ORIGINAL ARTICLE

Systemic teletherapists' meaningful experiences during the first months of the coronavirus pandemic

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Abstract

Fifty-five clinicians who provided teletherapy to couples, partnerships, families, and kin networks during the first two months of the coronavirus pandemic responded to a survey about their most and least meaningful experiences. Reflexive thematic analysis indicated that the participants experienced adjustments to their schedule or routines, they used technology glitches to promote client growth, and they altered how they engaged clients. Participants noted shifts in their personal and relational dynamics. They reported feeling fatigued and resilient. Participants described their adaptability, gratitude, digital and relational connectivity, and an ability to reframe negative experiences into opportunities for growth.

SYSTEMIC TELETHERAPISTS' MEANINGFUL EXPERIENCES DURING THE FIRST MONTHS OF THE CORONAVIRUS PANDEMIC

In March 2020, the coronavirus pandemic facilitated the need for many therapists to make a quick transition to teletherapy. Previously, teletherapy was used to treat family systems, but barriers such as a lack of training, discomfort with technology, and ethical considerations prevented many clinicians from treating clients via digital platforms (Anderson et al., 2017; Bischoff, 2004; Comer et al., 2017; Dausch & Saliman, 2009; Farero et al., 2015; Hertlein et al., 2014; Hertlein et al., 2014; Ianakieva et al., 2016; Pickens et al., 2020; Wrape & McGinn, 2019). At the beginning of the pandemic, many places in the United States determined that therapists were essential workers and permitted in-person clinical services. However, due to the risk of infection from person-to-person transfer, many therapists shifted to telehealth. Several regulatory bodies such as the Health

Insurance Portability and Accountability Act (HIPAA) adjusted their requirements temporarily to afford clients increased access to digital care during government-imposed stay-at-home orders (Office for Civil Rights, 2020).

Little is known about systemic therapists' own experiences of conducting online therapy during the early stage of a pandemic. We surveyed 55 clinicians to understand their perceptions of providing relational telehealth during the initial months of the coronavirus. The study's research questions included: What were the most and least meaningful experiences of providing relational telehealth during the coronavirus pandemic? What are the professional and self-of-the-therapist dynamics related to treating couples, families, partnerships, and relationships via teletherapy during a pandemic?

REVIEW OF LITERATURE

Burgoyne and Cohn (2020) documented how clients from across the lifespan experience telehealth sessions, tips for therapists to help clients engage, and how clinicians can translate interventions previously used in person to an online modality. Best practices for relational telehealth include the need for therapists to have sufficient technology, follow applicable licensure laws and ethical codes, verify client identity, and establish crisis interventions plans for remote clients (Caldwell et al., 2017; Pennington et al., 2017; Wrape & McGinn, 2019). Ianakieva et al., (2016) developed a model to help clinicians engage couples via telehealth. They recommended humanizing technology, taking a firm yet upbeat approach when introducing telehealth, and naming the differences between teletherapy and in-person sessions. Ianakieva et al., (2016) and Luxton et al., (2016) noted that many of relational teletherapy skills are similar to techniques used in face-to-face sessions. However, technology-mediated sessions have specific challenges 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 (Wrape & McGinn, 2019).

Barak et al., (2008) meta- related to the effectiveness of using telehealth to provide psychotherapy intervention provided support for the ethical use of clinical teletherapy. Pre-coronavirus, Bischoff (2004) recommended teletherapy if certain conditions such as cost, quality of connectivity, and client protections were met. Bischoff (2004) was guarded about using telehealth when more than one person was in session. However, Dausch and Saliman's (2009) case vignette showed promise when using telehealth to provide family-focused treatment to a veteran with traumatic brain injury. Later, Bischoff and coauthors advocated for the use of systemic telehealth with military families and in instances where there may be barriers such as access to treatment or stigma (Farero et al., 2015). Mogil et al., (2015) work with military families further supported using technology to reduce obstacles in providing systemic treatment.

More recently, Comer et al., (2017) compared using in-person sessions and videoconferencing to provide family-based cognitive behavioral treatment for obsessive–compulsive disorder. Results indicated no significant differences between the two groups' outcomes. Moreover, using teletherapy to provide family-based treatment for adolescents with disordered eating showed promising outcomes (Anderson et al., 2017). Families in Sibley et al., (2017) study indicated high satisfaction with teletherapy even with minor technological glitches. Therapists reported that teletherapy enhanced treatment for half of families in the study.

Pickens et al., (2020) surveyed 95 faculty members in Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)-accredited programs about their perceptions of using telehealth in clinical education. Despite studies that show telehealth's effectiveness, many systemic training programs did not incorporate teletherapy into clinical education before the coronavirus

pandemic. Participants noted multiple barriers such as educators having little or no training in tele-therapy, accreditation standards that prohibited counting telehealth hours toward the clinical hour component, complex and varied insurance and licensure regulations, and level of faculty's interest. These results resonate with Hertlein, Blumer, and Mihaloliakos (2014) study that suggested clinical issues such as confidentiality, challenges to building rapport, addressing risk, licensure concerns, and deficits in training as concerns regarding transitioning to telehealth. Prior to the coronavirus, many training programs did not provide students with telehealth experiences. Springer et al., (2020) phenomenological study's findings suggest that students and recent graduates desire more telehealth training to translate verbal and nonverbal cues to an online setting, increase therapist spontaneity, resolve technology issues, and provide client-centered services.

There is no precedent for providing telehealth therapy during a pandemic. Extant literature provides guidance for therapy during crises (Boss et al., 2003, 2016; Kanel, 2019). Research advises therapists to use attending skills to explore precrisis functioning, assess resources and coping mechanisms, and dialogue about how clients make sense or meaning of difficult events. However, the coronavirus created multiple changes for family systems and their communities (Roland, 2020), and clinicians should proceed cautiously when applying existing research to the current situation.

The emerging literature about providing systemic therapy during the coronavirus pandemic suggests that relational telehealth is needed and supports relationships in distress (Burgoyne & Cohn, 2020; Günther-Bel et al., 2020; Long, 2020; Roland, 2020; Stanley & Markman, 2020; Walsh, 2020). Stanley and Markman (2020) advocated for couples living amid a global crisis to increase their physical and relational safety by attending to their partnership (e.g., focusing on the positive and taking responsibility for action). Systemic teletherapy is one way for couples, families, and other relationship networks to find support during a pandemic.

There is a gap in the literature regarding what it is like for systemic clinicians to provide relational teletherapy services during a pandemic. When Rolland (2020) applied the family system illness model to working with client systems affected by the pandemic, he called for health-care clinicians to engage in self-care to protect against caregiver vulnerability. Burgoyne and Cohn's (2020) article had a paragraph on the self-of-teletherapist experiences (i.e., working through Zoom fatigue). Long (2020) provided clinical interventions (e.g., project voices, increase energy, and use experiential techniques), but did not focus on self-care techniques. Thus, it is important to hear the voices of participants who provided relational teletherapy during the early months of the coronavirus pandemic.

METHODOLOGY

This study's qualitative methodology was reflective thematic analysis (Braun & Clark, 2006, 2019). Utilizing critical incident prompts inspired by Piercy et al., (2016), the author developed a Qualtrics survey. Fifty-five licensed therapists shared their experiences of providing teletherapy to couples, families, partnerships, and kin networks during the early stage of the coronavirus global pandemic.

Procedures

The survey's introduction contained a brief overview of the study. Participants could be either full or provisionally licensed clinicians. Participants could opt into a drawing for one of four $25 gift cards.

The author's Institutional Review Board (IRB) determined that this study was exempt from review. The survey included an informed consent, which defined the study's purpose, risks, benefits,

incentives, confidentiality statement, a notice of the right to withdrawal, and an offer to obtain a summary of the results. To consent, participants clicked yes and continued.

Through the survey, we queried if participants currently provided teletherapy services to multiple clients in a session. If no, responses were not included in analysis. Participants indicated license type, how many years licensed (for longest held license), the number of years as a teletherapy provider, pre-coronavirus teletherapy experience, and the level of telehealth training completed. Demographic questions assessed gender, age, and ethnicity.

Open-ended questions centered around meaningful positive and negative experiences (e.g., What gives or draws away your energy, joy, and warmth?). Other qualitative prompts included questions about personal experiences (e.g., How has providing relational telehealth services affected you? How has providing relational teletherapy affected your clinical practice?). The final question was an open-ended prompt for additional thoughts.

Participants

To recruit participants, the researcher sent the Qualtrics link with a brief description of the study to several COAMFTE programs' graduate lists, the COAMFTE program director forum, colleagues, multicultural counseling associations, and relevant social media sites (e.g., therapist groups on Facebook). The survey opened on May 14, 2020, and closed on June 5, 2020. During this time, 90 people started the survey. Reasons for excluding responses included marking no on the informed consent, not providing relational teletherapy services, and not answering at least two open-ended questions. The total number of participants was 55. Per the assumptions of qualitative research, the findings are not generalizable beyond the participants of this study (Creswell, 2014).

Participant demographics table

The Table below describes participant demographics (Table 1).

TABLE 1 Demographics of participants

Demographic	Participants	
	n	%*
Total	55	100
Clinical license		
LMFT/A	38	69%
LMHC/A	09	16%
Psychologist	04	07%
Clinical social worker	04	07%
How many years licensed		
0–5	22	40%
6–10	13	24%

TABLE 1   (Continued)

Demographic	Participants	
	n	%*
11–15	03	06%
16–20	07	13%
Over 20	10	18%
*Gender		
Nonbinary or fluid	01	02%
Female	47	85%
Male	06	11%
No response	01	02%
Age		
21–39	03	05%
31–40	17	31%
41–50	21	38%
51–60	11	20%
Over 60	02	04%
No response	01	02%
*Ethnicity		
Asian	03	05%
Pakistani-Asian	01	02%
Asian and White	02	04%
Black or African-American	05%	
Latinx	02	04%
Latinx and White	01	02%
White	42	76%
Human race	01	02%
Number of years as teletherapy provider		
0–5	47	85%
6–10	04	07%
11–15	03	05%
Over 15	01	02%
Provided telehealth before COVID−19		
No	34	62%
Yes	21	38%
Training in telehealth		
Minimal	28	52%
Moderate	23	42%
Significant	02	04%
No response	02	04%

* Notes: Percent may not equal 100 due to rounding. Participants could indicate more than one response for ethnicity and gender; data recorded as provided.

Coders as instrument

The author identifies a White, heterosexual, cisgender female who has been a systemic therapist for 23 years. She is a program director and professor of a COAMFTE-accredited program and provides telehealth supervision but does not currently treat teletherapy clients. In order to limit researcher bias and increase trustworthiness (Morrow, 2005), the author recruited a coder to assist with data analyses. The coding assistant is a White, heterosexual, cisgender male who works with the author as a part-time academic specialist. He had graduate-level training in qualitative methodology. Additionally, the assistant coder is a licensed marriage and family therapy associate in private practice, who transitioned to telehealth in March 2020.

Coders reside in a major (region-blinded) metropolis where there was an increase in Black Lives Matter protests after May 25, 2020, the day police killed George Floyd and during the time data were collected. During data collection, coding, and analysis, there were major global and regional social, environmental, and political events. The coders debriefed how their systemic context held potential to affect data analysis and interpretation. They agreed that current social political events did not unduly affect the analysis.

Data analysis

Reflexive thematic analysis (Braun & Clark, 2006, 2019) identifies patterns of perception and meaning among participants who share common experiences. Researchers read the data, generate codes to label participants' critical statements, and group similar codes. Grouping goes beyond finding similar domains to identifying clusters of meaning, which become the finding's themes.

First, the author downloaded the Qualtrics responses into an Excel chart. Data were stored on an encrypted and secure platform. Data was analyzed as one grouping and subgroup clusters. Clusters included license type and if participants provided teletherapy pre-COVID.

The coding team soaked themselves in the data by reading the survey's responses independently multiple times (Creswell, 2014). At a meeting to compare independent analysis of 45 responses, the coders identified nearly identical themes, although the nomenclature differed slightly (e.g., changes in professional landscape vs. changes in schedule and routine). Emerging themes were technology impacts, changes in professional landscape, clinical conceptualization, and self-of-the-therapist dynamics. Each coder had an additional theme that the other did not identify. After discussion, the coders determined three themes. Ten additional surveys were coded to determine saturation (Creswell, 2014). After independently and collectively verifying the themes, the coders confirmed that there were no unresolved disagreements about themes or the analysis process.

FINDINGS

The coders identified three themes: (1) biopsychosocial self of the teletherapist dynamics, (2) changes to professional landscape, and (3) shifts in clinical conceptualizations. The finalized themes presented below use participant quotes to increase trustworthiness and authenticity (Creswell, 2014; Morrow, 2005). Quotes have been edited lightly. Participants and therapists are used interchangeably, for readability. Pseudonyms protect participants' anonymity.

Theme 1: Biopsychosocial self-of-the-teletherapist dynamics

Participants documented the personal and relational effects of providing relational telehealth services during the early months of the coronavirus. Physically, participants reported feeling discomfort from sitting at the computer for long periods. They experienced eyestrain, blurred vision, and motion sickness. Jordan, in their 30 s, a White nonbinary or fluid gender LMFT who has been licensed for less than 5 years, spoke for the fatigue felt by many by writing that providing systemic teletherapy in a pandemic "has made me tired." Likewise, Ben, a White, male LMFT in his 50 s who has practiced for a decade echoed, "It's exhausting. My body hurts in weird ways. I am also more mentally and emotionally exhausted."

Emotionally, participants stated they felt less confident, more anxious, and stressed. Jordan continued, describing an "increased emotional vulnerability." Participants worried about their clients and themselves. Several participants shared they were not sure they could maintain providing telehealth services given their level of fatigue. Mary, in her 50 s, a White LMFT who has practiced for a decade and transitioned to telehealth at the start of the pandemic wrote, "it takes more energy." She described providing teletherapy as "bitter and punishing." Ruby, a White LMFT and psychologist with over 20 years of experience, wrote that she felt "trapped in a room where everyone signs in and out (except for me). It feels much like…watching a Netflix series that I would not choose to watch."

Socially, many participants expressed feeling less connected to family, friends, and colleagues. Ruby continued,

> I would never describe myself as an introvert, but now more than any other time in my life, by the fifth day of providing therapy, I don't want to talk or listen to anyone and would really like to be by myself.

Other participants agreed, saying that they wanted to be alone more and often avoided non-therapy online encounters such as using social media or connecting with their support systems via technology. However, Dani, a White LMFT in her 30 s, wrote, "it's terribly lonely without the brief snippets of conversations I usually have with fellow therapists around the office suite."

Participants wrote about the effect telehealth had on their boundaries. A participant worried about their own privacy and if the client could see the therapist's family members or guess the location of the therapist's house. Lori, a White LMFT in her 50 s who provided telehealth before the pandemic, stated,

> Some of my clients are rather scary, and it is difficult for me to have them "in my home," so setting emotional boundaries has been important. On the other hand, there is a level of intimacy and closeness that comes with having a client talk into my ear (through the headset) and having them on my screen. More than one client has commented on this. I have had to be very careful to sequester myself away from others living in my home for purposes of confidentiality and privacy.

Similarly, Allison, a White psychologist in her 40 s with at least 16 years of experience of experience including providing telehealth pre-pandemic, responded that "when I am providing telehealth from home (during COVID), it has been difficult to transition into personal time, manage my own and family members' frustration, and multitask (i.e., check on my child's schoolwork during a break)." Participants indicated that it was difficult to share a small space with roommates or family while protecting client confidentiality.

The biopsychosocial self-of-the-therapist dynamics were not all negative. Participants reported greater self-compassion, feeling creative, an increased trust in themselves, and gratitude for employment and an ability to connect with clients. Jeney, in her 20 s, a female, Asian-White LMFT who provided telehealth before the pandemic, wrote that she was able to "witness/be a part of a genuine connection." She continued, "I am grateful to be able to continue to support clients and continue to feel valuable and helpful." Kim, in their 40 s, who identifies as Asian who has been licensed as an MFT for at least 16 years and did not provide teletherapy pre-coronavirus, echoed, "When I helped the couples finding connecting their current conflicts during COVID-19 to their relationships attachment trauma and/or childhood attachment trauma, I was able to help them use this crisis to become an attachment repairman."

Many participants reported a happy surprise with how well some of their clients transitioned to telehealth, found the needed support, and stayed connected during a difficult time. Dani wrote that she felt "connected with my clients despite the screens." Multiple participants reported valuing the increase of connection with their own families between sessions. Pam, a White LMFTA in her 30 s, wrote, "I appreciate being in my own house with supportive loved ones after difficult sessions are over." Other therapists agreed that they benefited from the proximal presence of their human and animal companions.

Theme 2: Changes in professional landscape

Participants articulated changes to their professional landscape such as adjustments to their schedule or routines, altering how they engaged clients, and using technology's hardships clinically. Martha, a Black LMFT licensed for less than 5 years who provided telehealth before the pandemic, stated she had "more flexibility" and additional openings in her schedule since she needed "less time between clients to clean up or organize." Other participants mentioned taking "more breaks" between sessions. Many therapists preferred to spread sessions out during the week, which they reported as different from their in-person method of seeing several clients back-to-back. Ella, a White recently licensed clinical social worker in her 50 s, said, "no more night sessions—yay."

Participants highlighted safety and confidentiality as important concerns in the landscape of relational telehealth. Val, in their 20 s, a White professional counselor licensed for less than 5 years said, "it's hard to ensure confidentiality and safety. I often find myself wondering about safety for clients due to the uncertainty of whether they have full confidentiality and privacy." Avery, a White, female LMFT in her 40 s who has practiced over 10 years, wrote, "it can be more challenging to provide couples therapy when children are around and can interrupt the session. There is benefit to seeing couples interact with their children, but more often it can be a distraction."

Several participants reported that their client demographics were more diverse ethnically and regionally. Former clients who had scheduling conflicts returned. Nina, a White LMFT who has practiced for over 15 years, said, "there has been some more freedom or choice for members to join for part of the session, particularly for someone to come when they were ready." Ellie, a White licensed clinical social worker in her 40 s, noted there was an "ability to connect with clients in convenient ways. It helps meet people where they are at right now." A few participants indicated being flexible with policies. For example, Amy, an Asian-White LMFT, offered "shorter sessions." There was a mixed account of the number of the weekly number of sessions increasing or decreasing. All but one participant who wrote about cancelations said there were less. David, a White seasoned therapist dually licensed as an LMFT and clinical social worker, saw more consistency and a need for logistical follow-up:

The show rate with telehealth is higher. I have had zero cancellations or no-shows since starting with telehealth a few months ago. At the same time, it seems that there has been more clients who do not schedule their next appointment as soon as they did—requiring an additional phone call.

Both new and veteran systemic teletherapy providers reported experiencing technological glitches such as screen freezes and Internet services cutting out. These malfunctions contributed to feeling a sense of disconnection from clients and the profession. Beth, a White, female LMFT in her 40 s who has practiced for over 20 years and did not provide telehealth before the pandemic, wrote, "screens freezing, loss of audio, disconnection, pixelated images contribute to frustration, disconnect, and possible burnout. It feels like we're wasting time when we have to deal with technology problems and I wonder how long clients will tolerate the disruption."

While acknowledging that using online services presented technological difficulties, many participants used the current situation to foster connections with telehealth clients. Kelly, 40 s, a White LMFT who had been practicing for at least 15 years and did not indicate gender, noted, "bringing humor into our unusual circumstances can foster connection." Participants said that they were able to use a platform familiar to younger clients, especially adolescents. June (30 ish), a White LMFT with over 10-year experience, wrote,

> I am able to connect with clients and they are able to open up as they would in the office or even more so in some cases as they are in their own environment. It is also a joy to see how children and young adults engage with this medium for me.

Several participants wrote that teletherapy provided a clear boundary for session times. Taylor, in her 40 s, who identified as a White nonbinary or fluid female LMFTA, used technology to help set a boundary: "when the session is over, it is like an immediate flipping of a switch." Taylor reported this felt "weird," but it was an "easier break."

Therapists reported monitoring different cues to assess rapport and the level of connection among clients and with the therapist. Kathy, 40 s, a seasoned LMFT who has provided telehealth for 15 years, stated:

> It is difficult to exchange eye contact or extended gazes, so I notice I am relying on tone of voice and smiles or other facial expressions as well as breathing observations to monitor rapport and mutual understanding between myself and the clients.

Moreover, participants opined that they could only hear one client at a time and they could not see body language and emotions. Ben lamented, "it's hard to see their faces clearly, it's hard to see nuances of emotions. I can't see their whole-body language. We get interrupted by cats and kids and phones and on and on." Dani agreed, "I feel like I'm not as good of a therapist without the ability to see full body language and feel the moods of the client as they arise in session."

Many participants found it harder to interact with relational clients. Avery said, "I try not to take on too many relational clients as I do find they take more energy." Martha said, "when couples or families start to argue, I find it hard to interject." Taylor worried about clients having an "easy out" by turning off the sound or video. And many participants found that it was harder for the therapist to direct clients' attentions to each other instead of the therapist. Pam wrote,

> When members of a system relate to me on the screen instead of each other it seems to take away from the work and I often redirect hem to face each other. I have had members

of a family system refuse to be on screen or talk, which is even more challenging over video.

Some participants transformed barriers into benefits. For example, Clara, in her 50 s, a Latinx seasoned psychologist and licensed mental health counselor with no pre-pandemic teletherapy experience, was unable to see clients' physical styles of communication via telehealth. Therefore, she asked the clients to track and describe each other's movements:

> Technology hinders my ability to share in clients' experiences of subtle somatic changes. My inability to draw on their bodies' style of communication with the other renders me without the tools I am accustomed to having. I have found myself trying to get them to be my eyes for each other, i.e., to track the others movements/body tensions and describe their impact. The work becomes more arduous in some ways but then in other ways gives them more responsibility for making the necessary changes.

Participants indicated that they treated clients who were more willing to open up online than they were during face-to-face sessions. Clara continued, wondering if a shared physical space had the potential to make conversations too intimate:

> A great deal of my clients with developmental trauma experience a faulty social engagement in their relationships. A connection with them that was not as forthcoming prior to our moving treatment to a telehealth approach. Recently, I asked myself how much of this connection is about the barrier between the couple and me. Is the barrier somehow safer for me—is it somehow safer for them? One client said that he found that being in the same room with me was too intimate. That resonated with me also.

Theme 3: Shifts in clinical conceptualizations

Providing telehealth to relational clients during a pandemic shifted how many participants conceptualized their clients. Gaby, a White LMFT for less than 6 years who is in her 30 s, wrote that she "tries to hold more space for ambiguity and see how things unfold over time, and not be too quick to conceptualize." Taylor wrote that they were "using broader strokes and theme-based conceptualizations, perhaps more problem solving in a pragmatic sense." Ellie echoed, "I have not been able to structure family sessions in some cases as I normally would, e.g., instead of whole family, I now prioritize the parent subsystem." Other participants reported adapting or not using certain models or techniques, especially Eye Movement Desensitization and Reprocessing (EMDR). Beth indicated,

> I know that some clients can be more difficult to engage over telehealth. I feel that clients who are less verbal and children are more difficult to engage with over telehealth. I miss being able to use my EMDR equipment in my office to get to the somatic, deeper root of issues.

Several participants noted that it was harder to work with children and their shorter attention spans. Jordan indicated, "I have struggled with engaging child clients over telehealth." Mia, a Latinx LMFTA in her 40 s, wrote, "it has been difficult to assess the client's symptoms without using the materials, and

techniques that require a space where the clinician and client are present (art, sand play therapy, card games, etc.)."

Erin, a White LMFT in her 30 s, increased her attention to clients' context. Telehealth afforded her the opportunity to "see the home environment of clients…and meet family members/pets that I have not otherwise." Two LMFTs related their experiences to conducting home visits. These participants wondered if they had a better view of clients' normative style of interactions and behaviors. Beth wrote,

> Telehealth reminds me of my days working as an in-home family therapist where you are able to experience, in a small way, what it feels to live in the home. There can be people and pets who move in and out of view, distractions, and chaos. You are able to experience more of your clients' by also observing more physical data such as colors, home furnishings, where they choose to have sessions.

Likewise, Lori reported that "seeing clients in their own homes/spaces has opened my eyes to larger relationship dynamics and conditions that are inherent in the clients' lives (e.g., power/control issues with partners present/absent, clutter, chaos, and disorganization)."

DISCUSSION

Participants' most and least meaningful experiences were clear. Throughout the responses, there was a profound negative effect on morale, especially related to personal social, emotional, and physical concerns. Therapists reported being fatigued and frustrated. While many participants expressed the losses or difficulties related to providing systemic teletherapy during a pandemic, they were also able to see their strengths. Teletherapists in this study often used the word "gratitude" or "grateful." They appreciated seeing their clients survive, grow, and have "a-ha moments." The therapists themselves adapted during an unprecedented crisis. Many actively shifted their professional landscapes and case conceptualizations to find new ways of interacting with clients.

Some participants indicated that their meaningful experiences of providing systemic teletherapy were similar to conducting therapy face to face. One of Val's most meaningful experiences was "seeing couples benefit from the skills and tools they learn, watching them come closer together and learning how to love each other well, and seeing them have progressed towards their goals." This aligns with previous telehealth research (Ianakieva et al., 2016).

It is unclear if participants were using the same theory or model to conceptualize clients as they did before the pandemic. Additional information is needed to determine which family therapy theories and models are effective for online treatment, especially during crisis situations. Moreover, future research is needed to understand how systemic teletherapists may need to adapt existing models and their interventions.

The coders were surprised that both seasoned and new systemic teletherapists experienced frustration with technological difficulties. Therapists who used telehealth prior to the pandemic described the fatigue and computer glitches similar to participants who switched to teletherapy at the start of the pandemic. Avery, who has provided telehealth for over 10 years, noted there were "issues with technology that interfere with being able to see or hear the client or interfere with them being able to see or hear me." While veteran teletherapists may have had technological experience, having additional uses on their bandwidth or platforms such as Doxy or Simple Practice could have affected services.

Additionally, using home equipment could have influenced therapists' experiences of having online sessions.

Many participants spoke about the joys and hardships related to providing therapy from their home. We did not ask where sessions were conducted or what percent of participants' caseloads were online. Thus, it was impossible to sort responses to find subthemes. Nonetheless, many participants described a sense of place and how it affected their work. Burgoyne and Cohn (2020) described how teletherapists' physical space influences therapy in both humanizing and problematic ways. Participants resonated with the ideas that clients may like having their own pets in telehealth sessions and could benefit from seeing the therapist's pets. This study adds that some therapists also may find clients' pets as a deterrent from the therapeutic process (e.g., a participant's report that "the client's cat was distracting").

Throughout the dataset, participants recounted their concerns about clients, the future of therapy, and larger social political issues. Many participants were unsure if or when they would return to in-person meetings. Safety and confidentiality were also concerns for this study's therapists, as has been documented in the literature (Günther-Bel et al., 2020; Wrape & McGinn, 2019). Participants worried about their clients. This study augments the existing research by noting that therapist may be concerned about the safety. For therapists providing telehealth from their homes, there is a concern that clients could identify the therapists' location. As the future of relational telehealth continues, protocols and codes of ethics may need to shift to address the safety of clients and therapists.

It can be difficult for telehealth therapists to balance home and work roles (Burgoyne & Cohn, 2020). The present study's participants offered examples of this struggle (e.g., having to check on a child's homework during break) and voiced concerns about the lack of energy left for caring for self and interacting with significant others. Additionally, participants enhanced the existing dialogue by describing the myriad of benefits of telehealth from home (e.g., enjoying free evenings, having access to family during breaks, and making a homemade lunch).

To create a boundary between work and home, Burgoyne and Cohn (2020) suggested the importance of establishing rituals to replace the experience of transitioning between in-person clients. One participant used the metaphor of a switch, which became a self-care boundary that delineated a separation between work and home. Future research is needed to develop resources to address teletherapy's potential compassion fatigue and burnout. Additionally, more information is needed about self-of-systemic teletherapists' dynamics.

Participants align with what is known about how nonverbal actions differ over teletherapy than in face-to-face sessions. Long (2020) and Burgoyne and Cohn (2020) documented how talking and receiving feedback from clients online differ from in-person therapy. The participants also noted lag time or Internet disruptions, hearing only one voice at a time, and not being able to see their clients' full body and nonverbal cues. They agreed they had to be more energetic and active. Participants described their resilience in the face of these barriers. They took advantage of technological glitches to promote dialogue between partners. They encouraged family members to assess one another to promote connection. They appreciated that some clients seemed to benefit from the distance created by telehealth (e.g., using the lag time to slow down the interaction or having a less intimate physical space).

A few of the study's licensed marriage and family therapists related seeing clients in their personal contexts to past experiences of providing home-based therapy. Participants documented that seeing clients' spaces afforded the therapist the opportunity to enhance their systemic conceptualizations. This is a salient area of future research. How a therapist perceives a home environment may say as much about the therapist as it does about clients (e.g., biases steeped in social locations). There is a wealth of literature from the early days of structural family therapy that describes home-based services (Colapinto et al., 1989). Are the same processes applicable for seeing clients in their living

areas without the therapist being physically in the same location? And how do the therapist's latent assessment of context affect the therapeutic dynamic?

LIMITATIONS

This study did not parse the effects the coronavirus and providing teletherapy (e.g., answer the qualitative question of how much each contributed to lower morale and weariness). We did not ask questions about clients' and therapists' physical spaces, percent of caseloads that that were individual or relational, the number of client sessions conducted via telehealth versus in-person sessions, and number of clients who transitioned to telehealth at the start of the pandemic versus who continued online therapy. Nor did we ask about the therapists' theory or model. Additionally, due to anonymous responses, participants were not afforded the opportunity to provide feedback on the data analysis, which could have increased triangulation and provided greater trustworthiness of the findings (Creswell, 2014).

The online survey format may have inhibited participants from offering robust accounts of their experiences. Future research could use interviews, which allow interviewers to draw out additional thoughts from participants. Moreover, mixed methods and quantitative studies will help the field understand and generalize therapists' experiences. This study's sample skewed White, female, middle aged, and with less than 5 years of providing telehealth. Although the researcher attempted to recruit diverse participants, the social political context of 2020 may have prevented therapists from marginalized backgrounds from participating. There is a need for continued research with diverse voices.

REFLECTION ON THE RESEARCH PROCESS

Qualitative methodology is recursive and does not take a linear approach (Creswell, 2014). Originally, the author wanted to know more about pandemic-related self-of-the-teletherapist experiences (Aponte & Kissil, 2014; Blow et al., 2007; Fife et al., 2014; Timm & Blow, 1999). While this study's findings has an emphasis on self-of-the-therapist dynamics, the coders noticed that participants were as likely to describe their clients as they did themselves, even when asked repeatedly about their own experiences. While much of the current literature focuses on what the teletherapist can do to facilitate online therapy, research must support the holistic wellness of therapists by continuing to ask, "what are systemic teletherapists' experiences of online therapy, and how do these dynamics affect treatment outcomes?".

CONCLUSION

In conclusion, the field of teletherapy is evolving, and the current pandemic has created opportunities and challenges for systemic therapists. The reverberations of the coronavirus pandemic-related transition to telehealth will reveal themselves over time. While some regulatory boards have reverted to pre-pandemic standards, it is unclear how systemic therapy education, privacy laws, insurance reimbursements, and code of ethics may change permanently.

The importance of this study is in hearing participants' accounts of providing telehealth during a unique moment in history. This study reveals systemic teletherapists' resilience. Participants described their adaptability, digital and relational connectivity, and their ability to reframe negative experiences into opportunities for growth. Participants' perceptions of self, clients, and the profession give clues to what is needed to support current and future systemic teletherapists.

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