fluid' construction of boundaries can facilitate the development of a deeper therapeutic relationship and sharing of power if the therapist is able to explore their meaning and purpose as they are constructed and to highlight and explore differences in perspective as they arise (Simpson et al, 2021). Békés and Aafjes-van Doorn (2020), found that clients they interviewed were incredibly positive about the transition to teletherapy, though psychotherapists also expressed positive, there were much less than that of their clients.

Working with Couples & Families

Marriage and family therapists working specifically with couples, face the complex and delicate task of simultaneously forming a strong alliance with two partners who often enter therapy with disparate narratives, coping styles, and fears. According to Hardy et al. (2021),

understanding the perspectives of couple therapists' who are now conducting teletherapy is critical to illuminate advantages, challenges, and recommendations for practice in addition to furthering the argument for insurance reimbursement of couple teletherapy; thus, helping to optimize the current and future delivery of telehealth services for couples. Previous research (Hardy et al., 2021) shows evidence of several ethical dilemmas reported while providing teletherapy to couples; such as dealing with privacy and confidentiality, blurring of boundaries, and emergency issues (e.g., violence); which indicates several different challenges while handling couple conflict in a teletherapy setting (e.g., harder to read and redirect the conflict and escalations). Additional recommendations for marriage and family therapists to consider include providing a roadmap of systems and policy level requirements to help facilitate the implementation of teletherapy and routine care during COVID-19 (Taylor et al., 2020). With regard to the ecological systems perspective, these recommendations for therapists include, training and supervision of teletherapy practices at the macro level being legitimized and integrated into standard mental health training; therapists are required to practice teletherapy in states where they are licensed; as well as the digital tools connect individuals to safety resources that provide in-the-moment support, such as a crisis hotline from a micro level system. Researchers such as Cravens Pickens et al. (2019) have sought to evaluate and incorporate the current teletherapy training and educational opportunities of COAMFTE accredited couple, marriage, and family therapy programs. Courses and training of teletherapy at the educational level would create endless benefits for students training to be future clinicians. It appears impossible to fully ensure privacy during a teletherapy session, thus it is important that marriage and family therapists are trained to help ensure confidentiality, while insurance providers need to consider a broader reimbursement for teletherapy during this pandemic era (Taylor et al., 2020).

Education & Training

As a field, marriage and family therapy has fallen behind other mental health disciplines (Caldwell et al., 2017) in providing adequate teletherapy training (Cravens Pickens et al., 2019). This may be a result of MFTs discomfort in providing teletherapy because of training gaps, concerns related to ensuring confidentiality, managing risk and crises from a distance, maintaining the therapeutic relationship, and adhering to licensure regulations (Morgan et al., 2021). According to Richartz et al., (2021) most MFT training programs have not historically placed a significant emphasis on teletherapy; this lack of telehealth training in MFT programs was brought to the spotlight in March of 2020 as the United States and world entered a public health state of emergency. MFT professionals and training programs were left scrambling to find out way to provide continuity of care for the clients as lockdowns increased (Richartz et al., 2021). Further as the ongoing COVID-19 pandemic became detrimental to the population, MFT training programs were tasked with the ethical dilemma of ensuring continuity of client care while addressing mounting concerns related to the spread of the virus (Morgan et al., 2021). For example, a recent study provided evidence that only half of faculty members in COAMFTE accredited MFT programs reported including any type of teletherapy curriculum in their courses, though most reported the belief that teletherapy training should have a place in the curriculum (Cravens Pickens et al., 2019). Even in training clinics that provide teletherapy training, the percentage of clients engaged in teletherapy services was extremely low prior to the COVID-19 pandemic (Burgoyne & Cohn, 2020).

At the master's level, one of the biggest student concerns, especially for those who intended to graduate in May 2020, was acquiring enough hours to graduate and if hours obtained via teletherapy would satisfy COAMFTE requirements (Morgan et al., 2021). Teaming hours

(i.e., clinical hours obtained by observing other trainees' cases) were also halted, further reducing opportunities for trainees to obtain clinical hours. Supervision also changed drastically. While the supervisor could join a live Zoom call, supervisors were no longer available onsite for in vivo consultation. If there were risk concerns or crises, supervisors were not immediately available and had to be contacted via phone. This left students with feelings of uncertainty, as they did not have the same safety net they had in the clinic (Morgan et al., 2021; Sahebi, 2020).

MFT trainees are encouraged to embrace ongoing adaptations and look for possibilities, instead of restrictions, in their use of teletherapy (Morgan et al., 2021). Reframing clinical challenges or setbacks is crucial in the context of the current pandemic and encouraging everyone to 'give themselves grace' and be transparent about their own struggles (e.g., zoom burnout, misattunements, joining difficulties). Supervisors and education can model how to adapt and meet these challenges to trainees. Supervisors are responsible for ensuring that clients receive competent and culturally informed services that address various intersectionalities, with the addition of attending to the impact of COVID-19 (Morgan et al., 2021; Sahebi, 2020). At the same time, supervisors must also attend to trainees' intersectionalities and encourage their exploration of how the pandemic may be affecting not only their therapeutic work, but their own anxieties (Sahebi, 2020).

Overall, as the ongoing COVID-19 pandemic continues, the individual (i.e. marriage and family therapists), will continue to grow and evolve their clinical work (i.e., microsystem) as the larger ecological systems such as AAMFT guidelines (macrosystems) continue to change and are based on contextual factors in regards to the COVID-19 pandemic (Robbins et al., 2012). Research shows evidence that the shift to teletherapy during the continued COVID-19 pandemic has a negative impact on the therapists and their clients. Marriage and family therapists may

embrace the benefits and learn from the challenges of relational teletherapy research to help balance their clinical and personal stressors. Although there are many other variables and stressors that marriage and family therapists have within their larger ecological system. Many marriage and family therapists have stressors not only within the relational teletherapy work, but also within their personal families, peers, school, work, quarantines and mask guidelines, finances, etc. Therapists are encouraged to practice daily self-care strategies to prevent burnout to help elevate the stressors they experience. Although new research is continuing to emerge, there appears to be limited research from marriage and family therapists perspectives about delivery of relational teletherapy and management of their self-care practices during the ongoing pandemic.

Self-Care for Therapists

AAMFT Code of Ethics (2019) defines self-care as the following statement: "Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment" (p.1). The American Counseling Association Code of Ethics (2014) identifies self-care as a professional responsibility and states, "counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (p.9). Recent studies have gained growing recognition on the importance of self-care among marriage and family therapists, especially during era of COVID-19 (Glennon et al., 2019; Kerr, 2016; Kraus, 2005; Lee et al., 2020; Miller et al., 2021; Williams et al., 2010; Pruitt & Glennon, 2019).

Posluns and Gall (2020) state that the therapist is powerful yet vulnerable tool in the caring process which requires attention and care in order to prevent negative consequences for both the therapist and for the clients' they serve. Regular self-care practice is one important way

to reduce occupational and personal stressors and avoid professional burnout. Burnout is defined as feelings of hopelessness and difficulties in dealing with work or or in carrying out one's job effectively (Bhutani et al., 2012). Sansbury et al. (2015) also defined burnout as a gradual and progressive process that occurs when work-related stress results in emotional exhaustion, and the inability to depersonalize client experiences, and a decreased sense of accomplishment. Marriage and family therapists who neglect self-care, subject themselves to a negative feedback cycle as follows; the therapist becomes more irritable, external influences are more irritating, and the cycle continues until one faces burnout, or worse (Rokach & Boulazreg, 2020).

Rokach & Boulazreg (2020) report that occupational stress has been detrimental to the wellbeing of therapists physically, psychologically and emotionally, and has been positively correlated with anxiety, depression and anger, which in turn contributed to absenteeism and job related interpersonal conflicts. Marriage and family therapists, like the rest of humanity, experience disappointments, losses, and illnesses, all of which result in the clinician's need of handling the stress in his or her private life in addition to that of their clients (Rokach & Boulazreg, 2020). Though there is a stigma that therapists are to separate their personal life from their professional one, it is impossible at times. Now, more than ever, it is crucial for marriage and family therapists to be aware of their stressors and manage them through proper self-care practices throughout the COVID-19 pandemic to avoid burnout. For example, Miller et al. (2021) provides insight that therapists are experiencing distress associated with COVID-19 and the importance of self-care practices to reduce COVID-19 related distress. Thus, during these stressful and uncertain times produced by the global COVID-19 pandemic, the notions of self-care and effective coping strategies for marriage and family therapists are particularly salient (Reilly et al., 2021).

Benefits of Self-Care Practices

The ecological system theory suggests that positive individual variables will create links among other subsystems and factors, creating positive ecodevelopment among their entire system (Robbins et al., 2012). The benefits and value of self-care practices to marriage and family therapists are positive individual factors. Literature has shown that self-care has shown a range of positive outcomes such as perceived self-improvement, increased skill usage, increased confidence, reduced burnout, and enhanced safety in working with clients (Kerr, 2016; Knight, 2013; McGinn, 2015). Marriage and family therapists are more likely to engage in self-care if they feel safe with the process, have personal resources, and are a part of a supportive group. One of the greatest barriers when engaging in self-care appears to be the time needed to fully engage in such practices (McGinn, 2015). Different strategies may have varying benefits and therapists need to allow themselves to take care of their bodies and their mind to allow themselves to bring the best version of themselves into session with their clients. For example, evidence from Kerr (2016), suggests that mindfulness can increase clinicians' communication skills, improve empathy and spirituality; reduce psychological distress; and can show significant improvements in emotional exhaustion, self-compassion, and a sense of personal accomplishment. Mindfulness practices can be incredibly effective in reducing stress and centering the mind between client sessions, at the start of the day, or when relaxing at the end of the day (Kerr, 2016). Oftentimes, therapists may not allow themselves the time to stop and take appropriate care of their own needs due to the nature of their professional work.

There will be times, especially during the COVID-19 era, when things may not be going well professionally for marriage and family therapists; though there are colleague assistance programs and other support networks, such as supervision, available that provide resources to

help to address the sources of stress and promote their wellbeing (Rokach & Boulazreg, 2020). Marriage and family therapists have essential resources available to them through engagement of regular supervision meetings; allowing them not only to focus on the technical aspects of their work as well as their affective reactions to their work as supervisees (Knight, 2013). Supervision allows therapists and students to explore their emotional responses and reflect on any changes in their response or work through effective check-ins with their supervisor to help normalize and validate their feelings. Supervisors should be prepared to assist their supervisees' in identifying coping strategies that may help manage negative manifestations associated with their work, through discussions and encouragement of regular self-care practices. Mental health agency settings may provide support to their employed therapist by providing support during regularly scheduled group supervision; mentoring through challenges; encouraging affective check-in style supervision meetings; structure team meetings with emotional check-ins; provide education to staff; and assigning case loads evenly among staff (Knight, 2013). Findings from Reilly et al. (2021), indicated that in addition to strategies that therapists can enact in their personal lives (e.g., physical exercise, spending time with loved ones), the majority are using their professional networks to cope with mental health effects of the pandemic. Overall, the practice of self-care and the development of awareness enhance the inner world of professionals, directly influencing professionals' quality of life, and likely the quality of their caregiving (Sanso et al., 2015).

During the ongoing COVID-19 pandemic, marriage and family therapists have had to face the reality of death more than ever among their clients, family, and friends and the loss that many therapists have endured during this time is irrefutable. Sanso et al., (2015) suggested that self-care plays an important role in helping therapists cope with frequent exposure to death and dying. Not only have therapists lost loved ones during this pandemic, but many have lost clients

among their family and couple work. Minimal formal training exists on how to prepare therapists to say goodbye to a client or deal with the emotional toll of a client's death. Morris et al. (2019) suggested like any other clinical skill, learning to discuss and deal with the death of clients takes time and practice which requires education and guidance from experienced therapists and supervisors.

As evidenced in this review, there appears to be limited resources in the current literature available on marriage and family therapists' self-care practices during the COVID-19 pandemic and how their self-care practices and professional work have been impacted with the ongoing ecological stressors as a result from the pandemic. The Center for Disease Control Prevention (CDC; 2022) states that as of July 14th 2022, the United States has lost 1,017,391 individuals to COVID-19. How many of those individuals were marriage and family therapists, family and friends of therapists, or clients? This opens up a conversation for future research on how marriage and family therapists are impacted by the deaths of clients and personal relationships from COVID-19 and how the larger ecological systems may impact their tele-therapeutic practices.

Rationale for the Study

Although there has been a steady increase in the practice of teletherapy over the last 20 years, until the recent COVID-19 pandemic, teletherapy was not used widely among marriage and family therapists. The pandemic continues to change the delivery of therapeutic services and interventions as we work to stop this deadly virus from spreading. For nearly two years, marriage and family therapists had no other means of providing services to their clients except for tele-therapeutic communications which provided benefits and challenges among their work and relationships with clients. As more people became vaccinated and boosters became available,

clinicians and mental health professionals started switching back to in-person therapy sessions although the certainty of this practice is delicate as new strands of the virus emerge. This study intends to provide insight on how marriage and family therapists have worked during the COVID-19 pandemic utilizing teletherapy and managed their professional and personal stressors through self-care practices and other supports. As new strains of COVID-19 (Delta and Omicron) make waves throughout the United States, teletherapy may continue to be the primary way for marriage and family therapists to provide services to individuals, couples and families.

Research Question

Literature, although new and evolving with this global pandemic, shows that marriage and family therapists have been resilient through the challenges and barriers as they find ways of adapting and providing the best care possible to the populations they serve (Asad et al., 2021; Disney et al., 2021; Goldin et al., 2021; Simpson et al., 2021; Sucala et al., 2013). The present study is designed to investigate the following question:

How has the shift and practice of teletherapy impacted marriage and family therapists professional therapeutic work and personal self-care practices through the ongoing COVID-19 pandemic.

Purpose of the Study

The purpose of this study is to gain an understanding of the experiences of marriage and family therapists working with families and couples during the COVID-19 pandemic and how they transitioned to relational teletherapy practices and continued to manage those teletherapy practices while engaging their own personal self-care. Comparing marriage and family therapists' perspectives and lived experiences within similar agency-based settings, home-based work, or working from a similar therapeutic modality may provide insightful evidence. This

study will assess marriage and family therapists experiences of switching to teletherapy throughout the pandemic; their therapeutic modality and populations they currently work with; challenges they have experienced; how they seek support; management of their time; as well as how they utilize self-care. Understanding couples therapists' attitudes toward delivering therapy online is imperative today to identifying obstacles to the pressing need to move from face-to-face to online treatment (Machluf et al., 2021).

Significance of the Study

The present study aims to contribute to current and past research exploring relational teletherapy, self-care practices and teletherapy during the COVID-19 pandemic. The current literature shows abundant evidence that although teletherapy has advantages, there are many barriers and challenges that marriage and family therapists are still struggling to overcome. This research explores how the ongoing COVID-19 pandemic has impacted the change of practice of teletherapy for marriage and family therapists and their self-care. The knowledge gained from this study will help bring insight to a topic that is new and relevant for the unseeable future in couple and family therapy research.

CHAPTER III: METHODOLOGY

Introduction

The purpose of this chapter is to explain the research methodological framework, sampling procedures and data analysis of the current study. The present study is based on a phenomenological method with interview questions examining how the global pandemic has impacted marriage and family therapists models of practice and self-care routine as they transitioned to relational teletherapy practices. Creswell (2007) states, "Phenomenology is a type of qualitative inquiry that describes an individual's or group's lived experiences of a phenomenon"(p. 57). The overall purpose of the qualitative research is to uncover in-depth knowledge from the participant's perceptions of the world through their experiences and words (Creswell, 2012).

Interpretive Phenomenological Analysis

A phenomenological study specifically describes the common meaning for several individuals of their lived experiences of a concept or phenomenon (Alase, 2017; Pietkiewicz & Smith, 2014; Creswell, 2012). The present study is an Interpretative Phenomenological Analysis (IPA); a qualitative research approach that examines how people make sense of their major life experiences (Smith & Shinebourne, 2012). IPA research gives voice to the individual's narratives of their experiences and analyzes the psychological process of the stories of the participants (Smith, 2004). Smith and Shinebourne (2012) suggest that IPA researchers are especially interested in what happens when the everyday norm of lived experiences takes on a specific significance; often this happens when something important occurs in an individual's life, such as the impact of a global pandemic. The main objective of interpretive phenomenology is to uncover or disclose a phenomenon by pulling away layers of forgetfulness or hiddenness that are

present in our everyday existence (Frechette et al., 2020). An interpretative phenomenological analysis is the best fit for this study because this researcher is curious about how the everyday experiences of marriage and family therapists' might have changed because of the length and breadth of the pandemic experiences. The purpose of this study was to gain an understanding of clinicians' experiences of providing teletherapy and their self-care practices throughout the ongoing COVID-19 pandemic, including the initial implementation of switching their services to teletherapy. This research study has been approved by the Antioch University New England's Institutional Review Board.

Research Method

Participants

IPA studies are conducted on smaller sample sizes as the aim is to find a reasonably homogeneous sample, so that, within the participant sample, researchers can examine convergence and divergence in some detail (Alase 2017; Smith & Osborn, 2007). A small sample size is not seen as a limitation in IPA studies, since the primary objective is not generalizability, but to illuminate the lived experience and context in as much depth as possible (Frechette et al., 2020). The goal of this study was to obtain a sample of two to twenty-five participants to be recruited through purposive sampling. In phenomenological research, the size of the participant pools can be between two and twenty-five (Alase, 2017). Smith et al. (2009) stated that, "samples are selected purposively, rather than through probability methods, because they can offer a research project insight into a particular experience" (p. 48). Additionally, due to the homogeneity of the research participants and the size of the sample pool, it was anticipated that this IPA research study will be rich and descriptively deep in its analytical process (Alase, 2017). In order to recruit a homogeneous sample pool, participants met the following criteria:

licensed marriage and family therapist; switched from in-person to remote tele-therapeutic services at the beginning of the the COVID-19 pandemic (March 2020); currently practicing relational teletherapy with clients; over the age of 18 years old; and have access to internet, including email, video conferencing (i.e., ZOOM), and telephone.

Recruitment

Upon approval from the Institutional Review Board (IRB) from Antioch University New England, (Appendix D), the participant recruitment began. Alase (2017) suggests that, in IPA participant selection and invitation processes, there are multiple ways to select and invite participants to a research project; an example is to send invitations to prospective participants. The potential participant's emails were collected from the AAMFT website via the Approved Supervisors List listed alphabetically by State. First, participants from states within surrounding New England states were selected and then states were chosen at random by the researcher randomly selecting states at the beginning, middle and end of the Approved Supervisor List. The invitation to participate (Appendix E), described the nature of this research study, included a virtual recruitment flyer, and requested that the recipient share the invitation with any potentially eligible colleagues. The attached virtual recruitment flyer, (Appendix A) invites any licensed marriage and family therapist interested in sharing their experiences of working with clients during the COVID-19 pandemic to contact this researcher via AUNE university email. Invitations for participation were also sent to the program directors of CFT programs within Antioch University New England to share with prospective participants among colleagues. The participants that met the required criteria and completed the Informed Consent form (Appendix C), were then contacted via emailed and invited to schedule an interview.

Prior to conducting semi-structured interviews, participants were provided with information about the purpose of the study through the virtual Informed Consent form (see Appendix C). All participants were informed about their anonymity and asked to voluntarily sign the electronic consent to participate. A total number of 15 potential participants completed the Google Docs Informed Consent. Of that 15, only 12 completed the semi-structured interview. Of the 12 participants, only 11 met the full criteria of the study; i.e. licensed prior to the pandemic, marriage and family therapists, and made the initial switch from in-person to relational teletherapy services at the beginning of the pandemic. Participants were not directly asked about their demographic information, though participants provided this information throughout the semi-structured interviews. Participants included 10 females and 1 male, resided within the United States, and years in practice ranged from recently licensed prior to the start of the pandemic to over 40 years in practice. Throughout the recruitment and interview process, participants had opportunities to ask questions and seek clarification on the research study. Each participant was entered into a drawing to win one of four $25 VISA gift cards as compensation for their participation and time after their interview was complete. The drawing was held once the overall participant pool of 12 was reached and the interviews were transcribed. The four winners were contacted via their email provided on the informed consent. The participants had the right to participate or withdraw from the research study at any time. If participants decided not to participate, they would not be penalized in any way. Participants had the ability to stop participating in the study at any time without penalties. If participants' choose not to answer any of the questions from the semi-structured interview, they were given the ability to opt to not answer those questions or end their participation within the research study. This researcher ended recruitment once the participant sample provided a good depth of information, as evidenced by

similar experiences and themes arising in the participants' interviews.

Data Collection

All participants were provided a Google forms link with an electronic version of the written informed consent (Appendix B) by reading and completing the form. Once each participant completed the Google form by electronically signing their name and email, they received email invitations with dates and times to participate in a scheduled 60-90 minute, semi-structured individual video interview conducted through a remote conferencing program, ZOOM, due to the health and safety concerns with the COVID-19 virus (Frechette, et.al., 2020). Over 200 emails were sent to potential participants. Of those potential participants, 15 completed the informed consent via the Google Form link. Of the 15 participants, 12 participants responded to the email to schedule a semi-structured interview. This researcher conducted 12 semi-structured interviews that lasted between 45 minutes to 75 minutes. Interviews were conducted and recorded via ZOOM.

The interviews involved the use of a semi-structured interview schedule to provide some structure focusing questions on relevant topics (Smith et al., 2009). Although there was an interview schedule set, the interview followed the guidance of each participant and where they led the conversation. The flexibility of the researcher during the interview is in line with the IPA process (Smith et al., 2009). Before the interviews began, this researcher readdressed the informed consent process and written permission from all participants. It is crucial that a phenomenological research study seek and obtain the approved 'informed consent' from participants before any study could commence (Alase, 2017). Smith and Osborn (2007) stated, semi-structured interviews "allows the researcher and participant to engage in a dialogue

whereby initial questions are modified in the light of the participants responses and the researcher is able to probe interesting and important areas which arise" (p. 57). Alase (2017) stated, qualitative researchers should only ask one or two central questions and follow up with no more than five to seven sub-questions. Several sub-questions followed each general central question and assisted in narrowing the focus of the study while allowing for open-ended questioning. The advantages of a semi-structured interview facilitated rapport and empathy; allowed for a greater flexibility of coverage, permitted the interview to go into novel areas which produced richer data (Smith & Osborn, 2007). In order to uncover the participants' lived experiences, the interviewer is referred to as a 'committed listener' as they have a desire to unearth what people care about and to listen for more than words, for their underlying beliefs, assumptions, and interpretations (Frechette, et.al., 2020).

The semi-structured interviews used open-ended questions with the instructors using the following interview questions (See Appendix C):

- What have your experiences of providing relational teletherapy to couples and families since the COVID-19 pandemic started?
    - What was your previous experience providing teletherapy to clients?
    - What resources and/or training did you receive/ have available to you?
    - What are the challenges you've experienced or encountered while providing relational teletherapy?
    - What are the benefits you've experienced or encountered while providing relational teletherapy?
    - Would you have done anything differently? If so, please explain.
    - How has the ongoing COVID-19 pandemic impacted your clinical practices and

experiences?

- What have been your self-care practices during the ongoing pandemic?
  - How have those changed or been impacted since the beginning of the COVID-19 pandemic?
  - What is your daily experience of balancing your teletherapy work and your self-care practices?
  - What have been the benefits you've experienced as you balance teletherapy and self-care practices?
  - What have been the challenges you've experienced as you balance teletherapy and self-care practices?
  - Would you have changed your self-care practices or done anything differently since the pandemic began?
  - What stressors do you continue to experience as the COVID-19 pandemic continues? (Meeting in-person again, differences in mask mandates, etc).

Upon completion of the interviews, one of the participants did not meet the interview guidelines, so their interview data was not included in the final research data. There are 11 participants included in this data analysis. The interview was divided into two sections. The first portion focused on the experiences of providing relational teletherapy during the initial pandemic and ongoing; the second portion focused on the participant's self-care practices and how those have been impacted throughout the pandemic. Interview guidelines including specific questions are located in Appendix C. This researcher used the transcription tool within the ZOOM application to help with the transcription process. Those transcripts were saved to this researcher's password protected computer in a private folder under a coded number to protect

each participant's confidentiality and identity. All of the information collected remained confidential. Participant's real names were not recorded on the videos and any personal or other identifying information was omitted from the transcriptions. Participants' names were changed for the purpose of keeping the data organized within the saved video files and for future data analysis.

Demographics

A total of 12 people were interviewed, though only 11 met the inclusion criteria for this qualitative study. All participants reside and were located within the United States at the time of the interview. All included participants held the credentials as a licensed marriage and family therapist (LMFT) prior to the beginning of the COVID-19 pandemic. All participants switched from in-person to remote tele-therapeutic services at the beginning of March 2020. All participants had practiced relational teletherapy with clients for at least three month from the time of the COVID-19 pandemic. All participants met via ZOOM for their semi-structured interviews. Participants practiced from both community agency based and private practice settings. The participants professional experience ranged from recently licensed (prior to March 2020) and 40 + years in practice.

Data Analysis

Once the recordings were transcribed into a Word document, they were saved as a participant number code and then sent to the participant via their personal email for member checking to be completed. Participants were asked to review the entire transcript and contact the researcher within two weeks of the date sent with any changes and to confirm that it was reviewed. If the researcher did not hear back from the participant within two weeks, the email

with the attached transcript stated that no response would mean they approve of the transcript. All 11 participants responded to confirm changes and that stated that their interview transcript appeared accurate.

During an Interpretative Phenomenological Analysis (IPA), the data is analyzed in two parts, the insider's perspective and the interpretative account. The first being the interpretative commentator, which includes the participant's words verbatim; and the second, being the interpretative account, which includes the researchers interpretation and process of the account of the participants (Alase, 2017). The data analysis process was complex and in-depth, occurring on many levels. This process involved much reflective engagement with the research data by looking deeply at the language in the text, reading the data multiple times, and writing from both the participant's interpretation as well as the researcher, with assumptions of the researcher used as an essential part of the process (Laverty, 2003). To assist in the participant being the sole focus, the researcher kept a reflective journal through the process of recording their experience and bracketing it off (Smith et al., 2009).

In an IPA study, different levels of interpretation can be utilized due to the flexible guidelines for analyzing the transcript (Smith et al., 2009). The IPA data analysis process entails data reduction, where the collected data are refined into manageable chunks, as well as data interpretation where meaning and insight is brought to the words of the participants within the study (Marshall & Rossman, 2016).

The data analysis procedure for IPA outlines a general 5-step process that was followed:

1. Reading and re-reading: involved listening to the audio while reading the transcription,

and then re-reading the transcription with the voice of the participant in mind. This writer used

ZOOM audio and transcription, and Microsoft Word to make any necessary corrections to transcripts.

2. Initial noting: this involved noting anything of initial interest in the transcript, identifying the way a participant thinks about an issue. These initial notes and comments on the data focused on key objects and the meaning to the participant (using descriptive, linguistic, and conceptual comments). The researcher made notations on paper versions of each transcript as the first level of coding.

3. Developing emergent themes: this involved looking at the initial notes/codes and mapping patterns. This included phrases with both the participant's words and thoughts and the researcher's interpretation. The researcher did this for each individual transcript by creating a table for each participant list keywords, conceptual comments, emerging themes, and subordinate themes.

4. Searching for connections across emergent themes: this involved written out color coded note cards for each question with emerging themes and sub-themes from each participants' interview and gathered themes that fit together and were collective across more than half the participants. At this point, some themes were discarded due to less than half the participants identified topics.

5. Looking for patterns across cases: once all the initial five steps had been done for each interview, this step grouped larger themes (Smith et al., 2009). and looked for grouping across all eleven interviews transcribed. These were then put into tables (See Appendix F). Then among those emerging themes, the major final superordinate and subordinate themes were color coded and put into a final themes table.

Reliability & Credibility

To ensure credibility and trustworthiness throughout the study, I implemented several techniques throughout the research process. My first technique was to write in a reflexive journal as needed. "A reflective journal is an essential tool for documenting the researcher's reflections. This documentation starts with a reflective piece about what brings the researcher to the particular study at hand and then continues with the researcher's reflections on how their own horizon of significance is brought to light via attunement to the research process" (Frechette, et.al., 2020, p. 5). The reflective journal was used to write down the researcher's thoughts and feelings after each interview (Oxley, 2016). This researcher wrote summary notes in the reflective journal after each interview and throughout the entire research study. This included any pre-existing assumptions before data collection and analysis. Validity was also completed in this process by writing down the extracts from transcripts in the written research study (Creswell, 2013). I also utilized peer debriefing and a third party detriangulator within my dissertation committee. This helped me to become aware of potential biases, conflicts, or any other questions or concerns that arose throughout this process. I also ensured that all transcriptions of data collected from the semi-structured interviews went through the member checking process to ensure participant's voices were being represented accurately. This process included emailing each participant their interview transcription and requesting they review and make any necessary changes and edits. Lastly, all recorded files and transcriptions from each participant and interview will be destroyed six months after the dissertation is completed.

The Researcher

Qualitative and IPA research view the researcher as a part of the interview process; often

viewed as another participant. However, the participant is still considered to be the expert in the study. I, the principal researcher, am a doctoral candidate in an accredited Couple and Family Therapy program. I have minimal experience with teletherapy as my role as a high school crisis counselor had to switch to teletherapy during the initial COVID-19 shutdown. The majority of my experience via the teletherapy platforms was from previous supervision. I was impacted professionally and personally by the COVID-19 shutdown and faced many challenges and stressors, such as having to support my four children's virtual schooling. I am also influenced by relational, humanistic, and ecological theories that shape the way I view the world. At the time, I was personally struggling to manage my self-care practices while attending to the needs of my children, work, and the additional roles and responsibilities within my life. I became interested in this topic after my own experiences of trying to navigate teletherapy and self-care; creating a curiosity if other therapists were having similar experiences. The high school I was employed with cut my position as the crisis counselor due to the circumstances with the pandemic, the school not returning to in-person learning that fall, and the unknown with the effectiveness of teletherapy for crisis counseling services. This challenge created a passion and motivation from within to create an awareness of teletherapy and the benefits and challenges within this service. I believe that teletherapy has changed the way marriage and family therapists provide services to their clients. It has paved the way for increased access to services and family engagement. Marriage and family therapists need more of a focus on teletherapy and self-care practices in the teaching and training of master's clinical programs. This would model and encourage a healthy balance between these two practices while also promoting client best practice. This study and process revealed some of the personal and professional experiences of marriage and family therapists that may produce some guidance to support clinician teaching and training in the

future.

Ethical Considerations

This study went through the approval process of the Antioch University New England's IRB prior to any interviews being completed. I am aware of my own personal biases and how they may have impacted the nature of the study and the data collection. I attempted to eliminate the impact of my biases by utilizing the mentoring of my dissertation chair. From a self-of-the researcher perspective, I am also aware that as a researcher, I went through similar experiences as the participants of this study. I also had the challenges of navigating platforms to host video interviews, internet connection issues, my infant interrupting interviews at times, all while balancing my own self-care practices and personal roles during this rigorous dissertation process.

Before individuals' participated in the study, they received a detailed informed consent form with the understanding that confidentiality will be ensured throughout the study through the process of removing all names and other identifying information from transcripts and results and utilizing a number coding system to identify each participant. Participants also had the opportunity to be removed from the study if, for any reason, they became uncomfortable in the process. This researcher used purposive sampling to attempt to include a semi-diverse population within the participants to avoid further biases as well and provide a more enriched, diverse and informed data collection.

Risks & Benefits

Qualitative research tends to be much more personal, therefore it carries some risks. Although the risks of participating in this study were very low, some participants may have found that participating in this research study resulted in stress related to sharing experiences and

emotions while recalling their experiences as a marriage and family therapist during the current COVID-19 pandemic. Participants were provided with information for National Alliance on Mental Illness (NAMI) at 1800-950-6264, or text "NAMI" to 741741 for 24/7 crisis counseling. Participation in this study provided participants with the benefit of sharing their experiences in research. The information they provided helps bring a greater understanding to the experiences of other marriage and family therapists in the mental health field who have been providing teletherapy services to those in need during the COVID-19 global pandemic and how they have been impacted and managing their stressors. As previously stated, participants were also entered into a drawing with the chance to receive one of four $25 VISA gift cards upon the completion of data collection.

Participant Protection

To adhere to the IRB human protection requirements, all of the devices, techniques and strategies were only used with the full consent and approval of the participants (Alase, 2017). All data and information were kept secure. The electronically signed consent form and data were kept on a password-protected computer. The original transcription audio files were given pseudonym numbers to keep anonymity (ex. PART 01). The participants were given the option in the consent form, for the participant to review transcripts (Smith et al., 2009). I consistently sought regular supervision from my dissertation committee chair and committee throughout the process to ensure the ethical quality of the data and research process.

Conclusion

In this chapter I provided a comprehensive overview of the IPA research method which was selected for this research study. This included an overview of the qualitative research

framework, a detailed description of the IPA research approach, and the reasons why I believe it was the best fit for this research study. In addition, I provided an explanation of the recruitment and participant selection process and the IPA data collection and data analysis processes. I also discussed the steps that I took to ensure reliability and credibility of this study and my personal roles as the researcher of this qualitative study. Lastly, I discussed an overview of my ethical considerations and efforts to protect the research participants throughout the study.

CHAPTER IV: PRESENTATION OF FINDINGS

Introduction

The analysis of the data revealed four major superordinate themes, and twelve subordinate themes to describe the experiences shared by the eleven marriage and family therapists interviewed (See Appendix F). The four superordinate themes of these therapists around the experience of balancing teletherapy and their own self-care were: technical barriers in teletherapy, increased accessibility to teletherapy services, the management of self-care, and awareness of the impact of pandemic stressors. These superordinate themes were identified when half or more of the participants personally shared about these specific topics. The essence of this topic and methodology entailed a critical and continuous process; therefore made it difficult to classify them into separate themes. Throughout each participant's interview, I found myself resonating with pieces of their shared journeys and experiences.

Themes

The four major themes gave an illustration of the participants' experiences of balancing teletherapy services while managing their own self-care. They captured the challenges and benefits within those experiences as well as a perspective of the stressors that they continue to face through the pandemic. Thirteen subordinate themes are connected to one another because when participants discussed their experiences, they included similar exchanges about the interconnectedness of teletherapy and self-care. There was not a clean-cut separation between providing teletherapy and managing personal self-care practices.

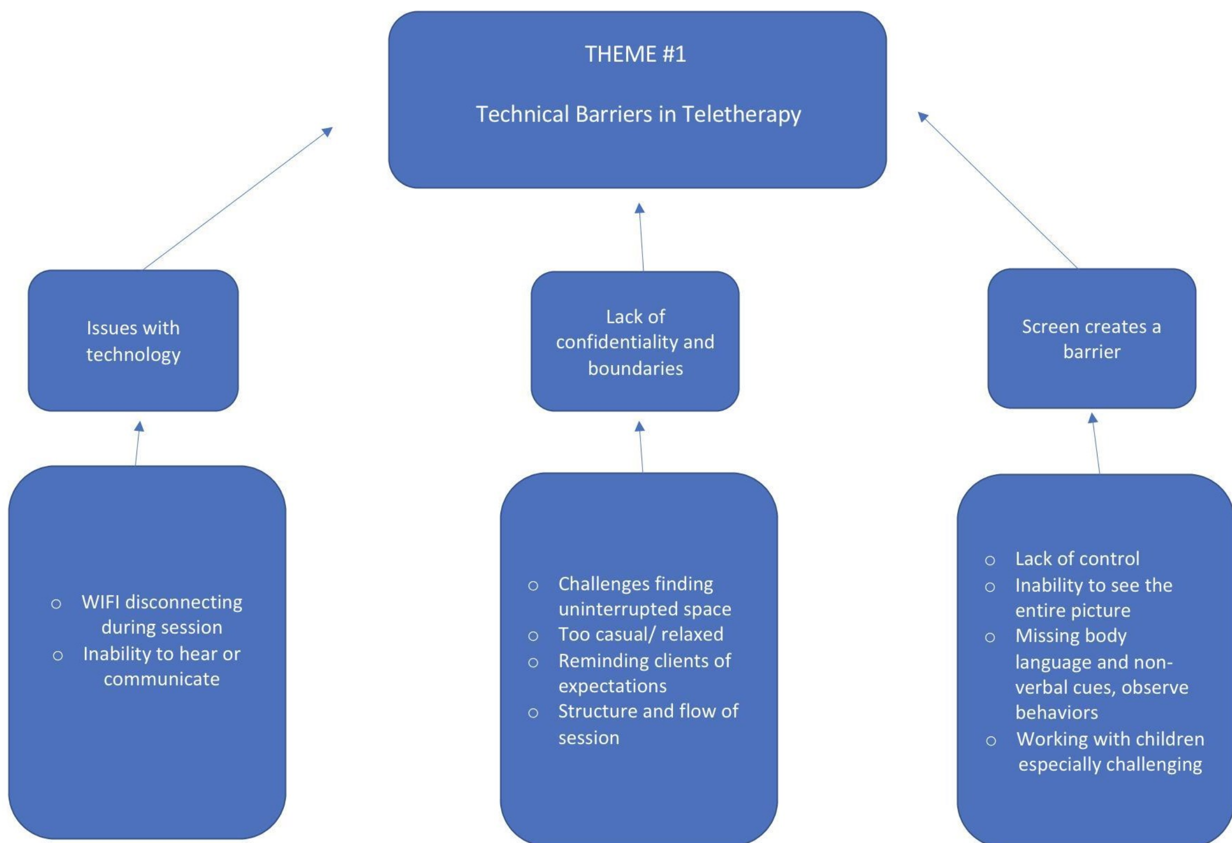
The themes are represented in Figures 1-4 provide a map of how the coding process and themes emerged. Each figure shows how the theme was formulated, starting from the bottom

row which was documented as an emerging theme by multiple participants. For example, two to three participants may have shared a similar experience, which was documented as an emerging theme. These emergent themes were interconnected to create the subordinate themes. In addition, emergent themes became a subordinate theme if more than half of the participants described or shared that experience. It is important to note that the researcher is not highlighting that some experiences are more noteworthy or not as serious as others, the coding process was following according to the IPA process and the data provided. Finally, the subthemes helped create the overall representation of each superordinate theme from the data.

Technical Barriers in Teletherapy

The participants were first asked about their experiences of providing relational teletherapy services during the initial COVID shutdown in March of 2020. Participants shared experiences that involved challenges and benefits, though the analysis showed that the majority focused on the challenges of teletherapy first. In addition, participants defined the data based on their own personal and professional experiences. The interview questions were also shaped by the theoretical lens of this study, viewing the experiences of the marriage and family therapists as part of the larger ecological system. The following are the three subordinate themes that made up the larger superordinate theme of technical barriers in teletherapy.

Figure 1: *Superordinate Theme, Subordinate, and Emergent Themes 1*



Issues with Technology

Most of the participants described their experiences of teletherapy as having many technological issues while trying to provide the service to their clients. These challenges ranged from finding a proper working platform to provide the service to internet disconnection. This was one of three subordinate themes under technical barriers in teletherapy. An example of the issues among the available technology is captured by this statement shared by a participant after being asked to define the challenges they experienced:

> "It was hard. It was horrifying early on to see people freeze and not be able to get back to them" (P5).

Another participant shared their experience of working with clients that didn't have the same technological resources available:

> "Technology problems; just when you have stuff go out or that maybe they don't have. I have people in rural areas that I see as well. I have some clients that were like two and a half hours away, that far away from a major city. So sometimes we would have internet trouble" (P6).

To provide additional evidence of the technological issues, one other participant shared their experiences:

> "To me it's more challenging because some of the people aren't in the same location and so then you have three interference opportunities for WiFi, or cell service access, or other other interruptions" (P2).

Lack of Confidentiality & Boundaries

The majority of participants shared their adversity while trying to maintain confidentiality and boundaries with their clients over teletherapy. This is the second subordinate theme. The lack of confidentiality and inability to control the client's environment is described by the following participant:

> "Clients being in charge of the logistical pieces of that. Some people are pretty adept at that and other people don't really have a good understanding of confidentiality or that importance of an uninterrupted space" (P4).

This participant shared their experiences of their difficulty setting boundaries with clients:

> "Reminding people that you have to pretend we're in the therapy office right now. I feel like people kind of take advantage of it sometimes. You have to remind them of the boundary" (P6).

Participants also described their own inability to manage their personal and professional boundaries while working at home. This participant describes that challenge:

> "I started noticing the boundaries that I had set up for myself when I was working in the office weren't really happening anymore. I would get up in the middle of the night and go check something on my computer because it was right there. I'd be like, oh who am I seeing tomorrow? So I think from that perspective, it started to blur the lines a lot for me where I have to always be in that environment and not be able to shut the door between home and work" (P4).

Many of the participants shared in detail their challenges of providing teletherapy at home, with children, and other roles during the COVID-19 pandemic shutdown. This participant highlights that struggle to balance their multiple roles:

> "Trying to navigate that dynamic of how do I be in my home and have that boundary. It was very difficult for me personally because being in my home, I was Mom. I was home and I struggled with keeping that therapist hat on the way I do in the office" (P3).

Screen Creates a Barrier

As the third subordinate theme, the screen creating a barrier was reported as one of the most significant negative experiences among participants. More than half the participants spoke about inability to read body language and non-verbal cues while providing relational teletherapy. This participant described their challenges with observing body language:

> "One of the biggest challenges is when you're in the room with two people, you can read the person's body language; you can see where things are going much easier. So I can stop the session and I can invite the other person to say something, but with telehealth it's been hard because I can't really see that much. The toughest part is when one person gets up and leaves the room" (P2).

The teletherapy screen has also created a barrier of less control over the session, especially while providing relational services. Several participants shared experiences about how the lack of control over their client's environment created challenges in treatment. An example of this struggle is shared by this participant:

> "There were several times in session when a lot of these difficult conversations are being held. I'm on the other side of the screen in a different location and there's a heated conversation happening and the [client] is off the screen. I'm thinking, what are you doing? I can't manage that in the same way I can in-person" (P5).

Another participant shared their experiences of the barriers with relational teletherapy:

> "Things that were very present for me, especially when we're talking families and couples, was what's happening behind the scenes and being able to as a therapist run the session and have boundaries around that keeps everyone safe" (P4).

One participant spoke about the challenges of working with children over teletherapy and the role the screen plays:

> "There's a lot more distraction, a lot more. You know, kids leaving the room and picking up something else; that is fine but just makes it harder to stay focused" (P4).

Another participant noted their experiences and their attempts to solving the issues that the screen had created:

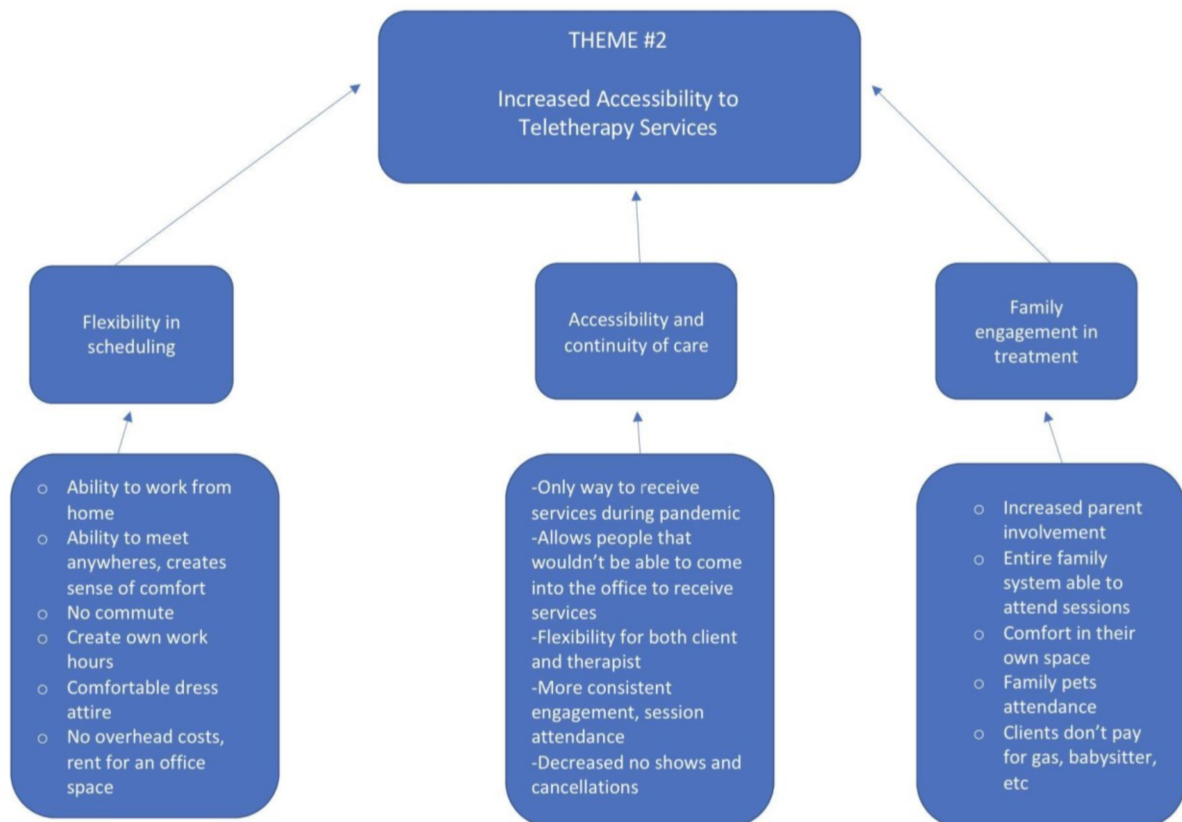
> "Keeping children engaged was really rough. I sought out a bunch of how to do telehealth with kids' types of training but even then it wasn't the same" (P4).

Increased Accessibility to Teletherapy Services

Participants shared benefits of their experiences while providing relational teletherapy through the COVID-19 shutdown. The data analysis showed that the majority of participants

found that accessibility to teletherapy increased relational engagement compared to in-person services. The data is defined by the participants' own personal and professional experiences. Many participants captured ways they experienced positive changes in their therapeutic relationships with clients. Several of the participants also emphasized the importance of teletherapy increasing accessibility to services and continuity of care among their clients. The following are the three subordinate themes that made up the larger superordinate theme of the increased accessibility to teletherapy services.

Figure 2: *Superordinate Theme, Subordinate, and Emergent Themes 2*



Flexibility in Scheduling

Within this first subordinate theme, the participants discussed that teletherapy created flexibility in their professional scheduling with clients. The majority of participants shared their views of high importance when it comes to the ability to offer therapeutic services from anywhere. They shared how it has created a sense of comfort for their clients and themselves to be in their own personal space. Many of the participants talked about how they have benefited from being able to create their own schedules and work hours, allowing them to be able to be more productive in other areas of their professional and personal lives, which is captured by the following statement:

> "I think for therapists, it's really opened up some flexibility; you can work at home if someone in the family's sick" (P5).

Another participant expressed how flexibility has created benefits for their clients as well:

> "I think the biggest is flexibility; just way more clients who are able to meet in general or meet at different times because they're home, they don't have to deal with a commute" (P5).

One participant recalled how the flexibility of teletherapy provided a sense of safety:

> "I can work late without worrying about, especially in the winter time, you know after 5 o'clock it's dark out. I can work without worrying about being in certain communities or being in my office by myself. That's a great benefit, just being able to be in my home office and see people as late as I want" (P5).

Accessibility and Continuity of Care

Every participant spoke about the second superordinate theme, accessibility for clients and continuity of care as a beneficial aspect of relational teletherapy. Every participant reflected

on how teletherapy increased session attendance among their clients and created a more consistent engagement in treatment. Participants spoke about how this resulted in a decrease in no shows and cancellations among clients when those patterns were typically consistent. Many participants shared the importance of being able to provide therapeutic services to their clients during a time when most were isolated in their homes, which is captured by the following statement:

> "I think one was that services were still accessible at a time when people were, many people were experiencing increased stressors because they were isolated in their home" (P5).

Another participant shared their experiences of increased continuity of care among clients as a benefit that teletherapy has facilitated:

> "You can have more continuity of care because even if it's not an emergency, you can still see that and a lot of clients really like the availability and convenience of it" (P5).

This participant reflected on how teletherapy has helped increase accessibility to teletherapy to populations that may not have had access to services prior to the pandemic:

> "I think it helped us definitely reach people who otherwise couldn't come to the office, even now having this hybrid system" (P5).

Family Engagement in Treatment

The majority of participants shared experiences that represented the third subordinate theme, an increase in family engagement in treatment through relational teletherapy services. Participants spoke about seeing pieces of the clients own environment and the comfortability they observed within that as another benefit of relational teletherapy provided to both therapists and clients. The majority of participants spoke about teletherapy increasing parental involvement

in treatment, which is captured in the following statement:

> “The benefits were definitely that I got a lot more parent engagement that I wouldn’t have any other time because the kids were and the parents were already having to do ZOOM meetings for school and for being involved in that. So it wasn’t a far stretch for them to be included” (P5).

One participant shared their point of view of the benefits of the entire family system being engaged in teletherapy treatment:

> “From my point of view, just having that involvement there for the whole family; it being easier for families… It makes it where they don’t have as many no shows because if something happens with something, there’s always something going on, they are able to maintain the session more because they can say, hey let's meet online, we have another kiddo that’s sick. We can meet online together as a family without siblings. So that’s made that a lot easier and I think that’s going to continue” (P7).

Some participants spoke about the benefits that teletherapy offered while working with children and adolescents, allowing them to see a new perspective of their world that an office setting could not provide. This participant shared their experience:

> “For some clients, I think being in their own space is just more comfortable. With kids, getting to see their space and letting them show me their room and their things, that has been a cool way to connect and hopefully make clients more comfortable” (P5).

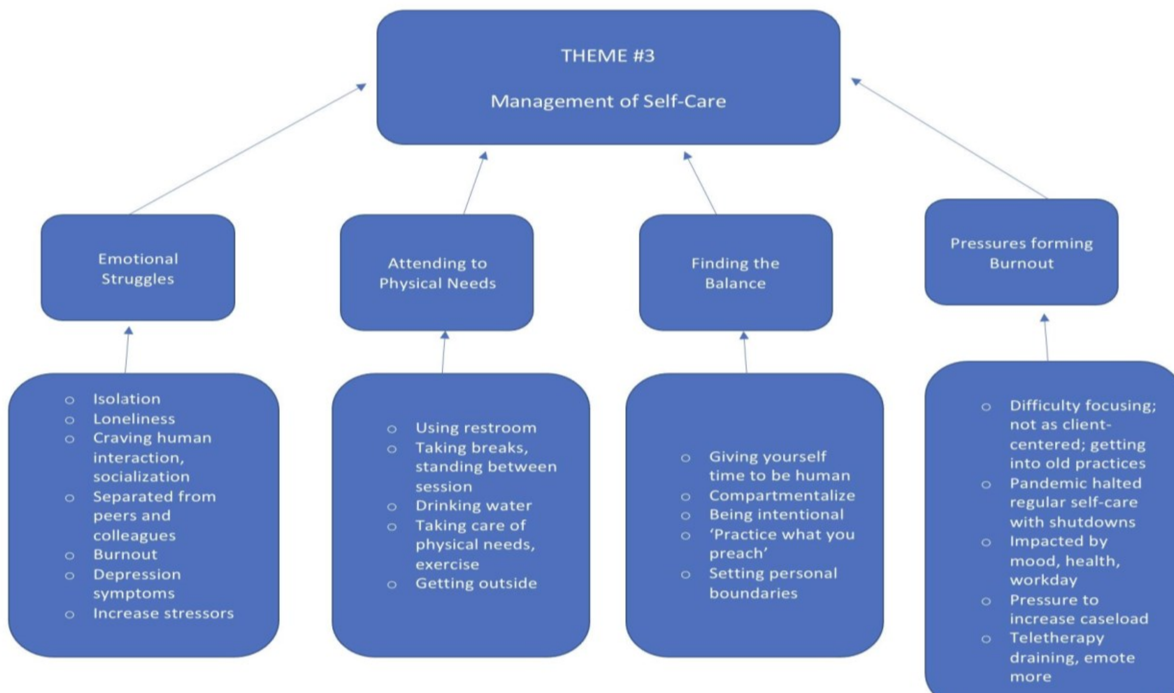
Another participant recalled their experience while working with adolescents:

> “Providing more support. Them just being more comfortable, them being able to share their world with me, and the adolescents who I couldn’t get to make eye contact in person, showing me their room, showing me the new shirt they got or whatever” (P6).

Management of Self-Care

Participants were asked to share their daily experiences of their self-care practices, their experiences of balancing teletherapy and self-care throughout the pandemic, and any benefits or challenges they experienced while balancing their self-care and teletherapy work. Many of the participants expressed emotional struggles, including feelings of isolation, loneliness and depression. While other participants reflected on the importance of being intentional in their self-care practices and attending to their physical needs while providing teletherapy to clients. The data analysis also showed that the majority of participants' were at risk of professional burnout as a result of the draining nature of teletherapy, the demand and pressures to increase their caseloads and overextend their professionally strutted work hours due to the demand for services. The following are the three subordinate themes that made up the larger superordinate theme of management of self-care.

Figure 3: *Superordinate Theme, Subordinate, and Emergent Themes 3*



Emotional Struggles

Emotional struggles, including feelings of isolation and loneliness were expressed by more than half of the participants while providing relational teletherapy throughout the COVID-19 pandemic. Isolation was reported as a result of being alone for long periods of time, being separated from peers and colleagues, and symptoms of burnout and depression. One participant recalled their experiences with the challenge of isolation while providing teletherapy through the earlier pandemic days:

> "The challenge was just the isolating factor of it. My [partner] is an [occupation], so during the pandemic I would be home doing telehealth sessions all day and I would be craving personal, physical interaction" (P12).

Another participant expressed the most challenging aspect for them in the balance of practicing teletherapy and self-care:

> "The isolation piece and feeling separated from peers and colleagues" (P11).

This participant processed the realization of the seriousness of their emotional struggles looking back on how their self-care was impacted throughout the early phases of the pandemic:

> "I was a little depressed being at home alone all day. Looking back, I don't think I realized as much during the time, but looking back that was what was going on" (P12).

Another participant spoke about the important of check-ins and how they utilized a weekly support system to lessen the feelings of isolation while providing teletherapy work in the following statement:

> "The type of work we do, I do have someone I check in with weekly and that's extremely helpful. But telehealth is extremely isolated. I'm thinking people may not have a team or a colleague they check in with, I don't know how they're surviving it" (P14).

Attending to Physical Needs

Ten out of the eleven participants expressed the importance of attending to their own physical needs in their daily self-care practices, especially while providing teletherapy during the early stages of the pandemic. Participants described the weight and physical tolls teletherapy had on them and how self-care was crucial during that time period which is captured in the following statement:

> "I mean that's not an option. You either take care of yourself or your body makes you take care of yourself because you get sick or you know. You can't just keep on keeping on without some form of taking care of yourself and refilling yourself and doing things you need to do" (P15).

Another participant captured the role self-care has on personal functionality:

> "I think it's become a top priority, not that it always wasn't a clear one but it had to be a top priority or I could not have functioned myself" (P15).

Taking care of one's personal and physical needs seems like an obvious piece within self-care practices, though the data analysis revealed something different. Many participants expressed having to be intentional with physical self-care practices while providing teletherapy. This participant shared their experiences of how they tried to manage this balance:

> "I try to go to the bathroom between every session, whether I need to or not just because it's a walk. But at the very least, standing up between sessions while I wait for the next one to launch. Making sure I'm doing that consistently" (P9).

Another participant shared how they found the ability to attend to both physical and emotional self-care needs:

> "One of my really important things for me was getting up and walking a couple miles

every morning with my husband, that gave us a dedicated time together plus exercise" (P8).

Another example of a participant's self-care management is described below:

> "Trying to eat healthy. Trying to be outside a little bit everyday. Spending time with people I love, either through talking to them or just being with them" (P11).

Another participant shared their experience of attending to their physical self-care needs:

> "Daily, I try to drink water. I'm not going to say how much, I just try to remember to drink water, I noticed that it helps me a lot" (P9).

Taking care of one's physical needs is not only done through physical activity and healthy eating habits. One participant went into detail about how they try to schedule time for a rest period during their teletherapy work day:

> "If there's time to take a nap, I take a nap" (P9).

Only three participants spoke about practicing mindfulness and breath work as a self-care practice. This participant shared how they incorporate mindfulness into their daily practice:

> "I do mindfulness and I try to do it daily. I take about a half an hour, sometimes just 20 minutes. But I do some breathing exercises and then I do some affirmations and tell myself what a great [person] I am. Then I do some visualizations, especially with my clients, with myself" (P9).

Finding the Balance

In addition to attending to their emotional and physical needs, participants stated how they were able to find a balance among their self-care and teletherapy practices. All participants reported their attempt to find balance, though some struggled more than others. Seven of the participants revealed that they struggled to find a balance while providing teletherapy and their

daily self-care practices. These participants shared how they attempted to overcome the challenges within finding that balance. A participant explained how they created the balance for self-care practices by setting boundaries, captured in the following statement:

> "Client wise, my weekends feel more like weekends. Having that boundary versus like, it just doesn't feel as finite. It felt like it was everywhere. Work all the time, clients all the time, family all the time. So having that clear boundary makes it much easier to be like, no it's self-care time" (P9).

Another participant spoke about the importance of setting boundaries between their clinical work and personal life in the following statement:

> "The biggest one is just having strong boundaries around clinical work, which is emotionally kind of trying to separate and not bringing it home. Also in terms of the times I see clients or responding to emails and things like that" (P9).

This participant spoke about their feelings of finding a balance within self-care and how providing teletherapy in the office setting has contributed to that:

> "It feels like a good balance. I am here in the office, so if a client cancels, I'm just doing other stuff that's work related. I get the drive and if I need to stay home, I can and not worry about 'oh shoot', my productivity is going down" (P9).

Eight of the participants' expressed how they would have changed their self-care practices at the beginning of the pandemic to help promote healthy practices and balance. This participant spoke about allowing themself to have more time, space, etc:

> "It would have given myself more time as a human and as a therapist to have better self-care, to grieve, to just cope, give myself the space a little bit better, rather than just jumping right back into it" (P14).

The following statement is another example of a participant's experiences of the changes

they had to make in order to balance their self-care and teletherapy work schedule:

> "I can't tell you how many times I've had to change my work schedule throughout this because the main thing being all the changes with the kids' schedules and seeing a lot of kids managing them too. So my self-care had to change back and forth and back and forth a million times" (P10).

Another participant shared their experiences of their challenges within finding a balance between teletherapy and self-care in the following statement:

> "It was very difficult being intentional at first. I didn't realize how often things just kind of fell into place, you don't think about your drive home as self-care, but man when it's gone I miss it" (P10).

Participants' also expressed how they have found a balance within their teletherapy work and self-care practices, including taking in the information from their own therapy practice, finding purpose among the days and learning new strategies. An example is provided in the following statement:

> "I do try to practice what I preach but it doesn't always work. So that's one of the things I do share with my clients, I go through days and weeks where I crash often" (P8)

Another participant shared their experiences of how they learned new strategies:

> "Well, I've learned to kind of compartmentalize and realize this is my client's issue. I'm very empathetic and I've worked with them but I am able to put that to the side and not take it into myself" (P11).

This participant expressed the important of human interaction among their self-care balance:

> "I think making it a point to leave my house for something, having some sort of purpose

even if it was going into the grocery store instead of doing curbside pickup, just to be around other humans" (P11).

Pressures Forming Burnout

Eight participants expressed an increase in professional pressures while providing teletherapy during the initial stages of the pandemic. Data analysis suggested these pressures included increasing their caseload and being more available to meet with clients due the nature of being home. One participant's experience described feeling pressure to be present and emote more during teletherapy sessions because it was difficult to engage clients, captured in the following statement:

> "It definitely felt more draining doing teletherapy the whole day than doing it in-person. I felt like for me, I had to emote more to get that engagement from my clients. I had to be a lot more attuned and a lot more, just to be present with them in the space" (P13).

Another participant expressed their experience of the pressures of providing teletherapy and how it impacted their personal self-care boundaries:

> "I think it's easier to work more. It's easier to not have boundaries because you're able to be like, oh I can just jump on the thing real quick and meet with you and just go upstairs. So it's hard to not want to do that because usually you would just be like, no I can't, I'm not in the office, I can't see you. But I think it's harder whenever you like, oh I could just jump on and see them" (P15).

One participant reflected on the challenges and pressure of the demand for services and how that took a toll of their practice:

> "That had been challenging too, just the need for therapy. So being really full sometimes and needing to say no to people, even though everyone else also has a really long waitlist. I think that is a secondary consequence of the pandemic" (P12).

The data reflects these pressures resulting in greater potential for burnout, especially in the earlier period of the pandemic when many of the participants lost access to some of regular self-care practices, such as going to the gym, health classes, social events, etc. This participant recalled their experiences of not having access to their regular self-care practices in the early stages of the pandemic:

> "At the beginning, not being able to do other self-care things that I would like to do, like going to a class or just socializing with people or things like that; going out to eat, not having access to those things" (P13).

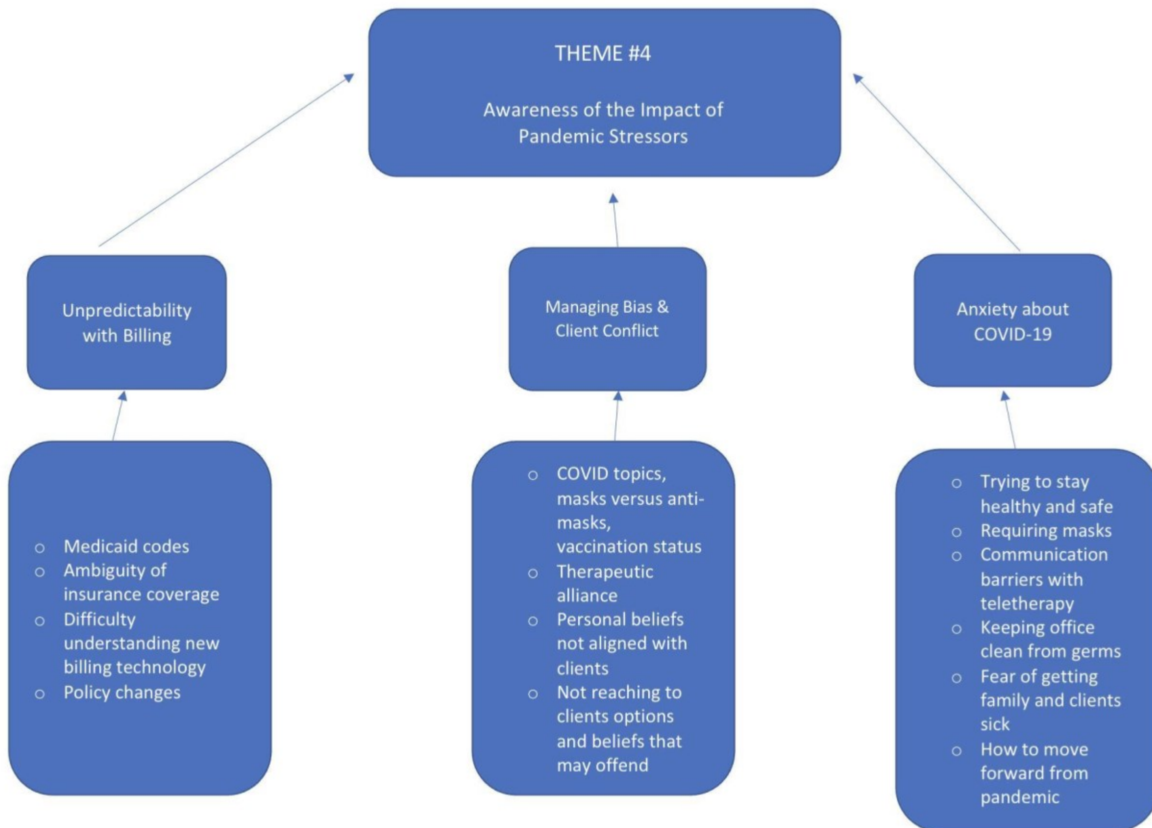
One participant expressed their experiences of the pressures and burnout with the use of key terms in their work with clients:

> "I think saturated is a word I would use often. The amount of what I'm processing, what's changing, and the turbulence. The turbulence that you know, the meta levels of that sometimes are a bit bumpy. So I would get saturated" (P13).

Awareness of the Impact of Pandemic Stressors

The participants were asked to share their personal experiences with stressors they continued to experience while balancing relational teletherapy and practicing self-care. The participants highlighted how their social, cultural, and historical experiences shaped their worldviews, values, and therapeutic identities. The following three subordinate themes help to understand how these have shaped their experiences balancing relational teletherapy and self-care and the awareness of the impact of pandemic stressors.

Figure 4: *Superordinate Theme, Subordinate, and Emergent Themes 4*



Unpredictability with Billing

Half of the participants reported having experienced issues and stress related to billing for the teletherapy services they provided clients. The data analysis shows that participants were unsure if insurances were accepting teletherapy services ongoing, which billing codes to use, and how long insurance will accept teletherapy as a billable and effective service modality. The following statement shows an example of one participants stressors with billing insurance:

> "We are still waiting to hear if [insurance] is going to extend in this area, which I really hope they do" (P13).

Another participant described their strain around keeping up to date with insurance

coverage for teletherapy:

> “I’m just trying to keep up with what insurances are doing. Most of them were, all of them were okay with telehealth but it was figuring out, okay how do I bill this because I’ve never done it before” (P22).

One participant reflected on their struggles of employing new electronic payment systems as a means to collect payment for billing and teletherapy services:

> “So the billing has been the most frustrating and I still don’t know how to use [electronic payment system]” (P25).

Another participant shared their continued stressors while continuing to provide teletherapy is keeping up with the ever-changing policies:

> “Recently, it’s felt more unclear or changing policies have been a stressor” (P10).

Personal Beliefs Impacting Therapeutic Alliance

The majority of participants reported feeling stress when their therapeutic alliance with clients was impacted by their own personal beliefs and biases. Participants experienced significant amounts of stress when discussing pandemic related topics with clients such as mask mandates, vaccinations, and COVID as a larger system, especially when the clients beliefs and views did not align with the participants. The following statement shows an example of one participants experience of having the therapeutic alliance impacted by pandemic related topics:

> “They just sit there and say it's not real or it's not that bad. That has actually been very frustrating to me as a continuing frustration, that people here, now that it's less, they’re like, see told you it wasn’t the end. I’m like, I can’t even be in this room and have a conversation with you right now, I feel like we need a break” (P15).

Another participant reflected how their geographical location played a role in their clients

reactions and beliefs about the pandemic:

> "One of the biggest stressors for me is because of where we live in this rural area, there are quite a lot of people that don't feel strongly about heeding the advice of science, scientists and doctors about the masks and vaccines" (P14).

One participant described personal and professional relationships being negatively impacted by differences in views about the pandemic:

> "The main thing that has been an interesting issue to me is the differences within a family about their attitudes about COVID and how they can alienate some people. It's been challenging to me" (P18).

This participant reflected on the global pandemic and the new experiences and stressors that continue to occur as a result:

> "I think looking back, it's hard to recognize how you as a clinician are going through trauma at the same time as your clients and you were going through the same thing, which has never happened before. I've never experienced that as a clinician. So that was a new thing to experience, we're all going through this same unified trauma together, navigating how do we deal with a pandemic and people dying that we love" (P22).

Anxiety About COVID-19

Fears and anxiety about spreading COVID-19 to clients and loved ones was a reported stressor for half of the participants. Participants report as they transitioned to a hybrid model of teletherapy and in-person services, experiencing significant stressors on how to keep their clients, themselves, and their loved ones safe. One participant illustrated that stress by recalling experiences while working a hybrid model:

> "I've had clients that had done everything right and then came in and we're in-person. Then told me the next day, guess what my partner tested positive and I did a home test

> and I’m positive too. So then that impacts everybody, myself, my family, all the other clients that we’re seeing in-person that day” (P14).

Another participant expressed their anxiety about being the COVID-19 exposure to their loved ones in the following statement:

> “I was the factor that could get my family sick, so knowing that too was hard” (P19).

Lastly, a participant processed their anxiety and stressors about switching from teletherapy to in-person services and moving forward through the ongoing pandemic:

> “Now the stressors have been, do we go back? Do we make everyone come back? What do we do about sharing offices? How do we keep things cleaner? What do we do when clients are kind of paranoid about it? Do you have to reveal that you’re vaccinated? Do you have to wear a mask if you’re not? So it’s just been figuring that stuff out going forward. I think that has been the biggest stress” (P11).

Conclusion

The results of this study revealed four major themes: technical barriers in teletherapy, increased accessibility to teletherapy services, the management of self-care, and awareness of the impact of pandemic stressors. Among these themes included 13 subthemes, which provide evidence of the participants experiences of providing relational teletherapy during the COVID-19 pandemic. These results provide insight into how marriage and family therapists clinical work and self-care practices were impacted both negatively and positively during this shift to teletherapy. The challenges and hardships appeared to be the most significant during the initial shift from in-person to teletherapy work, though as the pandemic has continued results indicate that every participant noted how beneficial teletherapy has been not just among their professional and personal lives, but also the lives of their clients.

CHAPTER FIVE: DISCUSSION

The literature on teletherapy since the COVID-19 pandemic is vast and ever growing, though after review as a whole, it is evident that the connection between the therapists' self-care and their professional teletherapy practices is lacking in the current literature available. This study sought to inquire how the shift and practice of teletherapy impacted marriage and family therapists' balance of their professional therapeutic work and personal self-care practices through the ongoing COVID-19 pandemic. Utilizing an Interpretative Phenomenological Analysis (IPA), there are numerous ways one can see and interpret this data. The participants were eleven licensed marriage and family therapists from all regions of the U.S. Their experience ranged from recently licensed prior to the global pandemic to more than 40 years in practice. They each participated in a 45-90 minute semi-structured interview. The analysis revealed four superordinate themes and twelve subordinate themes. These results included the main themes of: technical barriers in teletherapy, increased accessibility to teletherapy services, the management of self-care, and awareness of the impact of pandemic stressors. The frame of these results is influenced by the researcher's background using a humanistic and ecological systemic theoretical lens.

The relationship between teletherapy and self-care is an important evolving topic, especially with the recent events of the global pandemic. Teletherapy is defined as mental health counseling over the phone or online using virtual video platforms (Villines, 2020). Self-care is the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider (WHO, 2018). In mid-March of 2020, teletherapy became the required method of providing therapeutic services as a result of the COVID-19 pandemic and remained the only safe means to

provide treatment for many marriage and family therapists. Until recently, many therapists had never received training or education about how to properly provide teletherapy services to their clients and many had never provided teletherapy services, unless it was a special circumstance (Burgoyne & Cohn, 2020; Captari, 2020; Richartz et al., 2021).

The results of this study provide evidence that COVID-19 created numerous positive and negative experiences for marriage and family therapists that impacted their professional lives and their self-care practices. Further, the results in this study revealed participants struggling to find a balance between their relational teletherapy work and self-care practices during the initial stages of the pandemic. These experiences may have been exacerbated by the state of the world during the initial phase of the pandemic and the lack of experience providing teletherapy services by the majority of the participants. The themes demonstrate what contributed to the participants' relationship to teletherapy and self-care and how they navigated the dynamics that demonstrated a need for more support to create that balance between these two practices.

Bronfenbrenner's ecological model created the most aligned context to make sense of this complex yet connected relationship with teletherapy and self-care. This model uses concepts of behavioral, relational, environmental, social, and ecological layers that help to understand the experiences the participants had to teletherapy and self-care. These behavioral, relational, and systemic layers describe the multisystemic relationship within the individual and the era of the pandemic and how it influences a therapist's balance of teletherapy and self-care practices. The discussion will focus on marriage and family therapists' experiences of balancing their teletherapy and self-care practices, including some key suggestions for managing self-care and troubleshooting teletherapy from participant experiences. Also, it is crucial during this process to have dialogue addressing the multisystemic lens that consciously or unconsciously perpetuates

biases and power dynamics that can be harmful. The following section will discuss how the research findings relate to current literature, limitations, and future research.

Negative Impacts on MFTs

Participants of this study illustrated the challenges and hardships of providing relational teletherapy during the COVID-19 pandemic, especially during the initial shift from in-person services to teletherapy. The transition to teletherapy required a degree of comfort, curiosity, and rudimentary training that was not available for therapists or clients supports (Pruitt & Glennon, 2019). Six of the participants had not provided teletherapy regularly prior to the COVID-19 pandemic, therefore they were unfamiliar with the platforms required to facilitate the initiation of teletherapy services. The remaining five therapists had limited experience with teletherapy, using it only due to special circumstances, it was not regular practice. The most common negative impacts of the pandemic described by participants included technical issues of teletherapy practice and roadblocks within their self-care practices.

The participants acknowledged the following technology issues among providing relational teletherapy during the pandemic: internet connectivity issues, lack of confidentiality and boundaries, and the inability to observe body language cues. These findings reflect previous research (Eppler, 2021) that reviewed the specific challenges of teletherapy, such as fitting multiple clients in camera view, the inability to hear multiple clients speaking simultaneously when using separate devices, and the limited use or observation of body language. Many participants described experiences of freezing or losing the internet connection during sessions and having to navigate through that challenge. More than half the participants described issues with internet or digital interferences due to couples and families connecting from different

locations. Therapists are often expected to be “experts” in technology, however, lack of training and knowledge of technology may limit the ability of the therapist to access the means for therapy or instruct the client on how to use the technology during session (Richartz et al., 2021). In regards to ecological systems theory, the structure of the larger systems needed to change (e.g. better internet connections, HIPAA compliant teletherapy platforms) in order to meet the changing needs of both therapists and their clients. For example, one participant spoke about how they had to switch from one telehealth platform to another due to the increased surge of teletherapy activity creating technological and connectivity issues that the platform was not prepared for.

At this point in the pandemic, many marriage and family therapists have never met some of their clients face to face due to the nature of teletherapy, which continues to challenge the therapeutic alliance and relationship. Building an alliance and gaining rapport takes time and unfortunately, with the barriers of teletherapy and the inability to observe body language, this can make that process more difficult (Eppler, 2021). Participants within this study discussed how the pandemic had also brought the unique challenge of differences in beliefs and views on major topics such as mask mandates, vaccinations, and the pandemic as a whole. Half of the participants expressed their frustrations and internal struggles maintaining a professional role while clients expressed their personal beliefs about COVID being a myth. The results revealed depending on the participants locations, political views of the pandemic and mandates in place were strongly impacted. These differences in views are influenced by larger corporate companies and political agendas. This can be frustrating from therapist perspectives as the outer systems may not be following the recommended guidelines for COVID procedures which impacts their ability to safely transition back to in-person services, prolonging lockdowns and closures.

Every participant discussed struggling with lack of control over their client's environment and trusting their clients with the more logistical pieces of the therapeutic process, such as maintaining a confidential space. Participants disclosed that many teletherapy sessions were interrupted, especially by children in the homes. This gap in confidentiality appeared to force most participants to try to set strict and rigid boundaries within the teletherapy sessions, though most participants reported struggling to set and maintain those boundaries over teletherapy. This shift in the tone of teletherapy and the rigid boundaries that must be set are felt throughout the therapist's ecological system, especially at the micro (individual) and meso (client) system levels. Further, the therapeutic relationship has changed due to these systems and the power dynamics shifted as therapists' needed to collaborate with clients' to meet the basic tenets of ethical therapeutic practice. Therapists' are in a more vulnerable place while conducting teletherapy because of their limited ability to ensure ethical practices that they typically had control over, are now out of their control and their license could be at stake (Wrape & McGinn, 2019; Burgoyne & Cohn, 2020; Eppler, 2021).

Participants noted that boundaries were not only a challenge to set for their clients but also to set for themselves, especially with the nature of the COVID-19 shutdown. Many participants described a lack of structure related to maintaining their typical work hours, for example they reported answering emails or checking their schedules during the middle of the night. Half of the participants discussed struggling to maintain boundaries because they were working from home to provide teletherapy while their children were also home due to school closures and would often be interrupted or need to pause sessions to check on them. These findings align with previous research that has reported the challenges and limitations around confidentiality and the softening of boundaries with teletherapy, although the pandemic has

created some unique elements (Simpson et al., 2021; Burgoyne & Cohn, 2020; Scharff et al., 2020). Participants also described an inability to interpret body language and non-verbal cues of the clients due to the limited space available over the screen. A few participants also discussed the difficulty of assessing a situation when a client leaves the screen or room. The therapist does not have control over the client's environment and must decide in the moment what is best practice to ensure everyone's safety. It wasn't until the COVID-19 shutdown in March of 2020, when people were forced to make this shift to teletherapy and do their diligence to provide the best treatment possible, that the focused switched to the gaps and limitations within teletherapy services (e.g., Heiden-Rootes et al., 2021; Burgoyne & Cohn, 2020; Captari, 2020; Ojha et al., 2020).

The challenges of providing relational teletherapy while balancing personal self-care practices were illustrated by participants as feeling isolated, pressure to meet the demand of services, and roadblocks in prioritizing self-care. Although two of the participants were unable to identify challenges, the remaining nine participants reported experiencing isolation, struggling to prioritize self-care, feeling increased pressure to meet the demands of providing teletherapy services. Prior to the pandemic, the majority of the participants worked in a professional setting where they would see colleagues and clients face-to-face; the shift to teletherapy created a sense of isolation and loneliness as many of the participants were alone during their work hours without physical human interaction. As the shift to teletherapy became more permanent with the mandates of the pandemic, the increase and demand for therapeutic services became overwhelming for some participants. Many therapists were unprepared for the tremendous loss of energy as they dealt with Zoom fatigue, overstretched personal and professional boundaries, and the removal of the 'energy in the room' (McCoyd et al., 2022).

The COVID-19 related shutdowns also meant that many of the participants lost access to regularly scheduled self-care practices such as attending the gym, yoga classes, or weekly social gatherings with support systems. Further, the typical ways of coping with stress were inaccessible or more difficult to achieve (e.g., spontaneous consultation with colleagues between sessions, involvement in a religious/spiritual community, going to the gym or other forms of physical activity, traveling and attending conferences) at a time when our self-care matters more than ever (Captari, 2020). Participants expressed how this negatively impacted their ability to work and how important it was for them to find other ways to practice self-care through simple actions such as standing up between teletherapy sessions, mindfulness, and taking care of other personal physical needs. Previous literature reflects the importance of regular self-care for therapists, especially while providing teletherapy due to the increased potential for burnout and constant state of stress from the pandemic (Kerr, 2016; Lee et al., 2013; Miller et al., 2021; Glennon & Pruitt, 2022). Independent providers of mental health services faced their own unique challenges, especially during the pandemic. Previous research (e.g. Phillips & Williams, 2021) is consistent with the results of this study in illuminating the importance of participants utilizing key resources to aid them during the pandemic; emphasizing the importance of independent providers remaining regularly connected with colleagues, professional groups, and professional organizations.

Participants discussed their struggles with pandemic related stressors in regards to their professional work and self-care management, including anxiety about getting and spreading COVID-19, issues with billing, and different views and beliefs about the pandemic from clients impacting the therapeutic relationship. Some participants illustrated their thoughts and experiences about how they made the shift back to in-person services and their fears and

anxieties about how to keep themselves, their family, and their clients safe, though some have remained only teletherapy. Billing, coding, and additional payment issues were present among the majority of participants; although teletherapy remains as a covered services at this time, many participants worry how long teletherapy services will remain a billable service. Results reflect how larger insurance companies and state regulations played a role as a larger meso and impacted the daily operations of therapists', their clients needing services, and the individualized stress levels among the uncertainty within billing and the pandemic. The pandemic has shed light on how people learn to use new systems (i.e. teletherapy, increased stress, living with pandemic), showing resilience in a time of adversity. It appears additional support for the billing, coding, and payment of teletherapy would be an asset to many practicing marriage and family therapists.

Positive Impacts on MFTs

Although there have been many challenges and hardships from the pandemic, it would be remiss not to highlight the positive changes and advancement in the mental health field as a result of the event in history. Participants described one of the benefits they noticed immediately was the flexibility in their scheduling. This included no commute to work, ability to stay home sick with a family member if needed, and comfortability in attire and environment during session. As evidenced by Stoll et al. (2020), teletherapy opens doors in many ways and creates flexibility for both therapists and their clients. Many of the participants discussed the benefit of not having a commute; one female participant went into detail about teletherapy eliminating their fear of safety due to the neighborhood they were working in or it being dark outside. The ease and convenience of the flexibility with teletherapy aligned with previous studies (Burgoyne & Cohn, 2020; Richartz et al., 2021). Another participant highlighted how she was incredibly thankful for the ability to work from home and attend to her children while they were engaged in

virtual learning. This flexibility has allowed therapists and their clients the ability to have one less stressor during a time when the events of the world feel overwhelming.

The pandemic has been a time of struggle and loss for many, it has also created an opportunity for populations to receive access to mental health care that were not able to prior to the pandemic, due to barriers with transportation, location, and time. All of the participants expressed how teletherapy provided increased consistency with client appointments and treatment. Marriage and family therapists have been able to provide teletherapy to populations that would not have had access to services prior to the pandemic. This change has allowed therapists to reach populations that they would not have been able to serve in-person. Assuming the therapists met licensing criteria, they may be able to serve populations from all over the world. One participant illustrated their positive experience of working with a client who lives overseas and the opportunistic teletherapy has created for them.

Participants discussed how teletherapy has promoted more consistency in treatment and decreased no show rates, which resulted in more billable hours and productivity for the therapist. Participants spoke about how important it is for consistency in treatment throughout the pandemic, especially during the initial stages because it was such an isolating time; having scheduled appointments and events that felt “normal” decreased symptoms of isolation and depression. For many of the participants, teletherapy was the first time that they were able to see a glimpse into their clients’ home environment. Participants described teletherapy increasing family engagement in treatment compared to in-person services, prior to the pandemic. For many families, teletherapy meant less stress as they did not have to worry about finding a babysitter or budget for gas money to attend. Participants noted that an additional benefit for both therapist and client was being able to be in the comfort of their own space. This isomorphic process

provides evidence on the importance of therapists' having their own self-care available during this time. More than half the participants went into detail about how clients became more vulnerable while in their own personal space, resulting in improvements in their therapeutic alliance. Family pets being able to attend teletherapy sessions have also facilitated in promoting the therapeutic relationship as it allows the therapist to observe another family member within the system. This provides evidence that the client's system including their family pets, family members, and being in their own comfortable space (i.e. bedroom) allows therapists conducting teletherapy to engage in valuable work and therapeutic alliances with their clients that would not be possible within the face to face office setting.

Maintaining a healthy work-personal life balance and a positive lifestyle have been the hallmark of self-care in the helping professions (Glennon et al., 2019). Throughout the pandemic, that balance has been forcefully shifted for many marriage and family therapists'. Not only that, but participants also find themselves living the same collective trauma as their clients that come to them for help (Mukhtar, 2020). Though the participants of this study had to overcome many adversities that they were not prepared or trained for, they managed to overcome the obstacles and come through stronger than before. Participants' experiences reflected that once they felt more comfortable and confident in providing teletherapy services, their professional work improved aligning with their own personal self-care practices and mental health. Previous research (e.g. Phillips & Williams, 2021) reports that ongoing healthy emotion regulation and self-care strategies help providers prepare for a wide variety of stressors in their practices, lives, and in the larger world, which is consistent with literature indicating that a continuum of self-care is most effective when practiced on an ongoing basis and not simply when therapists' are in a challenging situations. The majority of the participants expressed the importance of self-care

and were in favor of teletherapy practices and their hopes of teletherapy being utilized as a service for the foreseeable future due to the advancements and strengths that have been produced as a result of the global pandemic.

Promoting Self-Care Among MFTs

Although research about the COVID-19 pandemic and how to utilize teletherapy is vast and ever growing among the literature in the field of marriage and family therapy, there is minimal research available about marriage and family therapists' self-care practices while utilizing teletherapy during the pandemic. The results from this qualitative study provide a glimpse into the experiences of marriage and family therapists' experiences of balancing their self-care practices while providing relational teletherapy during the COVID-19 pandemic. The results revealed that the emotional and physical needs of therapists must be considered a priority as one hosts teletherapy sessions during this unknown and stressful era.

This study indicated that therapists experienced an increase in emotional struggles, including feelings of isolation, loneliness, depression, separation and burnout while providing teletherapy throughout the pandemic. Limited ability to connect to social supports and colleagues have had an impact on the emotional health of therapists as well. Further, it is recommended that marriage and family therapists formulate a self-care plan that allows them to be able to stay connected to their loved ones, colleagues, and other important social connections throughout the unknown future of the pandemic. Results also indicated that physical health was negatively impacted as therapists practiced teletherapy during the pandemic. Again, the early stages of the pandemic appeared to have the most impact as mandates and closures meant there was a lack of resources available to the public (i.e., gyms closed and classes were canceled). More than half of

the participants of this study reported that prior to the pandemic, they had been actively engaged in gym routines and classes, all of which were halted when the pandemic began. Unexpectedly, the participants' drinking and eating habits were negatively impacted while providing teletherapy as a result of this study. The majority of participants reported having to intentionally drink water, eat food, or get up and walk around between teletherapy sessions. This may have been because participants' were engaging in teletherapy sessions back to back, without breaks. This lack of attending to the body's physical needs may have also been from the stress and energy that goes into providing teletherapy sessions, especially as participants' were learning how to use the technology and platforms. This study shows evidence that marriage and family therapists' must listen to the needs of their body while providing teletherapy sessions. This may include making time for themselves to eat, drink, and move their bodies as needed throughout their scheduled work day.

Making time for oneself appeared to be one of the major components in creating and managing healthy self-care practices among the participants of this study. The results indicated that the ability to find a balance between teletherapy practices and self-care practices was truly dependent on the individual participant and their ability to set boundaries. Six of the participants shared the importance of setting and maintaining personal boundaries with clients and within themselves to promote their self-care practices. For example, one participant spoke about at the end of their teletherapy sessions, they would shut the door to the office in their spare bedroom as it symbolized the end of their work day. The results of this study provide evidence for the recommendation for marriage and family therapy to explore what their own personal boundaries look like while providing teletherapy sessions so their self-care practices are not being limited or negatively impacted. Therapists should also allow themselves to have the space to be human and

make time for themselves as they deem appropriate for their own needs. The pressures that marriage and family therapists have endured throughout the COVID-19 pandemic are evidenced within the results of this study. Nearly every participant shared experiences dealing with pressures to increase their caseloads due to the demand for services and an inability to refer to any available outside resources. Results also provided evidence that participants were at risk of burnout due to the pressures, limited self-care resources, and the energy that is required while providing teletherapy sessions. Burnout is not unknown to therapists, though it is important to recognize the signs and symptoms and to adjust self-care practices as needed to assist in burnout prevention. According to the results of this study, it appears that managing self-care practice and setting boundaries for oneself are the best preventative measures for teletherapy burnout. One participant shared their thoughts about how self-care should be address in the future as evidenced in the following statement:

"I think that to become more intentional with our self-care is just something so very necessary to learn; if it's not in school, it's got to be a CE or something" (P11).

Implications

In March of 2020, everything changed. Although teletherapy was not a new modality in the therapy and counseling profession, for the majority of marriage and family therapists they were expected to start providing this service to their clients as fast as possible, without resources or training. The initial COVID-19 shutdown turned the entire therapy world inside down and created a gateway for teletherapy services to thrive. Teletherapy was once viewed as a backup plan for many therapists or a means to continue treatment virtually during special circumstances; it is now a preferred mode of treatment by many professionals and clients (Burgoyne & Cohn, 2020; Goldin et al., 2021). Multiple studies (e.g. Connolly et al., 2020; Disney et al., 2021; Maier

et al., 2021; Pruitt & Glennon, 2019) have been completed and published since the start of the pandemic showing evidence of the effectiveness of treatment and insight on how to work with certain populations via teletherapy. Self-care is identified as vital for the health and wellness of those in the mental health field and is a common topic throughout teletherapy research; there lacks an evaluation of teletherapy in relation to the perceived well-being of the therapists (Richartz et al., 2021). Though many advancements have been made since the initial stages of the pandemic, there is still limited focus on the therapist' experiences and how they manage their own self-care and stressors during this global pandemic.

This research study found evidence of challenges and benefits to teletherapy while also examining the marriage and family therapists internal struggles and stressors unique to the COVID-19 pandemic. This evidence allows insight into the profession on the importance of self-care. Many marriage and family therapists are taught about the importance of self-care while receiving their education and training but not many get the chance to master that self-care into a practice that decreases burnout, secondary trauma, and compassion fatigue. Marriage and family therapists have never experienced a pandemic or life event like COVID-19 so it is crucial that research and literature highlights not only how important it is but also normalizes the internal struggles that professional experience. Humanizing professionals, such as marriage and family therapists, allows the world and their clients to see that they are people too, they have stressors too, they are struggling during the pandemic. Marriage and family therapists having stressors and internal battles within themselves is not new information but this pandemic allows researchers to highlight this information during a unique time and promote the importance of practicing and maintaining self-care practices that work for each individual. Finding a way to achieve balance during and after the pandemic is of paramount importance; this requires the therapists' to be

flexible and adapt to their new reality in a sense that some of their previous self-care strategies used during and outside of teletherapy may still work, some may not (Pruitt & Glennon, 2019). This shift creates space and an opportunity to develop and explore new self-care strategies.

Limitations

This study had several limitations. First, this study had a small sample size of eleven participants. The sample size was adequate for a phenomenological study; however, this smaller sample size limited the wider range of experiences compared to a larger sample size. More participants would have illustrated more descriptive experiences of balancing relational teletherapy and self-care. Participants varied in age, though this researcher did not evaluate demographics such as age, location, and gender. Another limitation is this study is generalizable and described only the experiences of licensed marriage and family therapists that were located in the United States. Participants from different professional counseling backgrounds may have provided different perspectives among the research. This research focused on the experiences of initial shift to teletherapy during the COVID-19 pandemic.

Further, while qualitative studies are designed to have more open-ended questions, this researcher did have some directive prompts and language that may have shaped how participants answered the questions. For example, I asked about stressors they continued to experience throughout the ongoing pandemic and provided examples such as billing issues, mask mandates, and vaccination status. I also shaped the questions using teletherapy and self-care as a variable. This may have shaped the way participants answered questions and how the results were framed. Participants' answers were based on their own understanding and definition of teletherapy and self-care.

Future Research

This research study is the first of its kind in the sense that sought to evaluate the balance of relational teletherapy work and self-care practices of marriage and family therapists during the COVID-19 pandemic. This research creates a curiosity for future research to be considered. First, a larger qualitative study would be beneficial as it would gather a more diverse population of participants, further enriching the data determined from this study. Future studies may also want to further examine the demographic information of participants as there may be patterns and correlations within the demographics and the participants data. This researcher is requesting a call for other qualitative studies within different areas of mental health to examine the relationship between teletherapy and self-care of clinicians and therapists. Lastly, future research may consider the long term effects of marriage and family therapists practicing exclusively teletherapy or a hybrid model and impacts on their personal self-care practices utilizing scales to measure depression or anxiety.

Conclusion

The ongoing COVID-19 pandemic has taken the lives of more than 1.01 million people in the United States, with the numbers continuing to rise. Until the global pandemic, teletherapy had been limited in its use due to perceptions around safety, confidentiality, quality of care and reimbursement issues; though the rapid shift within the mental health fields to provide teletherapy in the face of the pandemic revealed both positive attributes as well as unforeseen challenges (Richartz et al., 2021). This study gave an illustration and description of licensed marriage and family therapists and their experiences of balancing relational teletherapy and self-care during the COVID-19 pandemic. This was the first phenomenological study to examine how

marriage and family therapists' balance of teletherapy work and personal self-care practices were impacted by the global pandemic. Previous research and literature provides evidence of the benefits and challenges of teletherapy work and how clinicians transitioned from in-person practices to teletherapy at the initial stages of the pandemic. The systemic and ecological lens in this study explored and emphasized the importance of the marriage and family therapists finding a balance within their relational teletherapy work and self-care practices from a multisystemic lens in a larger global impact, unique to the pandemic. This phenomenological study allowed participants to voice their experiences including their thoughts on the evolvement of teletherapy in the mental health community:

> "We have created a new world and a new world as a result of the pandemic. I think that this helps us create a new mental health world as well and that telehealth does stay forever. That it gives access to care for people who were boxed out of that for various reasons before. I hope it gives consistent care because it's also a very big problem within mental health and I think one that's very overlooked" (P16).

The results of this study found that marriage and family therapists experienced barriers and advancements while providing teletherapy during the pandemic while also being forced to acknowledge their internal struggles and stressors that are unique to the COVID-19 pandemic. The technical barriers in teletherapy that marriage and family therapists' experienced included increased issues with technology, lack of confidentiality and boundaries, and the screen creating a barrier in treatment. Increased accessibility to teletherapy services provided evidence that marriage and family therapists had flexibility in scheduling, increased accessibility and continuity of care, and increased family engagement in treatment. The results also revealed that the management of self-care among marriage and family therapists included needing to address emotional struggles, attending to physical needs, finding a balance, and professional pressures

increasing burnout. Lastly, results revealed that marriage and family therapists gained an awareness of pandemic related stressors which included unpredictability with billing, managing bias and client conflict, and anxiety about COVID-19. It is important for marriage and family therapists to understand these results so that they may be able to utilize the information from this study to create awareness and promote healthy teletherapy and self-care practice in their own lives.

This research study helps fill gaps within current literature about therapists conducting teletherapy while balancing self-care practices during the COVID-19 pandemic. Further, this study helps readers increase their understanding of the importance in understanding the challenges that come with teletherapy work and how important it is to maintain effective self-care practices. The majority of participants in this study had positive support systems and connections to professional outlets. Due to the overwhelming amount of research that has been published on the effectiveness of teletherapy on a broad spectrum of populations, it appears teletherapy will be here to stay and become a normalized practice going forward.

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APPENDIX A: RECRUITMENT FLYER

Marriage and Family Therapists:

Have you provided relational teletherapy during the COVID-19 global pandemic?

You are invited to participate in a confidential and exciting research study that seeks to explore the experiences of marriage and family therapists providing teletherapy during the global pandemic and how it affects their clinical and self-care practices.

Participants in this study must be a licensed marriage and family therapist (LMFT) prior to the beginning of the COVID-19 pandemic; switched from in-person to remote tele-therapeutic services at the beginning of March 2020; practiced relational teletherapy with clients for at least three month; and have access to internet, including email, ZOOM, and telephone.

You will be entered into a drawing to receive one of four $25 VISA gift cards as compensation for your participation.

Elizabeth A. Dumayne, MA., MFT

PhD Candidate

Couple and Family Therapy Program

Department of Applied Psychology

Antioch University New England

APPENDIX B

Informed Consent

Project Title: The Experiences of Marriage and Family Therapists As They Balance Relational Teletherapy and Self-care During the COVID-19 Pandemic

Project Investigator: Elizabeth Dumayne, MA

Dissertation Chair: Lucille Byno, Ph.D, LMFT

1. I understand that this study is of a research nature. It may offer no direct benefit to me.

2. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any potential risks for myself. I understand that the investigator may drop me at any time from the study.

3. The purpose of this study is to understand the experiences of marriage and family therapists balancing their practice of teletherapy and self care during the COVID-19 global pandemic.

4. As a participant of this study, I will be asked to take part in the following procedures:
   a. The interview will be video recorded within the ZOOM video conferencing application..
   b. The virtual video file will be kept in a secure folder within a password protected computer, before and after the data is transcribed.
   c. The video file will be labeled with a confidential ID number, including a fake name and date of the interview that has no identifying information included, until the results are written into a report.
   d. A committee overseeing my research will review the report.
   e. After the paper is submitted to a journal, the paperwork, including the transcripts, video files and consent forms will be shredded and/or destroyed.
   f. Some of your direct quotes may be included in the final write up but your name will in no way be connected to your quotes. All names will be changed and any identifying information will also be changed.
   g. After the data is transcribed and written in report form, I will send a copy of that section to you via email. Please review it and provide feedback regarding its consistency with your experiences shared in this interview.

5. The risks, discomforts and inconveniences associated with the above procedures might be:

During or after this interview process you may experience some psychological distress, due to expressing some sensitive information. This interview asks you to express some experiences that may have been painful or psychologically burdensome to you. Participants will be provided with information for National Alliance on Mental Illness (NAMI) at 1800-950-6264, or text “NAMI” to 741741 for 24/7 crisis counseling.

6. The possible benefits of the procedure might be:
   a. Direct benefit to me: You will receive a $20 VISA gift card for your participation in the interview. You may also benefit from sharing and processing your personal experiences and stressors.

b. Benefits to others: Potential benefits to others may be reading and relating to your personal experiences, which shall remain anonymous.

7. Personal identifiers will be removed and the de-identified information may be used for future research without additional consent.

8. Information about the study was discussed with me by Elizabeth Dumayne. If I have further questions, I can contact her at [redacted].

9. Though the purpose of this study is primarily to fulfill my requirement to complete a formal research project as a dissertation at Antioch University New England, I also intend to include the data and results of the study in future scholarly publications and presentations. Our confidentiality agreement, as articulated above, will be effective in all cases of data sharing.

If you have any questions about the study, you may contact Elizabeth Dumayne via email at [redacted].

If you have any questions about your rights as a research participant, you may contact Kevin Lyness, PhD at [redacted].

I, ____________________________ understand and consent to all of the stipulations outlined above.

____ _________________________

Signature Date

____ _________________________

Print Name Date

Thank you for your participation!

Sincerely,

Elizabeth A. Dumayne, MA

Ph.D Candidate

Antioch University New England

APPENDIX C: INTERVIEW PROTOCOL

- **Who do you plan to interview?**

I plan to interview licensed marriage and family therapists that provided teletherapy to couples and families during the ongoing COVID-19 pandemic within the United States. I am not limiting participants to agency based or private practice. Participants will not be limited on the amount of time they have worked with their clients.

- **Where do you plan to interview your participants?**

Due to the ongoing COVID-19 pandemic, I will be conducting interviews via Zoom. I shall plan for a back up platform such as Skype or via telephone if necessary.

- **How long will your interviews last?**

The interview will last between 60-90 minutes long as the participants' experiences may vary.

Interview Questions

- What have your experiences of providing relational teletherapy to couples and families since the COVID-19 pandemic started?
  - What was your previous experience providing teletherapy to clients?
  - What resources and/or training did you receive/ have available to you?
  - What are the challenges you've experienced or encountered while providing relational teletherapy?
  - What are the benefits you've experienced or encountered while providing relational teletherapy?
  - Would you have done anything differently? If so, please explain.
  - How has the ongoing COVID-19 pandemic impacted your clinical practices and experiences?
- What have been your self-care practices during the ongoing pandemic?

- How have those changed or been impacted since the beginning of the COVID-19 pandemic?
- What is your daily experience of balancing your teletherapy work and your self-care practices?
- What have been the benefits you've experienced as you balance teletherapy and self-care practices?
- What have been the challenges you've experienced as you balance teletherapy and self-care practices?
- Would you have changed your self-care practices or done anything differently since the pandemic began?
- What stressors do you continue to experience as the COVID-19 pandemic continues? (Meeting in-person again, differences in mask mandates, etc).

Additional Probing Questions:

-What does this change mean for you on a daily basis?

-What do you mean by the word "X"?

APPENDIX D: IRB APPLICATION

1. Name and mailing address of Principal Investigator(s):

Elizabeth Dumayne

For faculty applications, Co-Principal Investigator(s) name(s):

2. Academic Department: Couple and Family Therapy

3. Departmental Status: Student

4. Phone Number: (a) Work (b)

5. Name & email address of research advisor: Lucy Byno

a) Name of research advisor

Lucy Byno

b) E-mail address of research advisor

6. Name & email address(es) of other researcher(s) involved in this project:

a) Name of Researcher(s)

Jinsook Song & Janet Robertson

b) E-mail address(es)

7. Project Title: The Experiences of Marriage and Family Therapists Balancing Relational Teletherapy

and Self-care During the COVID-19 Pandemic: An Interpretative Phenomenological Analysis

8. Is this project federally funded: No

Source of funding for this project (if applicable): Self-Applicant

9. Expected starting date for data collection: 03/13/2022

10. Expected completion date for data collection: 04/15/2022

11. Project Purpose(s): (Up to 500 words)

In March of 2020, the World Health Organization (WHO) officially declared a global pandemic due

to the spread of Coronavirus (COVID-19). Since this declaration, COVID-19 has spread like wildfire across the globe, even with mandates of social distancing, quarantining, and enforcement of wearing masks in public settings. Utilizing the theoretical framework of Bronfenbrenner's (1979) ecological systems theory, the global pandemic has impacted everything in the entire ecological system, creating a cascading effect on the other systems, such as state regulations, mental health agencies, clients and marriage and family therapists; including their clinical work and self-care.

This study will explore the impacts of the ongoing COVID-19 pandemic on marriage and family therapists and how their experiences of balancing their relational teletherapy practices and their own self-care. The present study is designed to investigate the following question:

How has the shift and practice of teletherapy impacted marriage and family therapists professional therapeutic work and personal self-care practices through the ongoing COVID-19 pandemic?

The present study is an Interpretative Phenomenological Analysis (IPA); a qualitative research approach that examines how people make sense of their major life experiences (Smith & Shinebourne, 2012). IPA research gives voice to the individual's narratives of their experiences and analyzes the psychological process of the stories of the participants (Smith, 2004). The main objective of interpretive phenomenology is to uncover or disclose a phenomenon by pulling away layers of forgetfulness or hiddenness that are present in our everyday existence (Frechette et al., 2020). An interpretative phenomenological analysis is the best fit for this study because this researcher is curious about how the everyday experiences of marriage and family therapists' might have changed because of the length and breadth of the pandemic experiences.

The purpose of this study is to gain an understanding of the experiences of marriage and family therapists working with families and couples during the COVID-19 pandemic and how they transitioned to relational teletherapy practices and continued to manage those teletherapy practices while engaging their own personal self-care.

This researcher plans to disseminate findings by first summarizing the entire study. Then, relating findings to and differentiating from findings within the literature review, identifying limitations, and gaps within the study. This will then allow this researcher to relate the study to

possible future research and develop an outline for a future study (Creswell, 2012). This researcher has a personal connection to the topic, I could then relate study to personal outcomes, professional outcomes, and social meanings and relevance. Within the conclusion, future research studies will be addressed and a review of the findings will be stated. This researcher plans to submit this study for publication upon completion and defense.

12. Describe the proposed participants- age, number, sex, race, or other special characteristics. Describe criteria for inclusion and exclusion of participants. Please provide brief justification for these criteria. (Up to 500 words)

In order to recruit a homogeneous sample pool, participants must meet the following criteria: licensed marriage and family therapist (LMFT) prior to the beginning of the COVID-19 Pandemic; switched from in-person to remote tele-therapeutic services at the beginning of the the COVID-19 pandemic (March 2020); practiced relational teletherapy with clients for at least three month; and have access to internet, including email, video conferencing (i.e., ZOOM), and telephone.

In phenomenological research, the size of the participant pools can be between two and twenty-five (Alase, 2017). IPA studies are conducted on smaller sample sizes as the aim is to find a reasonably homogeneous sample, so that, within the participant sample, researchers can examine convergence and divergence in some detail (Alase 2017; Smith & Osborn, 2007). A small sample size is not seen as a limitation in IPA studies, since the primary objective is not generalizability, but to illuminate the lived experience and context in as much depth as possible (Frechette et al., 2020). Upon approval from the Antioch University New England's Institutional Review Board, a sample of two to twenty-five participants will be recruited through purposive

sampling. Smith et al. (2009) stated that, "samples are selected purposively, rather than through probability methods, because they can offer a research project insight into a particular experience" (p. 48). Additionally, due to the homogeneity of the research participants and the size of the sample pool, it is anticipated that this IPA research study will be rich and descriptively deep in its analytical process (Alase, 2017). This researcher will end recruitment once the participants provide a good depth of information, as evidenced by similar experiences and themes arising in the participants' interviews.

13. Describe how the participants are to be selected and recruited. (Up to 500 words)

Alase (2017) suggests that, in IPA participant selection and invitation processes, there are multiple ways to select and invite participants to a research project; an example is to send invitations to prospective participants. Potential participants will receive an invitation to join this study via email. In addition to that, if for any reason the number of participants is not reached, a snowball strategy will be applied to help attract more participants to the research based on soliciting the advice and help of the participants who have already agreed to participate in the research project to help 'put in good words' to attract other participants to join in the research project (Alase, 2017). Invitations for participation will also be sent to the program directors of CFT programs within Antioch University to share with prospective participants among colleagues. If the participant sample size is not met from the first round of email invitations, then online social media groups (i.e., Facebook, Linkedin) will be utilized that are specific to clinicians who have been practicing teletherapy during the pandemic. A virtual recruitment flyer, (Appendix A) will be posted inviting any licensed marriage and family therapist interested in sharing their experiences of working with clients during the COVID-19 pandemic to contact this researcher via AUNE university email. The participants that meet the required criteria will be

invited to schedule an interview.

14. Do you have a prior or current relationship, either personal, professional, and/or financial, with any person, organization, business, or entity who will be involved in your research?

No

15. Describe the process you will follow to attain informed consent.

Prior to conducting semi-structured interviews, participants will be provided with information about the purpose of the study as well as an Informed Consent form (see Appendix C). All participants will be informed about their confidentiality and asked to voluntarily sign the electronic consent to participate. Throughout the recruitment and interview process, participants will have opportunities to ask questions and seek clarification on the research study. If participants require further explanation or questions in regards to the AUNE's research process and their rights as human participants, they may contact the Dr. Shawn Fitzgerald, AUNE Provost or Dr. Kevin Lyness, IRB Committee Chair (Appendix B).

Each participant will be entered into a drawing to win one of four $25 VISA gift cards as compensation for their participation and time after their interview is complete. The drawing will be held once the overall participant pool has been reached and the winners will be contacted via email.The participants will have the right to participate or withdraw from the research study at any time. If participants decide not to participate, they will not be penalized in any way. Participants can decide to stop participating at any time without penalties. If participants' wish not to answer any of the questions, they may opt to not answer questions or may end their participation within the research study.

16. Describe the proposed procedures, (e.g., interview surveys, questionnaires, experiments, etc). in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described. USE SIMPLE LANGUAGE, AVOID JARGON, AND IDENTIFY ACRONYMS. Please do not insert a copy of your methodology section from your proposal. State briefly and concisely the procedures for the project. (500 words)

This researcher will send out the recruitment flyer and link to the informed consent (via google forms) [redacted] to potential participants. Participants will complete the google form, providing their email and electronic signature consenting to this research study. Next, this researcher will contact the potential participants that have signed and completed the informed consent to set up the interviews. Lastly, this researcher will lead a 60-90 minute, semi-structured video interview with participants through ZOOM video conferencing application. All information collected within google forms and ZOOM interviews will be kept private and confidential. Interview guidelines including specific questions are located in Appendix C.

17. Participants in research may be exposed to the possibility of harm - physiological, psychological, and/or social - please provide the following information: (Up to 500 words)

a. Identify and describe potential risks of harm to participants (including physical, emotional, financial, or social harm).

Although the risks of participating in this study are very low, some participants may find that participating in this research study might result in stress related to sharing experiences and emotions while thinking about and sharing experiences as a clinician during the current COVID-19 pandemic. Participants will be provided with information for National Alliance on Mental

Illness (NAMI) at 1800-950-6264, or text “NAMI” to 741741 for 24/7 crisis counseling.

b. Identify and describe the anticipated benefits of this research (including direct benefits to participants and to society-at-large or others)

Participation in this study will provide participants with the benefit of sharing their experiences in research. The information they provide will help bring a greater understanding to the experiences of other clinicians in the mental health field who have been providing therapeutic services to those in need during the COVID-19 global pandemic and how they have been impacted and managing their stressors. As previously stated, participants will also be entered into a drawing with the chance to receive one of four $25 VISA gift cards upon the completion of data collection. To adhere to the IRB human protection requirements, all of the devices, techniques and strategies will only be used with the full consent and approval of the participants (Alase, 2017).

c. Explain why you believe the risks are so outweighed by the benefits described above as to warrant asking participants to accept these risks. Include a discussion of why the research method you propose is superior to alternative methods that may entail less risk.

The benefits appear to outweigh the risks to participants in this study because participants may end their participation in the study at any time. Participants may also choose to not answer questions that may be harmful or triggering during semi-structured interview. Participants will be marriage and family therapists that were part of the initial transition to teletherapy and the ability to share their experiences will provide insight to the field of MFT.

The IPA approach is flexible and responsive, and encourages an organic flow of questioning, interpretation, and meaning making as the process unfolds, for both the participant and the

researcher (Smith et al., 2009). This involves not only examining what is said, but also looking beyond the words themselves to begin questioning what those words might mean in the larger context of the experience. An IPA approach also differs from traditional phenomenological approaches because of its ability to not only identify, but it also allows one to capitalize on both convergent and divergent themes, rather than simply focusing on the commonalities (Pringle et al., 2011). Thus, an IPA approach enables this researcher to reflect on the subjective nature of reality and illuminate each participant's view of remedial education, while maintaining the validity and uniqueness of the participant in the discovery of those themes.

d. Explain fully how the rights and welfare of participants at risk will be protected (e.g., screening out particularly vulnerable participants, follow-up contact with participants, list of referrals, etc.) and what provisions will be made for the case of an adverse incident occurring during the study.

Before individuals' participate in the study, they will receive a detailed informed consent with the understanding that confidentiality will be ensured throughout the study through the process of removing all names and other identifying information from transcripts and results and utilizing a number coding system to identify each participant. Participants will also have the opportunity to be removed from the study if they are for any reason they are uncomfortable in the process. If participants are struggling during the interview process, they will be provided with information for National Alliance on Mental Illness (NAMI) at 1800-950-6264, or text "NAMI" to 741741 for 24/7 crisis counseling immediately.

18. Explain how participants' privacy is addressed by your proposed research. Specify any steps taken to safeguard the anonymity of participants and/or confidentiality of their responses.

Indicate what personal identifying information will be kept, and procedures for storage and ultimate disposal of personal information. Describe how you will de-identify the data or attach the signed confidentiality agreement on the attachments tab (scan, if necessary). (Up to 500 words)

My plan in managing the data will include the question of "why is this important?" and remind myself what the purpose of my dissertation question is throughout the research process. My plan is that with this mindset; while also keeping the original research question in mind, I will be able to ensure confidentiality and accuracy in the results. Alase (2017) suggests that an IPA research study should destroy data through deletion of any video, audio and/or taped recorded information after it has been transcribed for the safety and protection of the participants. I will be the only individual that will have access to these video recordings with ZOOM. The data will always be locked on a password protected device, that only I have access to when it is not being transcribed. I have a timeline planned out to help ensure organization and time management. Once data is transcribed and approved through participant member checking, all video recordings will be destroyed after six months up on completion of this dissertation.

19. Will audio-visual devices be used for recording participants? Will electrical, mechanical (e.g., biofeedback, electroencephalogram, etc.) devices be used? (Click one) Yes

If YES, describe the devices and how they will be used:

This researcher will be utilizing the ZOOM application to record and transcribe the audio of the semi-structured interviews with participants. The video files will be saved with the coding system stated above and stored on a password protected computer that only this researcher has access to.

20. Type of Review: Expedited

Please provide your reasons/justification for the level of review you are requesting.

An expedited review is requested due to the mid summer timeframe this researcher plans to complete this study. This researcher plans to start collecting data during the second week of March 2022.

This research has been approved for submission by my advisor and by others as required by my program (e.g., my departmental IRB representative, thesis or dissertation committee or course instructor as applicable).

No

21. Informed consent and/or assent statements, if any are used, are to be included with this application. If information other than that provided on the informed consent form is provided (e.g. a cover letter), attach a copy of such information. If a consent form is not used, or if consent is to be presented orally, state your reason for this modification below. *Oral consent is not allowed when participants are under age 18.

Attached.

22. If questionnaires, tests, or related research instruments are to be used, then you must attach a copy of the instrument at the bottom of this form (unless the instrument is copyrighted material), or submit a detailed description (with examples of items) of the research instruments, questionnaires, or tests that are to be used in the project. Copies will be retained in the permanent IRB files. If you intend to use a copyrighted instrument, please consult with your research advisor and your IRB chair. Please clearly name and identify all attached documents when you

add them on the attachments tab.

Attached.

I have agreed to conduct this project in accordance with Antioch University's policies and requirements involving research as outlined in the IRB Manual and supplemental materials.

I certify that I have attached documentation confirming completion of the CITI Modules.

Yes

APPENDIX E: PARTICIPANT RECRUITMENT EMAIL

Greetings,

My name is Elizabeth Dumayne, a doctoral candidate in the Couple and Family Therapy program at Antioch University New England, (AUNE). My dissertation research focuses on the experiences of licensed marriage and family therapists balancing relational teletherapy and self-care during the COVID-19 pandemic. It has been approved by AUNE's IRB.

The research study consists of LMFTs completing a brief informed consent via google form and participating in a 60-90 minute semi-structured interview via Zoom. Four participants will be randomly selected to win a $25 VISA gift card for participation.

I am reaching out to you to see if you would share my recruitment flyer with licensed MFTs that you may know. I am hoping to gather a diverse group of participants across the states.

Attached is my recruitment flyer and a link to my informed consent via google forms,

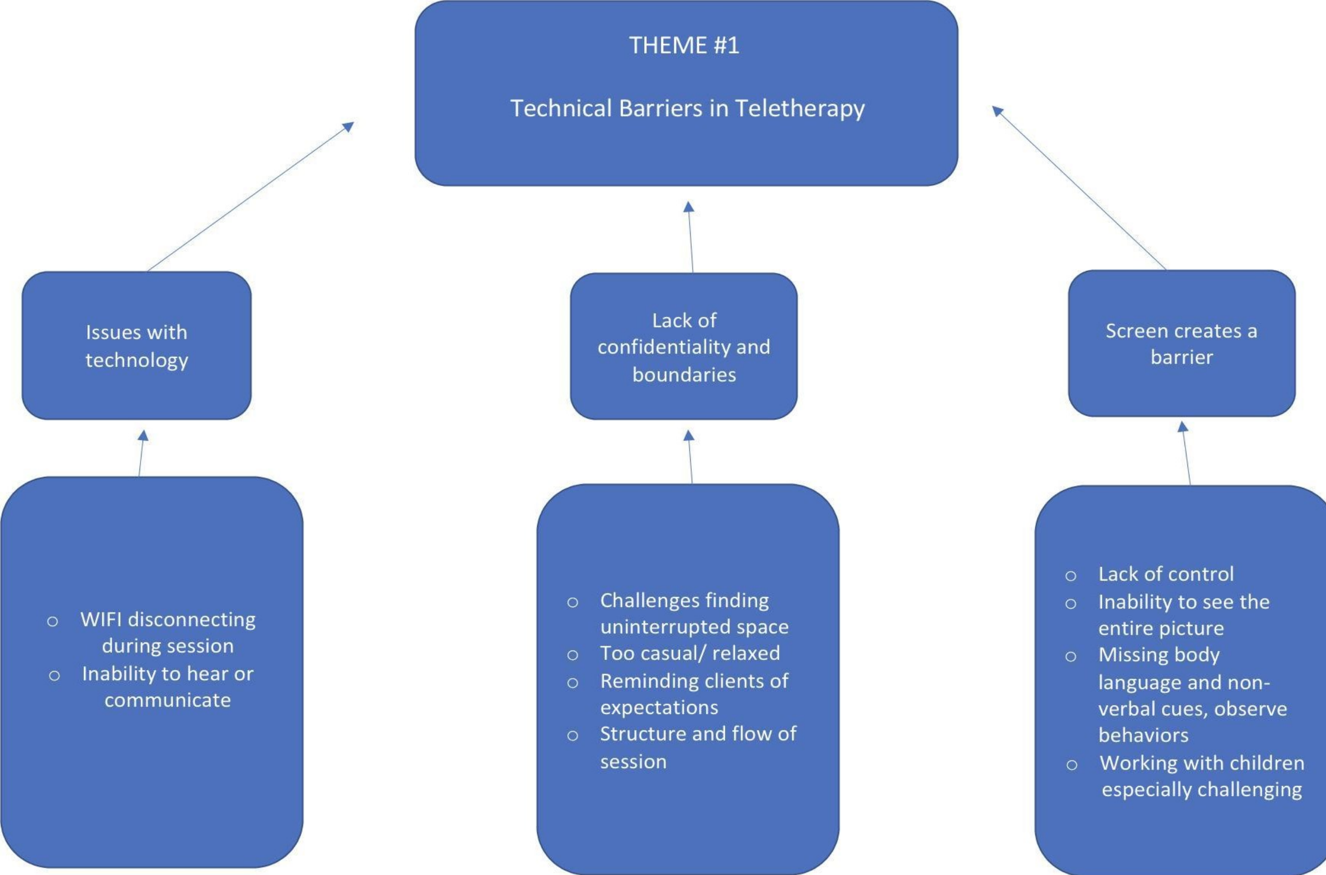
If you have any questions, I may be reached at

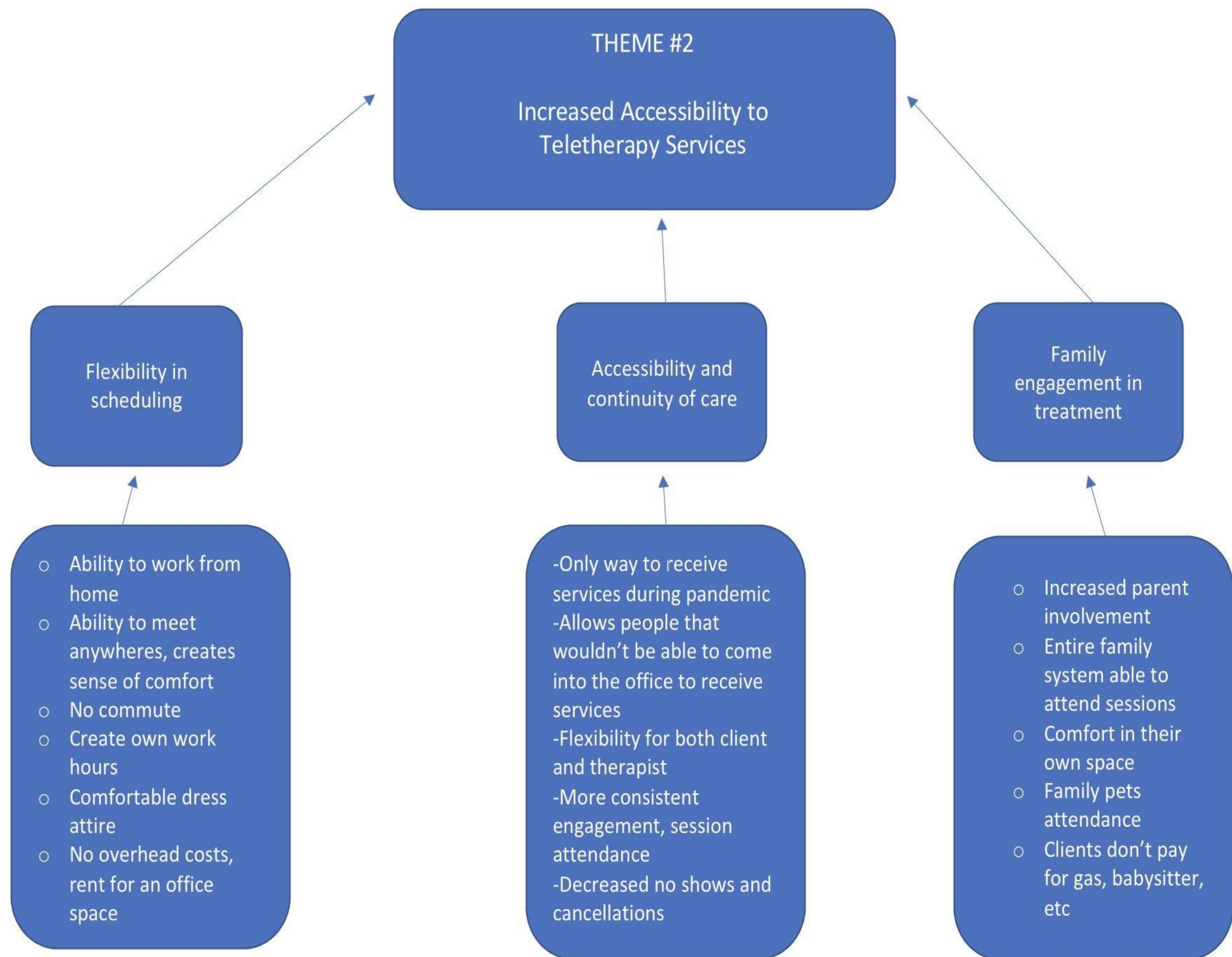
Thank you for your contribution.

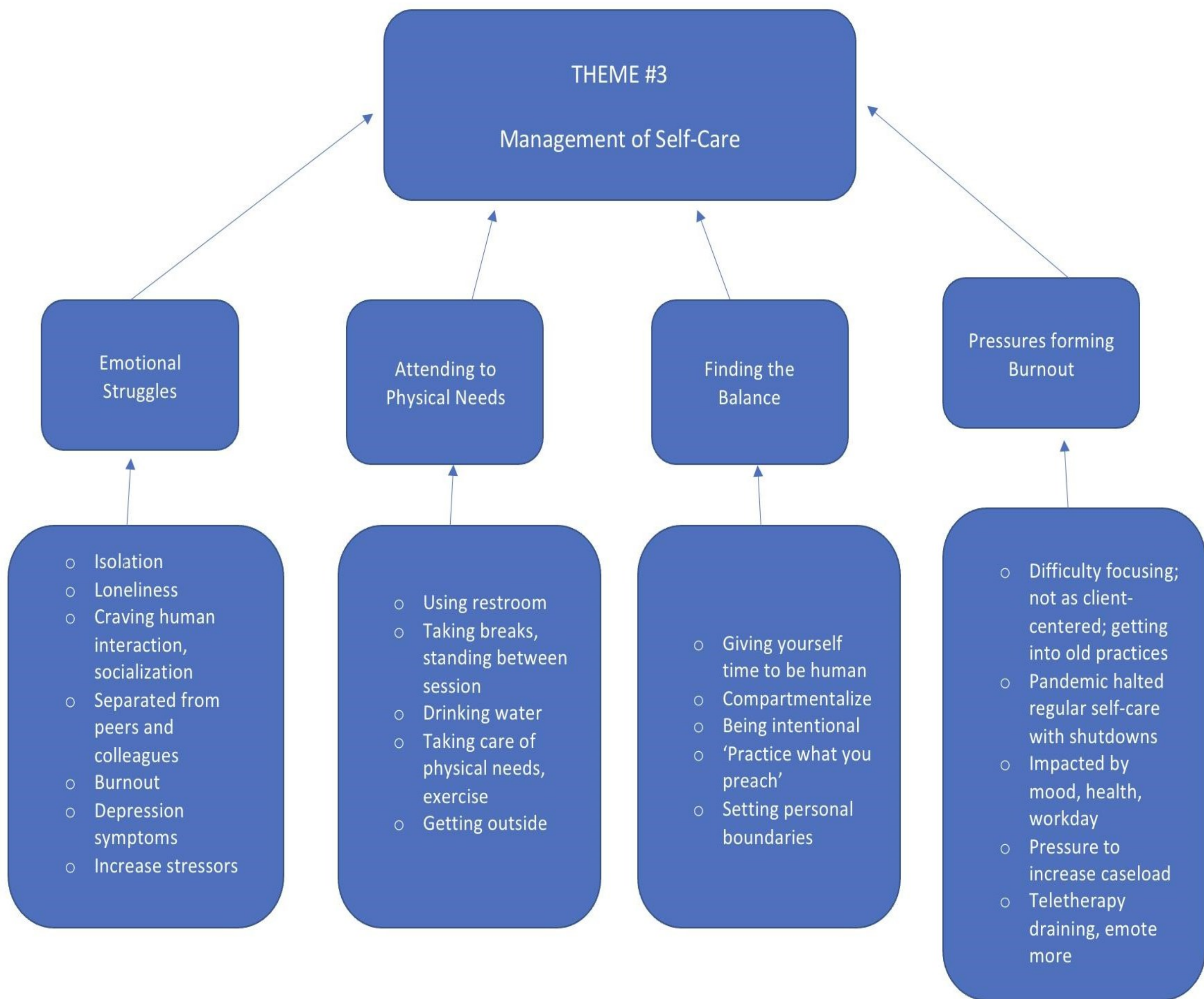
Sincerely,

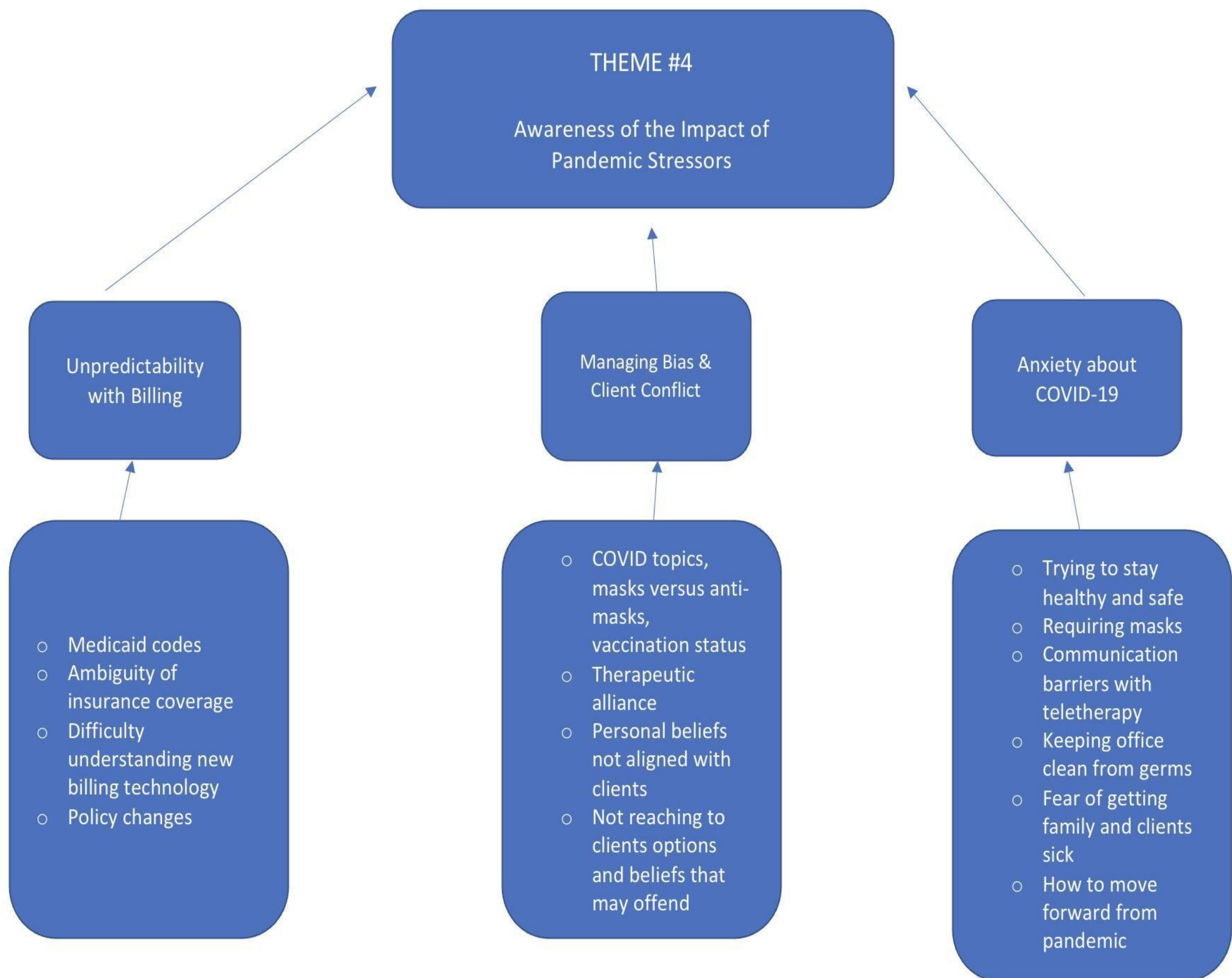
Elizabeth Dumayne, MFT

APPENDIX F: FIGURES OF THEMES & CODING PROCESS




THEME #2
Increased Accessibility to Teletherapy Services
Flexibility in scheduling
Accessibility and continuity of care
Family engagement in treatment
Ability to work from home
Ability to meet anywheres, creates sense of comfort
No commute
Create own work hours
Comfortable dress attire
No overhead costs, rent for an office space
-Only way to receive services during pandemic
-Allows people that wouldn't be able to come into the office to receive services
-Flexibility for both client and therapist
-More consistent engagement, session attendance
-Decreased no shows and cancellations
Increased parent involvement
Entire family system able to attend sessions
Comfort in their own space
Family pets attendance
Clients don't pay for gas, babysitter, etc


THEME #3
Management of Self-Care
Emotional Struggles
Attending to Physical Needs
Finding the Balance
Pressures forming Burnout
Isolation
Loneliness
Craving human interaction, socialization
Separated from peers and colleagues
Burnout
Depression symptoms
Increase stressors
Using restroom
Taking breaks, standing between session
Drinking water
Taking care of physical needs, exercise
Getting outside
Giving yourself time to be human
Compartmentalize
Being intentional
'Practice what you preach'
Setting personal boundaries
Difficulty focusing; not as client-centered; getting into old practices
Pandemic halted regular self-care with shutdowns
Impacted by mood, health, workday
Pressure to increase caseload
Teletherapy draining, emote more


THEME #4
Awareness of the Impact of Pandemic Stressors
Unpredictability with Billing
Managing Bias & Client Conflict
Anxiety about COVID-19
Medicaid codes
Ambiguity of insurance coverage
Difficulty understanding new billing technology
Policy changes
COVID topics, masks versus anti-masks, vaccination status
Therapeutic alliance
Personal beliefs not aligned with clients
Not reaching to clients options and beliefs that may offend
Trying to stay healthy and safe
Requiring masks
Communication barriers with teletherapy
Keeping office clean from germs
Fear of getting family and clients sick
How to move forward from pandemic